TECHNICAL ASSISTANCE AND PROGRAM SUPPORT FOR IOWA MEDICAID

MED-19-011

STATE OF IOWA DEPARTMENT OF HUMAN SERVICES

AUGUST 3, 2018

TECHNICAL PROPOSAL

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TRANSMITTAL LETTER / BID PROPOSAL SECURITY / EXECUTIVE SUMMARY

TRANSMITTAL LETTER

The transmittal letter serves as a cover letter for the Technical Proposal. It must consist of an executive summary that briefly reviews the strengths of the bidder and key features of its proposed approach to meet the specifications of this RFP.

Mercer Health & Benefits LLC (Mercer) submits our transmittal letter in this section.

BID PROPOSAL SECURITY

The bidder shall submit a bid bond, a certified or cashier's check, or an irrevocable letter of credit in favor of or made payable to the Agency in the amount of $5,000.00. The bid proposal security must be valid beginning on the Bid Proposal due date for 120 days. The bidder understands that if the bidder elects to use a bond, a surety licensed to do business in Iowa must issue the bond on a form acceptable to the Agency. The bidder understands that the bid proposal security shall be forfeited if the bidder is chosen to receive the contract and withdraws its Bid Proposal after the Agency issues a Notice of Intent to Award, does not honor the terms offered in its Bid Proposal, or does not negotiate contract terms in good faith. The bidder further understands that the bid proposal security submitted by bidders will be returned, if not forfeited for reasons stated above, when the Bid Proposals expire, are rejected, or the Agency enters into a contract with the successful bidder, whichever is earliest.

Mercer provides a check in the amount of $5,000 in the front pocket of the original Technical Proposal. Mercer acknowledges the proposal security is valid beginning on the Bid Proposal due date (August 3, 2018) for 120 days. Mercer understands that the bid proposal security shall be forfeited if Mercer is chosen to receive the contract and withdraws its Bid Proposal after DHS issues a Notice of Intent to Award, does not honor the terms offered in its Bid Proposal, or does not negotiate contract terms in good faith. Mercer further understands that the bid proposal security submitted will be returned, if not forfeited for reasons stated above, when the Bid Proposals expire, are rejected, or DHS enters into a contract with the successful bidder, whichever is earliest.

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Katie Falls, MSW
Principal

Government Human Services Consulting
2325 E Camelback Road, Suite 600
Phoenix, AZ 85016
+1 928 606 9035
Katie.Falls@mercer.com
www.mercer-government.mercer.com

Mary Tavegia
Iowa Medicaid Enterprise
100 Army Post Road
Des Moines, Iowa 50315 :

August 1, 2018

Subject: Mercer Transmittal Letter – Request for Proposal (RFP) MED-19-011 for Technical Assistance and Program Support for Iowa Medicaid

Dear Ms. Tavegia,

Mercer Health & Benefits LLC (Mercer) is pleased to respond to RFP MED-19-011 for Technical Assistance and Program Support for Iowa Medicaid released by the Iowa Department of Health Services (DHS). As requested in Section 3.2.1, Mercer includes our executive summary in this letter.

We assert the greatest strength of our proposal is our proposed staffing. As the Engagement Leader/Account Manager, I am responsible for the overall project. I have more than 30 years of experience including extensive policy, operations, and administrative experience. My areas of expertise include policy and program development and operations for Federal and state-funded health and human services programs, strategic planning, and overseeing large-scale, multi-year, complex projects. Prior to joining Mercer, I served as the Cabinet Secretary of the New Mexico Human Services Department that administered Medicaid, behavioral health services, child support enforcement, the Supplemental Nutrition Assistance Program, Temporary Assistance for Needy Families, and numerous other public assistance programs. I am currently Mercer's Engagement Leader for Ohio and Idaho.

I will be ably assisted by our proposed Project Manager, Michele Walker, MPG, MPA. Michele has extensive project management experience with complex projects, handling communication and ensuring projects are conducted efficiently, timely, and within budget. Michele has more than 25 years of experience and held senior positions for over 17 years within the U.S. Department of Health and Human Services, including 12 years with the Centers for Medicare & Medicaid Services (CMS). In Michele's tenure with Mercer, she has been working on the design and implementation of managed care programs and statewide Medicaid managed long-term care programs, including project managing projects related to managed care procurement and evaluation, behavioral health redesign, and long-term services and supports. Michele is also a subject matter expert in Medicaid policy, having assisted several states with the development of 1915(b), 1915(c), and 1915(i) waivers and Medicaid State Plan Amendments (SPA). Michele's recent experience includes assisting a state develop a Section 1115 Substance Use Disorder Waiver.

We have identified Stefanie Kurlanzik, JD, as the back-up Project Manager. Stefanie will also serve as the Project Lead for tasks related to waivers and managed care. Since joining Mercer in 2012, Stefanie has focused on Medicaid policy consulting with a specific emphasis on assisting states and territories with developing requests for managed care contract proposals and associated program waivers and SPAs. Stefanie's recent experiences includes assisting a

Services provided by Mercer Health & Benefits LLC

Transmittal Letter
Mary Tavegia
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state draft and submit a Section 1115 waiver to implement Medicaid work and community engagement requirements. Stefanie is currently assisting the state with their Federal negotiations.

Cumulatively, our proposed team has more than 225 years of professional experience. Six of our proposed staff and our proposed subcontractor previously worked for CMS. In addition to our policy experts for waivers and managed care, our proposed staff also includes subject matter experts (SMEs) in eligibility/benefits, long-term services and supports, behavioral health, pharmacy, and payment and financing/program integrity.

The significant experience Mercer brings is important. As important, however, is the commitment of our staff to keeping abreast of new information in the changing political environment. Significant changes to rules, regulations, and policy direction have impacted Medicaid programs. We track those changes and offer training and information to our staff. For example, when the Medicaid Managed Care Final Rule was published by CMS in April 2016, in less than a month Mercer prepared and delivered a webinar to 156 state Medicaid personnel and other stakeholders regarding the sweeping changes. We had established a work group to track the various iterations of the Final Rule, thus were prepared as soon as the rule was finalized. Likewise, we have done several engagements related to Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). An interdisciplinary team of Mercer policy, clinical, and actuarial consultants have been trained and have assisted multiple states in identifying areas within the Medicaid program that will require modification to comply with MHPAEA

Section 4 of our proposal addresses our approach to the three key scope of work areas identified in the RFP: (1) technical assistance, (2) policy support, and (3) ad hoc analyses. In general, our approach to all requests includes:

- Planning – Mercer's approach to a request for technical assistance will be multi-layered, iterative, and results-oriented.
- Performing the Requested Analysis – After a clear understanding of your expectations and the perimeters of the requested analysis, we will complete the analysis.
- Finalizing the Deliverable – We will deliver the final product in the format requested by DHS. Prior to delivery, all Mercer work products undergo an in-depth peer review (quality control) process. Our goal is to exceed your expectations.

For each subtask, we outline example approaches we have employed for similar work and we provide several examples of how we have addressed other similar, client projects. For example, for the sub-task area 1.3.1.1.B related to CMS clarifications, we describe our work with Delaware. On November 1, 2017, CMS issued a State Medicaid Director letter outlining a streamlined approach for section 1115 substance abuse demonstrations seeking federal funding to provide Substance Use Disorder (SUD) services in an Institute for Mental Diseases (IMD). We were engaged by six states to provide assistance with this waiver option. Specifically, in Delaware, we prepared a policy summary chart comparing the SUD 1115 requirements to Delaware's current program for SUD treatment to identify any gaps. Ultimately, we developed the draft and final 1115 amendment for SUD and IMD.

In Section 5 we provide our background and experience. In response to 3.2.5.1.2, we provide a table with descriptions of all services similar to those sought by this RFP that Mercer has provided to other clients within the last two years. You will note we have worked with state

clients of every size, each with their own unique Medicaid program. In some of those projects we are also the actuary of record. In others, we are not. We recognize Mercer is not the actuary of record for DHS and want to assure you we can work effectively and efficiently with other vendors. We routinely work with other state vendors on projects and we are adept at managing those relationships.

Our Cost Proposal is provided separately from the Technical Proposal as required in the RFP.

We are in receipt of the following documents released after the RFP:

- Notice of Intent to Release RFP MED-19-011 released on July 10, 2018.
- MED-19-011 Resource Library released July 11, 2018.
- MED-19-011 Questions and Answers released July 17, 2018.
- Letters of Intent to Bid on RFP MED-19-011 released July 17, 2018.

As a Principal with Mercer, I am authorized to bind Mercer into contract. Should you have any questions regarding our response, please do not hesitate to contact me by telephone at +1 928 606 9035 or by email at Katie.Fallsi@mercer.com.

Sincerely,

Katie Falls

Katie Falls, MSW
Principal

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PROPOSAL TABLE OF CONTENTS

The Bid Proposal must contain a table of contents.

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RFP FORMS

The forms listed below are attachments to this RFP. Fully complete and return these forms behind Tab 3:

- **Release of Information Form**
- **Primary Bidder Detail & Certification Form**
- **Subcontractor Disclosure Form (one for each proposed subcontractor)**
- **Certification and Disclosure Regarding Lobbying**

Mercer provides the required forms in this section.

Attachment A: Release of Information

(Return this completed form behind Tab 3 of the Bid Proposal.)

Mercer Health & Benefits LLC (name of bidder) hereby authorizes any person or entity, public or private, having any information concerning the bidder's background, including but not limited to its performance history regarding its prior rendering of services similar to those detailed in this RFP, to release such information to the Agency.

The bidder acknowledges that it may not agree with the information and opinions given by such person or entity in response to a reference request. The bidder acknowledges that the information and opinions given by such person or entity may hurt its chances to receive contract awards from the Agency or may otherwise hurt its reputation or operations. The bidder is willing to take that risk. The bidder agrees to release all persons, entities, the Agency, and the State of Iowa from any liability whatsoever that may be incurred in releasing this information or using this information.

Mercer Health & Benefits LLC
Printed Name of Bidder Organization

Katie Falls
Signature of Authorized Representative

August 1, 2018
Date

Katie Falls
Printed Name

Attachment B: Primary Bidder Detail & Certification Form

(Return this completed form behind Tab 3 of the Proposal. If a section does not apply, label it "not applicable".)

Primary Contact Information (individual who can address issues re: this Bid Proposal)	
Name:	Katie Falls
Address:	2325 E. Camelback Road, Suite 600, Phoenix, AZ 85016
Tel:	+1 928 606 9035
Fax:	+1 602 522 6499
E-mail:	Katie.Falls@Mercer.com

Primary Bidder Detail	
Business Legal Name ("Bidder"):	Mercer Health & Benefits LLC
"Doing Business As" names, assumed names, or other operating names:	Not Applicable
Parent Corporation Name and Address of Headquarters, if any:	Mercer (US) Inc 1166 Avenue of the Americas, New York, NY 10036
Form of Business Entity (i.e., corp., partnership, LLC, etc.):	Limited Liability Company
State of Incorporation/organization:	Delaware
Primary Address:	2325 E. Camelback Road, Suite 600, Phoenix, AZ 85016
Tel:	Katie Falls, +1 928 606 9035
Local Address (if any):	Not Applicable
Addresses of Major Offices and other facilities that may contribute to performance under this RFP/Contract:	See Attached List
Number of Employees:	280+
Number of Years in Business:	30+
Primary Focus of Business:	Consulting Services
Federal Tax ID:	34-2015463
DUNS #:	616213125
Bidder's Accounting Firm:	Deloitte & Touche, LLP
If Bidder is currently registered to do business in Iowa, provide the Date of Registration:	October 1, 2004
Do you plan on using subcontractors if awarded this Contract? {If "YES," submit a Subcontractor Disclosure Form for each proposed subcontractor.}	YES
	(YES/NO)

Request for Confidential Treatment (See Section 3.1)		
Location in Bid (Tab/Page)	**Statutory Basis for Confidentiality**	**Description/Explanation**
None		

Exceptions to RFP/Contract Language (See Section 3.1)			
RFP Section and Page	**Language to Which Bidder Takes Exception**	**Explanation and Proposed Replacement Language:**	**Cost Savings to the Agency if the Proposed Replacement Language is Accepted**
		See Attached	

MED-19-011
Technical Assistance and Program Support for Iowa Medicaid

Attachment B: Primary Bidder Detail and Certification Form

List of Major Offices and other facilities that may contribute to performance under this RFP/Contract:

- 2325 E. Camelback Road, Suite 600, Phoenix, AZ 85016
- 3560 Lenox Road, Two Alliance Center, Atlanta, GA 30326
- 333 S. 7th Street, Minneapolis, MN 55402
- 1050 Connecticut Avenue, N.W., Washington, DC 20036

Mercer Health & Benefits LLC
Request for Exceptions
to
Request for Proposals No. MED-19-011

The following are suggestions for modifications to the materials provided by the Iowa Department of Human Services (the "Agency") in connection with the Request for Proposals No. MED-19-011 relating to Technical Assistance and Program Support for Iowa Medicaid. Mercer Health & Benefits LLC ("Contractor") is willing to discuss and consider alternatives that are mutually acceptable to Contractor and the Agency.

Prior to the commencement of any work in connection with this RFP, Contractor will work with the Agency to arrive at a mutually acceptable service agreement. Contractor's performance of Services for the Agency is subject to the negotiation and execution of such an agreement. All references are to Attachment G: Sample Contract unless otherwise stated.

Exceptions to RFP/Contract Language (See Section 3.1)			
RFP Section and Page	**Language to Which Bidder Takes Exception**	**Explanation and Proposed Replacement Language**	**Cost Savings to the Agency if Proposed Replacement Language is Accepted**
Attachment G, 1.3.3.5 Payment of Invoices, p. 32	Additional Language	Contractor's billing practices require a thirty day payment period. **Contractor's invoices shall be paid within 30 days of receipt.**	N/A
Attachment G, 1.4 Insurance Coverage, p. 33	Professional Liability Each Occurrence: $2 Million Aggregate: $2 Million	Contractor's Professional Liability insurance is procured on a "per claim" basis. Professional Liability ~~Each Occurrence~~$2 Million **per claim** Aggregate$2 Million	N/A
Attachment G, 1.5 Business Associate	The Business Associate agrees to comply with the Business Associate Agreement Addendum (BAA), and any amendments thereof, as posted	**Mercer Health and Benefits will enter into a mutually acceptable Business Associate Agreement to document our commitment to**	N/A

Exceptions to RFP/Contract Language (See Section 3.1)			
RFP Section and Page	**Language to Which Bidder Takes Exception**	**Explanation and Proposed Replacement Language**	**Cost Savings to the Agency if Proposed Replacement Language is Accepted**
Agreement, p. 33	to the Agency's website: http://dhs.iowa.gov/HIPAA/baa.	**maintaining HIPAA compliance with respect to our services.**	
Attachment G, 2.1 Definitions, "Confidential Information", p. 35	Additional Language	Confidential Information should not include: information required to be disclosed by law or court order. **(7) is required to be disclosed by Receiving Party by law or court order.**	N/A
Attachment G, 2.1 Definitions, "Confidential Information", p. 35	"Deliverables" means all of the services, goods, products, work, work product, data, items, materials and property to be created, developed, produced, delivered, performed, or provided by or on behalf of, or made available through, the Contractor (or any agent, contractor or subcontractor of the Contractor) in connection with this Contract.	Because Mercer works with many different clients, both public and private, across many different industries it is important for us to retain ownership interest in our intellectual capital. "Deliverables" means all of the services, goods, products, work, work product, data, items, materials and property to be created, developed, produced, ~~delivered, performed, or provided~~ by or on behalf of, or made available through, the Contractor (or any agent, contractor or subcontractor of the Contractor) **specifically and exclusively for the Agency** in connection with this Contract.	N/A
Attachment G, 2.5 Termination, 2.5.6.2, p. 38	Immediately cease using and return to the Agency any property or materials, whether tangible or intangible, provided by the Agency to the Contractor.	Contractor cannot agree to return all data upon request because our data back-up strategy does not allow for this (i.e., client data is co-mingled on back-up tapes).	N/A

Exceptions to RFP/Contract Language (See Section 3.1)			
RFP Section and Page	**Language to Which Bidder Takes Exception**	**Explanation and Proposed Replacement Language**	**Cost Savings to the Agency if Proposed Replacement Language is Accepted**
		Notwithstanding anything to the contrary in the foregoing, Contractor, subject to the confidentiality provisions of this Agreement, may (i) retain copies of Confidential Information that it is required to retain by law or regulation, (ii) retain copies of its work product that contain Confidential Information for archival purposes or to defend its work product and (iii) in accordance with legal, disaster recovery and records retention requirements, store such copies and derivative works in an archival format (e.g. tape backups), which shall not be returned or destroyed.	
Attachment G, 2.7.1 Indemnification, p. 38	The Contractor agrees to indemnify and hold harmless the State and its officers, appointed and elected officials, board and commission members, employees, volunteers, and agents (collectively the "Indemnified Parties"), from any and all costs, expenses, losses, claims, damages, liabilities, settlements, and judgments (including, without limitation, the reasonable value of the time spent by the Attorney General's Office,) and the costs, expenses, and attorneys' fees of other counsel retained by the Indemnified Parties directly or indirectly related to, resulting from, or arising out of this	The indemnification as drafted would allow the State to claim indemnification from the Vendor when Vendor is not at fault or even when the State itself is at fault. Putting a contractor at risk for potential liabilities that are outside of their control is unfair and non-commercial. Indemnification should only be to the extent that damages are attributable to the indemnifying party. The Contractor agrees to indemnify and hold harmless the State and its officers, appointed and	N/A

Exceptions to RFP/Contract Language (See Section 3.1)			
RFP Section and Page	**Language to Which Bidder Takes Exception**	**Explanation and Proposed Replacement Language**	**Cost Savings to the Agency if Proposed Replacement Language is Accepted**
	Contract, including but not limited to any claims related to, resulting from, or arising out of: **2.7.1.1** Any breach of this Contract; **2.7.1.2** Any negligent, intentional, or wrongful act or omission of the Contractor or any agent or subcontractor utilized or employed by the Contractor; **2.7.1.3** The Contractor's performance or attempted performance of this Contract, including any agent or subcontractor utilized or employed by the Contractor; **2.7.1.4** Any failure by the Contractor to make all reports, payments, and withholdings required by federal and state law with respect to social security, employee income and other taxes, fees, or costs required by the Contractor to conduct business in the State of Iowa; **2.7.1.5** Any claim of misappropriation of a trade secret or infringement or violation of any intellectual property rights, proprietary rights, or personal rights of any third party, including any claim that any Deliverable or any use thereof (or the exercise of any rights with respect thereto) infringes, violates, or misappropriates any patent, copyright, trade secret, trademark, trade dress, mask work, utility design, or other intellectual property	elected officials, board and commission members, **and** employees~~, volunteers, and agents~~ (collectively the "Indemnified Parties"), from any and all costs, expenses, losses, claims, damages, liabilities, settlements, and judgments (including, without limitation, the reasonable value of the time spent by the Attorney General's Office,) **incurred by the Indemnified Party** ~~and the costs, expenses, and attorneys' fees of other counsel retained by the Indemnified Parties~~ **in connection with a third party claim to the extent** directly ~~or indirectly related to, resulting from, or~~ arising out of ~~this Contract, including but not limited to any claims related to, resulting from, or arising out of~~: 2.7.1.1 Any **material** breach of this Contract **by Contractor**; 2.7.1.2 Any negligent~~, intentional, or wrongful~~ act or omission **or conduct in bad faith** of the Contractor or any agent or subcontractor utilized or employed by the Contractor; 2.7.1.3 ~~The Contractor's performance or attempted performance of this Contract, including any agent or subcontractor utilized or employed by the Contractor;~~ **[Reserved]** 2.7.1.4 Any failure by the Contractor to make all reports, payments, and withholdings required by federal and state law with respect to social	

Exceptions to RFP/Contract Language (See Section 3.1)			
RFP Section and Page	**Language to Which Bidder Takes Exception**	**Explanation and Proposed Replacement Language**	**Cost Savings to the Agency if Proposed Replacement Language is Accepted**
	right or proprietary right of any third party.	security, employee income and other taxes, fees, or costs required by the Contractor to conduct business in the State of Iowa; 2.7.1.5 Any claim of misappropriation of a trade secret or infringement or violation of any intellectual property rights, proprietary rights, or personal rights of any third party, including any claim that any Deliverable or any use thereof (or the exercise of any rights with respect thereto) infringes, violates, or misappropriates any patent, copyright, trade secret, trademark, trade dress, mask work, utility design, or other intellectual property right or proprietary right of any third party. **Contractor shall have no responsibility for any losses, liabilities or damages to the extent they are attributable to the acts or omissions of an indemnified person or any third party other than Contractor's subcontractors.**	
Attachment G, 2.8 Insurance, pp. 38-39	**2.8.1 Insurance Requirements.** The Contractor, and any subcontractor, shall maintain in full force and effect, with insurance companies licensed by the State of Iowa, at the Contractor's expense, insurance covering its work during the entire term of this Contract, which includes any extensions or renewals thereof. The Contractor's insurance shall,	Contractor's Professional Liability coverage is provided by an unlicensed captive. Contractor's Professional Liability insurance is procured on a "per claim" basis. **2.8.1 Insurance Requirements.** The Contractor, and any subcontractor, shall maintain in full force and effect, with**, other than with respect to its**	N/A

Exceptions to RFP/Contract Language (See Section 3.1)			
RFP Section and Page	**Language to Which Bidder Takes Exception**	**Explanation and Proposed Replacement Language**	**Cost Savings to the Agency if Proposed Replacement Language is Accepted**
	among other things: **2.8.1.1** Be occurrence based and shall insure against any loss or damage resulting from or related to the Contractor's performance of this Contract regardless of the date the claim is filed or expiration of the policy. **2.8.1.2** Name the State of Iowa and the Agency as additional insureds or loss payees on the policies for all coverages required by this Contract, with the exception of Workers' Compensation, or the Contractor shall obtain an endorsement to the same effect; and **2.8.1.3** Provide a waiver of any subrogation rights that any of its insurance carriers might have against the State on the policies for all coverages required by this Contract, with the exception of Workers' Compensation. The requirements set forth in this section shall be indicated on the certificates of insurance coverage supplied to the Agency.	**Professional Liability coverage,** insurance companies licensed by the State of Iowa, at the Contractor's expense, insurance covering its work during the entire term of this Contract, which includes any extensions or renewals thereof. The Contractor's insurance shall, among other things: **2.8.1.1** **Other than with respect to its Professional Liability coverage,** Be occurrence based and shall insure against any loss or damage resulting from or related to the Contractor's performance of this Contract regardless of the date the claim is filed or expiration of the policy. **2.8.1.2** Name the State of Iowa and the Agency as additional insureds or loss payees on the policies for all coverages required by this Contract, with the exception of Workers' Compensation **and Professional Liability**, or the Contractor shall obtain an endorsement to the same effect; and **2.8.1.3** Provide a waiver of any subrogation rights that any of its insurance carriers might have against the State on the policies for all coverages required by this Contract, with the exception of Workers' Compensation **and Professional Liability**. The requirements set forth in this section shall be indicated on the certificates of insurance	

Exceptions to RFP/Contract Language (See Section 3.1)			
RFP Section and Page	**Language to Which Bidder Takes Exception**	**Explanation and Proposed Replacement Language**	**Cost Savings to the Agency if Proposed Replacement Language is Accepted**
		coverage supplied to the Agency.	
Attachment G, 2.8.3 Certificates of Coverage, p. 39	**2.8.3 Certificates of Coverage.** The Contractor shall submit certificates of the insurance, which indicate coverage and notice provisions as required by this Contract, to the Agency upon execution of this Contract. The Contractor shall maintain all insurance policies required by this Contract in full force and effect during the entire term of this Contract, which includes any extensions or renewals thereof, and shall not permit such policies to be canceled or amended except with the advance written approval of the Agency. The insurer shall state in the certificate that no cancellation of the insurance will be made without at least a thirty (30) day prior written notice to the Agency. The certificates shall be subject to approval by the Agency. Approval of the insurance certificates by the Agency shall not relieve the Contractor of any obligation under this Contract.	Notice of cancellation will be provided in accordance with policy provisions. Contractor will endeavor to provide the Agency with 30 days' notice prior to any termination, cancellation or material change to the required policies. **2.8.3 Certificates of Coverage.** The Contractor shall submit certificates of the insurance, which indicate coverage and notice provisions as required by this Contract, to the Agency upon execution of this Contract. The Contractor shall **endeavor to** maintain all insurance policies required by this Contract in full force and effect during the entire term of this Contract, which includes any extensions or renewals thereof, and shall **endeavor to** not permit such policies to be canceled or amended except with the advance written approval of the Agency. ~~The insurer shall state in the certificate that no cancellation of the insurance will be made without at least a thirty (30) day prior written notice to the Agency.~~ The certificates shall be subject to approval by the Agency. Approval of the insurance certificates by the Agency shall not relieve the Contractor of any obligation under this Contract.	N/A

Exceptions to RFP/Contract Language (See Section 3.1)			
RFP Section and Page	**Language to Which Bidder Takes Exception**	**Explanation and Proposed Replacement Language**	**Cost Savings to the Agency if Proposed Replacement Language is Accepted**
Attachment G, 2.9.3 Access to Agency Information that is Confidential Information, p. 39	Access to such Confidential Information shall comply with both the State's and the Agency's policies and procedures.	Contractor can only comply with policies and procedures that it has had an opportunity to review. Access to such Confidential Information shall comply with both the State's and the Agency's policies and procedures **to the extent that such policies and procedures have been provided to Contractor in writing**.	N/A
Attachment G, 2.9.5 Contractor Breach Notification Obligations, p. 40	In the event of a breach of the Contractor's security obligations or other event requiring notification under applicable law, the Contractor agrees to follow Agency directives, which may include assuming responsibility for informing all such individuals in accordance with applicable laws, and to indemnify, hold harmless, and defend the State of Iowa against any claims, damages, or other harm related to such breach.	Contractor has standardized incident management and notification processes which cannot be customized to individual client requirements. Contractor's notification terms have been provided as an alternative. In the event of a **Security Incident** ~~breach of the Contractor's security obligations~~ or other event requiring notification under applicable law, the Contractor agrees to **notify the Agency within a reasonable time upon learning of Security Incidents, as required by applicable law or regulation. Notification shall take the form of a phone call, which may be followed in writing, to the designated Client Account Contact(s) and shall include (a) problem statement or description, (b) expected resolution time (if known), and (c) the name**	N/A

Exceptions to RFP/Contract Language (See Section 3.1)			
RFP Section and Page	**Language to Which Bidder Takes Exception**	**Explanation and Proposed Replacement Language**	**Cost Savings to the Agency if Proposed Replacement Language is Accepted**
		and phone number of the Contractor representative that the Agency may contact to obtain updates. Contractor agrees to keep the Agency informed of progress and actions taken to resolve the Security Incident. ~~follow Agency directives, which may include assuming responsibility for informing all such individuals in accordance with applicable laws, and to indemnify, hold harmless, and defend the State of Iowa against any claims, damages, or other harm related to such breach~~. **"Security Incident" shall mean the (a) actual unauthorized access to or use of Agency Confidential Information, or (b) unauthorized disclosure, loss, theft or manipulation of unencrypted Confidential Information (or encrypted Confidential Information where unauthorized decryption has or is likely to occur) that has the potential to cause identity theft or financial harm to the Agency's employees or participants.**	
Attachment G, 2.9.9 Contractor's Inability to Return and/or Destroy Information,	Contractor's Inability to Return and/or Destroy Information. If for any reason the Agency Information cannot be returned and/or destroyed upon expiration or termination of the Contract, the Contractor agrees to notify the Agency with an explanation as to the conditions which make return and/or	Contractor cannot agree to return all data upon request because our data back-up strategy does not allow for this (i.e., client data is co-mingled on back-up tapes). **Notwithstanding anything to the contrary in the foregoing, Contractor, subject to the**	N/A

Exceptions to RFP/Contract Language (See Section 3.1)			
RFP Section and Page	**Language to Which Bidder Takes Exception**	**Explanation and Proposed Replacement Language**	**Cost Savings to the Agency if Proposed Replacement Language is Accepted**
p. 40	destruction not possible or feasible. Upon mutual agreement by both parties that the return and/or destruction of the information is not possible or feasible, the Contractor shall make the Agency Information inaccessible. The Contractor shall not use or disclose such retained Agency Information for any purposes other than those expressly permitted by the Agency. The Contractor shall provide to the Agency a detailed description as to the procedures and methods used to make the Agency Information inaccessible no later than thirty (30) days after making the information inaccessible. If the Agency provides written permission for the Contractor to retain the Agency Information in the Contractor's information systems, the Contractor will extend the protections of this Contract to such information and limit any further uses or disclosures of such information.	**confidentiality provisions of this Agreement, may (i) retain copies of Confidential Information that it is required to retain by law or regulation, (ii) retain copies of its work product that contain Confidential Information for archival purposes or to defend its work product and (iii) in accordance with legal, disaster recovery and records retention requirements, store such copies and derivative works in an archival format (e.g. tape backups), which shall not be returned or destroyed.**	
Attachment G, 2.10.1 Ownership and Assignment of Other Deliverables, p. 41	Additional Language	The Agreement should include protection for Contractor's existing intellectual property. **Notwithstanding anything to the contrary in the Agreement, Contractor shall retain all patent, copyright and other intellectual property rights in the methodologies, methods**	N/A

Exceptions to RFP/Contract Language (See Section 3.1)			
RFP Section and Page	**Language to Which Bidder Takes Exception**	**Explanation and Proposed Replacement Language**	**Cost Savings to the Agency if Proposed Replacement Language is Accepted**
		of analysis, ideas, concepts, know-how, models, tools, techniques, skills, knowledge and experience owned or possessed by Contractor before the commencement of, or acquired by Contractor during or after, the performance of the Services (collectively, "Intellectual Property"). To the extent that any of Intellectual Property is embodied in any of the Deliverables, Contractor will grant to the Agency a non-exclusive, non-transferable, royalty-free license to use the Intellectual Property for its internal use, but solely in connection with and to the extent necessary for use of the Deliverables as contemplated by the Agreement.	
Attachment G, 2.11.1 Construction of Warranties Expressed in the Contract with Warranties Implied by Law , p. 41	Warranties made by the Contractor in this Contract, whether: (1) this Contract specifically denominates the Contractor's promise as a warranty; or (2) the warranty is created by the Contractor's affirmation or promise, by a description of the Deliverables to be provided, or by provision of samples to the Agency, shall not be construed as limiting or negating any warranty provided by law, including without limitation, warranties that arise through the course of dealing or usage of trade. The warranties expressed in this Contract are	Contractor is providing services under the proposed agreement and is not transferring any ownership interests to Contractor's IP that would justify any such warranties. Contractor expressly disclaims all UCC style warranties because we are a services provider not a provider of products. **Except as specifically stated in the Agreement, Contractor does not make any representations or warranties, express or implied, regarding any matter, including the merchantability, suitability, originality, title, fitness for a**	N/A

Exceptions to RFP/Contract Language (See Section 3.1)			
RFP Section and Page	**Language to Which Bidder Takes Exception**	**Explanation and Proposed Replacement Language**	**Cost Savings to the Agency if Proposed Replacement Language is Accepted**
	intended to modify the warranties implied by law only to the extent that they expand the warranties applicable to the Deliverables provided by the Contractor. With the exception of Subsection 2.11.3, the provisions of this section apply during the Warranty Period as defined in the Contract Declarations and Execution Section.	**particular purpose or results to be derived from the use of the Services provided under the Agreement.**	
Attachment G, 2.13.16 Joint and Several Liability, p. 45	Joint and Several Liability. If the Contractor is a joint entity, consisting of more than one individual, partnership, corporation, or other business organization, all such entities shall be jointly and severally liable for carrying out the activities and obligations of this Contract, for any default of activities and obligations, and for any fiscal liabilities.	This provision should be deleted. Contractor shall not be joint and severally liable.	N/A
Attachment G, 2.13.21 Severability, p. 46	Severability. If any provision of this Contract is determined by a court of competent jurisdiction to be invalid or unenforceable, such determination shall not affect the validity or enforceability of any other part or provision of this Contract.	The intent of the parties should be respected. **It is the intent of the parties that the provisions of this Agreement shall be enforced to the fullest extent permitted by applicable law. To the extent that the terms set forth in this Agreement or any word, phrase, clause or sentence is found to be illegal or unenforceable for any reason, such word, phrase, clause or sentence shall be modified, deleted or interpreted in such a manner so as to afford**	N/A

Exceptions to RFP/Contract Language (See Section 3.1)			
RFP Section and Page	**Language to Which Bidder Takes Exception**	**Explanation and Proposed Replacement Language**	**Cost Savings to the Agency if Proposed Replacement Language is Accepted**
		the party for whose benefit it was intended the fullest benefit commensurate with making this Agreement as modified, enforceable and the balance of this Agreement shall not be affected thereby, the balance being construed as severable and independent.	
Attachment G, 2.13.25 Records Retention and Access, p. 46	Additional Language	Due to the confidential and proprietary nature of Contractor's operations and to protect the integrity and security of its operations parameters should be established for any audit. **Any audit or inspection should be limited to books and records directly relating to the Services, conducted at the Agency's expense, made upon reasonable prior written notice, during normal business hours and shall be subject to the execution of a confidentiality agreement reasonably satisfactory to Contractor.**	N/A
Attachment G, 2.13.27 Reimbursement of Audit Costs, p. 47	Reimbursement of Audit Costs. If the Auditor of the State of Iowa notifies the Agency of an issue or finding involving the Contractor's noncompliance with laws, rules, regulations, and/or contractual agreements governing the funds distributed under this Contract, the Contractor shall bear the cost of the Auditor's review and any subsequent assistance provided	Contractor should be able to review and challenge audit results. **If upon final determination an audit discloses that the Agency overpaid Contractor for fees, expenses or other charges under this Agreement for readily identifiable components of Services (as examples for illustrative**	N/A

Exceptions to RFP/Contract Language (See Section 3.1)			
RFP Section and Page	**Language to Which Bidder Takes Exception**	**Explanation and Proposed Replacement Language**	**Cost Savings to the Agency if Proposed Replacement Language is Accepted**
	by the Auditor to determine compliance. The Contractor shall reimburse the Agency for any costs the Agency pays to the Auditor for such review or audit.	**purposes only: such as a billing in excess of actual hours worked, miscalculation of actual supplies consumed, etc.), Contractor will refund to the Agency the amount of that overpayment. In addition, if that audit discloses that such overpayment was for ten percent or more than the total amount actually due to Contractor in the aggregate during the period covered by the audit, Contractor will also reimburse the Agency for the reasonable out-of-pocket expenses incurred in respect of the part of such audit which revealed the overcharging, up to the amount of the overcharge; provided that Contractor was first given a reasonable opportunity to review and verify results of such audit.**	
Attachment G, 2.13.28 Staff Qualifications and Background Checks, p. 47	The Agency reserves the right to conduct and/or request the disclosure of criminal history and other background investigation of the Contractor, its officers, directors, shareholders, and the Contractor's staff, agents, or subcontractors retained by the Contractor for the performance of Contract services.	Contractor should not be required to turn over background check results to the Agency. **Upon request, Contractor shall certify that the results of such background investigations have not disclosed a conviction for a felony, a crime of dishonesty or fraud, or a crime of moral turpitude (and it is understood and agreed that Contractor shall be under no obligation to turn over the results of any such background**	N/A

Exceptions to RFP/Contract Language (See Section 3.1)			
RFP Section and Page	**Language to Which Bidder Takes Exception**	**Explanation and Proposed Replacement Language**	**Cost Savings to the Agency if Proposed Replacement Language is Accepted**
		investigations to the Agency).	
Additional Term		To the extent permitted by law, the Agreement should contain appropriate financial limitation of liability cap. **A. The aggregate liability of Contractor, its Affiliates and any officer, director or employee of Contractor's and our Affiliates ("Contractor Parties") to the Agency, its Affiliates, its officers, directors or employees or those of the Agency's Affiliates and any third party (including any benefit plan, its fiduciaries or any plan sponsor) for any and all Losses arising out of or relating to the provision of any Services at any time by any of the Contractor parties shall not exceed the greater of one times the compensation for the Services giving rise to such Loss and $100,000. Contractor shall have no liability for the acts or omissions of any third party (other than its subcontractors).** **B. In no event shall either party or its Affiliates be liable in connection with this Agreement or the Services to the other party, its Affiliates or any third party for any loss of profit or incidental, consequential, special, indirect, punitive or similar damages. The**	Contractor's prices assume a commercially reasonable limitation of liability.

Exceptions to RFP/Contract Language (See Section 3.1)			
RFP Section and Page	**Language to Which Bidder Takes Exception**	**Explanation and Proposed Replacement Language**	**Cost Savings to the Agency if Proposed Replacement Language is Accepted**
		provisions of this Section shall apply to the fullest extent permitted by law. Nothing in this Section limiting the liability of a party shall apply to any liability that has been finally determined by a court to have been caused by the fraud of such party. **C. For purposes of this Agreement "Loss" means damages, claims, liabilities, losses, awards, judgments, penalties, third party claims, interest, costs and expenses, including reasonable attorneys' fees, whether arising under any legal theory including, but not limited to claims sounding in tort (such as for negligence, misrepresentation or otherwise), contract (whether express or implied), by statute, or otherwise, claims seeking any kind of damages and claims seeking to apply any standard of liability such as negligence, statutory violation or otherwise. For the avoidance of doubt, multiple claims arising out of or based upon the same act, error or omission, or series of continuous, interrelated or repeated acts, errors or omissions shall be considered a single Loss.**	
Additional Term		The Agreement should contain a provision of information and assistance clause. Contractor needs to be able to rely upon the accuracy and	N/A

Exceptions to RFP/Contract Language (See Section 3.1)			
RFP Section and Page	**Language to Which Bidder Takes Exception**	**Explanation and Proposed Replacement Language**	**Cost Savings to the Agency if Proposed Replacement Language is Accepted**
		completeness of information provided to us for performance of the Services. **The Agency will provide all necessary and reasonably requested information, direction and cooperation to enable Contractor to provide the Services, and any direction (whether verbal or written) shall be effective if contained expressly in the applicable Statement of Work or if received (whether verbally or in writing) from a person known to Contractor or reasonably believed by Contractor to be authorized to act on the Agency's behalf. Contractor shall be permitted to use all information and data supplied by or on behalf of the Agency without having independently verified the accuracy or completeness of it except to the extent required by generally accepted professional standards and practices.**	
Additional Term		Contractor believes that the parties should first endeavor to resolve any dispute through a negotiated settlement. If the parties are unable to resolve a dispute in a reasonable time, then the dispute should be resolved by an independent trier of fact.	N/A

Exceptions to RFP/Contract Language (See Section 3.1)			
RFP Section and Page	**Language to Which Bidder Takes Exception**	**Explanation and Proposed Replacement Language**	**Cost Savings to the Agency if Proposed Replacement Language is Accepted**
		IN THE EVENT OF A DISPUTE BETWEEN US ARISING OUT OF OR RELATING TO THIS AGREEMENT, WE EACH AGREE TO WAIVE AND NOT DEMAND A TRIAL BY JURY.	

PRIMARY BIDDER CERTIFICATIONS

1. BID PROPOSAL CERTIFICATIONS. By signing below, Bidder certifies that:

1.1 Bidder specifically stipulates that the Bid Proposal is predicated upon the acceptance of all terms and conditions stated in the RFP and the Sample Contract without change except as otherwise expressly stated in the Primary Bidder Detail & Certification Form. Objections or responses shall not materially alter the RFP. All changes to proposed contract language, including deletions, additions, and substitutions of language, must be addressed in the Bid Proposal. The bidder accepts and shall comply with all Contract Terms and Conditions contained in the Sample Contract without change except as set forth in the Contract;
1.2 Bidder has reviewed the Additional Certifications, which are incorporated herein by reference, and by signing below represents that Bidder agrees to be bound by the obligations included therein;
1.3 Bidder has received any amendments to this RFP issued by the Agency;
1.4 No cost or pricing information has been included in the Bidder's Technical Proposal; and,
1.5 The person signing this Bid Proposal certifies that he/she is the person in the Bidder's organization responsible for, or authorized to make decisions regarding the prices quoted and, Bidder guarantees the availability of the services offered and that all Bid Proposal terms, including price, will remain firm until a contract has been executed for the services contemplated by this RFP or one year from the issuance of this RFP, whichever is earlier.

2. SERVICE AND REGISTRATION CERTIFICATIONS. By signing below, Bidder certifies that:

2.1 Bidder certifies that the Bidder organization has sufficient personnel resources available to provide all services proposed by the Bid Proposal, and such resources will be available on the date the RFP states services are to begin. Bidder guarantees personnel proposed to provide services will be the personnel providing the services unless prior approval is received from the Agency to substitute staff;
2.2 Bidder certifies that if the Bidder is awarded the contract and plans to utilize subcontractors at any point to perform any obligations under the contract, the Bidder will (1) notify the Agency in writing prior to use of the subcontractor, and (2) apply all restrictions, obligations, and responsibilities of the resulting contract between the Agency and contractor to the subcontractors through a subcontract. The contractor will remain responsible for all Deliverables provided under this contract;
2.3 Bidder either is currently registered to do business in Iowa or agrees to register if Bidder is awarded a Contract pursuant to this RFP; and,
2.4 Bidder certifies it is either a) registered or will become registered with the Iowa Department of Revenue to collect and remit Iowa sales and use taxes as required by Iowa Code chapter 423; or b) not a "retailer" of a "retailer maintaining a place of business in this state" as those terms are defined in Iowa Code subsections 423.1(42) & (43). The Bidder also acknowledges that the Agency may declare the bid void if the above certification is false. Bidders may register with the Department of Revenue online at: http://www.state.ia.us/tax/business/business.html.

3. EXECUTION.

By signing below, I certify that I have the authority to bind the Bidder to the specific terms, conditions and technical specifications required in the Agency's Request for Proposals (RFP) and offered in the Bidder's Proposal. I understand that by submitting this Bid Proposal, the Bidder agrees to provide services described herein which meet or exceed the specifications of the Agency's RFP unless noted in the Bid Proposal and at the prices quoted by the Bidder. The Bidder has not participated, and will not participate, in any action contrary to the anti-competitive obligations outlined in the Additional Certifications. I certify that the contents of the Bid Proposal are true and accurate and that the Bidder has not made any knowingly false statements in the Bid Proposal.

Signature:	Katie Falls
Printed Name/Title:	Katie Falls, Principal
Date:	August 1, 2018

Attachment C: Subcontractor Disclosure Form

*(Return this completed form behind Tab 3 of the Bid Proposal. Fully complete a form for **each** proposed subcontractor. If a section does not apply, label it "not applicable." If the bidder does not intend to use subcontractor(s), this form does not need to be returned.)*

Primary Bidder ("Primary Bidder"):	Mercer Health & Benefits LLC
Subcontractor Contact Information (individual who can address issues re: this RFP)	
Name:	Brenda Jackson
Address:	511 Canyon Drive, Lawrence, KS 66049
Tel:	+1 785 843 7023
Fax:	+1 785 843 7023
E-mail:	BrendaJeffJackson@earthlink.net

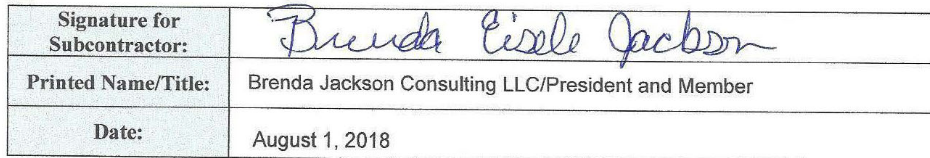
Subcontractor Detail	
Subcontractor Legal Name ("Subcontractor"):	Brenda Jackson Consulting, LLC
"Doing Business As" names, assumed names, or other operating names:	Not applicable
Form of Business Entity (i.e., corp., partnership, LLC, etc.)	LLC
State of Incorporation/organization:	Kansas
Primary Address:	511 Canyon Drive, Lawrence, KS 66049
Tel:	+1 785 843 7023
Fax:	+1 785 843 7023
Local Address (if any):	Not applicable
Addresses of Major Offices and other facilities that may contribute to performance under this RFP/Contract:	Not applicable
Number of Employees:	1
Number of Years in Business:	12
Primary Focus of Business:	Health Care Consulting
Federal Tax ID:	26-3479526
Subcontractor's Accounting Firm:	Spruce Corporation
If Subcontractor is currently registered to do business in Iowa, provide the Date of Registration:	Not registered currently
Percentage of Total Work to be performed by this Subcontractor pursuant to this RFP/Contract.	7%
General Scope of Work to be performed by this Subcontractor	
Brenda Jackson Consulting will assist with tasks related to behavioral health, LTSS, and Pharmacy subject matter expertise as needed.	
Detail the Subcontractor's qualifications for performing this scope of work	
Brenda has been in the field since 1993 including nine years at CMS. From 1996-2005, Brenda reviewed and approved all Iowa Medicaid managed care contracts, waivers, and health plans for CMS. While at CMS, Brenda was also the Iowa State Representative for three years. In that position, Brenda was the CMS lead contact with Iowa on all State Plan and HCBS and managed care waiver requests. In her current role, Brenda advises a variety of states on SPAs, managed care, and HCBS policy and operations including assisting states with strategic communications with CMS.	

By signing below, Subcontractor agrees to the following:

1. Subcontractor has reviewed the RFP, and Subcontractor agrees to perform the work indicated in this Bid Proposal if the Primary Bidder is selected as the winning bidder in this procurement;
2. Subcontractor has reviewed the Additional Certifications and by signing below confirms that the Certifications are true and accurate and Subcontractor will comply with all such Certifications;
3. Subcontractor recognizes and agrees that if the Primary Bidder enters into a contract with the Agency as a result of this RFP, all restrictions, obligations, and responsibilities of the contractor under the contract shall also apply to the subcontractor; and,
4. Subcontractor agrees that it will register to do business in Iowa before performing any services pursuant to this contract, if required to do so by Iowa law.

The person signing this Subcontractor Disclosure Form certifies that he/she is the person in the Subcontractor's organization responsible for or authorized to make decisions regarding the prices quoted and the Subcontractor has not participated, and will not participate, in any action contrary to the anti-competitive obligations outlined in the Additional Certifications.

I hereby certify that the contents of the Subcontractor Disclosure Form are true and accurate and that the Subcontractor has not made any knowingly false statements in the Form.



Signature for Subcontractor:	Brenda Eisele Jackson
Printed Name/Title:	Brenda Jackson Consulting LLC/President and Member
Date:	August 1, 2018

Attachment E: Certification and Disclosure Regarding Lobbying

(Return this executed form behind Tab 3 of the Bid Proposal.)

Instructions:
Title 45 of the Code of Federal Regulations, Part 93 requires the bidder to include a certification form, and a disclosure form, if required, as part of the bidder's proposal. Award of the federally funded contract from this RFP is a Covered Federal action.

1) The bidder shall file with the Agency this certification form, as set forth in Appendix A of 45 CFR Part 93, certifying the bidder, including any subcontractor(s) at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) have not made, and will not make, any payment prohibited under 45 CFR § 93.100.
2) The bidder shall file with the Agency a disclosure form, set forth in Appendix B of 45 CFR Part 93, in the event the bidder or subcontractor(s) at any tier (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) has made or has agreed to make any payment using non-appropriated funds, including profits from any covered Federal action, which would be prohibited under 45 CFR § 93.100 if paid for with appropriated funds. All disclosure forms shall be forwarded from tier to tier until received by the bidder and shall be treated as a material representation of fact upon which all receiving tiers shall rely.

Certification for Contracts, Grants, Loans, and Cooperative Agreements

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, ''Disclosure Form to Report Lobbying,'' in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Statement for Loan Guarantees and Loan Insurance

The undersigned states, to the best of his or her knowledge and belief, that:

If any funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this commitment providing for the United States to insure or guarantee a loan, the undersigned shall complete and submit Standard Form-LLL, ''Disclosure Form to Report Lobbying,'' in accordance with its instructions.

Submission of this statement is a pre-requisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required statement shall be subject to a civil penalty of not less than $10,000 for each such failure.

I certify that the contents of this certification are true and accurate and that the bidder has not made any knowingly false statements in the Bid Proposal. I am checking the appropriate box below regarding disclosures required in Title 45 of the Code of Federal Regulations, Part 93.

☒ The bidder is NOT including a disclosure form as referenced in this form's instructions because the bidder is NOT required by law to do so.

☐ The bidder IS filing a disclosure form with the Agency as referenced in this form's instructions because the bidder IS required by law to do so. If the bidder is filing a disclosure form, place the form immediately behind this Attachment E in the Proposal.

Signature:	Katie Falls
Printed Name/Title:	Katie Falls, Principal
Date:	August 1, 2018

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APPROACH TO MEETING DELIVERABLES

The bidder shall address each Deliverable that the successful contractor will perform as listed in Section 1.3 (Scope of Work) by first restating the Deliverable from the RFP and then detailing the bidder's planned approach to meeting each contractor Deliverable immediately after the restated text. Bid responses should provide sufficient detail so that the Agency can understand and evaluate the bidder's approach, and should not merely repeat the Deliverable.

Bidders are given wide latitude in the degree of detail they offer or the extent to which they reveal plans, designs, examples, processes, and procedures. Bidders do not need to address any responsibilities that are specifically designated as Agency responsibilities.

1.3.1.1. Task Area 1 Deliverable – Technical Assistance and Support for Federal and State Program Changes

Mercer understands that over the course of the Contract, the Department of Human Services (DHS) may request technical assistance that may include but is not limited to:

- Complete analysis of required or proposed state or federal legislative policy changes impacting the Iowa Medicaid programs.
- Complete analysis of federal sub-regulatory guidance and program clarifications issued by the Centers for Medicare and Medicaid Services (CMS) for impacts to the Iowa Medicaid and Children's Health Insurance Program (CHIP).
- Present DHS with policy options and draft work plans to guide the State's implementation of program changes.
- Research and identify Medicaid and CHIP program national best practice standards for State leadership consideration.
- Serve as the technical resource to DHS staff, using Contractor's expertise to anticipate CMS questions and minimize CMS approval timelines.

Mercer agrees to comply with these requirements.

Mercer's Core Approach to all Technical Assistance Deliverables

What Mercer will provide under this Contract is a consistent approach to assisting DHS with technical assistance, policy support, and any ad-hoc requests. Our approach ensures collaboration between the appropriate Mercer team members and DHS to ensure we are meeting DHS' needs and providing deliverables that meet the DHS' expectations.

Planning

As with all projects, Mercer's approach to a request for technical assistance will be multi-layered, iterative, and results-oriented. We will begin with ensuring our team has a full understanding of the technical assistance request. Mercer will collaborate with DHS to identify needs, identify deliverables, and develop a plan. Depending on the nature of the request, Mercer would draw upon its pool of skilled policy advisors to ensure we have the appropriate subject matter experts (SMEs) participating in the specific technical assistance analysis for DHS. With the appropriate team in hand, we would likely schedule a kick-off meeting with DHS to discuss at a minimum:

- Whether additional research is necessary for the analysis (e.g., state regulations/statutes, relevant examples from other states).
- The appropriate format for the targeted audience of the analysis (e.g., presentation, whitepaper, high-level summaries for stakeholders, memorandums, etc.).
- Whether additional data to support the analysis is necessary and where the data can be obtained (e.g., state specific data, national data).
- The timeline to complete the analysis and associated work plan to ensure the analysis is performed according to the agreed upon timelines.

Mercer will provide detailed notes of the kick-off meeting that identify next steps and corresponding due dates. In addition, Mercer will provide a final description of the scope of the technical assistance and corresponding work plan to complete the analysis for the DHS' approval. Once DHS has approved the approach for completing the technical assistance, the analysis will begin.

Performing the Requested Analysis

Mercer will provide the technical assistance in the agreed upon fashion. Depending on the request and audience for the analysis, the technical assistance may include:

- Analysis of how DHS can achieve its objectives in accordance with federal requirements.
- Analysis of what federal or state statutes, regulations or policies may stand in the way of achieving DHS' objectives and solutions to addressing potential barriers.
- Analysis, based on other state's experiences, of what federal requirements are likely to be "waivable", and which are not.
- Analysis of non-Medicaid/CHIP federal requirements, e.g., the Americans with Disabilities Act.
- Preparation of position papers for CMS or other stakeholders in support of the State's proposal.
- Concept papers in the early stages of planning to identify options and federal rules which much be waived.
- Summary of research of other States' CMS approved and denied state plan amendments (SPAs) and waivers including identification of the key regulatory issues impacting CMS' decisions.

The technical assistance may require a discussion of opportunities/pathways for implementing the initiative and potential regulatory obstacles. Mercer will review federal regulations pertaining to the initiative, researching options available to DHS for obtaining federal authorization for the initiative, including reviewing what federal regulations would

need to be waived to implement the initiative. Mercer's review would include researching CMS-approved SPAs and waivers, programs, financing arrangements, service definitions, etc. for other states to understand what opportunities there might be for Iowa. Knowing what position CMS has taken with other states is critical to understanding the regulatory framework perceived by CMS and identifying avenues to mitigate any anticipated obstacles. With Mercer's current and historical work with more than 30 states, and the national perspective of our former CMS staff, we will be able to quickly identify states that have implemented or attempted to implement initiatives similar to Iowa's intentions. At the same time, in the changing federal policy environment for Medicaid, we are creative in our advice and not necessarily constrained by past policy in recommending solutions.

Finalizing the Deliverable

Virtually every project we complete requires the development of written reports and other deliverables. Mercer's approach to completing deliverables emphasizes the importance of effective communication and collaboration with DHS staff. At the beginning of a project, the Mercer project management team will work with DHS staff to develop a project management plan that includes processes for developing final and any interim deliverables needed to complete the final product. For example, a final deliverable could be an options paper to implement a program policy change, and an interim deliverable could be an outline of the options paper.

Mercer's standard practice is to not consider a deliverable complete until our client has reviewed and signed off on the deliverable. For large deliverables, Mercer typically requests a meeting to discuss the deliverable after DHS has had an opportunity to review. This meeting provides the opportunity for DHS to give feedback and, if needed, and identify any changes that need to be made to the deliverable. Mercer only considers the deliverable to be complete when DHS communicates that it meets or exceeds expectations. As further described below, all deliverables undergo Mercer's rigorous peer review process.

While we understand that the request for technical assistance may encompass an array of Medicaid and CHIP issues that were not identified in the Request for Proposal (RFP), we have provided high-level approach for the tasks enumerated in A-E in the RFP and provided examples of similar technical assistance performed for other clients below. We believe these examples further demonstrate our depth and breadth of experience and illustrate how we approach technical assistance requests.

Sub-Task Area 1.3.1.1.A. Complete analysis of required or proposed state or federal legislative policy changes

Federal Policy

Our clients look to us to stay abreast of current federal requirements and policies affecting how they operate their Medicaid programs. We respond by regularly monitoring legislative activity (such as the Graham-Cassidy health care bill and CHIP funding), and the Federal Department of Health and Human Services, CMS, Federal Office of Management and Budget (OMB), Office of Inspector General (OIG), Federal General Accounting Office (GAO) for current actions and updates and tracking significant policy actions. Our combination of good relationships with CMS officials and

having former CMS officials on our policy and operations team who have insights into federal operations, and supporting a wide array of Medicaid policy projects across multiple states, gives us an advantage benefiting our clients. Our clients trust us to quickly bring relevant information to their attention and to provide guidance on how to interpret federal requirements, as well as the underlying factors driving requirements.

Mercer customizes our analysis to meet each state's needs. For example, we may issue brief policy "flashes" on a change when it is first issued, produce a policy white paper for an in-depth review, develop a detailed comparison chart of the current state to the proposed or required changes, or provide a verbal briefing on an issue. Below are three specific examples of our approaches:

Examples of Mercer Approach:

1. The CMS Medicaid/CHIP Managed Care Final Rule

The Medicaid/CHIP Managed Care Final Rule, published May 6, 2016, implemented sweeping changes to how states deliver Medicaid managed care programs. In some instances, the Final Rule codified longstanding sub-regulatory policy, particularly for managed long-term services and supports (MLTSS) programs (i.e., beneficiary support systems). In other cases, the Final Rule imposed new requirements, some requiring time to implement, such as the quality rating system. When the Medicaid/CHIP Managed Care Rule was first proposed, Mercer worked with many of our clients to (i) review the impact of the proposed rule on each state using a Mercer-developed gap analysis tool customized for each state's needs and (ii) assist states in drafting formal comments to CMS on the proposed rule. We used a Mercer team that included individuals who were knowledgeable about a state's managed care program and paired them with additional SMEs as needed to supplement state resources. We know that a 60-day comment period in some states can be as few as 30 days for policy analyses, once review and clearance by senior leadership is factored in. Where needed, Mercer's role was to help provide a review structure and "all hands on deck" to meet the 60-day deadline for comments.

Similarly, when the Medicaid/CHIP Managed Care Rule was finalized, Mercer provided a range of off-site and on-site assistance to our clients including webinar trainings for state Medicaid/CHIP staff and managed care plans (at state request), detailed gap analyses describing what was necessary for compliance, and drafting specific contract language to implement changes. We helped states negotiate "enforcement discretion" with CMS, gain approval of "directed" and "pass-through" payments, and develop compliance approaches for the new rules governing payments for IMD. In some states, we provided targeted, ad-hoc assistance with rule questions. In Delaware, Mercer partnered with State staff to lead a comprehensive initiative comprised of multiple workgroups, project management and a team of SMEs in order to work through the implementation of the rule provisions. In each case, we customized our level of support based on the policy and operational resource capacity of an individual state.

With the expected release of another proposed rule to "deregulate" and revise the 2016 Medicaid/CHIP Managed Care Final Rule expected this year, the Mercer team is closely watching the Federal OMB regulatory review process and proactively preparing to assist our clients again in analyzing the impact of the proposed rule changes and providing detailed state-specific analysis as requested. A key member of our proposed Mercer team includes Nicole Kaufman, one of the lead authors of the 2016 final rule.

2. The Home- and Community-Based Services (HCBS) Final Rule

The HCBS Final Rule was published January 16, 2014. Most provisions of the Final Rule were effective March 14, 2014. Arguably, the most challenging requirement of the Final Rule has been for states to determine that all HCBS settings are appropriate for providing integrated community supports. Since 2014, Mercer has provided support to states in implementing the HCBS Final Rule. We have worked with Connecticut, Delaware, Missouri, and New Mexico in developing assessment strategies and tools to determine the status of HCBS providers' compliance with the settings requirements of the Final Rule. Most notably, we have worked with our clients to develop and implement participant, case manager, managed care organization (MCO), and provider surveys to determine that HCBS are provided in appropriate provider settings. Our approach included:

- Determining the appropriate sample size for survey distribution.
- Developing the survey tools.
- Validating the survey tools.
- Developing and providing training on the use of the survey tools.
- Manning a hotline to address and respond to inquiries while surveys are live.
- Tracking the status of survey results.
- Analyzing survey results.

With our support, Connecticut, Delaware, Missouri, and New Mexico were able to demonstrate successful compliance with the Federal settings requirements. Delaware has received both initial and final CMS approval (and was the fourth state in the country to do so). Connecticut, Missouri, and New Mexico have received initial approval. We are now working with clients to develop monitoring strategies and tools to measure ongoing provider compliance with all applicable requirements.

Mercer also helped Delaware review the managed care external quality review regulations and gain approval from CMS for 75% enhanced federal match on certain HCBS transition plan activities.

3. The Mental Health Parity Rule

We have invested considerable resources to develop the expertise to support client implementation of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). An interdisciplinary team of Mercer policy, clinical, and actuarial consultants have been trained and have assisted multiple states in identifying areas within the Medicaid program that will require modification to comply with MHPAEA.

An example of our approach for MHPAEA projects included:

- Project management and a kick-off meeting.
- Designing a communication and engagement plan.
- Identifying benefit packages, defining benefits, mapping benefits to classifications and identifying/testing limits.
- Non-quantitative treatment limits (NQTL) data collection and tracking.
- NQTL analysis and preliminary determinations.
- Producing internal and external reports.

At the state level, we have provided MHPAEA training, technical assistance, analysis, and report drafting for Arizona, Delaware, Louisiana (technical assistance only), Missouri, New Mexico, Ohio, Pennsylvania, and Oregon. Due to our partnership with CMS as a MHPAEA technical assistance contractor, we have been uniquely positioned to advise states on the interpretation and implementation of the MHPAEA Rule and have successfully assisted each state in customizing their approach and timely submissions to CMS.

State Policy

In addition to implementing federal requirements, states must respond to state legislative proposal and implement Medicaid in a manner consistent with both state and federal laws. Mercer has experience in assisting states in evaluating and complying with state legislative changes.

Examples of Mercer Approach:

1. North Carolina

In January 2016, the North Carolina Department of Health and Human Services (DHHS) contracted with Mercer to assist with the preparation of a legislative report required by State statute and a section 1115 demonstration application. In providing this assistance, Mercer:

- Drafted a legislative report addressing elements specified in State legislation.
- Drafted slides and speakers notes for meetings of the Joint Legislative Oversight Committee on Medicaid and North Carolina Health Choice.
- Drafted talking points for DHHS' meetings with legislators.
- Provided feedback on draft Prepaid Health Plans (PHP) statutory licensure requirements.
- Prepared an options paper on PHP licensure.
- Reviewed State regulations and provided feedback on which provisions are addressed by Medicaid law or generally included in PHP contracts.
- Reviewed State legislation and discussed potential language changes with DHHS staff.
- Provided feedback on the draft legislative report regarding the North Carolina Heath Transformation Center.
- Drafted a section 1115 demonstration application that reflected the specific requirements required by State legislation.

2. Missouri

In addition, since 2003, Mercer has assisted the Missouri Department of Social Services with completing an annual report on CHIP that is mandated by statute. The State requires analysis on defined issues. Each year, Mercer meets with the Department to discuss the format of the report, the data elements that are necessary, updated research specific to the CHIP population. Specifically in performing this work, Mercer:

- Developed data requests to inform the analysis.
- Summarized available data in charts and tables to clearly illustrate trends and comparisons between programs, populations, etc.

- Performed research related to the national CHIP population to address national trends.
- Ensured the report complies with all statutorily required mandates.

Sub-Task Area 1.3.1.1.B: Analysis of federal sub-regulatory guidance and program clarifications issued by CMS

Sub-regulatory guidance and program clarifications from CMS comes in a variety of forms: State Medicaid Director Letters, Information Bulletins, policy preprints, SPAs, waivers, APD and contract approvals, calls with state staff, financial deferrals/disallowances, and more. Mercer regularly tracks sub-regulatory guidance, including SPA and waiver approvals, and our SMEs regularly meet to discuss guidance and program clarifications that we learn of through client work.

As described throughout, Mercer's team of former CMS officials and SMEs provides us with unique perspective on sub-regulatory guidance and program clarifications. Recent examples of sub-regulatory guidance that Mercer has assisted states with interpreting and implementing include the State Medical Director letter related to SUD 1115 Demonstrations and the Center for Medicaid & CHIP Services (CMCS) Information Bulletin on electronic visit verification (EVV), as described in detail below.

Mercer customizes our analysis to meet each state's needs. For example, we may issue brief policy "flashes" on a change when it is first issued, produce a policy white paper for an in-depth review, develop a detailed comparison chart of the current state to the proposed or required changes, or provide a verbal briefing on an issue.

Examples of Mercer Approach:

1. Substance Use Disorder (SUD)/Institutions for Mental Disease (IMD) 1115 Demonstrations

On November 1, 2017, CMS issued a State Medicaid Director letter outlining a streamlined approach for section 1115 substance abuse demonstrations seeking federal funding to provide SUD services in an IMD. We were engaged by six states to provide assistance with this waiver option.

In Delaware, we:

- Prepared a policy summary chart comparing the SUD 1115 requirements to Delaware's current program for SUD treatment to identify any gaps.
- Performed a cost analysis of complying with the Medicaid managed care rule for IMDs to determine the financial benefit of the SUD 1115 option.
- Briefed State leadership on the 1115 waiver development.
- Developed a high-level work plan for the SUD application timeline.
- Held weekly calls with Medicaid leadership on the development of the SUD 1115 amendment.
- Developed the draft and final 1115 amendment for SUD and IMDs to CMS.

2. Electronic Visit Verification (EVV)
Mercer has been engaged to assist states in meeting the EVV requirements put in place by the 21st Century Cures Act. As Mercer has assisted states with this effort, CMS has provided additional sub-regulatory guidance and Congress has temporarily extended the deadline. Mercer has tracked the evolution of the requirement and has informed states through a special EVV Listserv and other communications as the deadlines have changed and as best practices have emerged. For example, Mercer was engaged by the Arizona Health Care Cost Containment System to develop, implement, and capture information from a statewide stakeholder process for individuals and families regarding the EVV system design. Mercer conducted a provider survey to capture feedback on design and gauge the potential scope of the effort for EVV Vendor bid preparation. The initiative will result in a stakeholder informed EVV system design and procurement.

Sub-Task 1.3.1.1.C. Present policy options and draft s to guide State implementation of program changes

We understand that decision-makers in State Medicaid programs are faced with numerous, multi-faceted, and complicated policy choices and decisions. Once we have analyzed an issue and gathered information on specific state considerations, Mercer begins with a presentation of policy options that addresses the details of options but also highlights the bottom-line takeaways for decision makers (i.e., the “so what?” questions). Our policy options are often informed by operational, financial, clinical and other strategic considerations of importance to State Medicaid Directors and decision-makers. Once a decision has been made, Mercer SMEs, including project management professionals, draft work plans that are used to guide states through program and policy implementation. These work plans range from simple to complex based on the size, visibility and complexity of the project.

Examples of Mercer Approach:

1. Medicaid Expansion Benefits – Alternative Benefit Plan (ABP) Design
Mercer assisted California, Delaware, and Louisiana with the selection of each State’s benefit package for the Affordable Care Act (ACA) Medicaid expansion population. Each project entailed:

- A kick-off meeting.
- Feedback from the state on policy priorities and interest in Medicaid alignment.
- Selection of essential health benefits benchmark benefit plan options for comparison.
- Review of Medicaid state plan benefits.
- Review of the ABP final rule.
- Discussion of the medically-frail exemption implications.
- Drafting policy recommendations for the State Medicaid program.

In California, Mercer issued a formal, detailed report on the benchmark benefit plan options that led to the State’s selection of its ABP benefit package. In Delaware and Louisiana, Mercer developed a tool for documenting the analysis, completed the tool,

and reviewed the results with State Medicaid staff.

2. Non-Emergency Medical Transportation (NEMT) Program Change
Ohio engaged Mercer to assist the state in analyzing how to make changes to its existing NEMT program. In Ohio, the Medicaid NEMT benefit is currently administered by the State's 88 county departments of job and family services and the managed care plans provide NEMT trips over 30 miles. Mercer held a kick-off meeting with Ohio to discuss its goals for NEMT redesign, share examples of other NEMT programs across the country and discuss possible options for Ohio to consider. In addition, we provided a sample work plan to illustrate how the work effort would change depending on the option Ohio selected. Over time, this project has been influenced by stakeholder responses and other external forces. We have adapted as necessary and continue to advise Ohio in considering options, understanding stakeholder concerns, and adjusting our project plan as necessary to accommodate the ever-changing environment.

Sub-Task 1.3.1.1.D. Research and identify Medicaid and CHIP program national best practice standards

Our clients often request environmental scans of what other states are doing on a specific issue. While we are able to conduct this research through secondary sources, because we have experience working with over 30 states and territories, we are also able to consult with our own colleagues to gain an understanding of what states are doing.

Examples of Mercer Approach:

1. Virginia Joint Legislative Audit & Review Commission (JLARC)
The 2015 Virginia General Assembly, through House Joint Resolution (HJR) No. 637, directed the JLARC to study the Commonwealth's Medicaid program. The study mandate specifically directed JLARC to examine processes used to determine eligibility, whether the most appropriate services are provided in a cost-effective manner, and to review evidence-based practices and strategies that have been successfully adopted in other states and could be used in the Commonwealth. To assist with the review, JLARC contracted with Mercer to conduct research into five specific areas (Task Areas) of interest in order to identify key drivers of cost growth through tasks, such as measuring the cost effectiveness of specific aspects of Virginia's Medicaid program, comparing current Virginia Medicaid practices against those of other states, and identifying specific practices that could be used to reduce costs while maintaining or improving the quality of care. The five specific task areas were:

Task Area 1 – Managed Care Cost and Oversight
Task Area 2 – Increasing Enrollment of Disabled Beneficiaries
Task Area 3 – Service Utilization of High-Cost Beneficiaries
Task Area 4 – Long-Term Care Services
Task Area 5 – Community-Based Mental Health Resources

Mercer surveyed the federal regulatory landscape, interviewed Virginia Medicaid officials, gathered and analyzed program data, and produced a detailed report of program and policy recommendations relating to program design, oversight and

monitoring. For additional information, a full copy of the report Mercer's work supported can be found at http://jlarc.virginia.gov/medicaid-2016.asp.

2. Procurement and Readiness Review/Kansas

One area where we rely not only on secondary sources but on past experiences is with state managed care procurement design, evaluation and readiness review. We have been asked by clients in the past to help them develop managed care procurements that, among other things, (i) ensure the State is contracting with prepared partners, (ii) mitigate protests, and (iii) include best practice requirements. Mercer's assistance related to managed care procurements is shaped by lessons learned from procurements in other states. We often draw from not only our experiences with other states but also conduct research and analysis to identify national best practice standards through interviewing states and reviewing related policies/contracts, reviewing Office of Inspector General Reports to identify problem areas, and staying current on Medicaid trends.

With these guidelines, and the breadth and depth of Mercer expertise in all aspects of Medicaid and publicly funded health services, Mercer has provided strong, supportive leadership and assistance to clients' procurement process. For example, recently for the State of Kansas, we were asked to consult on the state's a procurement process including the RFP, evaluation criteria and tools, and readiness review process. In developing the RFP, we broke out into targeted teams comprised of Mercer SMEs and state staff who would be responsible in implementing and managing the related areas. These teams met and discussed current processes in the state, looked at national best practices and other state examples of contractual requirements and then developed program requirements to be included in the RFP. Among other things, Kansas was interested in including value based purchasing requirements in the RFP. The team met with Mercer SMEs to discuss the state's goal for value-based purchasing (VBP) and to understand other state examples for how they have implemented and managed VBP requirements. Mercer was then able to take the decisions reached in the team meetings to draft RFP language.

Sub-Task 1.3.1.1.E Serve as technical resource to State staff to anticipate CMS questions and minimize approval timelines

Mercer has assisted numerous states with technical assistance support that requires federal approval, and we are aware of typical questions that CMS will ask and the "hot buttons" that federal reviewers look for in their review. Most importantly, our experienced team of health care consultants is intimately knowledgeable with the terminology that can make the difference between an efficient CMS review and approval process and a process that is long and drawn out. The Mercer team brings the skills and experience to help DHS navigate the federal approval process, including engagement with federal partners such as the OMB, successfully. Mercer will draw upon its extensive experience in assisting DHS in securing timely positive CMS approvals.

One of the challenges today is interpreting emerging CMS policy from the new Trump Administration. In some cases, history and precedent are still reasonable predictors, but in other cases, we are anticipating CMS reactions in unchartered territory. In addition to the information we receive from sources such as public reports, environmental scans, and SPA and waiver tracking, our Mercer policy team meets regularly to compare

experiences with our clients to identify policy themes, shared experiences with CMS discussions, and other information that helps us best leverage our national experience for our clients. State confidentiality is always respected in these discussions.

Examples of Mercer Approach:

1. Puerto Rico
Mercer has worked with the multiple states and territories acquiring approvals for capitation rates, cost sharing, SPAs, waivers, RFPs, and MCO contracts. For example, Mercer assisted Puerto Rico in the procurement of managed care plans to provide health services to qualified individuals under MiSalud, the Commonwealth's Medicaid program. Mercer developed managed care contracts and worked with the Medicaid agency's attorneys to revise as needed. Mercer took a lead role in negotiating with CMS regarding the contractual elements and how certain requirements would be operationalized by the Medicaid agency, which paved the way for federally-required approval of the contracts.

2. Louisiana
Mercer helped prepare Louisiana's waiver application (including public notice materials) and the implementation plan for an SUD 11115 waiver. Both must both be approved prior to Federal funding of SUD 1115 waivers.

One of the successes with Louisiana was the expedited approval of Louisiana's SUD 1115 prior to capitation payments being subject to the new managed care rules for "in lieu of" services for IMDs. Mercer provided Louisiana staff with talking points and anticipated CMS questions to ensure that Louisiana was prepared for CMS discussions. We also developed a proposed approach to budget neutrality for a managed care SUD 1115 that as well-received by CMS and reflected in the final approval. This behind the scenes work was critical to Louisiana achieving approval of their 1115 waiver in an expedited fashion.

3. Ad-hoc Technical Requests
Our policy SMEs routinely field questions from our state clients about a range of policy issues and CMS strategies. Examples of very issues include: IMDs, directed payments, provider taxes, behavioral health coverage, Medicaid eligibility, managed care contract approvals, hospital upper payment limits, Medicaid buy-in, and section 1332 Waivers. While no single individual knows everything there is to know about Medicaid policy, every individual Mercer policy SME has the depth of our entire team supporting our technical assistance.

Performance Measure Assurances

Mercer assures that it will (i) provide Deliverables to DHS and CMS that are 100% free from grammatical, formatting, or technical errors, (ii) provide Deliverables on time as determined by DHS 100% of the time, and (iii) respond to DHS emails and telephone calls within eight business hours of receipt.

Mercer's approach to ensuring compliance with these performance measure standards begins with our approach to project management.The Mercer team's exceptional project management skills allow us to plan, schedule, monitor, and control a process to deliver a project on time and on budget through communication and facilitation that meets or

exceeds your expectations. We apply rigorous project management standards and processes to our work and continuously capture lessons learned and best practices in our training and development programs. Our team will employ our project management tools and techniques to effectively coordinate and manage the work efforts of assigned staff, ensuring all tasks, activities, and functions are completed effectively and in a timely manner.

Mercer understands the work anticipated for this engagement is dynamic in nature, and we are prepared to work side-by-side with DHS to identify initiatives, scope the work, and advise DHS when additional resources are needed to complete the work.

Mercer will lead a cross-organizational team in the development of a detailed project management plan that describes how the project will be managed to meeting project objectives. It is during the planning process that the project management team is the busiest, facilitating discussions and making decisions about how to complete the work, including:

- Identifying project stakeholders and their influence on/role in the project.
- Developing a communication plan that establishes frequency and type of communication.
- Identifying, sequencing, and scheduling tasks to develop a work breakdown structure (project work plan).
- Assigning project resources to each task and populating a RACI Chart.
- Establishing measures and processes for controlling and assuring quality.
- Identifying project risks and mitigation/contingency plans (including documenting the process for risk management).
- Establishing a tool to track risks, actions, issues, and decisions.
- Identifying criteria for determining that each deliverable (work product) is complete.
- Identifying method, content, and frequency of status reporting.
- Developing criteria and processes to measure and influence project success.

The Responsibility, Action, Consultation, Information (RACI) Chart is used to identify the roles stakeholders will have for the tasks listed in the work plan. It is then used to determine the strategy for project communications. Each stakeholder is identified by the role that they are required to perform for the delivery of each milestone, as follows:

R →	**Responsible for delivery of milestone**
A →	**Takes action to complete the milestone**
C →	**Must be consulted before milestone can be completed**
I →	**Must be kept informed in relation to the milestone**

Following standard project methodology, once planning is complete, the project advances to executing and monitoring/controlling project work (also known as do/review processes), which happen simultaneously. At this point in the project lifecycle the project will consume the most resources and produce the most deliverables because it is where most of the work is carried out. Mercer's project management team will work with DHS to coordinate work and identify areas where resources need to be leveled to ensure that project execution is going according to plan. Mercer's Project Manager is responsible for managing project constraints and overseeing the day to day project activities including ensuring that:

- Quality management activities are taking place (e.g., as part of peer review, deliverables are being checked against criteria established in the planning process and described in the project management plan).
- Communication is flowing to all project team members and stakeholders as intended (i.e., project team members are following established communication protocols).
- Schedule and scope variances are addressed (e.g., team is meeting timelines).

To ensure high-quality consulting and work products, all work performed by Mercer is subject to a strict quality assurance process. We have clear, professional standards regarding the process of “peer review” (quality control) at various steps in product development. Mercer believes peer review of professional work delivers the highest-quality service to our clients. Peer review ensures our work is consistent with best practice and conforms to our objective of delivering work that is both excellent and error free. Mercer requires that all our professional work be thoroughly peer reviewed by properly qualified colleagues before being released to the client. Professional work includes, but is not limited to, letters, reports, spreadsheets, proposals, presentations, speeches, and articles, as well as internal documents that our consultants may rely upon in providing advice to clients. Professional work also includes advice provided orally or transmitted by facsimile or other electronic means.

We apply peer review from a number of perspectives, reviewing all work products for:

- Technical accuracy of all calculations and work products including overall reasonableness.
- Consulting appropriateness to ensure soundness of the approach and that the appropriate issue/question has been completely addressed in a clear manner.
- Editorial correctness.
- Final look to ensure a professional work product appearance that meets delivery and other specifications.

In addition to monitoring individual contributions, Mercer also monitors the project as a whole to ensure that it is on track to meet the requirements agreed upon with DHS to complete the technical assistance analysis:

- Stick to the schedule.
- Anticipate and manage risks.
- Communicate effectively.
- Deliver results.

Task Area 2 Deliverable – Policy Support Services to Ensure Federal Compliance

Mercer understands that DHS is seeking policy support services to ensure Federal compliance including but not limited to:

A. Provide support for policy development of DHS initiatives impacting Medicaid and CHIP, as requested.
B. Provide policy guidance to DHS staff to support ongoing operations of Iowa’s current Medicaid and CHIP programs.

C. Assist in drafting required federal authority documents necessary to secure federal approval for new or updated Medicaid or CHIP policy changes, including, but not limited to:
   a. SPAs
   b. Section 1115 Demonstration Waivers
   c. Section 1915(b) Waivers
   d. Section 1915(c) Waivers
   e. Section 1915(i) Waivers
   f. Public and Tribal Notices
D. Assist in drafting state-specific documents for program implementation, including, but not limited to:
   a. State administrative rules
   b. Communications to Medicaid or CHIP Members, Medicaid providers, and other interested stakeholders
   c. Draft work plans for policy implementation
E. Assist DHS staff in responding to Federal inquiries regarding Medicaid and CHIP programs.
F. Provide policy guidance and requested support to DHS staff regarding required federal reporting.
G. Participate in meetings and calls with DHS staff, CMS staff and other federal or state partners.
H. Facilitate weekly calls with DHS staff and the Contractor.
I. Serve as a technical resource to DHS staff.

Mercer agrees to comply with these requirements.

Mercer's Core Approach to Policy Support for Federal Compliance

The Mercer team possesses rich and varied experience in helping states (i) identify regulatory obstacles and opportunities and (ii) achieve federal approval to implement policy changes within the states' Medicaid/CHIP program. This has included initiatives to modernize eligibility (e.g., MAGI conversion, express lane eligibility, transition to 1634 for aged, blind and disabled), covered services (e.g., behavioral health services for children and adults, ABPs, 1915(i) SPAs), system delivery (e.g., MLTSS, health homes, integrated care models in both fee-for-service (FFS) and managed care), reimbursement (e.g., hospital DRGs, nursing facility reimbursement, shared savings and other payment reforms in both FFS and managed care), and program sustainability/financing (e.g., cost-sharing, provider taxes, intergovernmental transfers, upper payment limits, and certified public expenditures).

The key to our success in helping states evaluate, plan, negotiate, and implement federally-complaint initiatives in their Medicaid/CHIP programs is our in-depth understanding of the statutes, regulations and policies that govern the Medicaid and CHIP programs and **how to use these rules to further a state's policy and program goals.** This includes familiarity not only with the black-letter law set forth in the Social Security Act (particularly Title XIX and Title XXI) and the Code of Federal Regulations (particularly Title 42 and parts of Title 45), but also:

- State Medicaid Director and State Health Official letters
- CMCS Informational Bulletins

- Frequently Asked Questions posted on the CMS website
- The State Medicaid Manual
- Proposed rules
- Application and instructions for Section 1915(b) and 1915(c) waivers
- "Unwritten" policies as to what CMS has or has not been willing to waive in Section 1115 demonstration projects
- Recently approved SPAs, 1915(b) waivers, 1915(c) waivers, and Section 1115 demonstration projects
- The current administration's policy and program priorities

The Mercer team can identify the statutory, regulatory and sub-regulatory obstacles to achieving DHS' objectives and, more importantly, find ways to overcome them. Indeed, our team has a wealth of experience with assisting states in obtaining approval of different Federal authorities including State Plan, 1915(b), 1915(c), 1915(i), and 1115 authorities. Mercer has hired several former CMS and state Medicaid officials as full-time Mercer employees in our Policy, Operations and Planning Sector and, as such, has first-hand knowledge of the inner workings of CMS. As a result, we have a heightened appreciation of CMS' expectations of states – we know the right questions to ask and the appropriate timing to engage CMS. The experience of the Mercer team gives it an unparalleled "tool box" to identify the best approach for obtaining federal approval for Iowa's initiatives.

As described in the technical assistance task, in order to provide services to our clients, we monitor, track, and analyze CMS publications regarding policy, regulations, and other guidance and implications for state programs. In light of the potential for dramatic changes in Medicaid at the Federal level and the continually evolving regulatory environment, we believe our experience in this area makes us a valued partner for upcoming anticipated (and any unexpected) policy changes. The expertise and background of our staff has allowed us to assist our clients with a wide range of health policy issues.

Whether it be technical assistance or policy support, Mercer's approach is consistent and structured. With every request, DHS will know what to expect from Mercer – we will listen to DHS' goals and expectations, develop a plan to meet those goals and expectations and deliver the necessary support. Depending on the request, we will start with gathering information and relevant research including but not limited to, other state experience, previous waiver/SPA submissions, and any other relevant documentation. We would then hold a kick-off meeting with DHS to review goals for the policy support, discuss any data needs or open policy questions, explore options for addressing any necessary changes and establish timelines for the support. Understanding the timeline and key milestones is critical as it relates to federal compliance. For example, if the policy support is around an 1115 Demonstration, we will develop a project plan that identifies not only CMS transparency requirements for public notice but also that takes into account when final policy decisions must be made and when materials need to be reviewed by key leadership.

There are many aspects to determining the right policy strategy. Mercer is committed to being DHS' on-going strategic partner and leverage our work in numerous other states to help you decide what is best for Iowa. Decision points that are part of any policy strategy include, but not limited to the following:

- What are the specific goals and objectives of the new initiative? Short-term versus long-term?
- What is DHS seeking to change or do differently going forward?
- What populations and services will be impacted?
- Does the new initiative require a waiver or could it possible be accomplished through a SPA? What are the pros and cons of each approach?
- Does the new initiative fall within the realm of what CMS can approve under a non-1115 waiver or is an 1115 waiver the only route to achieve DHS' goals?
- Is an 1115 waiver a better overall solution even if a non-1115 waiver can accommodate the requested changes?
- How can various waiver authorities be used to build future changes/innovations over time as needs and goals evolve?
- What is the best approach for engaging CMS? Is a "concept paper" needed?
- What questions should be asked (or not asked) of CMS?
- How should external stakeholders be engaged and when, including as needed to conform to federal requirements on public notice?

Mercer will use its Medicaid expertise to assist Iowa with the requested policy support, this may include but is not limited to:

- Designing the key features of a proposal (e.g., eligibility, enrollment, covered services, service delivery, quality improvement, payment, and financing).
- Conducting regulatory analysis (e.g., identifying regulatory obstacles and finding ways to overcome them).
- Conducting stakeholder meetings.
- Drafting the SPA waiver/contract proposal.
- Participating in negotiations with the federal government.
- Implementing the waiver/proposal (e.g., developing and managing an implementation work plan, assisting with procurement, helping with organizational redesign and drafting policies and procedures).

Once the scope of the policy support is defined and a timeline and project plan are agreed to, we will then provide the support and manage the project plan to meet the DHS' request. We anticipate that the policy support will require working closely with DHS throughout the project. Our approach to drafting a waiver application is illustrative of how we anticipate partnering with DHS as we provide policy support:

- Meet with DHS to understand the goals of the proposal and to discuss its design.
- Conduct a regulatory analysis.
- As applicable, prepare documents to assist DHS in making key decisions.
- Conduct a financial analysis, if requested, or partner with the IME actuary or financial staff to ensure consistency between the policy and financial analysis.
- Follow-up with DHS as necessary to resolve outstanding questions/issues.
- Conduct an internal review of the waiver/proposal.
- Provide an initial draft to DHS.

Mercer will work with DHS to establish a process for gathering feedback from DHS on policy support deliverables. Feedback can be provided verbally (e.g., during a walkthrough of the document) and/or in writing. We will then revise the deliverable and provide a clean and "track change" version to DHS.

As requested, Mercer can also participate in discussions with CMS through in-person meetings, conference calls, or written communications. As explained above, Mercer has assisted numerous states with policy support that requires federal approval and we are aware of typical questions that CMS will ask and the "hot buttons" that federal reviewers look for in their review. Most importantly, our experienced team of health care consultants is intimately knowledgeable of the terminology that can make the difference between an efficient CMS review and approval process and a process that is long and drawn out.

Mercer's assistance does not need to end with federal approval of a policy initiative. We are also able to assist DHS in resolving issues related to implementation and on-going operations as requested.

While we understand that the request for policy support may encompass additional tasks that were not identified in the RFP, we have provided high-level approach for the tasks enumerated in A-I in the RFP and provided examples of similar policy support performed for other clients below. We believe these examples further demonstrate our depth and breadth of experience and illustrate how we approach providing policy support to ensure federal compliance for our clients.

Sub-Task 1.3.1.2.A Support for policy development of state initiatives impacting Medicaid and CHIP

Our team has extensive experience for providing policy support in developing state initiatives that impact Medicaid and CHIP programs. In assisting with developing state initiatives it will be crucial to understanding the state's goal and timeframe. In helping DHS develop Medicaid/CHIP state initiatives, we will draw upon our experience in other states and conduct research as appropriate and necessary. We can provide the state with options to consider in developing state initiatives, outline pros and cons and describe explicit implementation steps to operationalizing the state initiative options.

Examples of Mercer's approach:

1. Louisiana Behavioral Health Integration
When the Louisiana Department of Health (LDH) implemented Medicaid and CHIP physical health and behavioral health integration in 2015, they were challenged to develop a long-term waiver strategy for their Healthy Louisiana managed care program that had largely relied on Section 1932(a) State Plan authority. Mercer helped LDH sunset its 1915(i) SPA, amend its 1915(c) waiver, and transition its authorities to a concurrent 1932(a)/1915(b)/1915(c) program in order to achieve its policy goals of preserving existing 1915(b)(3) savings and leveraging the 1932(a) SPA authority as much as possible.

2. Ohio Community Engagement Requirement
Mercer has a contract with the State of Ohio to provide program and financial modelling resources to the State agency as requested. In the fall of 2017, Ohio requested Mercer's assistance with an 1115 Demonstration waiver to implement community engagement requirements for their Group VIII Medicaid expansion population. The Ohio Department of Medicaid was required to pursue an 1115 waiver to impose a community engagement requirement through state statute. Specifically, Ohio asked that Mercer (i) work with the State to draft the waiver, (ii) assist with public transparency requirements, (iii) assist the state with CMS negotiations and (iv) provide technical assistance related to implementation. Mercer scheduled a kick-off meeting with Ohio to discuss the project and related timelines. In advance of that meeting, Mercer reviewed the other states' pending community engagement requests, Ohio's supplemental nutrition assistance program work requirements, and developed an initial timeline and work plan for discussion. During the kick-off meeting, we discussed Ohio's goals for the program, had initial discussions related to policy decisions for how the program would operate and finalized the timelines. Since that time, we have helped Ohio draft the waiver application, conduct public hearings to solicit public feedback on the draft application, summarize the over 900 comments received and submit the application to CMS. We are currently assisting Ohio with waiver negotiations and providing technical assistance around waiver implementation.

Sub-Task 1.3.1.2.B Policy guidance to support ongoing operations of current Medicaid and CHIP programs

Policy guidance to support ongoing Medicaid and CHIP operations is the core of our work with states, particularly with Delaware, Ohio, Louisiana, Missouri and New Mexico. We have provided the examples below to best illustrate the types of assistance we provide and serve as an extension of state Medicaid/CHIP policy staff.

Examples of Mercer's approach:

1. Delaware
An integral part of Mercer's support to Delaware is related to on-going advice and evaluation of Medicaid and CHIP policy issues and operations. Specifically, Mercer has provided the following consulting services related to ongoing operations to Delaware:

- Assistance with Delaware in compliance with a Department of Justice Olmstead settlement.
- Technical support on Medicaid claims rules and regulations for BH/substance abuse services provided to Medicaid-eligible populations.
- Interpretation and summaries of the ACA as it applies to Delaware's programs and new options/alternatives/mandates in the ACA.
- Technical support and comprehensive compliance support with the Medicaid/CHIP Managed Care Final Rule including a multi-track team to ensure State compliance with all Final Rule provisions.
- Technical support and comprehensive compliance support with the HCBS Settings Final Rule including helping Delaware become one of a small number of states with CMS-approved transition plans.

- Ad-hoc questions related to NEMT services, ACA expansion populations, 1115 waivers, 1915c waivers,VBP options and summaries of other state Medicaid initiatives.
- Research and evaluation of flexiblity to use managed care in lieu of services flexibility for value-added services.

2. Missouri

To support the operational efforts of the State and implement the policies and procedures in managed care, Mercer supports the State to interpret and implement Federal and state requirements. Mercer provides State training and consulting regarding the comprehensive requirements of the Medicaid Managed Care Final Rule and supports the State in developing and revising MCO contract language for compliance with the rule. Mercer provides procurement support for the MCO contracts, as well as the NEMT program including: drafting of RFP language, developing evaluation criteria, responding to bidder questions and providing input on price evaluation. Mercer has worked with the State to provide policy and actuarial consulting related to the potential Medicaid expansion population as defined in the ACA. Assistance has included alternative benefit package design, financial cost estimates for the expansion population under various delivery options and federal authority options for streamlined efficiency that best meets the needs of the State.

3. Virgin Islands

Mercer has provided Medicaid & CHIP policy and operational consulting services to the United States Virgin islands, Department of Human Services (U.S.V.I.), since 2009. Activities have included several rounds of Medicaid expansion, MAGI transition, ACA compliance, implementation of MMIS, and implementation of an Integrated Eligibility and Enrollment (IE&E) system. Specifically, Mercer has performed the following activities for U.S.V.I.:

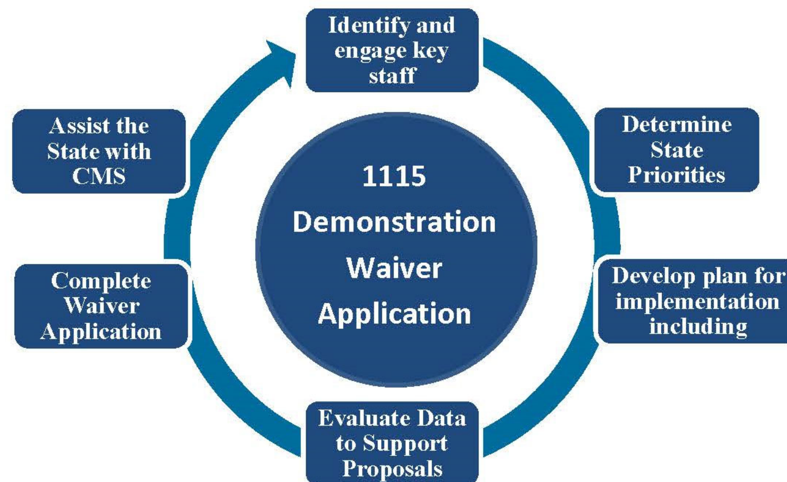
- Drafting and implementing numerous SPAs for compliance, expansion, and MAGI transition.
- Modernization of eligibility and enrollment processes and systems.
- Implementation of expansions, including analysis, CMS negotiation, SPAs, processes, systems, and training.
- Procurement and implementation of an MMIS through a partnership with West Virginia.
- MAGI transition, including analysis, CMS negotiation, SPAs, processes, systems, and training.
- Procurement of a Pharmacy Benefits Manager.
- Procurement of an IIE&E vendor, from writing the RFP, APDs, IAPDs, IAPDUs to participation in design and implementation and negotiations.
- Integration of Medicaid, SNAP, and TANF eligibility and enrolment systems and processes.
- Implementation of hospital presumptive eligibility including developing agreements, training materials and conducting training and implementation.
- Performed two reconciliations of past years’ funding claiming that resulted in reimbursement of over $34 million in federal funds.

Sub-Task 1.3.1.2.C Assist in drafting required federal authority documents necessary to secure federal approval for new or updated Medicaid or CHIP policy changes

Examples of Mercer's approach:

1. State Plan Amendments (SPAs)
Mercer has experience in assisting states and territories in drafting SPAs, completing public notice (if required), responding to CMS inquiries and gaining CMS approval. We help states with draft SPAs, public notice (when required), CMS informal and formal questions, and final approval. For example, we have assisted Puerto Rico in submitting Social Security Act section 1916 SPAs related to co-payments and cost sharing. In addition, we assisted Louisiana in completing its section 1932(a) managed care SPA and alternative benefit plan SPA defining the benefit package for its Medicaid expansion population. In both instances, Mercer's knowledge of the Social Security Act requirements and SPA template were critical in the Territory/States receiving timely approval from CMS.

2. Section 1115 Demonstration Waivers
Our comprehensive approach to supporting development of 1115 demonstration waiver applications consists of six major phases:



Mercer has experience assisting with the stakeholder process, concept paper, public meeting process, actual waiver application, budget neutrality and CMS negotiations. We have experience managing all aspects of the 1115 waiver design and development, and we have partnered with other state vendors (e.g., project managers, actuaries) when that is a state's preferred approach to waiver development. In 2018, Mercer has assisted states with six 1115 waiver applications. Our key steps include:

Identify and Engage Key Staff
Key state staff are identified and engaged early in the process. This includes those at the leadership level (e.g., Cabinet Secretaries, Medicaid Directors, Deputy Directors) and operational staff who are intricately involved in the daily program operations and have knowledge of the nuances of the program and associated issues.

Determine State Priorities

Successful 1115 waiver applications clearly articulate a state's goals, program objectives and design elements. We engage with the client, early in the process, to determine the state priorities in designing, or for waiver renewals modifying the state program. Through staff engagement we assess:

- Where there are gaps in the state's delivery system that need to be addressed.
- Relevant design components that need to be incorporated into the design.
- Stakeholder concerns and issues.
- Political environment.
- Identifying what information is readily available to use in policy and financial decisions.

Our value to states is that we can provide technical support on a variety of topics by offering a national perspective on trends and examples of initiatives CMS has approved, CMS' current priorities, and examples of program design elements from approved programs for consideration. Due to our experience in other states and understanding of federal policy operations, we often know CMS hot buttons and issues of concerns and share this guidance with our clients in developing and or modifying programs.

Develop Plan for Implementation

Building from the prior step, we work to develop a project plan for completion of the initiative that identifies: key milestones and tasks (including CMS requirements for public notice, review of final application by key leadership and timeframes for engaging key political leadership, project team members assigned to complete each task, target completion dates, and an explicit list of expected deliverables. The project plan is used to manage the comprehensive initiative and therefore should be updated regularly and used to help identify potential risks.

Evaluate Enrolment, Programmatic, and Financial Performance Related to the Development or Renewal of the 1115 Waiver/Data Production

An important component of developing an initial or renewal 1115 is having a complete historical picture of the enrollment and costs for the populations of the program including a comprehensive knowledge of changes that occurred historically or are being considered in the near future and identification of related data. These components are significant to the process because they often will support and inform proposed policies and also impact the states approach to the five year budget neutrality identifying areas of unknown or risk for the state. Once we are able to identify the data needed to help inform policy decisions, we look to our informatics experts to conduct multiple analyses to provide options for consideration. If we are working with DHS' actuary or other financial staff, our goal is to ensure that the budget neutrality demonstration and policy requests are aligned.

1115 waivers, both initial and renewal, are negotiated agreements between the state and CMS. During the negotiation process policy options and final decisions may change directly influencing the program. Having already identified and analyzed data to support the states policy positions and budget neutrality is a significant step in the development phase and also during CMS negotiation.

Complete the Waiver Application

CMS has specific requirements about the outline and specific focus areas to address in the waiver application. Section 42 CFR 431.412(a)(1) prescribes the elements to address in an 1115 waiver application including:

- A comprehensive program description of the application.
- A description of the proposed health care delivery system, eligibility requirements, benefit coverage and cost sharing that will apply to individuals impacted by the demonstration.
- Current and projected enrollment data and expenditures.
- Requested waiver and expenditure authorities.
- Address existing requirements for the 1115 Demonstration Waiver Renewal application prescribed in the STCs.
- A description of the research hypotheses that the demonstration will test and a plan for evaluating the hypotheses; and
- Documentation of the state's compliance with the public notice requirements.

Assist the State with CMS Questions

Once submitted we assist the state respond to questions and inquiries from CMS about the application and address areas where CMS requests requires modifications to proposed policies and approaches.

Our range of assistance to clients on various types of 1115 demonstration waiver programs includes but is not limited to:

- Develop programs for specialty populations such as former foster care youth transitioning from another state or system redesign for children with co-morbid behavioral health and physical health conditions.
- Develop strategies to maximize program efficiencies and obtain improved quality outcomes, such as value-based purchasing arrangements and Delivery System Reform Incentive Payment (DSRIP) programs.
- Designing and implementing integrated MLTSS.
- SUD initiatives.
- Designing community engagement requirements.

Our approach has a proven track record of obtaining CMS approvals as quickly as possible. Indeed, as described above our experience with Louisiana's SUD 1115 waiver resulted in an expedited approval. Our approach to 1115 waivers and our subject matter expertise enables us to help DHS obtain federal approval as quickly as possible. Our assistance to DHS can include helping respond to CMS' questions and/or preparing position papers that support the State's approach. Our national policy experts and former CMS staff who know what issues, concerns, and questions CMS will likely raise will be able to thoroughly prepare DHS staff for the negotiations.

3. Section 1915(b) Waivers

CMS has a specific and standardized process for submitting 1915(b) waiver requests and renewal requests. The 1915(b) Waiver Preprint is comprised of four sections, plus any needed additional documentation provided via attachments. Mercer has assisted

many states in developing their 1915(b) applications, renewals and cost effectiveness support.

Our experience related to policy support for 1915(b) waivers includes:

- **Louisiana:** CMS strategy, actuarial, and policy assistance for Louisiana's concurrent Section 1932(a)/1915(b)/1915(c) Healthy Louisiana Medicaid managed care program. Assistance included program design, drafting waiver applications (including the cost-effectiveness and cost-neutrality tests and the 1915(b)(3) waiver savings proposals), and federal waiver negotiations for the initial waiver approvals, amendments and renewals.

- **Missouri:** Actuarial and policy support for 1915(b) waiver renewals, amendments, and cost effectiveness analyses.

- **Ohio:** Development of the MyCare MLTSS demonstration for dual eligibles, which included support for program design and development of the state's 1915(b)/(c) waiver authority and assistance with CMS negotiations.

- **Pennsylvania:** Providing technical assistance over time on the Commonwealth's HealthChoices 1915(b) waiver that provides physical and behavioral health services.

4. Section 1915(c)

Mercer understands the 1915(c) template and has experienced professionals who have assisted states in completing these waiver applications. For example:

- **Ohio:** Provided technical guidance in amending an HCBS 1915(c) waiver to add a new shared living benefit.

- **Pennsylvania:** Managed the State's process to renew two 1915(c) HCBS waivers targeted to individuals with DD. Activities included:
  - Managed timeline for the processes.
  - Presented an overview of process and timeline to State leadership.
  - Developed waiver amendment language.
  - Provided technical support to the State on CMS requirements.
  - Tracked stakeholder responses to amendment changes.
  - Provided support in responding to CMS questions.

5. Section 1915(i) SPA

Similar to other SPAs and waiver applications, Mercer understands the 1915(i) SPA template and issues to consider when completing the template. Our experience working with other states on 1915(i) SPAs include developing the program, completing the SPA template, working with stakeholders, assisting with CMS negotiations and implantation. We offer the following as specific examples of this work:

- **Delaware:** Managed the Division of Medicaid and Medical Assistance (DMMA) initiative to develop a 1915(i) HCBS program, Pathways, targeted to people who are interested in and have the ability to work. Activities included:
  - Designed the program.
  - Developed the 1915(i) SPA template.

  - Developed 1915(b)(4) waiver allowing the state to limit case managers and transportation providers.
  - Developed and implemented stakeholder engagement strategies.
  - Developed stakeholder engagement materials.
  - Responded to CMS questions on the amendment and waiver.
  - Facilitated DMMA internal team meetings.
  - Tracked and monitored stakeholder responses to major issues.

- **Ohio:** Assisted the State in the development and implementation of a 1915(i) SPA targeted to individuals with severe and persistent illness.

6. Public and Tribal notices
Mercer understands the public notice requirements related to SPAs and waivers and recognizes that CMS is currently reviewing compliance with public notices with enhanced scrutiny. Mercer understands when public and Tribal notices are required (and even when not statutory required, when they should be used as a best practice). We have assisted states with the public notice processes in a number of different ways. For example, for 1115 Waivers, we have developed a checklist to ensure that the state complies with all of the federal transparency requirements. Recently, for Ohio, we drafted the state's 1115 Waiver public notices, developed a high-level presentation of the waiver request and presented the summary of the waiver at the state's two public hearings. We summarized all of the comments received and developed responses for the state to include in the state's 1115 application. In addition, while helping New Mexico design, develop, and implement its Centennial Care program (a fully integrated MLTSS), Mercer worked with the State to develop a new approach to public meetings. This approach randomly assigned participants to groups and asked each group to work on developing specific design features. Mercer believes that this approach significantly increased community involvement and ownership and ultimately resulted in an improved program design.

In 2013, Idaho engaged Mercer to assist with the Statewide Healthcare Innovation Plan (SHIP) model design process, including building a structure for discussion and then facilitating stakeholder engagement. Mercer designed a widely inclusive and collaborative stakeholder engagement plan to bring together consumers, payers, advocates, physicians, public health professionals, and tribal leaders, among others, in articulating Idaho's vision for change. Stakeholders with targeted expertise led the process by participating on the SHIP Steering Committee. In addition to facilitation of the Steering Committee, Mercer facilitated four stakeholder workgroups (on the topics of Clinical Quality Improvement, Network Structure, Health Information Technology, and Multi-Payer Models) who provided recommendations to the Steering Committee. The four workgroups were engaged over a period of months and met regularly. In addition, to ensure the broadest stakeholder input possible, Mercer facilitated focus groups, town hall meetings, and tribal consultations throughout Idaho.

Sub-Task 1.3.1.2.D. Assist in drafting state-specific documents for program implementation including:

1. State administrative rules
Mercer understands that each state uses its administrative code and other implementation/policy manuals in different ways. In addition, Mercer also understands

that each state has its own process and timeframe for updating its administrative code and implementation/policy manuals. We have experiencing assisting states with updating state regulations/policy manuals and drafting new state regulations/policy manuals.

For example, in 2011, New Mexico expanded Mercer's contract to include policy and operations services related to the transformation of the State's Medicaid service delivery system. This included assisting the State with the design, development, and implementation of Centennial Care, which is a fully integrated managed care program in which the MCOs are responsible for providing the full array of behavioral health, physical health, and long-term services and supports (LTSS) (both HCBS and institutional services) to members. Fully integrating the program meant that many changes had to be made not only to procurement process and contracts but also to the state's administrative code. Understanding that the process to update and change administrative code is cumbersome and requires significant notice to implement timely, Mercer worked with New Mexico to determine whether some implementation/operational details could be included in a policy manual where changes and updates could be incorporated more quickly. Mercer worked with a designated team at the state and also consulted with the Human Service Department's General Counsel as it navigated the process of both updating the administrative regulations and developing a policy manual for the Centennial Care program.

2. Communications to Medicaid or CHIP Members, Medicaid providers and other stakeholders

Mercer has experience in several states developing communications to members, providers and other stakeholders as well as conducting stakeholder sessions with these groups to develop and implement new Medicaid policies. We are well-versed in developing communication materials and strategies that present information that is specifically tailored for each audience. When soliciting feedback from stakeholders or introducing a new policy, it is critical that the communication strategy/communication materials are meaningful to the intended audience. To that end, sometimes it is appropriate to develop different communication strategies and materials for providers, members, advocates and other stakeholders. For example, we are currently assisting the Ohio Department of Medicaid with an NEMT redesign project. Part of this process involves regional stakeholder sessions that are specifically targeted to members, providers and county agencies. Each session will be targeted to a specific stakeholder group ensuring that all stakeholders have a voice in the process.

As another example, Mercer has experience in several states working with stakeholders to develop and implement VBP strategies. Our work with Idaho and Arizona in developing their State Innovation Model (SIM) planning and design grants are good examples of our work with states and providers to develop models that address gaps in the healthcare delivery system by introducing new models of care that are informed by consumers, providers, and payers. As part of these efforts, Mercer aided the states in identifying provider capacity, infrastructure support needs, available data to developed strategies to implement delivery system and payment reform strategies. Inherent in this approach is evaluating where key stakeholders are in their ability to implement and support targeted models, as well as where they need to be over time, identifying metrics linked to measuring progress and goals and strategies for exchange of information that provides feedback to both the state and providers.

3. Draft work plans for policy implementation
We have found that work plans are incredibly beneficial when planning for and implementing a new policy. Our experienced project managers have developed draft work plans in different formats, layouts and with varying degrees of information. We are able to adapt to whatever format and style DHS prefers. In the past, we have found that a combination of detailed work plans coupled with high-level dashboards that identify upcoming key activities and deadlines at a glance prove to be successful tools. We have experience managing implementation work plans where state staff and even other contractors are responsible for completing tasks. Examples of sample work plans and dashboards are provided in Appendix B.

Sub-Task 1.3.1.2.E. Assist State staff in responding to Federal inquiries regarding Medicaid and CHIP programs.

As explained throughout this proposal, Mercer has assisted numerous States with responses to Federal inquiries regarding Medicaid and CHIP programs. We are aware of typical questions that CMS will ask and the "hot buttons" that federal reviewers look for in their review. The Mercer team brings the skills and experience to help DHS navigate responding to federal inquiries whether related to the general questions on the program or specific to approving SPAs/waiver/required templates.

As a recent example, we have assisted a few of our clients in drafting 42 CFR 438.6(c) templates to implement delivery system and provider payment initiatives. These templates must be approved by CMS before CMS will approve rates and contracts. We provided technical assistance in answering questions posed by CMS related to these templates. All of the states that we have helped through this process have received timely approval of their templates.

Sub-Task 1.3.1.2.F. Provide policy guidance and requested support to Agency staff regarding required federal reporting.

Mercer's consultants have provided technical assistance to our state clients in completing required federal reporting. For example, we:

- Assisted New Mexico with its 1115 Demonstration quarterly and annual reports including quarterly evaluation of budget neutrality.
- Helped states prepare and troubleshoot issues with the CMS-64, CMS-37, and CMS-21 reports.
- Developed 1115 budget neutrality and annual waiver reports.
- Developed internal state policy manuals for waiver program and financial reporting.
- Helped states prepare and troubleshoot CMS 372 reporting issues.
- Assisted with SIM reporting to CMS.

Sub-Task 1.3.1.2.G. Participate in meetings and calls with State staff, CMS staff and other federal or state partners.

As a key, trusted advisor to our clients, Mercer is often asked to participate in and/or facilitate meetings and calls with state staff, CMS and other federal or state partners. In

preparing for these meetings, we collaborate with each client to define our role in the discussion and define meeting agendas and other meeting materials. During meetings, we take notes and identify next steps.

If the meeting is one that involves negotiations with key stakeholders, Mercer can provide an appropriate negotiation strategy, develop informative issue documents, and/or provide advice and assistance regarding negotiation strategies and responses to stakeholder positions.

Mercer's approach to facilitating negotiations will depend on the stakeholder group, the negotiation strategy, and the role that DHS would like us to play. In our experience, negotiations at the Federal level with CMS should be led by the State with assistance as needed from Mercer. It might also be effective in some cases for Mercer to have "off-line" conversations with various CMS officials with whom they have relationships in an effort to move the negotiation process forward. In other situations, such as stakeholder meetings, Mercer may act as facilitators – a neutral party to guide and manage the group to ensure there is good participation, minimal conflict, and that DHS' goals/objectives are met. As part of facilitating negotiations or stakeholder meetings, Mercer could assist DHS by drafting meeting agenda(s), presentation materials and meeting minutes. Mercer may also take on the role of presenting at a stakeholder meeting on a particular policy area as requested by DHS. In such instances, Mercer will work closely with DHS on the messaging and share draft presentations for review and approval.

Sub-Task 1.3.1.2.H. Facilitate weekly calls with State staff and the Contractor.

Many of our clients rely on Mercer's assistance to facilitate meetings/weekly calls during the course of a project to ensure successful and productive discussions. The degree of Mercer's meeting support is tailored to meet the individual needs of the client, the project, and the meeting. For example, there may be times when it is better for state staff to send a meeting agenda, while at other times the state may wish for Mercer to distribute agendas and meeting materials. Mercer project management staff will work with DHS staff to understand the objective of each meeting and identify how Mercer could best support DHS in achieving that objective.

Typical meeting support and facilitation activities include:

- Developing and circulating meeting agendas.
- Managing meeting logistics (e.g., sending meeting invitations, providing a free dial-in line, assisting with in-person meeting logistics).
- Taking notes or scribing, including tracking decisions made, follow-up assignments and responsible parties.
- Circulating meeting notes.
- Providing meeting summaries to State leadership.

Our team of consultants all have experience facilitating weekly meetings with different clients. We know you are busy; we strive to efficiently use weekly meetings to achieve the goals of each agenda topic which may be, for example, to relay information, provide updates on tasks, or discuss open policy issues. We firmly believe it is necessary to

save time at the end of each meeting to clearly define next steps and responsibilities and often our agendas include "next steps" as a topic item to ensure this occurs.

Sub-Task 1.3.1.2.I. Serve as a technical resource to State staff.

Medicaid is rarely static and serving as a technical resource is the core of what we do. Whether state politics or federal requirements require DHS to act, the breadth and depth of Mercer's resources will be a key asset for DHS to leverage in changing times. Mercer's team of experienced professionals and SMEs will be available as technical resources to state staff throughout this engagement. We are a large consulting firm with a deep bench of resources to draw from. As noted throughout our response, Mercer has full-time employees with the following credentials and/or experience:

- Former CMS and state Medicaid/CHIP officials and policy makers
- Certified Project Managers
- Credentialed actuaries, actuarial students, and actuarial consultants
- Statisticians, financial analysts, and data programmers
- CPAs
- Registered nurses/nurse practitioners
- Psychiatrists/psychologists
- Registered pharmacists
- Substance abuse/BH experts
- Data management and information systems consultants
- Risk-adjustment experts

We have provided additional detail on staffing for technical resources in Task Area 3 (Ad-hoc) and in 3.2.5.2 Personnel. For brevity, we did not repeat this content here. Mercer understands the needs of DHS are varied, with some predictable activities (e.g., scheduled waiver renewals) and others (e.g., compliance or new initiatives) that may be difficult to predict. The ever-changing nature of health care, particularly Medicaid, requires a certain amount of flexibility and ability to adapt. We propose to serve as a technical resource to DHS staff, whether for an ad-hoc question during the course of normal daily work, or more in-depth resources over a longer-term project. Our goal is to complement your DHS staff.

Performance Measure Assurances

Mercer assures that it will (i) respond to DHS emails and telephone calls within eight business hours of receipt, (ii) provide Deliverables to DHS and CMS that are 100% free from grammatical, formatting, or technical errors, (iii) provide agendas for all Contractor facilitated meetings eight business hours prior to scheduled meetings, and (iv) provide notes for all Contractor facilitated meetings within eight business hours of the conclusion of the meeting.

Mercer will rely on its project management and quality control processes to comply with Iowa's performance measures. With respect to providing timely agendas and notes for meetings, we have extensive experience in providing timely agendas and notes that summarize the discussion and highlight next steps to ensure meetings are successful and memorialized appropriately. We will provide agendas and notes to DHS in a format

that previously agreed upon. We have found that our clients have different preferences for the format of these items and we can easily adapt to the format DHS prefers.

A detailed description of Mercer's approach to project management and quality control is described in Task Area 1. For brevity, we have not repeated the text here.

1.3.1.3 Task Area 3 Deliverable – Ad-Hoc Analysis

Over the course of this Contract, DHS may seek ad-hoc analysis that is not covered through the technical assistance and policy support deliverables described above that could include but is not limited to (i) providing policy impact analysis to support review and proposed policy changes or (ii) other analyses identified by DHS.

Mercer agrees to comply with these requirements.

Approach to Ad-Hoc Analysis Requests

Mercer understands the needs of DHS are varied, with some predictable activities (e.g., scheduled waiver renewals) and others that may be difficult to predict. The ever-changing nature of health care, particularly Medicaid, requires a certain amount of flexibility and ability to adapt. As a result, DHS may require additional ad-hoc assistance as part of this Contract. Mercer's approach to an ad-hoc request, as it is with every project, is one of collaboration and mutual respect. We would expect to work closely with DHS to identify your needs, develop an approach and determine the appropriate deliverables that are necessary to complete the request.

Staffing

First, the Project Manager (or back-up, if needed), will be the first point of contact for any ad-hoc requests. Depending on the request, the Project Manager will include the relevant Mercer SMEs to consult on an approach for the analysis. We have back-up SMEs included in this RFP response and additional SMEs that have not been included. Most SMEs regularly work with one or more individuals with similar policy expertise, which allows us to be flexible in having the capacity to respond to ad-hoc policy requests and provides appropriate peer review for the technical accuracy of responses. If an SME required for an ad-hoc policy request is not familiar with Iowa, the Mercer Project Manager will be responsible for providing the appropriate background, context and additional peer review, as needed.

As noted above, Mercer team members bring vast policy and operational experience, including leadership at the state and federal levels, and understand the environment of running a Medicaid program. Our policy and state operations expertise is bolstered significantly through the additional resources Mercer brings to the table, including individuals with expertise in financial, clinical, behavioral health, pharmacy, and information planning. These resources are a natural extension of our core support to DHS under this engagement.

Kick-Off Meeting, Project Planning, and Completion of Request

With the appropriate team in hand, we would likely schedule a kick-off meeting with DHS to discuss at a minimum:

- Whether additional research is necessary for the analysis (e.g., state regulations/statutes, relevant examples from other states).

- The appropriate format for the targeted audience of the analysis (e.g., presentation, whitepaper, high-level summaries for stakeholders, memorandums, etc.).
- Whether additional data to support the analysis is necessary and where the data can be obtained (e.g., state specific data, national data).
- The timeline to complete the analysis and associated work plan to ensure the analysis is performed according to the agreed upon timelines.

Mercer will then provide a final work plan to complete the analysis and once approved by DHS will get to work to complete request. All deliverables provided as a part of the ad-hoc request will go through Mercer's rigorous peer review process.

We recognize that not all requests will involve this level of engagement and may be ad-hoc policy questions that can be answered quickly, for example, via email or phone. Based on our years of experience with states such as Delaware, Ohio, Louisiana and New Mexico, we have confidence that our team will be able to work with DHS to be responsive and still maintain the appropriate tracking and accountability through Mercer's peer review process and the Project Manager.

Additional Assistance

As noted above, when reviewing ad-hoc requests with DHS, Mercer can draw upon its pool of over 270 professionals to ensure that we have the appropriate SMEs providing consulting advice to DHS. In addition, our team can also draw upon Mercer's Washington Resource Group (WRG) that provides assistance and in-depth research and intellectual capital development to consultants and clients on legal, technical and marketplace issues. A key area of WRG expertise is health care policies and practices. WRG has assisted our projects in the past by providing additional information research, analysis and insight into national health care reform and its impact on our clients. Furthermore, even though we are only including one subcontractor in this proposal, our contact list of other individuals and firms is robust should a need arise for a specialty skill or increased band-width to ensure our team can effectively and efficiently help you achieve your goals in subsequent work orders stemming from this RFP. Mercer will of course ask prior permission to use a new subcontractor if the need should arise in the future.

Relevant Examples

The following examples highlight a few recent ad-hoc requests for policy analysis:

Arizona Health Care Cost Containment System (AHCCCS) Pharmacy Analysis

Based on a request from AHCCCS, Mercer has a contract with the State Health & Value Strategies (a program comprised of members of Princeton University's Woodrow Wilson School of Public and International Affairs) to conduct an opportunities and gap analysis of AHCCCS' current management of its Medicaid pharmacy benefit including rebate maximization, pharmacy benefit structure, network access and specialty drug management. As part of this work, Mercer is helping AHCCCS consider pricing strategies to tackle high cost drugs and assisting with determining whether any Federal waivers are necessary to support this approach.

Community First Choice Option (CFCO) Assessment

One of our client states requested that Mercer assess the pros and cons of the CFCO State Plan option. Mercer responded with a brief call to understand the context for the request, proposed a timeline for response, prepared a matrix comparison of the CFCO requirements to this state's current Medicaid rule, policies and contracts, and provided a written formal assessment of the option for this state.

Medicare Proposed Rule for "Site-Neutral Payments for Clinic Visits"

As a result of CMS publication of this Medicare proposed rule, Mercer recently received a request to help a state review how Medicaid's payment rates might vary for the same services across different settings/sites of care and our policy SMEs are reviewing the proposed Medicare rule to help inform the this analysis and brief the state.

Pennsylvania Behavioral Health Program Integrity

Mercer received an ad-hoc request to provide support with the survey design and perform an online survey of the HealthChoices MCOs to capture their input on the program integrity (PI) technical assistance needs to provide support to prevent fraud, waste and abuse. As part of this request, Mercer drafted and presented technical assistance training based on the survey results, conducted an environmental scan of other states' efforts in preventing fraud, waste and abuse, drafted a briefing document, and facilitated a brainstorming session with Field Office Team Leaders on PI monitoring activities. Mercer is actively monitoring the recent reports out of the OIG and GAO on program integrity in managed care to support these types of PI requests.

5

BIDDER’S BACKGROUND

The bidder shall provide the information set forth in this section regarding its experience and background.

3.2.5.1 Experience.
The bidder shall provide the following information regarding the organization’s experience:

Mercer’s roots trace back to 1937 when Marsh & McLennan, Inc., the US insurance brokerage firm, established an employee benefits department. In the intervening 80 years, we have learned a lot about health insurance in America and built a business around Medicaid consulting. In fact, in 1985 our first client was the first Medicaid agency to implement managed care. Today, with resources of more than 280 staff and experience with more than 35 states/territories, Mercer has the skill set and capability to become your trusted advisor to provide technical assistance, support, and ad-hoc analysis for current and new Medicaid programs and CHIP including, but not limited to, the SPA, federal regulations and guidance, 1915(b), 1915(c), 1915(i), and 1115 waivers and waiver renewals, as directed by DHS.

Although the Mercer name is often associated with Medicaid actuarial rate setting and related services, we have a deep bench strength of professionals with background in Federal policy requirements, especially related to SPA and waivers. Policy issues facing states prompted us to develop a specialty sector within Mercer to help our clients achieve desired health policy goals while maintaining compliance with federal requirements. Currently we have seven staff who previously worked at senior levels in CMS.

Our policy professionals are supported by our clinicians including master’s level social workers, PhD psychologists, licensed pharmacists, credentialed nurses, as well as financing and payment experts. Together with you, our team stands ready to help you with all facets of the technical assistance, support, and ad-hoc analysis you require.

Mercer’s Government specialty practice is dedicated solely to consulting to states and territories on their Medicaid managed care programs. Over the past 30 years of consulting to states and territories, we have worked with more than 30 and have current active contracts with 29. The lessons Mercer has learned from our broad client base translates directly to helping you with decision points in your program. The table on the following page shows a brief overview of our experience by state with services similar to those outlined in the RFP. In response to the next RFP item, we provide our specific technical experience.

Summary of Mercer Policy Experience

State	Waiver and SPA Support	Regulatory Analysis	Federal and Stakeholder Negotiations	Program Development and Modeling
Arizona	X	X	X	X
California	X	X	X	X
Connecticut	X	X	X	X
Delaware	X	X	X	X
DC	X	X	X	X
Florida	X	X	X	X
Georgia		X	X	X
Idaho		X	X	X
Kansas		X		
Kentucky		X	X	
Louisiana	X	X	X	X
Massachusetts				X
Missouri	X	X	X	X
Montana				X
New Jersey	X	X	X	X
New Mexico	X	X	X	X
North Carolina	X	X	X	X
Ohio	X	X	X	X
Oklahoma		X	X	
Pennsylvania	X	X	X	X
Puerto Rico	X	X	X	X
South Carolina	X	X		
Texas	X	X	X	
Virginia		X	X	
Virgin Islands	X	X	X	X
Washington	X	X	X	X
Wisconsin		X	X	

3.2.5.1.1 Level of technical experience in providing the types of services sought by the RFP.

Mercer's experienced multi-disciplinary staff provides policy expertise across all areas of consulting responsibility identified in the RFP. Below is a summary of consulting services that our experienced staff will be prepared to provide:

- **Policy Analysis, Development, and Review**—Mercer policy experts focus on issues related to Medicaid, CHIP and other health care policy issues, such as health care reform. Our experience includes advising states on general state plan, waiver and policy questions in the areas of eligibility, reimbursement and coverage including acute care, long-term care, behavioral health, 1115 demonstrations, 1915(b) and 1915(c) waivers, and contract rate setting. We also advise states on budget neutrality issues including hospital and disproportionate share hospital issues and are experienced in working with actuaries and financial staff on financial policy-related analyses. **Our staff includes seven individuals who previously**

worked for CMS who are experienced with federal approval and negotiation processes. **Our staff also includes at least fifteen former state Medicaid staff** who were responsible for policy and operations within state Medicaid and CHIP programs.

- **Clinical and Quality**—Mercer clinical consultants include physicians, psychiatrists, nurses, psychologists, social workers, pharmacists, long-term care health professionals, and dentists. These diverse and experienced groups of professionals focus on issues related to the development, analysis and monitoring of clinical quality; clinical improvement, and measurement issues. Mercer has developed innovative tools to assess a health plan's performance in the areas of quality improvement, provider management, member services, grievances, and appeals and access to care. Mercer serves as the external quality review organization for two states. **We have one physician, two psychologists, five nurses and two certified coders on staff** in the Government specialty practice.

- **Reporting and Monitoring for Health Care Programs**—Mercer's work includes a focus on issues related to the development, monitoring, and analysis of Medicaid and CHIP health care reporting guidelines and financial reports provided by contracted health plans. **Among our staff are five certified public accountants.**

- **Pharmacy Management Consulting**—Mercer pharmacists focus on issues pertinent to publicly-funded programs across the country, including policy development, SPAs, risk assessment and adjustment, preferred drug list (PDL) strategy, state MAC list development, collaborative purchasing, trend evaluation, health plan efficiency evaluations and pharmacy benefit manager/administrator vendor selection. **We have five pharmacists on staff.**

- **Behavioral Health Consulting**—Mercer provides expert consulting on behavioral health program and policy development, financing, payment reform, service delivery model development, integrated physical health and behavioral health, and fidelity adherence to evidence-base practices. We reinforce high-level strategic consulting with practical solutions and offer the expertise to successfully implement them. **Several of Mercer's behavioral health specialists have senior leadership state experience** and understand the barriers and opportunities involved in systemic change. Our behavioral health policy consulting integrates our policy, clinical, informatics and pharmacy expertise.

- **Informatics**—Mercer data analytics specialists focus on the interpretation and evaluation of detailed claims/encounter data, including data analysis and enhancement. **We are proficient in a plethora of data analytics.** Mercer's approach is unique in that our informatics staff work side-by-side with our policy specialists, clinicians and other SMEs and our in-house analytics capacity better enables the team to use data, when needed, to support our policy advice. Our informatics staff work closely with our clinicians, pharmacists, policy professionals, and other consultants to ensure an integrated approach when developing solutions for our clients.

- **Financial and Actuarial Services**—Mercer's actuaries and financial staff support the development of Medicaid managed care capitation and FFS rate setting for all

populations including physical health, behavioral health, long-term care, and dual eligibles. In addition to the actuaries and actuarial students in this specialty area, **our staff includes analysts and financial specialists who work closely with our policy staff on projects to support state Medicaid reporting to CMS, waiver financial demonstrations, and more.**

The depth and breadth of our staff provides expertise in all areas related to Medicaid, CHIP, and health care reform with a level of credibility that we believe no other firm can match.

3.2.5.1.2 Description of all services similar to those sought by this RFP that the bidder has provided to other businesses or governmental entities within the last twenty-four (24) months.

Mercer provides a table beginning on the following page to list our related experience.

Summary of Mercer Policy Support Experience (past 24 months)

State/Client	Service	Description
Arizona Health Care Cost Containment System	1115 Waiver Design and Implementation	Assisted in drafting the DSRIP amendment; developed protocols and tools for amendment implementation; assisting with audit protocol.
	State Plan	Assistance in developing and drafting a 1932 SPA to expand the State's American Indian Medical Home model.
	Pharmacy Options	Under a contract through State Health & Value Strategies, Mercer prepared a pharmacy benefit gap analysis and explored possible waiver opportunities related to high cost drugs.
	Mental Health Parity	Conducted the Medicaid/CHIP parity analyses.
	Electronic Visit Verification	Developing individual, family and provider stakeholder surveys regarding the EVV system design to result in a stakeholder-informed procurement.

State/Client	Service	Description
California Department of Health Care Services	HCBS Final Rule	Support for negotiations with CMS on transition plan, guidance on member and provider assessment strategy.
	Medicaid Managed Care Final Rule	Policy support for capitation rate setting, directed payments and pass-through payment provisions.
	Health Home Payment Policy and Rate Development	Developed a “hybrid” health home payment methodology for implementation of the Section 2703 Health Home option within Medi-Cal managed care and provided support to DHCS for approval of the SPA and final rate methodology.
	Pharmacy (Covered outpatient drug final rule)	Conducted a study to determine the costs to a pharmacy of buying and distributing drugs to Medi-Cal members. Mercer gave its study findings and implementation alternatives to DHCS, leading to submission of a SPA to CMS.

State/Client	Service	Description
Connecticut Department of Social Services	State Plan	Design, facilitate stakeholder input, and implement PCMH+, a value-based enhancement to person-centered medical homes with quality-linked incentives and shared savings distributions through a Medicaid SPA. Assistance included a concept paper for CMS.
	State Innovation Model	Policy support and technical assistance for SIM, including waiver and State plan funding options.
	HCBS Final Rule	Assistance with CMS questions and updates to the Transition Plan.

State/Client	Service	Description
	Hospital Payment Modernization	Policy and technical consulting to assist CT DSS in an overhaul of payment for acute hospitals, both inpatient (APR-DRG) and outpatient (APC).

State/Client	Service	Description
Delaware Department of Health and Social Services/Division of Medicaid and Medical Assistance	Alternative Benefit Plan SPA	Drafted the SPA to reflect the updated essential health benefits benchmark benefit plan and provided policy support for the actuarial equivalence documentation required by CMS.
	1115 Amendment	Drafted the five-year extension request and budget neutrality.
	1115 Amendment	Drafted the SUD amendment and budget neutrality.
	Interim 1115 Evaluation Report	Assisted with the design and development of the 1115 Interim Evaluation report required for CMS documentation of the waiver extension.
	MCO Procurement	Drafted a Request for Quotes and final contract language, consistent with CMS managed care final rule.
	Medicaid Managed Care Final Rule	Assessed the impact of the final rule on Medicaid and CHIP programs; Developed work plans and led work streams on managed rule implementation; Supported request to CMS for Review and recommend changes to contracts for compliance.
	HCBS Final Rule Implementation	MCO and provider compliance monitoring strategy.
	Electronic Visit Verification	Assistance with implementation of the EVV requirements of the 21st Century Cures Act.
	Mental Health Parity	Conducted the Medicaid/CHIP parity analyses.
	Ad-hoc Policy assistance	As needed by DMMA.
Delaware DHSS/ Health Care Commission	State Innovation Model	Policy, clinical and financial consulting services in support of Delaware's Accelerated Payment Reform Project under its SIM grant. Assistance includes including stakeholder meetings and materials, legislative reports, and the design of legislatively-mandated cost and quality benchmarks.

State/Client	Service	Description
Florida Department of Health/ Children's Medical Services	Program Design and Implementation	Assistance with developing a new risk-based payment and delivery model for medically-complex children. Includes program design, stakeholder support and readiness review.

State/Client	Service	Description
Idaho Department of Health and Welfare	State Innovation Model Design	Consulting services to Idaho in the design phase of its multi-payer SIM grant by providing assistance in all areas of development of the State's health innovation plan. Assistance includes research and subject matter expertise to the state's SIM grant work groups: provider network development, clinical and quality improvement, multi-payer payment model, health information technology, and Idaho's governing steering committee. For the work groups, which together involved over 100 stakeholders, Mercer facilitated meetings, developed and presented strategies to lead work group members through relevant decision points, researched and presented best practices across the subject areas, and project managed each work group.

State/Client	Service	Description
Kansas Department of Health and Environment	Procurement and Readiness	KanCare 2.0 procurement, evaluation, and readiness review assistance, and project management for implementation activities.

State/Client	Service	Description
Louisiana Department of Health (LDH)	Medicaid Managed Care Final Rule	Policy support for payment implications of the capitation rate setting, directed payments and pass-through payment provisions.
	1915(b) Waiver	Renewal of the Healthy Louisiana and Coordinated System of Care 1915(b)/(c) Concurrent Program, including CMS and OMB questions.
	1915(c) Waiver	Renewal of the Healthy Louisiana and Coordinated System of Care 1915(b)/(c) Concurrent Program, including CMS questions.
	1115 Waiver	Development and approval of a new SUD 1115 Waiver, including the Implementation Protocol and CMS negotiations.
	Alternative Benefit Plan	Provided policy support for the EHB benchmark benefit plan actuarial equivalence documentation required by CMS.
	Financial Reporting	Assisted LDH with the development of their waiver reporting guides for the CMS-64 expenditure reporting.
	Mental Health Parity	Assisted with the Medicaid/CHIP parity analyses.
	State rules	Assist with the review of State rules regarding Healthy Louisiana managed care program.
	Ad-hoc assistance	As needed by LDH.

State/Client	Service	Description
Missouri Department of Social Services	Medicaid Managed Care Final Rule	Provided gap analysis of state compliance with rule; provided trainings and webinars on certain provisions of the rule to State staff and MCOs; provided technical assistance on 438.6(c) directed payment templates and related CMS questions.
	Pharmacy	Assessment of the impact of the Covered Outpatient Drug Final Rule regarding the move to actual acquisition cost (AAC) ingredient cost reimbursement and the potential fiscal impact.
	Mental Health Parity	Assistance with the Medicaid/CHIP parity analyses.

State/Client	Service	Description
Montana Department of Public Health & Human Services	1915(b) Waiver	Independent Assessment of the Big Sky 1915(b)(4) Waiver and assistance with CMS.

State/Client	Service	Description
Nebraska Department of Health and Human Services	Long-term services and supports (LTSS)	Evaluation of Medicaid LTSS programs, including stakeholder engagement, and recommendations for program enhancements.

State/Client	Service	Description
New Jersey Division of Medical Assistance and Health Services	Medicaid Managed Care Final Rule	Provided a gap analysis of state compliance with rule; provided trainings and webinars on certain provisions of the rule to state staff; completed 438.6(c) directed payment templates and drafted answers to CMS questions on template.
	Inpatient Hospital Payment Method	Policy and technical consulting to facilitate a move from an outdated version of DRG to current APR-DRG methodology.

State/Client	Service	Description
New Mexico Human Services Department	1115 Extension	Policy support developing concept paper, facilitating stakeholder engagement, developing waiver application and budget neutrality, developing STCs and support in CMS negotiations.
	Stakeholder engagement	Facilitated a stakeholder meeting with tribal representatives to discuss Centennial Care Medicaid reforms and the potential impact on Native American members.
	MCO procurement	Designed procurement, developed RFP, facilitated scoring sessions, drafted reports for submission to CMS.
	Mental Health Parity	Conducted the Medicaid/CHIP parity analyses.
	Ad-hoc policy assistance	As needed by New Mexico Human Services Department.

State/Client	Service	Description
North Carolina Department of Health and Human Services	Money Follows the Person (MFP)	Landscape assessment and recommendations for institutional transitions as MFP funding sunsets.

State/Client	Service	Description
New York Department of Health	1115 Waiver	Policy support developing concept paper, facilitating multi-agency engagement, developing waiver application and budget neutrality, assisting with the negotiation of STCs and support in CMS negotiations. This included a 1915(i)-like at-risk population with HCBS services as well as the consolidation of six 1915(c) waivers into a single authority. Policy support was also giving on public notice and development of internal policies and procedures and external provider manuals.
	State Plan Amendments	Policy support facilitating multi-agency engagement, drafting multiple SPAs and the fiscal impact for each, and support in CMS negotiations. This also included assistance in the development of internal New York policies and procedures to implement the new State Plan services and development of manuals for providers.
	Stakeholder engagement	Assisted with the development and review of multiple presentations for stakeholder engagement. Delivered a webinar regarding the CMS authorities for stakeholders.

State/Client	Service	Description
Ohio Department of Medicaid (ODM)	1115 Waiver	Drafted new application for Work and Community Engagement requirements, assisted with stakeholder engagement and 1115 public notice; assisting with CMS.
	1115 Waiver	Providing policy support for an additional pending 1115, to include developing concept paper, facilitating staff engagement, developing waiver application, developing STCs and support in CMS negotiations.
	1915(c) Waiver	Policy support for developing new 1915(c) shared living benefit.
	1915(b) Waiver	Assistance drafting a waiver to test the cost effectiveness, feasibility and quality of outcomes associated with serving eligible recipients in a qualified nursing facility in lieu of a freestanding long-term care hospital.
	1915(b)/(c) Waivers	Policy support developing the MyCare 1915(b)/(c) concurrent waiver applications and financial tests, including support in CMS negotiations.
	1915(c) Waiver	MLTSS and 1915(c) streamlining. Policy support developing concept paper, facilitating State staff discussion, and developing decisions papers to support leadership decisions.
	1915(b) application and renewal	Policy support developing concept paper, facilitating State staff discussion, developing waiver application and cost effectiveness, and support in CMS negotiations.
	State Plan Amendments	Policy support facilitating multi-agency engagement, drafting multiple SPAs and the fiscal impact for each, and support in CMS negotiations. This also included assistance in the development of internal Ohio policies and procedures to implement the new State Plan services and development of manuals for providers. The topics of SPA assistance ranged from Pharmacy, Outpatient Hospital, Acupuncture, Mental Health, SUD, Alternative Benefit Plan updates, and general questions as needed.
	State Plan Amendments	Policy support facilitating staff engagement, drafting the 1915(i) SPA and the fiscal impact, and support in CMS negotiations. This also included assistance in the development of policies and procedures to implement the new State Plan and development of rates for providers.
	Mental Health Parity	Conducted the Medicaid/CHIP parity analyses.
	Access Monitoring Review Plan	Policy support to develop and update the Access Monitoring Review Plan required by CMS for SPAs.

State/Client	Service	Description
	State staff training	Conducted multiple state staff trainings on the State Plan and waiver CMS processes and expectations. Focus was on improving the initial submissions to CMS and reducing unnecessarily lengthy CMS negotiations.
	Stakeholder engagement	Assisted with the development and review of multiple presentations for stakeholder engagement. Participated in and facilitated multiple stakeholder meetings and webinars regarding reform efforts, new fees, and CMS authorities for stakeholders.
	Ad-hoc policy assistance	As needed by ODM.

State/Client	Service	Description
Oregon Health Authority	Mental Health Parity	Assistance with the Medicaid/CHIP parity analyses.

State/Client	Service	Description
Pennsylvania Department of Human Services	Medicaid Managed Care Final Rule	Assessment of the impact of the final rule on physical health, behavioral health, long-term care programs, and CHIP programs; Review and recommend changes to contracts for compliance.
	Mental Health Parity	Conducted the Medicaid/CHIP parity analyses.
	Program Integrity	Environmental scan of other states' efforts in preventing fraud, waste and abuse in behavioral health services and report on state-level tools, performance indicators and best practices.
	1915(b) Waiver	Technical assistance on policy and waiver cost-effectiveness issues.
	1115 Waiver	Developed the SUD 1115 waiver budget neutrality and provided policy support for CMS negotiations to reach agreement on an approach for managed care.
	Ad-hoc policy assistance: Financial	Policy opinions and research support into directed-payments, incorporating taxes/assessments into capitation rates, and ad-hoc requests from the Department concerning Medicaid/health policy and CMS rules/regulations.
	Ad-hoc policy assistance: behavioral health	Assessment of the policy and clinical implications of complex program changes, such as changes to coverage of Applied Behavioral Analysis services and physical health/behavioral health integration initiatives.

State/Client	Service	Description
Puerto Rico Department of Health	Program Design and Implementation	Comprehensive support for Medicaid program redesign, procurement and readiness. Assistance with Medicaid policy (e.g., IMDs, enrollment, managed care rule), contract development and CMS approvals.

State/Client	Service	Description
South Carolina Department of Health and Human Services (DHHS)	Provider Manuals	Assistance with updating and streamlining Medicaid provider manuals. This project supports SC DHHS staff ability to rapidly address program issues, respond to provider inquiries, respond to state and federal audits, fulfill legislative requests, and implement future program changes.
	Alternative Payment Methodologies	Assistance with development and implementation of alternative payment methodologies in the areas of hospital reimbursement and pharmacy dispensing fees, including SPA support.
	Financial Management and Value-Based Purchasing	Assistance with an evaluation of the current payment system and development of a modernized reimbursement methodology related to reimbursement rates for durable medical equipment and professional services. Includes State and Federal regulatory review, SPA review, review of provider manuals and updates where required.

State/Client	Service	Description
Virgin Islands Department of Human Services	Comprehensive policy assistance	Comprehensive technical assistance on Medicaid and CHIP program and financial laws, regulations, policies, and operational procedures. Areas of assistance include: Eligibility, RFPs, MMIS, Integrated Eligibility System, HIT, Pharmacy benefit manger, APDs, CMS budget and expenditure reporting, SPAs, federal claiming, stakeholder information and engagement, and CMS support.

State/Client	Service	Description
Virginia Joint Legislative Audit and Review Commission	Legislative report	Conducted a legislative-required report on State Medicaid administration and reporting practices, including Virginia statutes and regulations, the program's federal waiver authority, MCO contracts, and other sub- contractual policy guidance. Interviewed DMAS staff and MCOs. Provided an identification and assessment of potential strategies for Virginia using a broad spectrum of solutions and strategies that have

State/Client	Service	Description
		been employed in the industry, including political and operational considerations for strategies moving forward. Employed quantitative and qualitative methods to support findings and recommendations.
Virginia Department of Medical Assistance Services (DMAS)	Financial policy	Policy support to capitation rate setting and CMS approval.

State/Client	Service	Description
Washington Health Care Authority	1115 Waivers	Policy support to SUD 1115 budget neutrality demonstration.
	Federally Qualified Health Centers	Provide technical assistance on federal policy for Federally Qualified Health Centers cost-reporting.

State/Client	Service	Description
NASUAD	Business Acumen Toolkit	Assistance with the development of the Business Acumen Toolkit for disability network business strategies to provide a roadmap to financial and programmatic sustainability for community-based organizations.
CMS	Mental Health Parity	As a subcontractor to Truven Health Analytics, Mercer assisted CMS to provide technical assistance to states regarding the final Medicaid/CHIP parity rule. Project tasks have included drafting the parity toolkit, preparing slide decks and materials for CMS webinars participation in peer learning sessions with states, presenting on CMS webinars and peer learning sessions, providing individual TA to states, and providing training and technical assistance to CMS Regional Office staff.
National Governor's Association	Medicaid Transformation	Policy consultant for the development of the NGA Toolkit: "The Future of Medicaid Transformation: A Practical Guide for States".

3.2.5.1.3 List any details of whether the bidder or any owners, officers, primary partners, staff providing services or any owners, officers, primary partners, or staff providing services of any subcontractor who may be involved with providing the services sought in this RFP, have ever had a founded child or dependent adult abuse report, or been convicted of a felony.

Mercer does not have any owners, officers, primary partners, staff providing services, or any owners, officers, primary partners, or staff providing services of any subcontractor who may be involved with providing the services sought in this RFP, who have ever had a founded child or dependent adult abuse report, or who been convicted of a felony.

3.2.5.1.4 Letters of reference from three (3) of the bidder's previous clients knowledgeable of the bidder's performance in providing services similar to those sought in this RFP, including a contact person, telephone number, and electronic mail address for each reference. It is preferred that letters of reference are provided for services that were procured in a competitive environment. Persons who are currently employed by the Agency are not eligible to be references.

Mercer provides letters of reference from Delaware, Louisiana, and Ohio in Appendix C. Each letter provides telephone and email contact information.

3.2.5.1.5 Description of experience managing subcontractors, if the bidder proposes to use subcontractors.

Mercer intends to use Brenda Jackson, MPP, with Brenda Jackson Consulting, LLC. Mercer selects subcontractors who can augment our existing skill set. For this project, Mercer intends to use Brenda Jackson Consulting as a subcontractor. Mercer has had a subcontractual relationship with Brenda for more than five years. This long-term relationship translates to efficiencies working together. For example, Brenda has met and previously worked with every member of the team including our Project Manager, Michele Walker, MSG, MPA. Brenda is familiar with our project management processes and report development Brenda is also familiar with Mercer processes include peer review (quality control) requirements. Brenda, in particular, having worked so frequently with Mercer, is aware of our communication practices and peer review requirements.

3.2.5.2 Personnel.
The bidder shall provide the following information regarding personnel:

Mercer has proposed staff to meet the anticipated policy support and technical assistance needs identified by DHS in the RFP. We have back-ups and additional consultants with exceptional skills available for every position. However, for the sake of brevity, we have only included information for three individuals in the Tier 2 and Tier 3 positions for each main policy area (not including the Medicaid Project Manager or Back-up Project Manager.) Additionally, some of Mercer's proposed staff may move among the various positions; DHS should be assured that all proposed staff meet or exceed the requirements for each position. To support our Tier 1, 2, and 3 staff, Mercer will also utilize more junior staff, as needed and appropriate.

Staffing Approach for RFP Services

Tier 1
The Mercer Iowa policy support and technical assistance team will be led by **Katie Falls, MSW**, as the Iowa **Client Engagement Leader/Account Manager.** For this engagement, Katie will have overall responsibility for the Mercer team and will work closely with the Department's representatives, our Business Manager, and other team members to ensure that all project milestones are met and that deliverables fully meet or exceed the Department's expectations.

Michele Walker will serve as the **Project Manager**, responsible for the ongoing coordination of requests for assistance, team resources, and the day-to-day contact for DHS. Michele has over 20 years of Medicaid policy experience, including SPA, waivers, PACE programs, behavioral health design, and readiness reviews and has been managing projects of all sizes for Mercer since 2011. Michele has also worked closely as a project manager and as an SME with most of the team members proposed to support DHS on projects. The experience and synergy on our team result in efficiency for DHS.

Stefanie Kurlanzik will serve as the **Back-Up Project Manager**, and as a key SME on the policy teams. Stefanie currently serves as the policy lead for Mercer's Missouri and New Jersey projects, responsible for working with each State and the Mercer team to identify needs and coordinate policy resources with the larger Mercer team. Stefanie and Michele Walker have worked together on projects including Kansas and New Mexico and will create a seamless back-up for DHS if needed.

Tier 2
Mercer is proposing six **Policy Leads** to cover the array of potential assistance required by this RFP. The six policy leads will cover: (1) Eligibility and benefits; (2) Waivers and managed care policy; (3) Long-term services and supports; (4) Behavioral health; (5) Pharmacy; and (6) Payment, financing, and program integrity. Each of these Policy Leads is a senior-level SME for their area and will be responsible for working with DHS and the Mercer team to assess requests for assistance, provide strategic advice on approach and be responsible for the accuracy and quality of the policy advice.

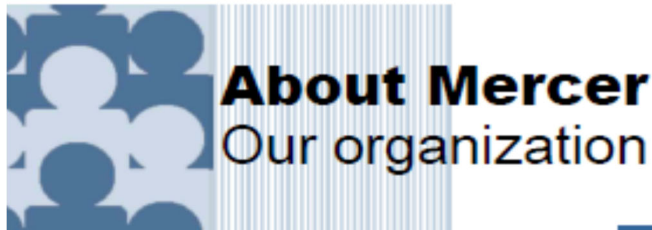
Tier 3
Mercer is pleased to offer a resource pool of SMEs prepared to support DHS as needs arise. Our proposal identifies two additional SMEs per policy area. We also have additional individuals with policy, operations, clinical, behavioral health, pharmacy, informatics and financial expertise as needed. The Project Manager and Policy Leads will be responsible for identifying the resources necessary to meet DHS requests.

3.2.5.2.1 Tables of Organization.
Illustrate the lines of authority in two tables:

- **One showing overall operations**
- **One showing staff who will provide services under the RFP**

Mercer provides three tables of organization to address the requirements. The first shows Mercer's overall operations. The second, titled Organization Structure/Mercer Government Human Services Consulting, "drills down" to depict how Mercer's Government Human Services Consulting fits within Mercer's overall operations. Mercer's

Government specialty practice is responsible for the services in our proposal. The last provides our table of organization for this project.



MMC

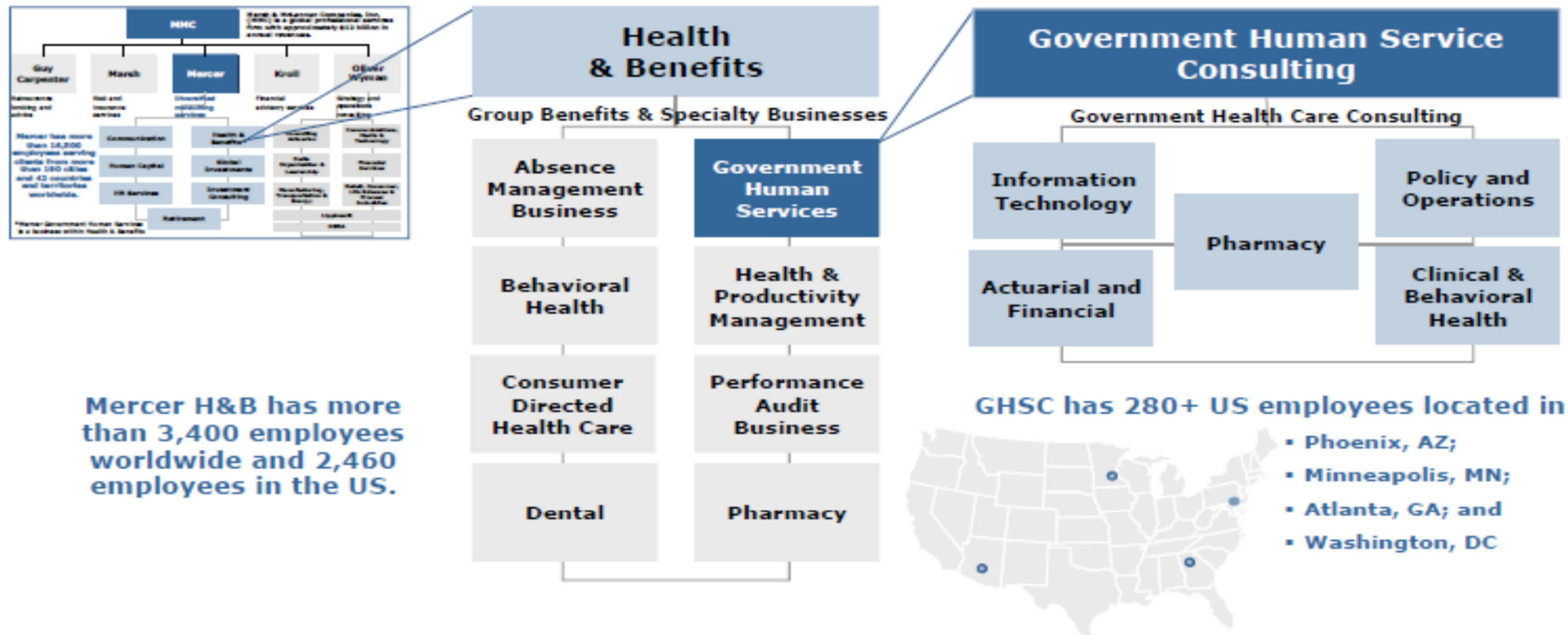
Marsh & McLennan Companies, Inc. (MMC) is a global professional services firm with more than $13 billion in annual revenues.

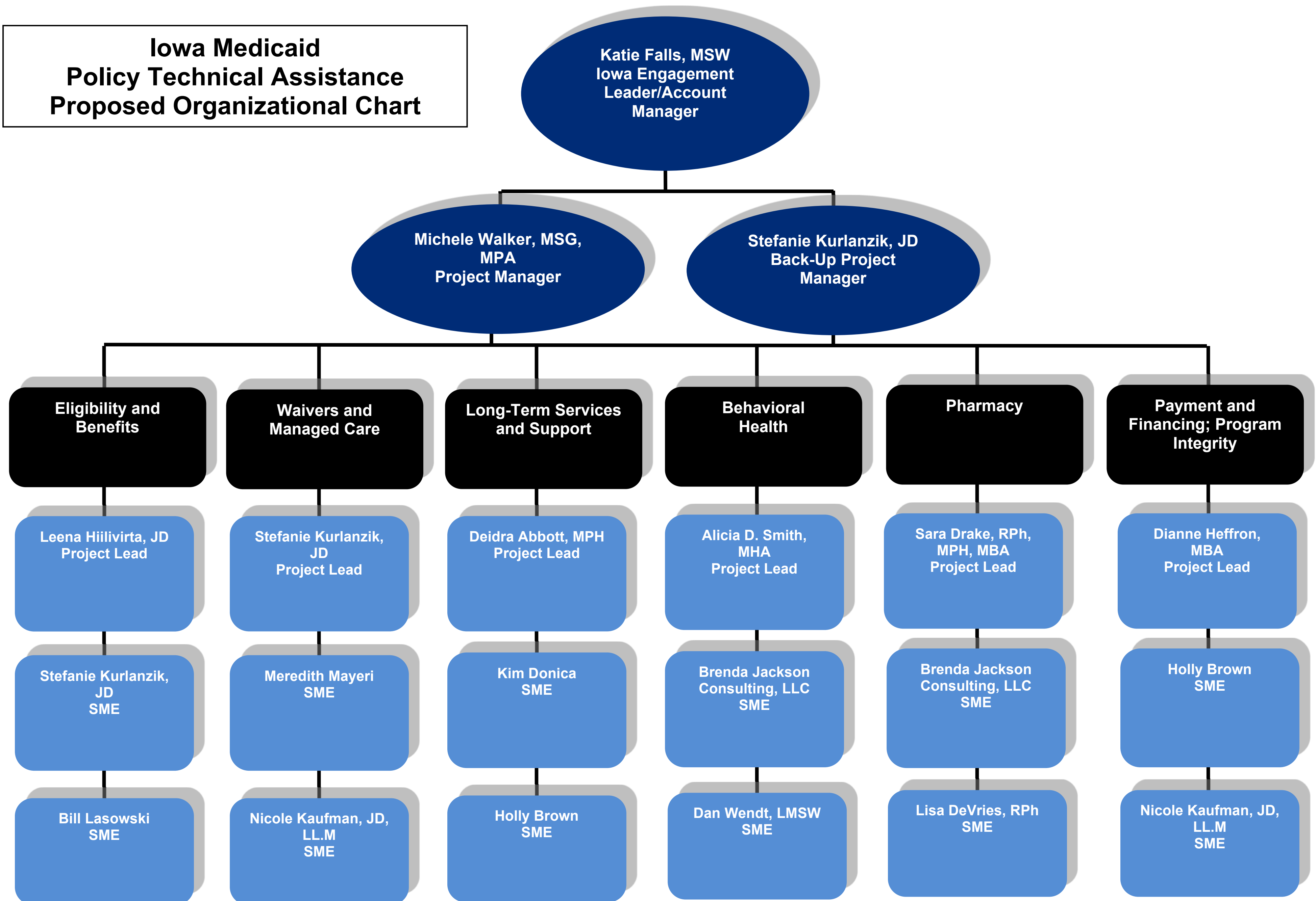
- **Guy Carpenter** — Reinsurance broking and advice
- **Marsh** — Risk and insurance services
- **Mercer** — Diversified consulting services
  - Communication
  - Health & Benefits
  - Human Capital
  - Global Investments
  - HR Services
  - Investment Consulting
  - Retirement
- **Oliver Wyman** — Strategy and operations consulting
  - Consulting Actuaries
  - Communications, Media & Technology
  - Delta Organization & Leadership
  - Financial Services
  - Manufacturing, Transportation & Energy
  - Retail, Consumer, Life Sciences & Process Industries
  - NERA

Mercer has more than 22,000 employees serving more than 28,000 clients worldwide.

*Mercer Government Human Services is a business within Health & Benefits

Organizational Structure
Government Human Services Consulting




Iowa Medicaid
Policy Technical Assistance
Proposed Organizational Chart
Katie Falls, MSW
Iowa Engagement
Leader/Account
Manager
Michele Walker, MSG,
MPA
Project Manager
Stefanie Kurlanzik, JD
Back-Up Project
Manager
Eligibility and
Benefits
Waivers and
Managed Care
Long-Term Services
and Support
Behavioral
Health
Pharmacy
Payment and
Financing; Program
Integrity
Leena Hiilivirta, JD
Project Lead
Stefanie Kurlanzik,
JD
Project Lead
Deidra Abbott, MPH
Project Lead
Alicia D. Smith,
MHA
Project Lead
Sara Drake, RPh,
MPH, MBA
Project Lead
Dianne Heffron,
MBA
Project Lead
Stefanie Kurlanzik,
JD
SME
Meredith Mayeri
SME
Kim Donica
SME
Brenda Jackson
Consulting, LLC
SME
Brenda Jackson
Consulting, LLC
SME
Holly Brown
SME
Bill Lasowski
SME
Nicole Kaufman, JD,
LL.M
SME
Holly Brown
SME
Dan Wendt, LMSW
SME
Lisa DeVries, RPh
SME
Nicole Kaufman, JD,
LL.M
SME

3.2.5.2.2 Names and Credentials of Key Corporate Personnel.

- **Include the names and credentials of the owners and executives of your organization and, if applicable, their roles on this project.**
- **Include names of the current board of directors, or names of all partners, as applicable.**
- **Include resumes for all key corporate, administrative, and supervisory personnel who will be involved in providing the services sought by this RFP. The resumes shall include: name, education, years of experience, and employment history, particularly as it relates to the scope of services specified herein. Resumes shall not include social security numbers.**

Mercer Health & Benefits LLC is a wholly owned subsidiary of Mercer (US) Inc. Mercer is a wholly owned subsidiary of Marsh & McLennan Companies. Marsh & McLennan Companies is a public company traded on stock exchanges with no primary owners.

The names of the executives comprising the board of directors of Mercer (US) Inc. and the senior leadership of the US firm are listed below. None have a role in this project.

Directors

NAME	TITLE	LOCATION
Julio A. Portalatin	Director	New York
Richard Nuzum	Director	New York

Officers

NAME	TITLE	LOCATION
Julio A. Portalatin	Chief Executive Officer	New York
Julio A. Portalatin (Interim)	President	New York
René Beaudoin	Chief Operating Officer	Toronto
Jackie Marks	Chief Financial Officer	New York
Ferdinand Jahnel	Treasurer	New York
Marian C. Miller	Secretary & General Counsel	New York
Vicki S. Menard Margaret M. O'Brien	Assistant Secretaries	Deerfield New York
Karen Farrell	Assistant Treasurer	New York
Frank A. Cammaroto Sheryl Mulraine-Hazell Thomas O'Keeffe	Assistant Vice-Presidents(Tax)	Hoboken

Resumes for all key personnel who will be involved in providing the services sought by this RFP are provided in Appendix A.

3.2.5.2.3 Information about Project Manager and Key Project Personnel.

- **Include names and credentials for the project manager and any additional key project personnel who will be involved in providing services sought by this RFP. Include resumes for these personnel. The resumes shall include: name, education, and years of experience and employment history, particularly as it relates to the scope of services specified herein. Resumes shall also include the percentage of time the person would be specifically dedicated to this**

project, if the bidder is selected as the successful bidder. Resumes should not include social security numbers.

- **Include the project manager's experience managing subcontractor staff if the bidder proposes to use subcontractors.**
- **Include the percentage of time the project manager and key project personnel will devote to this project on a monthly basis.**

Project Manager and Key Project Personnel

We are always very excited when we receive a RFP with a scope that aligns so well with our core competencies. That excitement is accentuated when we can offer the perfect fit for a **Project Manager** in **Michele Walker, MSG, MPA**. Michele has extensive project management experience with complex projects, handling subcontractors, maintaining internal and external communication, and ensuring projects are conducted efficiently, timely, and within budget. Michele also works as a Medicaid and CHIP specialist. Her work includes advising clients on changes in federal laws, regulations (including sub-regulatory guidance), and policy in the area of Medicaid, CHIP, health care reform, managed care, state funding mechanisms, managed care rate setting, Program for All-Inclusive Care for the Elderly (PACE), long-term care and dual-eligibles. She also has extensive experience working with the Centers for Medicare & Medicaid Services and reviewing preparing and negotiating Medicaid 1915(b), 1915(c) and 1115 waivers and 1932(a)/1915(i) SPAs.

On large projects such as this one, we propose a back-up Project Manager. **Stefanie Kurlanzik, JD,** will fulfill this role along with serving as the **Project Lead for Waivers and Managed Care** tasks. Stefanie's area of focus is Medicaid policy consulting with a specific emphasis on assisting states and territories with developing requests for managed care contract proposals and associated program waivers and Medicaid SPAs. She has demonstrated experience and success providing clients with strategic approaches and recommendations for program design, agency oversight and monitoring of health plan and provider contracts, and evaluating health plan and provider readiness to execute and fully comply with state Medicaid contracting requirements and performance expectations.

The table below provides a list of our proposed staff:

NAME	ROLE	AREA OF EXPERTISE
Katie Falls, MSW	Engagement Leader/ Account Manager	All
Michele Walker, MSG, MPA	Project Manager	All
Stefanie Kurlanzik, JD	Back-up Project Manager Project Lead	All Waivers/Managed Care
Leena Hiilivirta, JD	Project Lead	Eligibility/Benefits
Deidra Abbott, MPH	Project Lead	Long-Term Services and Supports
Alicia Smith, MHA	Project Lead	Behavioral Health
Sara Drake, RPh, MPH, MBA	Project Lead	Pharmacy
Dianne Heffron, MBA	Project Lead	Payment and Financing/Program Integrity
Holly Brown	Team Member Team Member	Long-Term Services and Supports Payment and Financial/Program Integrity

NAME	ROLE	AREA OF EXPERTISE
Lisa deVries, RPh	Team Member	Pharmacy
Kim Donica	Team Member	Long-Term Services and Supports
Meredith Mayeri	Team Member	Waivers/Managed Care
Brenda Jackson, MPP	Team Member	Behavioral Health
	Team Member	Pharmacy
Nicole Kaufman, JD, LL.M	Team Member	Waivers/Managed Care
	Team Member	Payment and Financing/Program Integrity
Bill Lasowski	Team Member	Eligibility/Benefits
Dan Wendt, LMSW, CPHQ	Team Member	Behavioral Health

A brief narrative of Project Lead is provided below:

Katie Falls, MSW, will serve as the **Engagement Leader/Account Manager.** Katie brings extensive policy, operations, and administrative experience to the Mercer team. Areas of expertise include policy and program development and operations for federal and state funded health and human services programs, strategic planning, and overseeing large-scale, multi-year, complex projects. Prior to joining Mercer, Katie served as the Cabinet Secretary of the New Mexico Human Services Department that administered the Medicaid, behavioral health services, child support enforcement, the Supplemental Nutrition Assistance Program, Temporary Assistance for Needy Families and numerous other public assistance program. In this capacity, Katie worked closely with legislators, health care providers, health care payers, stakeholders, and tribal leaders from the State's 23 tribes to design and implement health and human services policies and programs. While at the Human Services Department, Katie also oversaw the State's 35 county-based field offices responsible for processing Medicaid and other public assistance eligibility applications and redesigned the eligibility process to improve operations and efficiencies.

Leena Hiilivirta, JD will serve as the **Project Lead for Eligibility and Benefits.** Leena brings extensive experience with providing policy support and technical assistance to state Medicaid programs. Leena has over 20 years of public sector health care consulting experience, with a focus on policy analysis and program design and development. Leena has worked with a number of states in developing programs for medical, behavioral health, and/or LTSS. Her expertise includes analyzing federal requirements, identifying policy options, drafting federal authorities (waiver requests and SPAs), negotiating approval of waiver requests and SPA with CMS, and assisting states with MCO procurements.

Deidra Abbott, MPH, will serve as the **Project Lead for LTSS.** Deidra brings extensive Medicaid policy and program operational experience to the Mercer team. Deidra has been a health care consultant since 2006. In this role she has provided strategic guidance to clients in the development, implementation, and operation of Medicaid programs and initiatives. Her particular area of focus is long-term services and supports and as such she has lead client work in developing and implementing the HCBS final rule and the MLTSS requirements regarding the Managed Care final rule. Prior to consulting, Deidra led development and monitoring of HCBS programs at the federal level for CMS; this experience has given her a unique perspective on federal policy development and strategies.

Alicia Smith, MHA, will serve as the **Project Lead for Behavioral Health**. Alicia has extensive experience with Medicaid and other public assistance programs and has worked extensively with mental health and SUD systems and providers. She has assisted state and local government programs design and implement numerous service delivery and payment reform efforts, including the development and approval of Medicaid health homes and similar care management programs. Alicia has consulted to several states on a wide range of issues including program design and implementation, Medicaid 1115 waiver and state plan development. With 25 years of health care experience, Alicia draws from her considerable knowledge of federal Medicaid regulations to assist clients in devising appropriate behavioral health coverage strategies. As a former Medicaid policy analyst, she utilizes her expertise in benefits design to develop compliant and sustainable behavioral health programs.

Sara Drake, RPh, MPH, MBA, will serve as the **Project Lead for Pharmacy.** Sara is a licensed pharmacist who has Masters Degrees in Business and Public Health from the University of California Berkeley and has over 10 years of experience working in public and private health care programs. Sara served as the Pharmacy Program Manager and Deputy Director of Health Care Purchasing and Service Delivery at the Minnesota Department of Human Services until early 2017 where she worked closely with the Medicaid and Medical Directors' teams to lead a team of state and vendor staff in management of the prescription drug benefit for Minnesota's Medical Assistance (Medicaid) and MinnesotaCare (Basic Health Plan) populations. Sara has participated in multiple state, regional, and national workgroups and advisory committees relating to prescription drug policy and is well versed in pharmacy management trends, opportunities, and challenges. In addition to her pharmacy work at DHS, Sara provided oversight and leadership to health care benefit policy and rate teams, and the managed care contracting and compliance teams. Since joining Mercer, Sara has worked closely with actuarial teams to conduct managed care efficiency analyses and provide clinical support in the areas of pharmacy and other health care services. She also offers pharmacy policy support to multiple clients and teams including interpretation of statute, regulation, and guidance; drafting of responses to CMS questions; and facilitating conversations with other policy experts.

Dianne Heffron, MBA will serve as the **Project Lead for Payment and Financial/Program Integrity** joined Mercer in 2013 after 10 years in Medicaid at CMS, where she was responsible for the overall financial management of the federal Medicaid program budget of hundreds of billions of dollars through oversight of federal grant outlays, state budget and expenditure reporting, national Medicaid reimbursement and state financing policy, and other activities to promote the program's fiscal integrity. As a member of the Senior Executive Service, Dianne advised the Department of Health and Human Services senior management on policy development and statutory and regulatory interpretation. Dianne has worked with virtually every state regarding Medicaid reimbursement policy, Medicaid financial operations and state Medicaid financing strategies, including the development and review of provider taxes. She has also worked extensively in developing section 1115 demonstrations, including budget neutrality models and innovative programs directed at the uninsured and delivery system reform.

Along with our Project Leads, we offer a team of seasoned professionals with significant experience. Team Members include:

Holly Brown brings extensive reimbursement, Medicaid waiver and Medicaid payment expertise to Mercer. Prior to joining Mercer in 2018, Holly worked for another consulting firm for 14 years assisting several states with a variety of Medicaid issues, including program evaluations, program design and rate development for Medicaid services. She assists states to interpret and respond to policy changes and identify impacts to state-specific programs, including developing SPAs and corresponding with CMS to obtain approval of program changes. Holly has also facilitated several stakeholder meetings with providers and other interested stakeholders with payment rate issues for Medicaid programs, specifically for HCBS waivers for individuals with intellectual/developmental disabilities.

Lisa deVries, RPh, is a licensed pharmacist with 32 years professional practice, originating with licensure in the State of Iowa. Her extensive pharmacy practice includes independent and retail pharmacy along with Pharmacy Benefit Management (PBM) experience. Lisa worked on client pharmacy benefit implementations for both commercial clients, as well as Medicaid clients. In her role at Nebraska Medicaid she was responsible for contract oversight for the Drug Utilization Review (DUR) and PBM contracts. In addition, she prepared fiscal impact notes and position statements for Medicaid in response to legislative bills or requests from legislators. Quarterly rebate responsibilities included developing unit conversions, review of rebate disputes for both pharmacy, medical and encounter claims. Monthly and quarterly reporting was done for pharmacy program oversight and monitoring to ensure efficient operations, as well as identifying potential areas for additional cost or quality control measures to be implemented. Lisa also drafted provider notices as required for program operations. Coordination of changes requiring updates to state statutes, as well as SPAs were also among her duties. As a team member for DUR, PBM, and PDL RFPs, Lisa worked to secure additional federal funding where possible through use of CMS Advance Planning Document process, as well as drafting the scope of work for state requirements and scoring RFP responses.

Kim Donica brings extensive experience in the development and operations of both institutional and HCBS LTSS programs for older adults, adults and children with physical disabilities and chronic conditions and adults and children with intellectual and developmental disabilities. Kim has developed and implemented LTSS programs under a myriad of federal authorities (1915 c, 1915b/c and 1915i) in both FFS and managed care programs. Activities have included: policy development, procurement, development of waivers including service specifications, protection from harm processes, quality metrics, etc., development of statutory language, as well as administrative code rules needed to support program operations, development of operational policies and procedures and monitoring and program oversight. Kim also has expertise in the following policy areas: home health, hospice, Private Duty Nursing, durable medical equipment, MFP, pre-admission screening resident review, tele-medicine, Medicaid School Programs and Medicaid eligibility for LTSS including Qualified (Miller) Income Trusts. A social worker by training Kim spent many years working directly with older adults and people with disabilities in a variety of settings before going to the state Department of Medicaid where she held a variety of positions culminating in the Chief of LTSS.

Subcontractor Brenda Jackson, MPP, with Brenda Jackson Consulting, LLC has been in the field since 1993 including nine years at CMS. From 1996-2005, Brenda reviewed and approved all Iowa Medicaid managed care contracts, waivers and health plans for CMS. While at CMS, Brenda was also the Iowa State Representative for three years. In that position, Brenda was the CMS lead contact with Iowa on all State Plan and HCBS and managed care waiver requests. In her current role, Brenda advises a variety of states on SPAs, managed care and HCBS policy and operations including assisting states with strategic communications with CMS.

Nicole Kaufman, JD, LL.M. Prior to joining Mercer in 2016, Nicole held a senior position in the CMS, Baltimore Central Office's Division of Managed Care Plans. Nicole was the SME for Medicaid managed care policy and served as the primary author of CMS' Medicaid Managed Care Final Rule (April 2016) and Proposed Rule (June 2015). Nicole also specialized in the negotiation of complex section 1115 demonstration projects that involved delivery system integration and delivery system reform incentive payment programs. Nicole utilizes her past federal Medicaid experience to support clients in the design, implementation, and oversight of Medicaid managed care program authorities and contracts, as well delivery system reform initiatives under section 1115 demonstration projects.

Bill Lasowski is a recognized national expert on all aspects of Medicaid and CHIP program and financial policy and operations. Prior to coming to Mercer in 2012 Bill spent over 32 years at CMS, where he served in his last position as Deputy Director, Center for Medicaid and CHIP Services. He was instrumental in developing national policies and procedures that support effective Medicaid and CHIP program implementation and administration. He advised senior CMS and Department of Health and Human Services decision makers on public policy and operational options and strategies. He has wide-ranging experience collaborating and negotiating with Congressional staff, the OMB, other federal agencies, states, advocacy groups, contractors, and the general public on health care issues. Bill worked on numerous federal laws, regulations, policy issuances, SPAs and complex state financing issues to ensure states were complying with federal requirements. Bill has worked with virtually every state regarding Medicaid reimbursement policy, Medicaid financial operations, state Medicaid financing strategies including the development and review of provider taxes. Bill has worked in developing financial models for section 1115 demonstrations including budget neutrality models and innovative programs directed at the uninsured and delivery system reform.

Meredith Mayeri brings over 20 years of Medicaid and CHIP subject matter expertise. Over her career with CMS and Mercer, and through four different federal Administrations at CMS, Meredith has focused on Medicaid managed care policy, 1915(b) waivers, 1115 waivers, Medicaid financing, payment and delivery system reform. Meredith specializes in the strategic use of Medicaid federal authorities to achieve state policy and operational goals. Meredith currently co-leads Mercer's Policy and Operations Sector, a group of professionals devoted to the roles that states play in administering Medicaid and CHIP programs.

Dan Wendt, LMSW, CPHQ, is a licensed masters-level social worker and a certified professional in health care quality with 30 years of experience in the field of behavioral health. Dan possesses extensive experience with integrated Medicaid physical health and behavioral health managed care programs. Prior to joining Mercer, Dan served as

the Chief Quality Officer for four years at a national capitated BH-MCO. Prior to that role, Dan held the position of Vice President of Quality for another national BH-MCO and was responsible for all aspects of managing and overseeing the quality management department. Dan has also previously served as the Arizona Department of Health Services/Division of Behavioral Health Services Division Chief of Quality Management and Evaluation. Dan has assisted Mercer's Policy and Operations Sector with the design and evaluation of Medicaid service delivery systems. In addition, Dan has helped clients with the identification and assessment of 1915(c) waiver performance measures serving enrollees with special health care needs.

Resumes for all staff are provided in Appendix A.

Managing Subcontractors

Mercer selects subcontractors who can augment our existing skill set. For this project, Mercer intends to use Brenda Jackson Consulting as a subcontractor. Mercer has had a subcontractual relationship with Brenda for more than five years. This long-term relationship translates to efficiencies working together. For example, Brenda has met and previously worked with every member of the team including our Project Manager, Michele Walker, MSG, MPA. Brenda is familiar with our project management processes and report development Brenda is also familiar with Mercer processes include peer review (quality control) requirements. Brenda, in particular, having worked so frequently with Mercer, is aware of our communication practices and peer review requirements.

Time Commitment

In accordance with the response in the RFP Questions and Answers, Mercer is prepared to make an aggregate FTE commitment of three FTEs to DHS/IME for the services described in the RFP, the RFP services, and additional resources will be made available (if needed) once we have the opportunity to engage with DHS/IME on priorities and needs. We understand that the demanding and dynamic nature of administering state Medicaid programs requires that your policy consultants to be knowledgeable, flexible and nimble in our ability to accommodate the ebbs and flows of technical assistance requests. An 1115 waiver, for example, allow for advance planning and may require a large pool of resources more resources for a defined period of time while other times may be slower with ad-hoc requests or routine requests. We pride ourselves in developing long-term client relationships that allow the Mercer team to anticipate client requests and proactively offer resources and advice.

APPENDICES

A

APPENDIX A: RESUMES

Resumes for Mercer's proposed team are provided in this appendix..

Deidra Abbott, MPH

QUALIFICATIONS

Deidra is a Principal in Mercer's Government Human Services Consulting group and is affiliated with the Washington, DC office. She has extensive experience with Medicaid and other public assistance programs and has worked at length with long-term services and supports (LTSS) and home-and community-based services (HCBS) initiatives. She has designed and implemented numerous HCBS waiver programs, including the development of waiver documents and working with state staff to guide the document through the Centers for Medicare & Medicaid Services (CMS) approval process. Deidra has provided support to several states, including Connecticut, Delaware, Florida, Hawaii, Kansas, Louisiana, Missouri, Nebraska, New Mexico, Ohio, Pennsylvania, Tennessee, the District of Columbia and the territory of Puerto Rico on a wide range of issues, including program design and implementation, health plan readiness reviews, health plan contract issues and working with stakeholder groups to drive program improvement. For several of these clients, Deidra has led and managed the comprehensive client engagement.

EXPERIENCE

Before joining Mercer in 2012, Deidra was a consultant at Alicia Smith & Associates, LLC, providing a wide range of services and supports to both public and private sector clients. Deidra also worked at CMS from 2000 to 2006, where she served as the Technical Director for the HCBS waiver program. In this capacity, Deidra led development of federal policy, implementation and coordination of HCBS LTSS programs and services.

Deidra's experience and accomplishments include:

- Providing the following support to states: designing and modifying programs; technical support interpreting and analyzing CMS requirements and implications for state programs; facilitating managed care procurement processes; managing readiness review processes; guidance in responding to CMS inquiries and negotiations; developing stakeholder engagement processes and materials and facilitating stakeholder engagements; and developing documents including, but not limited to Request for Proposal (RFPs), Managed Care Organization (MCO) contracts, readiness review materials, waiver applications, regulations, policy manuals, and concept papers.
- Providing technical assistance and support to California, Connecticut, Delaware and New Mexico in monitoring implementation of their state-wide HCBS transition plan activities to

Deidra Abbott, MPH
Principal

EDUCATION

Master's degree, Public Health Policy and Administration
University of Michigan

Bachelor's degree, Public Health (Health Education), University of North Carolina

EXPERIENCE

29 years professional experience

CORE COMPETENCIES

LTSS program analysis, design and implementation

Program operations

Procurement development and support

Evaluation, plan development and implementation

Medicaid policy analysis

Project management

Stakeholder engagement

AFFILIATIONS

American Public Health Association

meet all applicable federal requirements for appropriate HCBS provider settings and responding to CMS comments. Activities include: providing project management support for and monitoring implementation of transition plan activities; developing and implementing comprehensive stakeholder engagement strategy; leading development and implementation of participant and provider surveys; providing strategic guidance and assistance in updating the transition plan; and providing technical support in negotiations with and responding to CMS.

- Providing technical assistance and support to the Kansas Department of Health and Environment in: 1) Developing KanCare 2.0 RFP for Managed Long Term Services and Support program implementation and facilitating process to assess contractors for readiness for delivery of new capitated managed care program design; and 2) Leading the team in developing the KanCare 2.0 readiness review process.
- Working with the Ohio Department of Medicaid on several projects to assist in developing expanded access to community benefits. Activities include: Team lead providing technical assistance in analysing alignment of HCBS waivers to streamlining administrative processes and build efficiencies. Team lead for project providing support in designing a benefit that allows for expanded access to assisted living services. Subject matter expert on team assisting in evaluating opportunities to increase availability of self-directed supports and services. Member of team developing 1915(b)(4) waiver for pilot program to test the feasibility of providing care in a nursing facility as an alternative to freestanding long-term care hospital services.
- Managing engagement with the New Mexico Human Services Department in strategic planning for renewal of Centennial Care, capitated managed care program (1115 demonstration and research waiver). Activities include: management of project plan; leading strategic planning in developing stakeholder engagement; facilitating stakeholder meetings; providing technical assistance in the development/modification of program design; assisting with CMS negotiations; developing health plan contracts and procurement documents; developing procurement evaluation tools; training State staff on evaluation processes; facilitating evaluation teams and designing readiness review tools. Also managed the engagement working with the State to develop the initial Centennial Care program.
- Key member of the team assisting the Nebraska Department of Health and Human Services in its effort to redesign the Medicaid LTSSS delivery system. Activities include: developing comprehensive stakeholder engagement strategy and facilitating stakeholder meetings across the State in order to obtain feedback on issues of concern; evaluating current system and identifying areas for improvement; recommending federal authorities to achieve program goals and objectives; and developing report synthesizing identified issues and describing implementation strategy.
- Provided guidance to Delaware in the development of a 1915(i) HCBS program, Pathways. Pathways is designed to provide greater options for individuals with disabilities to gain supports for employment. Tasks included: assistance in developing the state plan amendment and the concurrent 1915(b)(4) waiver; providing technical assistance on

implementation issues; developing program operating materials such as policy manual and service plan; and facilitating workgroup meetings.

- LTSS subject matter expert to the Louisiana Department of Health and Hospital Services in the development of an integrated LTSS managed care program. Tasks included technical assistance in determining the appropriate waiver authority, program design, federal regulations and requirements and assisting in negotiations with CMS.
- Provided guidance to Delaware in the development of a 1915(i) HCBS program, Pathways. Pathways is designed to provide greater options for individuals with disabilities to gain supports for employment. Tasks included assistance in developing the state plan amendment and the concurrent 1915(b)(4) waiver; providing technical assistance on implementation issues; developing program operating materials, such as policy manual and service plan and facilitating workgroup meetings.
- Participated in a team that lead the Pennsylvania Department of Public Welfare's initiative to streamline service definitions for like services across all HCBS programs managed and administered by the Department.
- Leading a project for the Tennessee Department of Finance and Administration, Bureau of TennCare to design and implement a state-wide, managed LTSS program for eligible elderly and disabled persons (CHOICES). Tasks included researching best practices regarding adult care homes; developing issue papers to facilitate management decision making; developing policies and procedures and program guidance materials; providing technical assistance on program design elements, such as care coordination, self-direction, nursing facility transition and transition of care; amending existing MCO contracts to include long-term care program requirements; analyzing policy options for effective program implementation; assessing MCO readiness and developing a stakeholder engagement plan and conducting outreach to stakeholders.

EMPLOYMENT HISTORY

Name of Employer(start with most recent employer)	Dates of Employment	Job Title	Work Related To This RFP (Yes or No)
Mercer Health & Benefits LLC	January 2012 - Current	Principal	Yes
Alicia Smith and Associates, LLC	January 2006 - December 2011	Consultant	Yes
Centers for Medicare & Medicaid Services	February 2000 - December 2005	Technical Director	Yes
University of Maryland, School of Nursing	February 1999 - January 2000	Special Assistant	No
College of American Pathologists	October 1992 - January 1999	Assistant Director for Professional Affairs	No
Health Care Financing Administration	January 1988 - October 1992	Policy Analyst	Yes

Holly Brown

QUALIFICATIONS

Holly is a Principal within Mercer's Government Human Services Consulting (Mercer) group, part of Mercer Health & Benefits LLC. She has 14 years of experience assisting healthcare payers, providers and managed care organizations to evaluate, develop and review health care programs, reimbursement systems and health care fee-for-service claims data. Holly has management experience with the review of waiver programs and has worked with states to determine the impact of program and reimbursement changes on its systems. Holly specializes in leading large projects focused on the evaluation of health care delivery systems, rate development and reimbursement methodology design.

Holly Brown
Project Manager

EDUCATION
Bachelor's degree, Biomedical Engineering, Cum Laude
Vanderbilt University

EXPERIENCE
14 years professional experience

CORE COMPETENCIES
Payment rate development
Reimbursement methodology design
Home and community-based waivers
Programs for individuals with intellectual and developmental disabilities

AFFILIATIONS
Project Management Institute
SAS Users Group

EXPERIENCE

Prior to joining Mercer in 2018, Holly worked for Navigant Consulting, Inc., where she worked with several states on a wide range of Medicaid issues.

Holly's experience includes:

- Providing ongoing technical assistance to clients on 1915(c) waiver issues such as program design, program implementation, payment rates and ongoing monitoring of programs.
- Assisting states with all phases of program changes, from evaluation and design to stakeholder outreach, impact analyses and obtaining approval from Centers for Medicare & Medicaid Services (CMS). Working with several states to develop State Plan Amendments and developing other federal reporting documentation, including Upper Payment Limit (UPL) demonstrations.
- Managed an assessment of the 1915(c) Home-and Community-Based Services waiver programs for the Commonwealth of Kentucky Department of Medicaid Services to redesign the waivers. Supported the review of the waiver applications and parameters of each program to determine options that would meet the Commonwealth's goals and assisted the Department to conduct meetings with Medicaid members, Medicaid providers and other interested stakeholders through focus groups in 10 cities across the State.
- Managed the development of payment rates for the Divisions of Developmental Disabilities (DD) in Arizona, Nebraska and Wyoming. Analyzed provider survey data to build a cost model for each service and researched rate methodologies used by other states. Conducted technical advisory group meetings, focus groups and town hall meetings with the waiver provider community. Developed a final report of rate recommendations, including a transition

plan, rate update plan and budget impact.

- Managed implementation activities related to a new cost-based rate methodology for the State of North Dakota DD Division. Developed a Provider Manual and updated Medicaid waiver documentation for the new system's implementation. Developed recommendations for North Dakota's Administrative Code and created detailed service descriptions for DD services.
- Managed the development of uniform statewide payment rates for substance abuse services for adults and children for the Texas Department of State Health Services Mental Health and Substance Abuse Services Division. Developed and conducted a provider cost survey, and analyzed the submitted survey information to develop cost-based rate models for each service.
- Supporting states to design and develop payment rates and reimbursement methodologies for Medicaid services using standard approaches, such as the Outpatient Prospective Payment System for outpatient hospital services and the Resource-Based Relative Value Scale for physician services. Assisted with implementation activities and ongoing monitoring of the programs.
- Assisted a state with the development, implementation and calculation of annual payments for two Medicaid supplemental payment programs for inpatient and outpatient hospital services, funded through inter-governmental transfers and a private hospital tax.
- Managed the annual calculations of the UPL's per federal regulations for the States of Nebraska and Wyoming for inpatient and outpatient hospital services, physician, clinic and psychiatric residential treatment facilities.
- Managed the annual calculations of Disproportionate Share Hospital payments to eligible hospitals for the States of Nebraska and Wyoming.
- Assisted states to develop payment rates for various Medicaid services, including inpatient and outpatient hospital, physician, Federally Qualified Health Centers, Rural Health Clinics and Ambulatory Surgical Centers.
- Assisted the States of Arizona, Nebraska, and Wyoming to update the inpatient hospital reimbursement systems based on the All Patient Refined Diagnosis Related Groups. Analyzed cost and claims data to determine the appropriate base rates and policy adjusters to meet the state's goals.
- Supporting states to explore value-based purchasing options, including a bundled payment program. Assisted with identification of health services to pursue for episodic payment, inclusions and exclusions from the program and appropriate payment levels, as well as developing policy options for consideration.
- Assisted the State of Wyoming to calculate a case rate for its high-fidelity wraparound program, operated through a combination 1915(b)/(c) waiver. Worked with the state to develop a rate and obtain approval from CMS for the one Medicaid behavioral health services vendor as part of the Department of Health's Care Management Entity program, which serves children with high behavioral health needs across the State.
- Assisted the State of Mississippi in the implementation of a voluntary managed care program, MississippiCAN, for its high-cost Medicaid population. Assisted with all aspects of

implementation, including establishing reporting measures and frequencies to evaluate the performance of the program.

EMPLOYMENT HISTORY

Name of Employer (start with most recent employer)	Dates of Employment	Job Title	Work Related To This RFP (Yes or No)
Mercer Health & Benefits LLC	April 2018 – Present	Principal	Yes
Navigant Consulting, Inc.	June 2004 – March 2018	Associate Director	Yes
Vanderbilt Medical Center	August 2002 – May 2004	Research Assistant	No

Lisa deVries, RPh

Lisa deVries, RPh
Senior Associate

EDUCATION
Bachelor's degree, Pharmacy
University of Iowa

EXPERIENCE
32 years professional experience
Former state Medicaid pharmacy program administrator

CORE COMPETENCIES
Pharmacy benefit management
Pharmacy claims processing
Medicaid drug rebates

AFFILIATIONS
Licensed pharmacist in Iowa, Missouri and Nebraska
Nebraska Pharmacists Association (NPA)
National Council for Prescription Drug Programs (NCPDP)

QUALIFICATIONS

Lisa combines her experience in Medicaid and retail pharmacy to evaluate and assist Mercer's Medicaid clients on management of their pharmacy benefit. Lisa is responsible for reimbursement rate setting for fee-for-service (FFS) pharmacy claims for traditional and specialty medications. As a licensed pharmacist, her work experience includes pharmacy benefit management positions for both government and commercial insurance entities.

EXPERIENCE

Prior to joining Mercer, Lisa worked for the State of Nebraska Department of Health and Human Services. During this time she had several roles beginning with oversight of the operational aspects of the pharmacy program (including liaising with the State's pharmacy benefits manager. Eventually, as the Pharmacy Program Administrator, her responsibilities encompassed contract management including preferred drug list (PDL) oversight, and drug rebate and policy development. Prior to that, Lisa worked for Conduent/Xerox as the Clinical Account Manager for Nebraska. In her role as Director of Benefit Design at Prime Therapeutics, she was responsible for new client implementation as well as ongoing maintenance of benefit design operations.

Examples of Lisa's Mercer experience and other accomplishments include:

- Analyzing PDL utilization for select therapeutic classes, performing market shift assumptions and determining the financial impact of market shift, including Federal and supplemental rebates for a large Medicaid program.
- Developing and managing multiple client maximum allowable cost (MAC) and actual acquisition cost (AAC) rate-setting programs.
- Researching and responding to MAC and AAC provider rate inquiries.
- Providing pharmacy invoice submission support and rate analysis on a monthly basis.
- Benchmarking MAC and AAC performance for clients against national average drug acquisition cost, Federal upper limit, and commercial MAC programs.
- Evaluating 340B drug pricing and fiscal impact for Medicaid FFS client.
- Serving as Mercer GHSC Pharmacy Sector subject matter expert (SME) on drug reference databases, including First Databank and MediSpan, to support clinical initiatives and analyses.
- Evaluating rebate operations, including rebate recovery, for a large Medicaid program.

- Serving as pharmacy claim SME on technical initiatives related to pharmacy claims evaluations.
- Designing, implementing, and evaluating next generation in-house drug rebate systems and physician-administered drug rebate activities.
- Performing data analysis, and clinical and financial evaluations, coupled with policy evaluations, to develop management compliance recommendations.
- Analyzing pharmacy expenses to identify inefficiencies and operationalizing changes for positive budget impact while minimizing provider and patient disruption.
- Analyzing physician-administered drug billing inaccuracies and implementing changes to improve claims processing and rebate administration.

EMPLOYMENT HISTORY

Name of Employer(start with most recent employer)	Dates of Employment	Job Title	Work Related To This RFP (Yes or No)
Mercer Health & Benefits LLC	February 2016	Senior Consultant	Yes
Walgreens	January 2015-February 2016	Staff Pharmacist	Yes
Nebraska Department of Health and Human Services	October 2005 - December 2014	Pharmacy Consultant	Yes
Conduent (ACS/Xerox)	October 2003-October 2005	Clinical Pharmacist	Yes
Walgreens	November 1999-October 2003	Staff Pharmacist	Yes
Prime Therapeutics	January 1997-November 1999	Director Benefit Design	Yes
Retail community pharmacies	May 1985-January 1997	Staff Pharmacist	Yes
State of Nebraska	October 2006 -December 2014	Pharmacy Consultant	Yes

Kim Donica

QUALIFICATIONS

Kim Donica is a Principal in Mercer's Government Human Services Consulting group. Kim has experience with Medicaid and other public assistance programs, and has worked extensively with long-term services and supports (LTSS) and home-and community-based services (HCBS) initiatives and has led stakeholder engagement and education and/outreach activities on a variety of LTSS topics. She has designed and implemented 1915(b) and (c) waivers along with 1915(i) state plan HCBS options. Kim has consulted to several states, including Arizona, Florida, Kansas, and North Carolina on program design, implementation and evaluation as well as requirements development for procurement activities related to managed care and Electronic Visit Verification (EVV).

Kim Donica
Principal

EDUCATION
Bachelor's degree, Social Work
Indiana University

EXPERIENCE
30 years
professional experience

CORE COMPETENCIES
LTSS program analysis, design and implementation
Program operations
Stakeholder Planning and Engagement
Medicaid Analysis

EXPERIENCE

Prior to joining Mercer in 2017, Kim served as the Chief of LTSS at the Ohio Department of Medicaid. In this capacity, Kim led development and implementation of all LTSS in Ohio and was responsible for the team that developed and implemented Ohio's HCBS transition plan.

Examples of Kim's experience and accomplishments include:

- Assisted with program design and co-lead the development of the Invitation to Negotiate (ITN) for Florida's Children's Medical Services program which serves children with medical complexities in Florida's Title V, Title XIX and Title XXI programs. Policy development areas included but were not limited to Care Management for Children with Medical Complexity, Telehealth, LTSS, Quality, etc. Other activities included assisting with the development of the ITN evaluation tool and the development of communication materials used by Centers for Medicare & Medicaid Services (CMS) to communicate details of programs new design.
- Co-led the Service Coordination and Data and Reporting Groups as part of the re-design and re-procurement of KanCare 2.0 for the state of Kansas. Activities included the development of a service coordination model that included high needs children and adults (including children with Seriously Emotionally Disturbed (SED) and adults with Seriously and Persistently Mentally Ill (SPMI), development of service coordination Request for Proposal (RFP) requirements, development of KanCare 2.0 reporting requirements as well as general RFP language related to KanCAre 2.0 reporting processes.
- Led stakeholder and communications activities as well as led the development of RFP requirements for Arizona's EVV program. Activities included: participation in stakeholder meetings, development of communication materials and decision documents and development of RFP requirements.

- Developed and operated 1915 (c) waivers administered directly by the Ohio Department of Medicaid. Activities included: program design, development and approval of waiver amendments, waiver renewal activities, administrative code rule development, rate development, quality strategy and oversight of case management agency vendors. Served as one of the team leaders in the development and implementation of Ohio's dual demonstration program (1915 b/c waiver), My Care Ohio. Activities included: program design, development of procurement documents, working with CMS and Managed Care Organizations (MCOs) on the development of the three-way agreement, development and approval of the b and c waiver components, Administrative Code rule development, providing program and policy expertise to actuarial contractor to support development of capitation payments, development of quality strategy, provider agreement development and leading the development and implementation a comprehensive stakeholder engagement strategy.
- Developed and implemented the *Specialized Recovery Services* program, Ohio's first HCBS 1915(i) state plan program. The Specialized Recovery Services program provides care management, employment and peer support to individuals with severe and persistent mental illness. Tasks included: assistance in developing the state plan amendment and the concurrent 1915(b)(4) waiver; development of Administrative Code rules, leading the development and implementation of a comprehensive stakeholder engagement strategy, developing program operating materials such as policy manual and service plans.
- Served as a team leader as Ohio transitioned from a 209(b) to a 1634 state for purposes of Medicaid eligibility for individual who are aged, blind or disabled. Tasks included: leading the development and implementation of a comprehensive stakeholder engagement strategy, developing an RFP for procurement of a vendor to help support Qualified Income Trust (QIT) activities, developed QIT policies and procedures, assisted in the development of Administrative code rules, training and technical assistance to local partners regarding new eligibility rules.
- Responsible for the administrative oversight of Ohio's 1915(c) waiver programs administered by Medicaid's partner agencies. Activities included: ensuring compliance with federal and state statutes and regulations governing LTSS, overseeing the completion of waiver amendments and renewals and implementing a quality strategy that aligned quality expectations across waiver programs.
- Assisted in the development of innovative quality initiatives, payment methodologies and program integrity projects related to HCBS and nursing facility services. Activities included: development of an EVV program for use with certain waiver and state plan services, implementation of quality improvement projects related to nursing facilities who serve individuals who are vent dependent.

EMPLOYMENT HISTORY

Name of Employer(start with most recent employer)	Dates of Employment	Job Title	Work Related To This RFP (Yes or No)
Mercer Health & Benefits LLC	July 2017 - Present	Principal	Yes
Ohio Department of Medicaid	October 20114 - April 2017	Chief of Bureau of Long Term Services and Supports	Yes
		Chief of Program Development Section	Yes
		Chief of Clinical Operations Section	Yes
		Technical Assistance Manager	Yes
		Housing Coordinator	Yes

Sara Drake, RPh, MPH, MBA

QUALIFICATIONS

Sara's experiences across the pharmacy, government, and health care landscapes allow her to assist Mercer clients in evaluation, research, analysis, and implementation of both new and existing policy options for managing Medicaid benefits in both the managed care and fee-for-service environment.

EXPERIENCE

Prior to joining Mercer, Sara worked for the Minnesota Department of Human Services where she served in a dual role as the Deputy Director of Health Care Purchasing and Service Delivery and Pharmacy Program Manager. Prior to her role in state government, Sara's experiences included management consulting, nonprofit health plan, inpatient hospital pharmacy, and retail pharmacy. At Mercer, Sara assists clients in developing, implementing, and evaluating pharmacy policy and managed care pharmacy performance.

Examples of Sara's work at Mercer include:

- Revision of the pharmacy section of managed care financial reporting documents, including instructions document.
- Completion of a pharmacy benefit management gap analysis, which compared pharmacy benefit management performance across a state's contracted managed care organizations.
- Analysis and policy support on implementation of new pharmacy reimbursement methodology in compliance with the Centers for Medicare & Medicaid Services (CMS) covered outpatient drug rule.
- Drafting of framework for pharmacy value-based purchasing initiative.
- Evaluation of financial impact of implementation of a uniform preferred drug list for select drug classes.
- Managed care pharmacy efficiency analyses, including performance on clinical and financial benchmarks.
- Analysis of pharmacy carve-in, carve-out, Pharmacy Benefits Manager, Pharmacy Benefit Administrator and other arrangements for pharmacy benefit structure.
- Evaluation of pharmacy cost of dispensing for traditional and specialty drugs.

Sara Drake, RPh, MPH, MBA

Principal

EDUCATION

Master's in Business Administration, University of California at Berkeley

Master's in Public Health with an emphasis on health policy management, University of California at Berkeley

Bachelor's of Science in Pharmacy, University of Wisconsin-Madison

EXPERIENCE

20 years professional experience

Former state Medicaid pharmacy director

Former state Medicaid medical benefits policy manager

CORE COMPETENCIES

Medicaid pharmacy policy

Pharmacy benefit management

Pharmacy reimbursement

Medical benefit drug reimbursement

Medication therapy management programs

Public policy and pharmacy program design

340B pricing analysis, strategy, and implementation

Basic Health Plan (BHP) policy

Managed care procurement and implementation

AFFILIATIONS

Licensed pharmacist in Minnesota and Wisconsin

PUBLICATIONS AND PUBLIC FORUM PRESENTATIONS

- Presentation: “Medicaid and its role in the Minnesota Health Care System” presented at the Minnesota Pharmacists Association Annual Learning Event, 2017.
- Presentation: “Minnesota Pharmacy Program Overview” presented annually to the Drug Formulary Committee and public attendees 2011-2016.
- Participant: NGA expert roundtable on opportunities and challenges presented by new HCV treatments and other high impact drugs, 2014.
- Presentation: “CMS covered outpatient drug rule” delivered at MPhA legislative day, April 2016.
- Webinar series: “Modernizing Minnesota’s Pharmacy Reimbursement”, 2016.
- Presentation: “Specialty Drugs, The Challenges and Opportunities,” September 2014. Delivered to Minnesota Health Action Group.
- Panelist: “Life Savers or Budget Busters (or Both?): Welcome to the World of High-Cost Drugs.” Delivered to the National Governor’s Association at the conference: Learning from Each Other: How States Are Transforming Their Health Care Systems, April 2015.
- Publication: Adoption of medication therapy management programs in Minnesota 2006-11. Journal of the American Pharmacists Association, May 2013.
- Publication: Specialty pharmacy management, what employers should know. Employee Benefits Planner, August 26, 2013.

EMPLOYMENT HISTORY

Name of Employer(start with most recent employer)	Dates of Employment	Job Title	Work Related To This RFP (Yes or No)
Mercer Health & Benefits LLC	January 2017 - Present	Principal	Yes
Minnesota Department of Human Services	January 2009 - January 2017	Pharmacy Program Manager (2009 - 2017) Deputy Director, Purchasing and Service Delivery (2014 - 2017)	Yes
Deloitte	August 2008 – January 2009	Senior Consultant	No
Blue Shield of California	June 2005 – August 2008	Project Coordinator, Product Management	No
HealthEast	May 2001 – August 2005	Pharmacist	Yes

Katie Falls, MSW

Katie Falls, MSW
Principal

EDUCATION
Master's degree, Social Work
Smith College
Bachelor's degree, Music
Erskine College

EXPERIENCE
30 years professional experience

CORE COMPETENCIES
Program evaluation
Policy implementation analysis
Vulnerable population
Organizational operations analysis
Project management

QUALIFICATIONS

Katie combines her experience in health and human services policy and program operations to effectively assist state agencies in strategic planning, policy development, and implementation of new and revised Medicaid and Children's Health Insurance Program related programs. As Mercer's team lead for Ohio and Idaho, Katie ensures that projects are kept on track and each initiative is successfully completed. Katie has also worked with other Mercer teams, including Arizona, District of Columbia, Florida, Georgia, Kansas, Montana, and Pennsylvania, to help them those states build systems and processes designed to deliver quality health care.

EXPERIENCE

Prior to joining Mercer, Katie served as the Cabinet Secretary for the New Mexico Human Services Department. In this capacity, she was responsible for a $4.5 billion state agency that administered Medicaid, behavioral health services (BHS), child support enforcement, and numerous public assistance programs such as Temporary Assistance for Needy Families and the Supplemental Nutrition Assistance Program.

Katie served as the co-chair of New Mexico's Behavioral Health Purchasing Collaborative, a collaboration of 15 agencies that jointly purchased and administered publicly-funded BHS. Katie also served as chair of the New Mexico Health Care Reform State Leadership Team, which oversaw the planning and implementation of health care reform in New Mexico. She began her career as a clinical social worker, working in outpatient and inpatient behavioral health settings.

Since joining Mercer, Katie has continued working in the area of health care reform, and Medicaid programs and policies. Some of Katie's accomplishments include:

- Working with Ohio to help them develop and redesign new policies and programs to serve Medicaid clients, including those in need of behavioral health and/or long-term services and supports. As Mercer's team lead for this engagement, Katie is responsible for ensuring that the up to a dozen projects simultaneously occurring are appropriately staffed, managed, and coordinated. Katie also works on several Ohio projects, including providing policy and programmatic assistance to the State as it develops work and community engagement requirements for the State's Medicaid expansion population, assisting in the development of a Section 1115 Demonstration Waiver application to implement work requirements, and helping the Ohio Departments of Medicaid and Mental Health and Addiction Services redesign their community behavioral health system, including developing a 1915(i) State Plan Amendment, to enhance the State's delivery of quality behavioral health care. Katie also provides assistance to the State of Ohio by developing stakeholder communications

materials and facilitating public meetings, assisting with the State's federal negotiations for waiver approval, and developing and monitoring work plans for policy and program design and implementation.

- Working with the Idaho to help design new health care delivery and payment models across multi-payer systems through the State's State Innovation Model Design and Test Grant. As Mercer's team lead for this project, Katie ensures coordination across the project that includes supporting Idaho as it transforms primary care practices statewide to the Patient-Centered Medical Home (PCMH) model, planning and implementing a Medicaid PCMH Shared Savings program, financial analysis, operational plan development and monitoring, dashboard reporting, health information technology strategic planning, communication management, public presentations, and facilitation of statewide stakeholder workgroups and tribal consultation.
- Providing assistance to Kansas in the re-procurement of its Medicaid managed care plans. As one of the team leads for this project, Katie assisted the State in the development of a request for proposal. Currently, Katie is supporting Kansas as it conducts readiness reviews of the selected managed care plans and as the State plans and readies for implementation of new managed care plans' contracts. In this capacity, Katie oversees Mercer's team providing implementation project management that includes developing and managing project management tools; drafting, updating and monitoring implementation work plans; producing dashboard reports, and facilitating regular meetings with State staff and managed care plans.
- Working with Arizona's Medicaid Department to develop a federal Delivery System Reform Incentive Payment Program, develop strategies and resources to advance behavioral health and physical health integration, design models to improve care coordination for American Indians, and work with jails to establish new community re-entry procedures for justice-system involved individuals.
- Providing research, drafting of health plan contract language that meets federal and state requirements, facilitation of stakeholder meetings, and training of behavioral health peer surveyors for the Pennsylvania Department of Human Services to implement best practices in quality improvement activities, including behavioral health satisfaction survey administration.
- Working with the Georgia Department of Behavioral Health Services and Developmental Disabilities to develop new health care delivery policies and procure an Administrative Services Organization to provide a crisis call-center, mobile crisis services and provider network management.
- Providing a readiness review of Hawaii's health plans selected for the State's Medicaid managed care program across physical, behavioral and long-term care services.
- Working with Maricopa County, Arizona and Leon County, Florida to analyze the impact of the Affordable Care Act on the vulnerable populations they serve.

PUBLICATIONS AND PUBLIC FORUM PRESENTATIONS

- Testimony at state legislative hearings on Medicaid and other federal assistance programs.
- Monthly presentation on statewide health care delivery reform for the Idaho Health Care Coalition (statewide stakeholder advisory body).

EMPLOYMENT HISTORY

Name of Employer(start with most recent employer)	Dates of Employment	Job Title	Work Related To This RFP (Yes or No)
Mercer Health & Benefits, LLC	January 2011 - Present	Principal	Yes
New Mexico Human Services Department	January 2003 - January 2011	Cabinet Secretary, Deputy Cabinet Secretary, Income Support Division Director	Yes
Technical Assistance Collaborative, Inc.	October 2001 – January 2003	Senior Consultant	Yes
New Mexico Department of Health	July 1994 – October 2001	Deputy Director, Division of Health Improvement	Yes
Indian Health Service	June 1990 – August 1993	Clinical Social Worker, Navajo Tribal area	No

Dianne Heffron, MBA

QUALIFICATIONS

Dianne has extensive experience in the development of Medicaid financing strategies and related program design. Of particular focus are state reimbursement strategies, emerging purchasing models, delivery system design and the development of section 1115 demonstrations. Most recently, Dianne is working with Delaware to support the development of health care cost and quality benchmarks and implementation of total cost of care payment models. She is also working with Arizona to develop and implement an 1115 transformational incentive program. Her 1115 waiver work also includes Substance Use Disorder (SUD) waivers in Delaware, Pennsylvania and Washington, as well as renewals in California, Delaware and Texas. Dianne also worked with the National Governor's Association supporting the Medicaid Transformation Policy Academy. The Policy Academy supports three states seeking 1115 demonstration approval. She has also worked with Delaware, Louisiana, Missouri, New Jersey, New York and Oregon on reimbursement and funding design in both fee-for-service (FFS) and managed care environments. She has also worked on provider taxes, disproportionate share hospital payment policy, and emerging value-based purchasing arrangement in Arkansas and Minnesota.

Dianne Heffron, MBA
Principal

EDUCATION
Master's degree, Business Administration George Washington University
Bachelor's degree, Economics University of Maryland

EXPERIENCE
26 years professional experience

CORE COMPETENCIES
Federal Medicaid finance strategies
Reimbursement design
Medicaid transformational waivers

EXPERIENCE

Prior to joining Mercer in 2013, Dianne worked with the Centers for Medicare & Medicaid Services (CMS) serving as the director of the Financial Management Group since 2009 and the acting director of the Children and Adult Health Program Group in 2008. Dianne was responsible for the oversight of all Medicaid grants, the Department of Human Services' payment policy, reimbursement and funding policy from a national perspective. Prior to that, she worked on reimbursement and delivery system strategies with the National Association of Community Health Centers (NACHC). Prior to joining NACHC, Dianne worked on integrated delivery system strategies and strategic marketing with Johns Hopkins Medical Institutions.

Dianne has worked with virtually every state regarding Medicaid reimbursement policy, Medicaid financial operations and state Medicaid financing strategies, including the development and review of provider taxes. She has worked extensively in developing financial models for section 1115 demonstrations, including budget neutrality models and innovative programs directed at the uninsured and delivery system reform.

Dianne's accomplishments include:

- Developing transformational investment and incentive programs under section 1115 authorities while at CMS. Dianne has worked directly with Arizona, California, Delaware, Massachusetts, New York and Texas to develop and/or renew their waiver programs.
- Developing SUD waivers in Delaware, Pennsylvania and Washington.
- Supported the developed value-based payment strategies for Connecticut, Delaware, Kansas and Louisiana.
- Supported the National Governors Association policy academy focused on state transformation waivers. In particular, this policy academy provided support to Alabama, Nevada. and Washington in the submission or approval of 1115 waivers, as well as developing a road map to assist other states in developing similar programs.
- Creating a Medicaid state plan option to reimburse for care coordination activities using existing statutory and regulatory models that allowed states to implement value-based purchasing strategies. States taking early advantage of the model were Minnesota, Missouri, and Oregon.
- Assisting New York in tackling operational issues associated with instituting payment incentives, value-based strategies and financing issues within managed care.
- Worked with Oregon to develop options to institute alternate payment models to effectively implement a global budget model consistent with Medicaid managed care rules.
- Work with multiple states to restructure FFS reimbursement methodologies to support managed care capitated models addressing provider concerns regarding the upper payment limits programs and potential reduced revenues.
- Worked with multiple states on the development and use of provider taxes as funding sources in conjunction with section 1115 expenditure authorities and managed care models.

EMPLOYMENT HISTORY

Name of Employer(start with most recent employer)	Dates of Employment	Job Title	Work Related To This RFP (Yes or No)
Mercer Health & Benefits LLC	February 2013 - Current	Principal	Yes
CMS	October 2002 - February 2013	Director of Financial Management Group	Yes
National Association of Community Health Centers (NACHC)	October 1996 - October 2002	Vice President Business Development	Yes
John Hopkins Medical Institutions	November 1993 – October 1996	Senior Market Analyst	Yes

Leena Hiilivirta, JD

QUALIFICATIONS

Leena has over 20 years of public sector health care consulting experience. She specializes in policy analysis and program design and development. Leena has worked with a number of states in developing programs for medical, behavioral health, and/or long-term supports and services (LTSS). Her expertise includes interpreting federal requirements, addressing program design issues, drafting federal authorities (waiver requests and state plan amendments), and writing requests for proposals (RFPs) and contracts.

EXPERIENCE

Prior to joining Mercer, Leena was a consultant at Alicia Smith & Associates, LLC (ASA), which was acquired by Mercer in 2012. Prior to working for ASA, Leena was a consultant at a health care consulting firm that specialized in Medicaid.

Leena's experience includes:

- Leading Medicaid/Children's Health Insurance Program (CHIP) parity projects in Delaware, Ohio, and Oregon. Project tasks have included providing parity training for State staff and for managed care organization (MCO) staff; identifying benefit packages; helping define mental health (MH), substance use disorder (SUD), and medical/surgical benefits; defining classifications and mapping benefits; developing tools to collect information on financial requirements, quantitative treatment limitations and non-quantitative treatment limitations (NQTLs) from MCOs; collecting information from the state regarding NQTLs required or administered by the state; following up with the MCOs for additional information on NQTLs; reviewing and summarizing information from the MCOs and the state to conduct the NQTL analysis and draft preliminary determinations; facilitating state determinations of compliance; preparing the final parity documentation for Centers for Medicare & Medicaid Services (CMS) and the public; and responding to CMS questions.
- Providing technical assistance to other Medicaid/CHIP parity projects, including review of NQTL analyses and providing targeted technical assistance.
- Leading a project to assist CMS (as a subcontractor to Truven Analytics) to provide technical assistance to states regarding the final Medicaid/CHIP parity rule. Project tasks have included drafting a parity toolkit, preparing presentations for webinars, and preparing materials for peer learning sessions.
- Assisting Delaware with implementation of the final Medicaid managed care rule, including drafting revisions to the MCO contract.

Leena Hiilivirta, JD
Principal
Co-lead for Policy and Operations sector

EDUCATION
Juris Doctor Degree, cum laude
Georgetown University Law Center
Bachelor's degree, Psychology with honors
Haverford College

EXPERIENCE
20+ years professional experience

CORE COMPETENCIES
Design and development of Medicaid programs
Drafting federal authorities (waivers and state plan amendments)
Drafting MCO contracts
Assisting in state MCO procurements
Mental health parity

- Assisting Delaware to prepare a Request for Qualifications for MCOs to provide integrate medical, MH/SUD, and LTSS under its section 1115 demonstration program, including drafting the RFQ and assisting with the evaluation process.
- Assisting North Carolina with drafting a legislative report addressing key design elements of its proposed capitated managed care program and preparing a Section 1115 demonstration application to authorize the program.
- Assisting a state with developing a corrective action plan in response to a companion letter from CMS related to payment for MH/SUD services to children, including the federal authority options and applicable federal requirements.
- Assisting Ohio with an assessment of its Medicaid managed compliance program, including a review of other state Medicaid managed care contracts.
- Assisting a state with transitioning from a 209(b) state to a 1634 state.
- Helping Connecticut with the design and development of the State's PCMH+ program, which is a key component of the State's State Innovations Models Model Test Grant, including identifying the federal authority options, helping with the concept paper for CMS, and reviewing the RFP for provider entities to participate in Person-Centered Medical Home Plus .
- Working with Connecticut to assess and ensure compliance with the home and community based settings requirements for its 1915(c) and 1915(i) Home-and Community-Based Services (HCBS) programs, including preparing provider, participant, and care manager surveys, reviewing the State's transition plan for compliance with the final HCBS rule, and updating the transition plan in response to CMS comments.
- Assisting Washington with revising its MCO contract to include MH/SUD services.
- Working with Florida to draft an enrollment broker contract for the State's re-procurement.
- Leading the team that worked with Delaware Medicaid to re-procure MCOs to provide integrate medical, MH/SUD, and LTSS under its section 1115 demonstration program, including drafting the MCO contract and sections of the RFP, responding to MCO questions, and assisting with the evaluation process.
- Working with the National Governors Association Center for Best Practices to develop a compendium of best practices related to purchasing health care services by state Medicaid agencies in both managed care and fee-for-service (FFS). Responsible for preparing the section on Federal Law and Regulation, including the different types of federal authority for risk-based managed care and managed FFS initiatives and compliance with federal requirements.
- Assisting the State of Florida with the implementation of statewide Medicaid managed care, including drafting a 1915(c) waiver to replace five existing 1915(c) waivers, drafting the contract for managed LTSS and the contract for medical assistance (acute and behavioral health), and developing evaluation questions for the managed LTSS and medical assistance RFPs, preparing review tools for marketing materials, and developing a test for contract managers.

- Providing peer review of Medicaid managed care contracts for Louisiana, New Jersey, New Mexico, , and Puerto Rico.
- Assisting four states (including Connecticut, Delaware, and the Virgin Islands) with developing an alternative benefit plan for the new adult group.
- Helping Idaho draft its State Health Care Innovation Plan as part of the State's CMMI State Innovation Model design grant.
- Assisting the State of Ohio with the development of a Section 1115 waiver application to streamline and simplify Medicaid eligibility.
- Assisting the Tennessee Benefits Administration with various procurements for state and local employees, including a vendor to provide work-life and behavioral health services, a vendor to provide health management and wellness services, and a third party administrator to manage physical health services. This included drafting the contract and RFP questions.
- Working with Tennessee to incorporate long term services and supports into its MCO contracts.
- Assisting Tennessee in the procurement of MCOs to serve TennCare enrollees in the three regions of the State. Responsibilities included drafting the contracts and RFPs and preparing responses to bidders' questions. Also assisted in readiness review of the MCOs, which included developing a desk audit tool and reviewing specified policies and procedures.

EMPLOYMENT HISTORY

Name of Employer(start with most recent employer)	Dates of Employment	Job Title	Work Related To This RFP (Yes or No)
Mercer Health & Benefits LLC	January 2012 - Present	Principal	Yes
Alicia Smith & Associates	October 2006 - January 2012 (acquired by Mercer)	Consultant	Yes
Engquist, Pelrine & Powell	October 1993 - October 2006	Consultant	Yes

Brenda D. Jackson, MPP

QUALIFICATIONS

Brenda specializes in policy, program design and implementation and regulatory analysis for Medicaid and the Children's Health Insurance Programs with a focus on delivery system innovation, pharmacy policy, behavioral health redesigns and Centers for Medicare & Medicaid Services (CMS) policy compliance. She serves as the policy lead on pharmacy, Federally Qualified Health Centers (FQHC), mental health and substance use disorder issues for Mercer. Brenda has been in this field since 1993.

EXPERIENCE

Prior to working with Mercer, Brenda worked on Mental Health, Substance Abuse, Child Welfare, and managed care policy and redesign when she was employed by the (CMS), the State of Kansas and Deloitte & Touche Management Consulting. While employed by CMS, Brenda was the Iowa State Representative for three years and reviewed all Iowa managed care contracts, waivers, and plans for nine years.

Brenda D. Jackson, MPP
Consultant

EDUCATION
Master's degree, Public Policy
John F. Kennedy School of Government
Harvard University
Bachelor's degree, Economics and Political Science
University of Kansas

EXPERIENCE
24 years professional experience

CORE COMPETENCIES
Program design and implementation
Policy and regulatory analysis
Federal Medicaid funding and waivers
Pharmacy, mental health and Substance Use Disorder, FQHC and managed care policy
Value-based payment methodologies

Brenda's experience includes:

- Advising clients on general Medicaid policy questions in the areas of pharmacy, mental health, dual eligible coverage, health care reform, FQHC, Home-and Community Based Services (HCBS), 1115 applications, State Plan Amendments, 1915(b) and 1915(c) waiver applications, amendments and renewals, and contract rate setting.
- Assisting with Medicaid reimbursement policy development regarding FQHCs in Washington State as well as advising Louisiana and New York on FQHC policy.
- Advising a behavioral health subcapitated vendor of a Coordinated Care Organization in Oregon on Value-Based Purchasing and Recovery Oriented care.
- Assisting setting behavioral health fee-for-service rates in Delaware, Louisiana, Nebraska, Ohio, Pennsylvania, and South Carolina.
- Advising Delaware, Kansas, Nebraska, New York, North Carolina, Ohio, Pennsylvania, South Carolina, and Washington, on contracts, waivers and service definitions associated with mental health, substance abuse, developmental disabilities and foster care services.
- Providing ongoing technical assistance to clients on HCBS waiver issues on program design, program implementation and ongoing monitoring of programs. This includes providing technical assistance to states in understanding the impact of the new HCBS final rules on program operation and oversight and determining program compliance.

- Assisting with the design of behavioral health redesign and HCBS programs in Delaware, Louisiana, New York, Ohio, and South Carolina including writing State Plan Amendments, waivers, demonstration amendments, service definitions, rate-setting, implementation plans, timelines, stakeholdering, Medicaid Management Information System programming, coding, manuals, operational design, protocols and procedures.
- Assisted with the development of the Texas 1915(i) and advised on other waivers and programs within the State of Texas.
- Advised clients on submitting a Money Follows the Person (MFP) Grant Protocol (State of Connecticut), HCBS Waiver for Persons Living with AIDS/HIV (State of Connecticut), and actuarial rate-setting policy (multiple states).
- Advising states on CMS pharmacy policy regarding covered outpatient drug regulations, cost sharing, dispensing fees, selective contracting and rebates.
- Advising states on Pharmacy rules and regulations and serves as Mercer's lead policy expert on new Medicaid pharmacy outpatient rule recently issued by CMS.
- Assisting states with writing Pharmacy State Plan Amendments for CMS compliance.
- Assisting with amendments to the Pennsylvania 1915(b) waivers and advising on waiver strategy for the Specialty Pharmacy Selective Contracting Program.
- Assisting setting behavioral health fee-for-service rates in Delaware, Louisiana, Nebraska, New York, Ohio, Pennsylvania and South Carolina.
- Assisting Louisiana with their 1915(b)(c)(i) concurrent program including a System of Care initiative for at-risk children and supports services for adults with Severe Mental Illness.
- Assisting several states in support and implementation of Olmstead findings letters and settlements with the United States Department of Justice. These initiatives include developing Medicaid programs, authorities, contracts, service descriptions, and rates to support evidence-based services such as Assertive Community Treatment. The support has also included extensive analysis of housing resources and MFP initiatives in several states.
- Assisting with development of aspects of managed long-term supports and services programs for Massachusetts MFP 1915(b)(c) concurrent program, Kansas 1115 demonstration, Ohio 1915(b)(c) MyCare capitated alignment dual eligibles demonstration, New Jersey 1115 demonstration, Louisiana 1915(b)(c)(i) concurrent program, North Carolina 1915(b)(c) concurrent program; Florida 1915(b)(c) consolidation waiver including assisting with writing authority applications, development and training on readiness review tools, performing State readiness reviews and plan on-site reviews and advising on internal state re-structuring.
- Assisting with a 646 Medicare application for the redesign of the current North Carolina health care system by implementing a new care delivery model for Medicare beneficiaries that combines a comprehensive, physician-directed care management approach with an aggressive health information technology environment, connecting providers across the continuum of care.

- Assisting with the Maine mental health administrative services organization program design and contract development.
- Assisting with the Georgia 1115 employer-sponsored insurance health care reform design and application.
- Assisting with the development of the Kansas capitated substance abuse Request for Proposal, mental health reform contract and 1915(b)(c) concurrent waivers as well as the readiness reviews and transition to the 1115 demonstration.

Brenda's experience with CMS included:

- Leading the CMS rate-setting checklist and 1915(b) cost-effectiveness teams.
- Developing and implementing policy, procedures and guidelines for CMS' national comprehensive program with managed care plans for the provision of services to Medicaid beneficiaries.
- Reviewing and approving all Medicaid managed care contracts in Iowa, Kansas, Missouri, and Nebraska, while assisting with other contracts as requested.
- Assisting with state audits in rehabilitation, child welfare, juvenile justice, and mental health.
- Reviewing all Medicaid managed care Section 1915(b) programs and Section 1115 research and demonstration waiver applications for Iowa, Kansas, Missouri, and Nebraska.
- Performing onsite reviews and providing technical assistance on all Medicaid managed care programs in Iowa, Kansas, Missouri, and Nebraska.
- Liaison with the State of Iowa on all Medicaid issues, including State Plan submissions, State Children's Health Insurance Program, FQHC, 1915(c) home and community based waivers (including the Iowa AIDS/HIV waiver) and environmental scanning.
- Representing CMS and speaking at state, regional and national Medicaid managed care conferences.
- Serving as the Regional Office Program for All-Inclusive Care for the Elderly team leader.

PUBLICATIONS AND PUBLIC FORUM PRESENTATIONS

- Webinar: "CMS Covered Outpatient Drugs Final Rule," Brenda Jackson, Shawna Kittridge, Ralph Magrish, Mercer, February 2016.
- Presentation: "Managed Long-Term Services and Supports (MLTSS): Building Sustainable Recovery-Oriented Community-Based Programs for Behavioral Health and Intellectual/Developmental Disability Populations". National Association of States United for Aging and Disabilities. September 14, 2014.
- Presentation: "Ohio's Dual Demonstration Project: Lessons Learned." National HCBS Conference. September 11, 2013.
- Presentation: "Conflict Free Case Management Strategies for Integrated and Managed Care Long Term Services and Supports Environment". National HCBS Conference. September 9, 2013.

- Presentation: “Building a Person-Centered System of Care Using the Tools of Managed Care, Individualized Assessment and Acuity Based Budget”. National HCBS Conference. September 13, 2012.
- Presentation: “MLTSS: Opportunities for Innovative Program Design”. National HCBS Conference. September 11, 2012.

EMPLOYMENT HISTORY

Name of Employer(start with most recent employer)	Dates of Employment	Job Title	Work Related To This RFP (Yes or No)
Brenda Jackson Consulting, LLC	January 2006 - Present	President and Member	Yes
Mercer Human Resources Consulting	January 2006 – July 2007	Consultant	Yes
Centers for Medicare & Medicaid Services	October 1996 – October 2005	Health Insurance Specialist	Yes
State of Kansas	January 1993 – October 1996	Team Leader for Medicaid Managed care and Auditor	Yes
Deloitte and Touche	July 1992 – January 1993	Senior Consultant	Yes

Nicole Kaufman, JD, LL.M

QUALIFICATIONS

Nicole utilizes her past federal Medicaid experience to support clients in the design, implementation, and oversight of Medicaid managed care program authorities and contracts, as well delivery system reform initiatives under section 1115 demonstration projects. She brings a unique understanding of federal policy and process to help clients develop and execute strategies to achieve federal approvals, spanning authorities, managed care contracts, and provider payment initiatives.

Nicole is a Senior Associate in Mercer's Government Human Services Consulting Policy and Operations Sector, a part of Mercer Health & Benefits LLC (Mercer) in the Phoenix office.

EXPERIENCE

Prior to joining Mercer in 2016, Nicole held a senior position in the Centers for Medicare & Medicaid Services (CMS) Baltimore Central Office's Division of Managed Care Plans. Nicole was the subject matter expert for Medicaid managed care policy and served as the primary author of CMS' Medicaid Managed Care Final Rule (April 2016) and Proposed Rule (June 2015). Nicole also specialized in the negotiation of complex section 1115 demonstration projects that involved delivery system integration and delivery system reform incentive payment programs.

Nicole Kaufman, JD, LL.M
Senior Associate

EDUCATION

Master of Laws (LL.M), Health Law, Saint Louis University School of Law

Juris Doctor (JD), Southern Illinois University School of Law

Bachelor of Arts, History and Political Science, University of Illinois

EXPERIENCE

9 years professional experience

CORE COMPETENCIES

Medicaid laws and regulations

Medicaid managed care rate setting and payment policies

Medicaid state plan and waiver authorities

AFFILIATIONS

District of Columbia, Inactive Bar Member, Admitted June 2009

Missouri, Inactive Bar Member, Admitted September 2007

Nicole's client work and projects include:

- Assisting states in identifying the appropriate federal authority for managed care programs and negotiating approval with CMS.
- Assisting states in reviewing and modifying managed care contracts and policies for compliance with all aspects of the Medicaid Managed Care Final Rule.
- Collaborating with the Mercer actuarial team and state staff to evaluate provider payment initiatives and broader capitation rate development practices in light of the requirements in the Medicaid Managed Care Final Rule.
- Providing technical assistance to states in evaluating available managed care authorities in relation to program goals, including mental health initiatives under section 1115 demonstration authority.
- Supporting states throughout the procurement process, including development of proposal evaluation tools, facilitation of consensus scoring, and preparation of executive reports.

EMPLOYMENT HISTORY

Name of Employer (start with most recent employer)	Dates of Employment	Job Title	Work Related To This RFP (Yes or No)
Mercer Health & Benefits LLC	September 2016 - Present	Senior Associate	Yes
Centers for Medicare & Medicaid Services	June 2013 - August 2016	Technical Director - Managed Care Policy	Yes
Centers for Medicare & Medicaid Services	March 2012 - June 2013	Project Officer - 1115 Demonstrations	Yes
Center for Consumer Information and Insurance Oversight	December 2010 - March 2010	Health Insurance Specialist	No
George Washington University	November 2009 - November 2010	Research Scientist	No

Stefanie Kurlanzik, JD

Stefanie Kurlanzik, JD
Principal

EDUCATION
Juris Doctor
Boston University School of Law
Bachelor of Arts
University of Pennsylvania, History & Sociology of Sciences

EXPERIENCE
10 years professional experience

CORE COMPETENCIES
Managed care contracts and Regulations
Program evaluation
Policy analysis

AFFILIATIONS
Member of New York State Bar

QUALIFICATIONS

Stefanie is a Principal in Mercer's Government Human Services Consulting group serving as a consultant on state policy and operations projects. Stefanie's area of focus is Medicaid policy consulting with a specific emphasis on assisting states and territories with developing Requests for Proposals for managed care contracts and associated waivers and Medicaid state plan amendments.

EXPERIENCE

Prior to joining Mercer in 2012, Stefanie practiced law with Akin Gump Strauss Hauer & Feld LLP and Cadwalader, Wickersham & Taft LLP where she specialized in corporate restructuring. Stefanie's exposure to financial restructurings and large lending transactions led to the development of excellent research, communication, strategy and advocacy skills.

Stefanie has experience in providing clients with strategy and recommendations for Medicaid program design which includes drafting requests for proposals, managed care contracts, evaluations and readiness operational tools, and associated waivers and state plan amendments. She has assisted states in transitioning programs to managed care, developing integrated physical and behavioral health programs, and analyzing alternative payment models.

Stefanie's experience includes:

- Assisting Ohio in drafting its Community Engagement requirement 1115 waiver application and presenting a summary of the waiver at public hearings.
- Assisting Florida, Louisiana, New Mexico, and Puerto Rico in designing and implementing delivery system changes related to integration of long-term care services and supports and behavioral health.
- Drafting policy and strategy memorandums, reviewing regulations and providing a recommended course of action for Missouri, New Jersey, Pennsylvania, and Puerto Rico.
- Assisting Florida, Louisiana, Missouri, and New Mexico in strategizing and developing Medicaid program changes and developing and drafting 1915(b), 1915(c), and 1115 waivers.
- Developing requests for proposals for re-designed statewide managed care and for regional managed care programs for Delaware, Kansas, Missouri, New Mexico, and Puerto Rico.
- Assisting Delaware, Missouri, New Mexico, and Puerto Rico in developing re-designed managed care contracts.

- Assisting New Mexico in revising agency rules and regulations for its re-designed managed care program.
- Contributing to the drafting of a state-only funded behavioral health contract in Washington.
- Conducting managed care plan readiness reviews in Puerto Rico.
- Assisting Arizona in developing the Delivery System Reform Incentive Payment (DSRIP) proposal including the development of DSRIP projects and incentives.
- Leading stakeholder engagement sessions for Arizona's State Innovation Model (SIM).
- Drafting deliverables for Arizona's SIM.
- Analyzing and reviewing alternative payment model designs with Arizona and New York.

EMPLOYMENT HISTORY

Name of Employer(start with most recent employer)	Dates of Employment	Job Title	Work Related To This RFP (Yes or No)
Mercer Health & Benefits LLC	June 2011 - Present	Senior Associate Principal	Yes
Akin, Gump, Strauss Hauer & Feld	October 2008 - May 2011	Associate	No
Cadwalader, Wickersham & Taft	September 2007 - October 2008	Associate	No

Bill Lasowski

QUALIFICATIONS

Bill is a Principal in our Policy and Operations Sector (POpS) and works through our office in Washington, DC. With over 37 years of Federal and State health policy experience, Bill focuses on Medicaid & Children's Health Insurance Program (CHIP) policy and operations consulting with a specific focus on analyzing and providing solutions to States and Territories on the full range of Medicaid and CHIP issues.

EXPERIENCE

Bill is a recognized national expert on all aspects of Medicaid and CHIP program and financial policy and operations. He was instrumental in developing national policies and procedures that support effective Medicaid and CHIP program implementation and administration. He advised senior Centers for Medicare & Medicaid Services (CMS) and Department of Health and Human Services (HHS) decision-makers on public policy and operational options and strategies. He has wide-ranging experience collaborating and negotiating with Congressional staff, the Office of Management and Budget, other Federal agencies, States, advocacy groups, contractors, and the general public on health care issues. Bill joined Alicia Smith and Associates, LLC (ASA) in October 2011 and came to Mercer in January 2012 when ASA was acquired by Mercer. Bill provides client leadership to a wide range of government clients.

Bill Lasowski
Principal

EDUCATION

Bachelor's Degree, Political Science
Colgate University

EXPERIENCE

6.5 Years Consulting Experience

32.5 Years Government Experience CMS

2.5 years Govt. Dept. of Agriculture

2.5 years Govt. Department of Army

CORE COMPETENCIES

Medicaid & CHIP Policy &Operations

Medicaid & CHIP Laws, Regulations, & Policies

Operation & Program Evaluation & Solutions

Contracts, State plans, RFPs, IAPDs, Program & Operational Proposals & Liaison & Negotiations with Federal Partners

Bill came to ASA upon retirement from CMS, after more than 37 years of Federal government experience. The last 32 of those years were spent at CMS, working with Medicaid and the CHIP on health care policy and operational issues, including provider taxes, disproportionate share hospital payments, certified public expenditures, and federal upper payment limit issues. Bill worked on numerous federal laws, regulations, policy issuances, state plan amendments and complex State financing issues to ensure States were complying with Federal requirements. Bill has worked with virtually every state regarding Medicaid reimbursement policy, Medicaid financial operations, state Medicaid financing strategies including the development and review of provider taxes. Bill has worked in developing financial models for section 1115 demonstrations including budget neutrality models and innovative programs directed at the uninsured and delivery system reform.

Bill served in a number of key management and policy making positions with increasing decision making authority and responsibility during his years at CMS. For the last six years Bill was the Deputy Director for the Center for Medicaid and CHIP Services (CMCS). In that position he

provided day-to-day management of CMCS including overseeing some 400 staff, developing and executing program budgets and directing strategic planning and program implementation.

Prior to joining CMS, Bill worked with the Food Stamp Program at the Department of Agriculture, Food and Nutrition Service. During that time, he spent two years in Puerto Rico developing and implementing a Food Stamp eligibility and accounting system across the island.

Since coming to Mercer, Bill's accomplishments have included:

- Working with Puerto Rico (PR) and the Virgin Islands (VI) to design develop and operationalize Medicaid and CHIP accounting, budgeting and financial management processes, which enables PR and VI to develop and pay claims in a timely and accurate manner; produce all necessary supporting documentation and reports; develop a comprehensive Medicaid and CHIP program budget that supports Federal and local budget reporting; provide ongoing accounting, statistical, and management reports; and ensure that the PR and VI are properly claiming all local and Federal reimbursement.
- Enhancing Federal claiming in PR and the VI through various revenue maximization activities such as reviewing current programs, appropriations and administrative activities; developing scenario models for consideration; and obtaining governmental and CMS approval for implementation. This resulted in PR and VI receiving over $250 million and $20 million in additional Federal funding.
- Reviewing Medicaid and CHIP program integrity functions in PR and the VI to determine the improvements necessary to ensure compliance with all Federal and local laws, regulations and policies; and developing the necessary policy, procedural, operational and organizational changes necessary to implement the enhancements.
- Providing ongoing technical assistance to other Mercer consultants and States on Medicaid and CHIP program laws, regulations, policies and operational procedures.
- Working with PR and VI to develop necessary state plans and program guidance to support expansion of their Medicaid and/or CHIP programs including early expansions under Affordable Cares Act (ACA) and transformation of the PR and VI programs to modified adjusted gross income consistent with new ACA requirements. This included working with CMS and VI and PR staff in negotiations with CMS to receive necessary approval of program and operational documents, policies, and procedures.
- Working with VI to develop Advance Planning Documents/Implementation Advance Planning Documents, scopes of work and Contracts to implement its integrated eligibility and enrollment system, health information technology, hospital presumptive eligibility, cost allocation plan update, and renew its Medicaid Management Information System contract and negotiating with CMS for approvals.
- Developing numerous VI State plan amendments including; alternative benefit plan, Territory Modified Adjusted Gross Income, childless adult expansion, CHIP Medicaid expansion, hospital/Federally Qualified Health Center/Clinic/ presumptive eligibility, Non-emergency Medical Transportation, income level increase, etc., and negotiation with CMS for approvals.

- Analyze and assess for VI various initiatives to expand eligibility to maximize coverage in VI, benefits of implementing a Medicaid CHIP expansion to increase Federal matching for children, implement long-term support and services to replace decertification of only nursing facility on island, work on analysis of go/no-go decision for VI to implement ACA exchange, coverage of non-qualified aliens, and coverage of inmates, securing off-island contractor for off-island care, implementing transplant coverage, implementing disaster relief and 100% Federal funding post hurricane, care management for Medicaid and CHIP members, and work with VI and other VI staff and stakeholders to implement initiatives.
- Working with VI Governor, VI Governor's Office staff, VI Cabinet Heads, VI DC lobbyists, Federal HHS/CMS staff and Congressional staff to represent VI interests on Federal legislation and Federal funding requests.
- Facilitating and participating in numerous weekly and bi-weekly conference calls and meetings with VI staff, VI contractors, Federal staff, and other VI stakeholders.
- Preparing numerous letters, responses to CMS and other Federal agency inquires, responses to State Plan Amendment Resident Assessment Instruments, policy documents, program notices, guides, and other program information for program members, providers, stakeholders, Department of Human Services staff, and CMS.
- Client leader for National Governors Association Center for Best Practices Policy Academy Contract: *Leveraging Medicaid to Create Statewide Health Care Transformation*. This project provided consulting services, subject matter expertise, and technical assistance to States in order to reach agreement in concept with the Federal HHS on individual, global Medicaid waivers, State plan amendments, or other authorities that facilitated statewide health system transformation.
- Team leader for project with Virginia Joint Legislative Audit and Review Committee to study the impacts of increasing enrollment and costs of the disabled population in the Virginia's Medicaid program and analyzing potential policy and operational solutions.

EMPLOYMENT HISTORY

Name of Employer(start with most recent employer)	Dates of Employment	Job Title	Work Related To This RFP (Yes or No)
Mercer Health & Benefits LLC	October 2011 - Present	Principal	Yes
Centers for Medicare & Medicaid Services (CMS)	January 1979 - July 2011	Deputy Center Director CMCS	Yes
US Department of Agriculture	July 1976 - January 1979	Financial Analyst	No
US Department of Army	January 1974 - July 1976	Management Analyst	No

Meredith Mayeri

QUALIFICATIONS

Meredith is a Principal with Mercer and co-leader of Mercer's Government Human Services Consulting Policy and Operations Sector. Meredith is one of Mercer's senior policy consultants specializing in complex program design, payment policy, Medicaid managed care, 1115 waivers, and long-term services and supports (LTSS). Meredith helps drive the strategic planning process, recommends and develops federal authorities, and designs operational solutions for implementation.

EXPERIENCE

Prior to joining Mercer, Meredith was a Technical Director for the Centers for Medicare & Medicaid Services (CMS), specializing in Medicaid managed care programs, waivers and demonstrations, Medicaid financing, and children's health.

Since joining Mercer in 2010, Meredith's experience includes:

- Development and implementation of successful new waiver programs (section 1115, 1915(b) and 1915(c) waivers), including benefit and payment model design, authority options, support with CMS negotiations.
- Advising clients on changes in federal laws, regulations and policy in the areas of the Affordable Care Act (ACA), Medicaid managed care, state funding mechanisms, waiver renewals, fee-for-service and managed care rate setting, LTSS and dual eligibles.
- Developing Medicaid alternative benefit plan state plan amendments, including review of essential health benefits, actuarial equivalency, and mental health parity.
- Designing, implementing and renewing a section 1115 waiver to increase access to primary and behavioral health care within a patient-centered medical home model and support provider financial sustainability through diverse financing (Medicaid, commercial, grant funding).
- Consulting on emerging Medicaid value-based payment models.
- Developing policy, contracting and payment strategies for a statewide Medicaid enhanced primary care case management model that included provider shared savings in alignment with CMS Integrated Care Model guidance.
- Providing assistance in CMS negotiations to resolve payment policy and regulatory issues around accountable care organizations within Medicaid managed care.

Meredith Mayeri
Principal
Policy and Operations Sector Co-lead

EDUCATION
Bachelor's Degree, Economics
LaSalle University

EXPERIENCE
20+ years professional experience
Former CMS Technical Director

CORE COMPETENCIES
Medicaid policy and waiver strategy
Medicaid state plan and waiver authorities
Payment strategy and reform
Capitation and payment policy
Long-term services and supports
Independent Assessments
Project leadership

- Assessing the policy, operational and financial viability of an ACA Section 2703 Health Home model for individuals with chronic conditions within Medicaid managed care to align with State Innovation Model goals for multi-payer engagement in health homes.
- Conducting a comprehensive assessment and operational plan, including waiver, contract and operational requirements, for the implementation of a Medicaid managed long-term care expansion program.
- Conducting independent assessments of waivers in Montana and Texas
- Consulting engagements with California, Connecticut, Delaware, Florida, Louisiana, Montana, New Jersey, Pennsylvania, and Texas

EMPLOYMENT HISTORY

Name of Employer(start with most recent employer)	Dates of Employment	Job Title	Work Related To This RFP (Yes or No)
Mercer Health & Benefits LLC	March 2010 - Present	Principal	Yes
Centers for Medicare & Medicaid Services	April 98 - March 2010	Technical Director	Yes
U.S. Department of Education	September 1994 – April 1998	Student Loan Specialist	No

Alicia D. Smith, MHA

QUALIFICATIONS

Alicia is a Principal within Mercer's Government Human Services Consulting group, a part of Mercer Health & Benefits LLC (Mercer) in the Washington, DC office. She has experience with Medicaid and other public assistance programs and has worked extensively with mental health and substance use disorder (SUD) systems and providers. She has assisted state and local government programs design and implement numerous service delivery and payment reform efforts, including the development and approval of Medicaid health homes and similar care management programs. Alicia has consulted to several states on a wide range of issues including program design and implementation, Medicaid 1115 waiver and State Plan development. She also served as a technical assistance contractor to Centers for Medicare & Medicaid Services (CMS) for the SUD Innovation Accelerator Program (IAP) and through that project directly assisted three states (Maryland, Michigan, and Minnesota) in evaluating their SUD 1115 waiver opportunity; provided strategic consultation to several states that participated in the IAP since the program's inception, including states with recently approved SUD waivers; and provided coaching supports to states needing assistance with development of 1115 Implementation Plans and analyses of SUD provider network adequacy.

Alicia D. Smith, MHA
Principal

EDUCATION

Master's degree, Health Administration
Ohio State University

Bachelor's degree, Political Science
Central State University

EXPERIENCE

25 years
professional experience

CORE COMPETENCIES

Behavioral delivery system analysis and redesign

Behavioral health policy and program development

Medicaid waiver and state plan development

Managed care coordination models for vulnerable subpopulations

Fee-for-service rate setting

EXPERIENCE

Prior to joining Mercer in 2018, Alicia worked as a managing principal with a national health care consulting firm from 2007 through 2017 and was responsible for expanding the profile of the firm's behavioral health consulting practice. Alicia began her health care career in 1995 with the Ohio Department of Job and Family Services (now the Ohio Department of Medicaid) as a policy and program developer and has continued to utilize those skills to help clients establish and implement compliant, replicable, and sustainable health care reform strategies.

Examples of Alicia's experience and accomplishments include:

- Working with Virginia to develop a statewide strategy to address the long-term care needs of elderly adults with psychiatric conditions.
- Leading an effort on behalf of the City of Columbus (Ohio) to secure one million dollars for the Healthy Beginnings at Home: Housing Stabilization Program for Pregnant Women program for women at high risk for negative birth outcomes and experiencing housing instability.
- Assisting South Carolina develop a parity risk assessment plan and report.

- Providing targeted technical support, subject matter expertise, and resource development for the Medicaid IAP relating to SUD, primary/behavioral health integration, and severe mental illness (SMI) data analytics. The IAP is a collaborative effort between CMS the Center for Medicaid and Children's Health Insurance Services (CHIP) Center for Medicaid and CHIP Services (CMCS) and the Center for Medicare & Medicaid Innovation (CMMI) launched by the CMS in 2014.
- Serving as a national subject matter expert and developing a national guidance document for the CMS IAP to assist states conduct analysis of Medicaid claims and encounter data to better understand populations with SMI.
- Working with Michigan to develop and submit its 1115 Waiver for an expanded array of SUD services and assisted Michigan with development of its 1115 implementation plan.
- Assisting Missouri and Rhode Island become the first and second states in the U.S., respectively, receive CMS approval of their Medicaid Health Home State Plan Amendments. Working with Michigan, Ohio, and the District of Columbia to receive CMS approval of their Medicaid Health Home State Plan Amendments.
- Working with Michigan and the District of Columbia to support implementation of Health Home services, including design of information exchange and other technology solutions to ensure payment, quality outcomes reporting, and operational compliance.

PUBLICATIONS AND PUBLIC FORUM PRESENTATIONS

- Geropsychiatric System of Care in Virginia, November 10, 2017.
- Billing Effectively (and accurately) for Integrated Behavioral Health Services, Substance Abuse and Mental Health Services Administration/Health Resources and Services Administration Center for Integrated Health Solutions, June 6, 2016.
- Medicaid Health Home Best Practices (or, "How do behavioral health providers realize the promise of Integrated Care via Health Homes?"), National Council for Behavioral Health Annual Conference February 2014.
- Financing and Policy Considerations for Medicaid Health Homes for Individuals with Behavioral Health Conditions, April 15, 2013.
- Making the Ohio Medicaid Business Case for Integrated Physical and Behavioral Health Care, June 2010.
- Integrating Publicly Funded Physical and Behavioral Health Services: A Description of Selected Initiatives Final Report, February 2007.

EMPLOYMENT HISTORY

Name of Employer(start with most recent employer)	Dates of Employment	Job Title	Work Related To This RFP (Yes or No)
Mercer Health & Benefits LLC	January 2018 - Present	Principal	Yes
Health Management Associates	January. 2007 - December 2017	Managing Principal	Yes
Health Care Compliance Solutions, Inc.	September 2002 --December 2007	President and CEO	Yes
Vorys, Sater, Seymour and Pease, LLP	October 2000 - September 2002	Paralegal / Consultant	Yes

Michele Puccinelli Walker, MSG, MPA

QUALIFICATIONS

Michele specializes in policy and program development for Medicaid and Children's Health Insurance programs (CHIP) with a focus on delivery system innovation, behavioral health, dual eligibles and long-term care (LTC). She serves as project manager for the states of Arizona, Kansas, Minnesota, and Ohio coordinating a multi-faceted team and team member for other states such as Delaware, New York and North Carolina.

EXPERIENCE

Prior to joining Mercer, Michele held senior positions for over 17 years within the U.S. Department of Health and Human Services, including the Administration on Aging, the Centers for Medicare & Medicaid Services (CMS) and the Office of the Secretary's Regional Director for Region IX. During her 12 years at CMS, Michele served in senior positions within the Office of Legislation, the Division of Medicaid and Children's Health Operations and the Division of Medicare Health Plan Operations. Michele served as the Regional Executive Officer for the Office of the Regional Director, focusing on the implementation of health care reform. Highlights of her projects included:

- Managing the collaboration of a federal-private partnership with a foundation focusing on the impact of health care reform on the aging population.
- Directing the Federal Regional Council, which was comprised of 19 federal agencies in Region IX, including initiatives on health care reform, homelessness, Native Americans and sustainable communities.
- Designing, implementing and coordinating oversight of the Programs for All-Inclusive Care for the Elderly (PACE), including coordinating and tracking Medicare, Medicaid and Part D policy issues between PACE organizations, states and CMS; managing the PACE application review process; and directing the review and approval of PACE Medicaid capitation rates and program compliance/monitoring.
- Coordinating the oversight of Medicaid managed care and waiver programs, including 1915(b) and 1115 waivers and state plan amendments and review of actuarial sound rates.

While at Mercer, Michele has worked with the states of Arizona, California, Connecticut, Delaware, Florida, Kansas, Louisiana, Massachusetts, New Jersey, New Mexico, New York, North Carolina Ohio, Pennsylvania, and South Carolina, as well as the District of Columbia.

Michele Puccinelli Walker, MSG, MPA
Senior Associate

EDUCATION
Master's Degree, Gerontology
Master's Degree, Public Administration
University of Southern California
Bachelor's Degree, Human Development
University of California, Davis

EXPERIENCE
25 years professional experience

CORE COMPETENCIES
Program design and implementation
Policy and regulatory analysis
Behavioral health program design

AFFILIATIONS
Member, American Society on Aging
Member, Project Management Institute

Michele's experience includes:

- Project managing multi-faceted teams including coordination between state agencies for projects involving managed care procurement processes including drafting request for proposal language and evaluation steps, readiness reviews, behavioral health redesign and rate setting, and developing a coordinated system of care for children at risk for institutionalization. This includes developing project management tools such as work plans, risk logs, etc.
- Preparing and negotiating Medicaid 1915(b), 1915(c) and 1115 waivers and 1932(a)/1915(i) State Plan Amendments for the states of Delaware, Kansas, Louisiana, New Mexico, New York, Ohio, Pennsylvania, and the District of Columbia.
- Providing policy guidance as it relates to Medicaid actuarial rate setting and cost effectiveness/ budget neutrality calculations for managed care and Home-and Community-Based Services (HCBS) programs for the states of Ohio and South Carolina.
- Working on the design and implementation of statewide Medicaid managed LTC programs for the states of Delaware, Kansas, New Jersey, New Mexico, and Ohio.
- Working on the design and implementation of behavioral health system redesigns, including the Autism benefit for the states of Louisiana, North Carolina, Ohio, and South Carolina.
- Advising clients and designing Medicaid behavioral health coordinated systems of care for children at risk for out of home placement for the states of Louisiana and South Carolina.
- Participating in a workgroup with the National PACE Association on Medicaid rate setting for PACE programs.
- Advising clients on changes in federal laws, regulations (including sub-regulatory) and policy in the area of Medicaid, CHIP, health care reform, managed care, state funding mechanisms, managed care rate-setting, PACE, long-term care and dual-eligibles for the states of California, Delaware, Massachusetts, North Carolina, Ohio, and Pennsylvania.

PUBLICATIONS AND PUBLIC FORUM PRESENTATIONS

- Publication: Torres-Gil, Fernando M. and Michele A. Puccinelli. "Aging Policy in the Clinton Administration." *Journal of Aging and Social Policy*, Vol. 7(2) (1995): 13-18.
- Torres-Gil, Fernando M. and Michele A. Puccinelli. "Mainstreaming Gerontology in the Policy Arena." *The Gerontologist*, 34 (1994): 749-752.
- Torres-Gil, Fernando M. and Michele A. Puccinelli. "Aging: Public Policy Issues and Trends."
- *Encyclopedia of Social Work*, 19th Edition (1) (1993): 159-164.
- Presentation: The SCAN Foundation's 2013 LTSS Summit. *ARDC Business Plan Development.* November 13, 2013.
- Presentation: Mercer's Webinar for Clients. *Informational Review for Mercer Clients: Medicaid Home and Community-Based Services New Rule.* June 27, 2014.

- Presentation: Ohio's HCBS Public Stakeholder Meeting. *Medicaid Home and Community-Based Services Basics and New Rules.* July 30, 2014.

EMPLOYMENT HISTORY

Name of Employer (start with most recent employer)	Dates of Employment	Job Title	Work Related To This RFP (Yes or No)
Mercer Health & Benefits LLC	January 2011 – Present	Senior Associate	Yes
Department of Health and Human Services	June 2010 – January 2011	Regional Executive Officer	Yes
Department of Health and Human Services, Centers for Medicare & Medicaid Services	December 2008 – June 2010	Health Plan Account Manager	Yes
Department of Health and Human Services, Centers for Medicare & Medicaid Services	December 1999 – December 2008	Health Insurance Specialist/Waiver Coordinator	Yes
Department of Health and Human Services, Centers for Medicare & Medicaid Services	July 1998 – December 1999	Congressional Hearings and Presentations Coordinator	Yes
Department of Health and Human Services, Administration on Aging	May 1993 – July 1998	Executive Assistant and Social Science Research Analyst	Yes

Dan Wendt, LMSW

QUALIFICATIONS

Dan is a Principal with Mercer Health & Benefits LLC (Mercer) and performs clinical and behavioral health consulting for Mercer Government Human Services Consulting, a specialty practice devoted to publicly-funded health care programs. Dan is a licensed masters level social worker and a certified professional in health care quality with 30 years of experience in the field of behavioral health. Dan's unique background includes leadership roles within national behavioral health managed care organizations (MCOs), a state health department and a Medicaid agency as well as direct provider experience within acute psychiatric inpatient facilities. Dan's competencies include expertise in quality management, health care delivery system design and evaluation, performance and outcome measurement tool design and implementation, provider network adequacy assessments, waiver performance metric design, selection and evaluation, and Medicaid managed care contract monitoring and oversight.

EXPERIENCE

Dan possesses extensive experience with Medicaid physical health and behavioral health managed care programs and clinical service delivery systems. Prior to joining Mercer, Dan served as the Chief Quality Officer for four years at a national capitated behavioral health managed care organization (BH-MCO) that held the largest public sector behavioral health managed care contract in the United States. Prior to that role, Dan held the position of vice president of quality for another national BH-MCO and was responsible for all aspects of managing and overseeing the quality management department. Dan's quality management expertise includes grievance and appeals, complaint resolution, quality of care reviews, risk management, clinical oversight, implementation and ongoing evaluation of outcome tools, performance measure design, data sharing, data analytics and the development and maintenance of regional and statewide BH-MCO key indicator reporting formats.

Prior to leadership positions within BH-MCOs, Dan served in government positions at the Arizona Department of Health Services (AZDHS) and the Arizona Health Care Cost Containment System (AHCCCS), Arizona's Medicaid agency. While at AZDHS, Dan ensured programmatic compliance with federal and state requirements and provided leadership and oversight of the following functions: quality management, quality measurement design and specifications development,

Dan Wendt, LMSW
Principal

EDUCATION

Master's degree, Social Work
Arizona State University

Bachelor's degree, Science
Ball State University

EXPERIENCE

30 years
Professional experience

Years with Mercer 5

CORE COMPETENCIES

Performance measure development

Program evaluation

Program design to support transitions to community-based services for vulnerable populations

Behavioral health systems and organizations

Evaluation, plan development and implementation

Assessment of provider network adequacy and service availability

Study, design, survey development, data collection and statistical analysis

AFFILIATIONS

Certified Professional in Health Care Quality

Licensed Masters of Social Work

Lean Six Sigma Green Belt

contract compliance, Request for Proposal (RFP) development/evaluation and policy development. While at AHCCCS, Dan participated in operational and financial reviews of Medicaid capitated acute care physical health plans, BH-MCOs and long-term-care managed care contractors. Dan has a clinical background and is highly experienced in quality performance improvement concepts and approaches.

Dan joined Mercer in 2011, and has been engaged with projects in multiple states including:

- Assisted a State Medicaid Agency in the identification, tracking, evaluation and follow-up for a set of 1915(c) waiver performance measures for populations with special health care needs.
- Supporting the design and implementation of public behavioral health care delivery systems and the redesign and peformance improvement of existing managed care programs.
- Conducting operational and clinical assessments of MCOs – identifying opportunities for operational efficiencies and promoting the use of clinical best practices.
- Participating in RFP development and evaluation.
- Reviewing Medicaid agency and MCO policies and procedures as part of MCO readiness assessments.
- Leading readiness reviews and clinical performance reviews of BH-MCOs on behalf of government clients.
- Assisted with a statewide evaluation of adult care homes that informed a comprehensive approach to transition adults with complex and/or special needs to community living arrangements. Once implemented, performed annual evaluations of the contracted BH-MCOs to gauge progress with implementing required in-reach activities, member education, and program development to support and maintain member placements in the community.
- Leading a cost driver analysis of designated behavioral health services and providing technical assistance with the design and implementation of quality improvement activities to reduce avoidable cost and/or over utilization.
- Designing and implementing a comprehensive service capacity assessment and network sufficiency evaluation of evidence-based practices available to persons determined to have a serious mental illness within an integrated care service delivery system (physical health and behavioral health integration). The evidence-based practices included supported housing, supported employment, peer support and assertive community treatment teams.
- Performing a behavioral health network assessment for children in foster care.
- Consulting with state agencies to design and implement monitoring and oversight models for contracted MCOs, including the identification of relevant and aligned performance measures and outcome tools to support the continual assessment of delivery system goals.
- Assisted with the design and implementation of a quality bonus payment model under the Certified Community Behavioral Health Clinic demonstration program.
- Faciliated statewide focus groups with family members and providers to solicit input regarding performance measurement, effectiveness of services and meaningful outcomes.

- Researched and advised a Medicaid agency regarding value-based purchasing strategies.
- Participated in the development of multiple rate structures for foster care children transitioning to managed care. The analysis included a review of potential clinical factors that could influence the rates.
- Assisted Medicaid agencies by researching and presenting options to support performance-based contracting arrangements with contracted MCOs.
- Conducted a special onsite analysis of adult care homes and provided technical assistance to a state Medicaid agency to determine if the facilities met criteria for an institution for mental disease.
- Led and implemented a comprehensive analysis to determine compliance with the Mental Health Parity and Addiction Equity Act.
- Provided technical assistance by completing an analysis of MCO contracts and recommending revisions to ensure compliance with the Medicaid Managed Care Rule.
- Providing ongoing consultation and technical assistance to state agencies and their contracted
BH-MCOs and key system stakeholders.

EMPLOYMENT HISTORY

Name of Employer(start with most recent employer)	Dates of Employment	Job Title	Work Related To This RFP (Yes or No)
Mercer Health & Benefits LLC	September 2011 – Present	Principal	Yes
Magellan Health Services	July 2007 – August 2011	Chief Quality Officer	Yes
ValueOptions	May 2006 – July 2007	Vice President – Quality Management	Yes
Arizona Department of Health Services/Division of Behavioral Health Services	July 2002 – April 2006	Division Chief of Contract Compliance; Division Chief of Quality Management and Evaluation; Policy Office Chief	Yes
Arizona Health Care Cost Containment System	September 1998 – July 2002	Clinical Program Analyst	Yes

B

APPENDIX B: SAMPLE WORK PRODUCTS

Mercer provides the following work products to reflect our experience in delivering technical assistance, policy support, and ad-hoc support. Our sample products include:

1. A Mercer Webinar: Medicaid Managed Care/Mercer's First Look at the 2016 Final Rule (excerpted) (May 17, 2016)
2. A Mercer Webinar: Medicaid Managed Care and Pharmacy/Mercer's First Look at the 2016 Final Rule/Outpatient Drug Coverage (excerpted) (July, 2016)
3. A Mercer Webinar: Electronic Visit Verification (EVV) – Ready or Not? (excerpted) (April 2018)
4. Sample Generic Work Plan
5. Policy White Paper – Section 1915(i) Home- and Community-based Services State Plan Option
6. Policy White Paper – Summary of the Home- and Community-based Services (HCBS) Regulations (March, 2014)
7. Sample Dashboards

HEALTH WEALTH CAREER

A MERCER WEBINAR

MEDICAID MANAGED CARE

MERCER'S FIRST LOOK AT THE 2016 FINAL RULE

MAY 17, 2016

Presenters
Dianne Heffron, MBA
Ann Marie Janusek, ASA, MAAA
Stefanie Kurlanzik, JD
Mike Nordstrom, ASA, MAAA
Ron Ogborne, FSA, CERA, MAAA

Mercer Government Human Services Consulting
Atlanta, Minneapolis, Phoenix, and Washington, DC

AGENDA
WHAT WE'LL COVER TODAY

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RATE SETTING AND DOCUMENTATION

SUMMARY

Current Rules at 438.6	- Expanded and renumbered. - Rate setting rules now in 438.3-438.7, 438.9, and 438.60 (and sort of 438.206-208).
Medicaid Rate Review Approaching an "Audit"?	- Desire for more transparency and oversight. - More prescriptive in approach versus greater deference to actuarial experience/ expertise/judgment. - More documentation and timelines needing to be supplied/followed.
New Rules (Among Many) Relating to:	- Rate ranges. - "Pass-through" or "directed" payments. - Incentives and withholds. - Connecting availability, capacity, coordination, continuity of care with rate-setting process.
MLR for Medicaid (438.8, 438.74) and CHIP	- Rate setting must take into account/consider past/projected MLR performance.

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RATE SETTING AND DOCUMENTATION
KEY ELEMENTS

Rate Range Certifications

- Go the way of the dodo bird and Kardashian modesty.
- Come again? The +/-1.5% sure looks like a rate range.

Capitation Rates

- Developed to reasonably achieve at least an 85% Medical Loss Ratio (MLR) for the rate year.

Definitions (438.2)

- New are Overpayment, Provider, Rating Period, and Subcontractor.

Standard Contract Requirements (438.3)

- Must submit material to CMS for review no later than 90 days prior to the effective date of the contract.
- Mental Health Parity and Addiction Equity Act (MHPAEA) compliance.
- "In lieu of" services/settings coverage requirements.
- Annual audited financial reports specific to the Medicaid contract.

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RATE SETTING AND DOCUMENTATION
KEY ELEMENTS

Base Data

- State provides at least the three most recent and complete years prior to the rating period.
- Encounter data: Federal financial participation not available for Medicaid managed care expenditures if submitted encounter data to CMS does not meet their criteria for accuracy, completeness, and timeliness.

Special Contract Provisions Related to Payment (438.6)

- Newly defined "pass-through payment" with a "base amount" and reduction schedule.
- Directed payments.
- Withholds — analysis and development considerably more challenging.
- IMD capitation payments for short-term stay (no more than 15 days within a month).

Non-emergency Medical Transportation (438.9)

- Actuarial soundness applied to non-emergency medical transportation prepaid ambulatory health plans.

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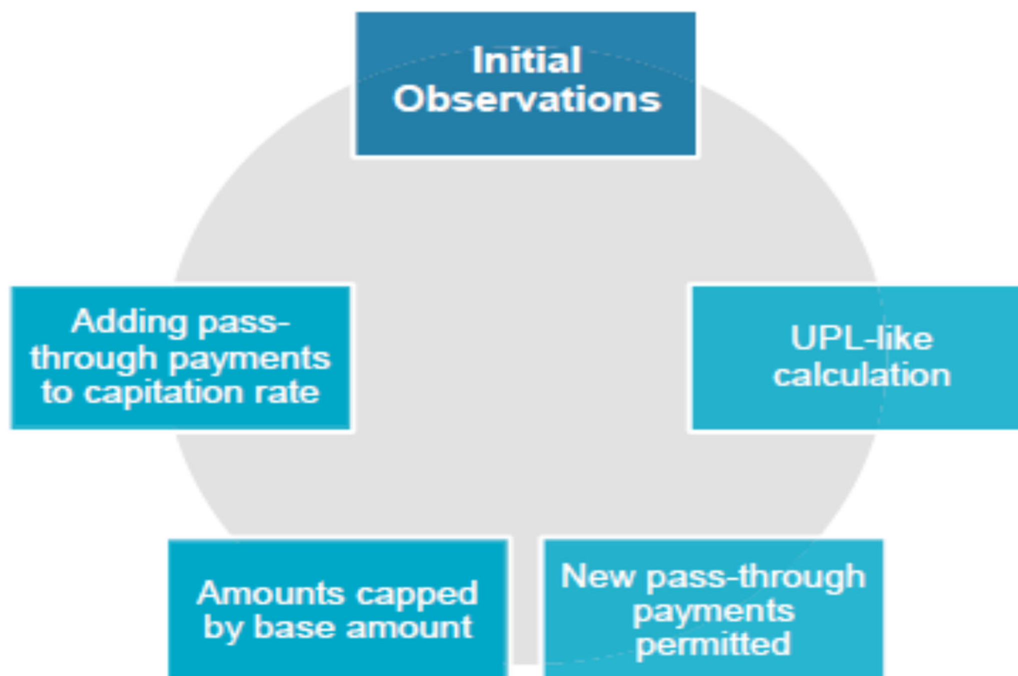
SPECIAL CONTRACT PROVISIONS — PASS-THROUGH PAYMENTS

KEY ELEMENTS



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SPECIAL CONTRACT PROVISIONS — VALUE-BASED PURCHASING
KEY ELEMENTS

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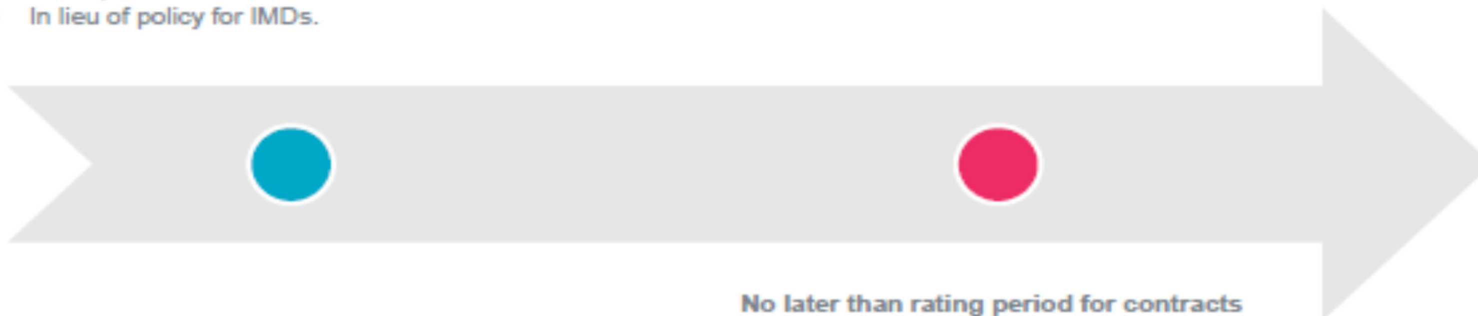
IMPLEMENTATION TIMELINES

Effective date — July 5, 2016

- "Much of" Section 438 basics associated with rate setting and certification, including incentive payments and description of risk mechanisms.
- In lieu of policy for IMDs.



No later than rating period for contracts starting on or after July 1, 2017

- "Rest of" Section 438 details associated with rate setting and certification.
- Audited financial reports.
- MLR standards.
- Withholds.
- Pass-through payments.
- Delivery system and provider payment initiatives.

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IMPLEMENTATION TIMELINES

No later than rating period for contracts starting on or after July 1, 2018

- Capitation rates adequate to meet Sections 438.206, 438.207, 438.208.
- No more rate range certifications.
- +/-1.5% (per rate cell) to capitation rates without revised rate certification.

No later than rating period for contracts starting on or after July 1, 2019

- Section 438.4(b)(9): Develop capitation rates so that health plan can reasonably achieve an MLR of at least 85%.

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NEXT STEPS
FOR CONSIDERATION
Complete a second, third, and fourth read of the rule.
Based on short-term and long-term goals, develop a strategy for those items that appear to allow for desired state flexibility.
At the right time, reach out to CMS.
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NEXT STEPS

Institutions for Mental Diseases (IMDs)

Managed Long Term Services and Supports (MLTSS)

Managed Care Pharmacy

OTHER TOPICS INCLUDED IN THE RULE

Access and Network Adequacy

Quality and External Quality Review

Beneficiary Protections and Informing

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HEALTH WEALTH CAREER

A MERCER WEBINAR

MEDICAID MANAGED CARE AND PHARMACY

MERCER'S FIRST LOOK AT THE 2016 FINAL RULE

JULY 20, 2016

Presenters
Brenda Jackson
Barb Mart
Ralph Magrish
Ron Ogborne

Mercer Government Human Services Consulting
Atlanta, Minneapolis, Phoenix, and Washington, DC

AGENDA
WHAT WE WILL COVER TODAY

OUTPATIENT DRUG COVERAGE

DRUG UTILIZATION REPORTING AND 340B DATA EXCLUSIONS

DUR PROGRAM REQUIREMENTS

DUR REPORTING

OTHER REQUIREMENTS

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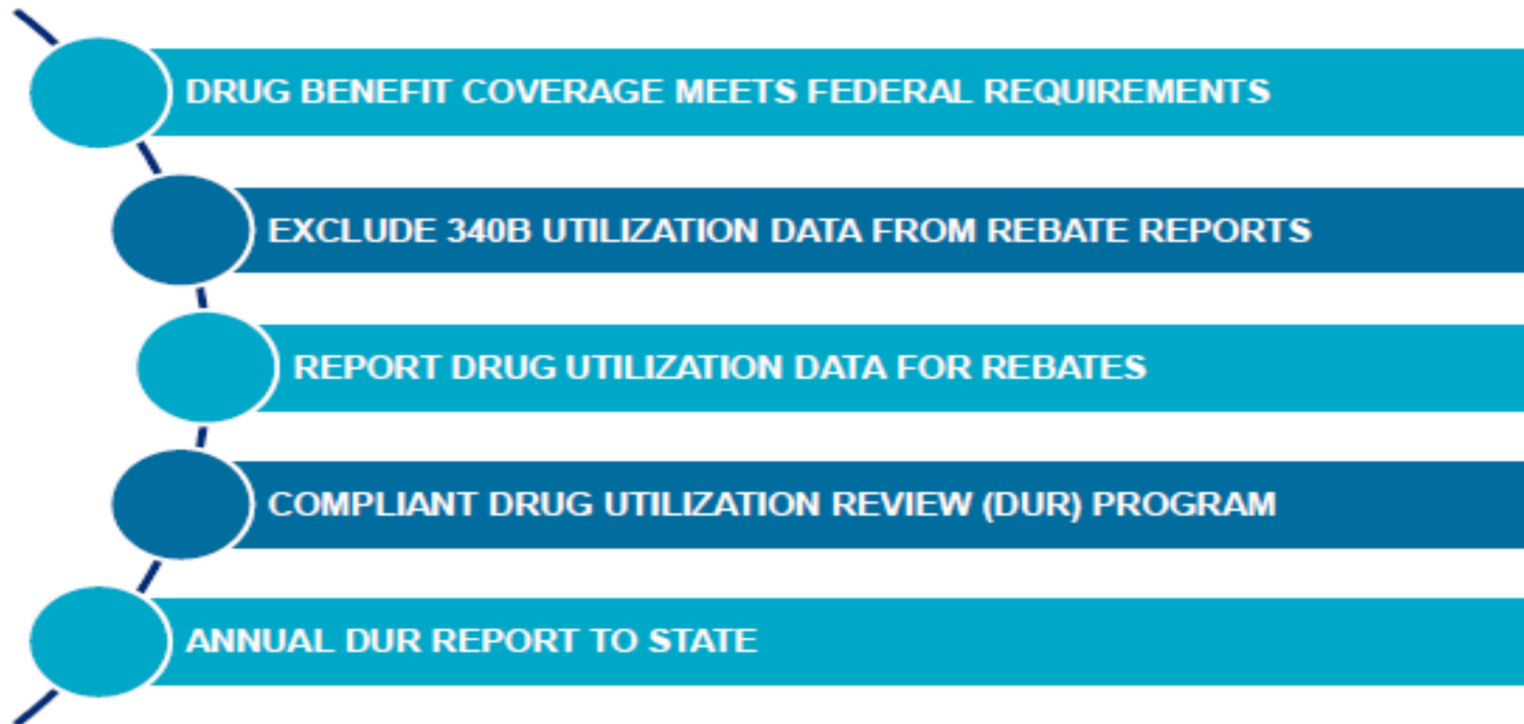
CONTRACTUAL OBLIGATIONS
PHARMACY IMPLICATIONS
DRUG BENEFIT COVERAGE MEETS FEDERAL REQUIREMENTS
EXCLUDE 340B UTILIZATION DATA FROM REBATE REPORTS
REPORT DRUG UTILIZATION DATA FOR REBATES
COMPLIANT DRUG UTILIZATION REVIEW (DUR) PROGRAM
ANNUAL DUR REPORT TO STATE
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3

OTHER FINAL RULE REQUIREMENTS
PHARMACY IMPLICATIONS

PRIOR AUTHORIZATION

ASSESSMENTS AND HEALTH RECORDS

TRANSITION OF CARE

ACCESS STANDARDS

ENROLLEE INFORMATION

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KEY TAKEAWAYS

EVALUATE NEED FOR AND DEVELOP NECESSARY CONTRACT REQUIREMENTS

ESTABLISH PROCESSES TO ENSURE ACCURATE 340B CLAIM IDENTIFICATION

ENSURE LINKAGES BETWEEN PHARMACY AND MCO CONTRACT ADMINISTRATION STAFF

IDENTIFY RESOURCES TO MEET INCREASED ADMINISTRATIVE RESPONSIBILITIES

RESULT WILL BE CLOSER ALIGNMENT BETWEEN FFS AND MCO COVERAGE

NEED FOR CONSISTENT DEFINITIONS ACROSS BOTH FFS AND MCOS

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HEALTH WEALTH CAREER

A MERCER WEBINAR

ELECTRONIC VISIT VERIFICATION (EVV) – READY OR NOT?

FOCUSING ON DESIGN & IMPLEMENTATION

APRIL 26, 2018

Presenters
Mike Smith, Principal
Kim Donica, Principal
Lorene Reagan, Senior Associate

Mercer Government Human Services Consulting
Atlanta, Minneapolis, Phoenix, and Washington, DC

AGENDA
WHAT WE WILL COVER TODAY

TODAY'S OBJECTIVES	21ST CENTURY CURES ACT QUICK REVIEW	FINANCIAL IMPACT OF EVV	STATE EXAMPLES	SYSTEM DESIGN AND PURCHASE	RESOURCES	Q & A

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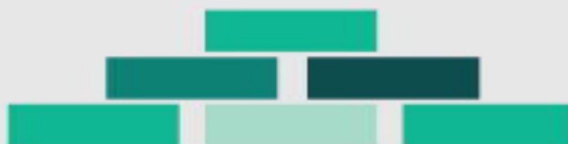
21ST CENTURY CURES ACT OVERVIEW SEC.12006

PURPOSE	REQUIREMENTS	FFP
		
Prevents fraud, waste and abuse	Personal care services by January 1, 2019	90/10 for design, development or installation of an EVV System
	Home health services by January 1, 2023	
	Penalties for non-compliance up to a 1% reduction in Federal Medical Assistance Percentage (FMAP)	75/25 for the operation and maintenance of the system
	"Good faith" language for states that run into delays	
	Track the type, recipient, date and location of service in addition to start/stop time of the service	

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PERSONAL CARE SERVICES

MEDICAID COVERS PCS FOR ELIGIBLE INDIVIDUALS

- Medicaid State Plan options
- Medicaid waiver
- CMS-approved demonstration authorities

CONSISTS OF SERVICES SUPPORTING ADL

Including movement, bathing, dressing, toileting, transferring and personal hygiene

OFFERS SUPPORT FOR IADL

Including meal preparation, money management, shopping, and telephone use

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SAMPLE WORK PLAN

Task Description	Entity(ies) Assigned	Date Due
Waiver construction, modification, and implementation		
Project initiation		
Schedule meeting dates with [State] to perform needs assessment, determine project scope, document the State's goals, and understand hot topics	[State] and Mercer	TBD
Determine project status meeting/reporting frequency	[State] and Mercer	TBD
Waiver construction		
Assess waiver, SPA, legislation and policies for regulatory requirements	Mercer	TBD
Deliver recommendations on relevant policy issues	Mercer	TBD
Integrate fiscal data and regulatory information to determine policy impacts	Mercer	TBD
Prepare draft of waiver	Mercer	TBD
Amend drafts in response to [State] feedback	Mercer	TBD
Prepare draft of proposal for cooperative agreements	Mercer	TBD
Amend drafts in response to [State] feedback	Mercer	TBD
Prepare final cooperative agreements and Waiver for submission	Mercer	TBD
Provide input into procurement documents	Mercer	TBD
Assess necessary changes to operations, policies and business rules to support waiver.	Mercer	TBD
Document revisions to operations and policies to support waiver	Mercer	TBD
Implementation		
Partner with [State] to implement operations and policies to support waiver language.	Mercer	TBD
Formulate on-going stakeholder communication plan	Mercer	TBD
Develop test scenarios to ensure operational accuracy of implementation	[State] and Mercer	TBD
Perform data monitoring on expected impacts, as directed by [State]	Mercer	TBD
Regulatory analysis		
Project initiation		TBD
Schedule meeting dates with [State] to perform needs assessment, determine project scope, document [State] goals, and understand hot topics	[State] and Mercer	TBD
Determine project status meeting/reporting frequency	[State] and Mercer	TBD
Analysis		
Review and summarize regulations relevant to the project	Mercer	TBD

Task Description	Entity(ies) Assigned	Date Due
Identify regulations that are key to implementation of project	Mercer	TBD
Review federal regulations that would need to be waived	Mercer	TBD
Evaluate the ease or difficulty of obtaining waiver	Mercer	TBD
Evaluate regulatory parameters for cost sharing, co-pays or other revenue options	Mercer	TBD
Analyze options for program financing, eligibility, service coverage,	Mercer	TBD
Research innovative health delivery system designs	Mercer	TBD
Provide written analysis and recommendations	Mercer	TBD
Prepare report of sustainability options	Mercer	TBD
Partner with [State] to negotiate with the federal government	Mercer	TBD
Initiate waiver modification work plan for changes requiring waiver revision	Mercer	TBD
Implementation	Mercer	
Assess necessary changes to operations and policies to support innovation	Mercer	TBD
Develop stakeholder communication plan	Mercer	TBD
Develop test scenarios to ensure operational accuracy of implementation	[State] and Mercer	TBD
Partner with [State], as necessary, to implement systems changes	Mercer	TBD
Perform data monitoring on expected impacts, as directed by [State]	Mercer	TBD
Federal and Stakeholder Negotiations		
Project initiation	Mercer	
Schedule meeting dates with [State] to perform needs assessment, determine project scope, document [State] goals and understand hot topics	Mercer	TBD
Determine project status meeting/reporting frequency	[State] and Mercer	TBD
Negotiation process		
Propose recommendations to [State] on relevant issues	Mercer	TBD
Develop draft negotiation strategy	Mercer	TBD
Amend and finalize strategy in response to [State] feedback	Mercer	TBD
Prepare data-driven responses for potential stakeholder issues	Mercer	TBD
Facilitate negotiations	Mercer	TBD
Provide post-negotiation meeting summary to [State]	Mercer	TBD
Implementation		
Assess necessary changes to policies to support innovation	Mercer	TBD
Develop on-going stakeholder communication plan	Mercer	TBD

Task Description	Entity(ies) Assigned	Date Due
Assess changes necessary to systems and operations	Mercer	TBD
Partner with [State], as necessary, to implement systems changes	Mercer	TBD
Perform data monitoring on expected impacts, as directed by [State]	Mercer	TBD
Program development and modeling		
Project initiation		
Schedule meeting dates with [State] to perform needs assessment, determine project scope, document [State] goals and understand hot topics	[State] and Mercer	TBD
Determine project status meeting/reporting frequency	[State] and Mercer	TBD
Data acquisition		
Identify data needs and submit data request for data necessary for rate development and fiscal impact analysis	Mercer	TBD
Validate data	Mercer	TBD
Meet to discuss data discrepancies and determine resolution	[State] and Mercer	TBD
Program modeling		
Develop decision log to document related policy topics	Mercer	TBD
Conduct research on innovative program designs		TBD
Assess waiver, SPA, legislation and policies for regulatory requirements	Mercer	TBD
Provide recommendations on relevant policy issues	Mercer	TBD
Assess potential impacts to waiver and SPA language	Mercer	TBD
Evaluate program changes for targeted population, merging clinical and financial data to ensure improved quality and reduced cost	Mercer	TBD
Develop tools as necessary to identify targeted population or eligibility criteria	Mercer	TBD
Develop strategies for reducing disruption of health care	Mercer	TBD
Produce screening tools for the determination of eligibility	Mercer	TBD
Establish business and policy rules	Mercer	TBD
Determine provider qualifications and requirements	Mercer	TBD
Develop data models for budget analysis and projections	Mercer	TBD
Finalize program model	Mercer	TBD
Stakeholder communication		
Participate in stakeholder meetings	[State] and Mercer	TBD
Prepare training materials for topics requested by [State] before meetings	Mercer	TBD

Task Description	Entity(ies) Assigned	Date Due
Deliverable and implementation		
Produce deliverable that includes subject-matter expertise, financial analysis, fiscal models, projections, [State] options, and recommendations	Mercer	TBD
Propose regulatory, waiver or SPA modifications, as necessary	Mercer	TBD
Assist in responding to CMS regarding waiver or SPA changes	Mercer	TBD
Develop provider communication plan	[State] and Mercer	TBD
Assess changes necessary to systems and operations	Mercer	TBD
Assist in developing test scenarios to ensure accuracy of operational changes	Mercer	TBD
Partner with [State], as necessary, to implement systems changes	Mercer	TBD
Perform data monitoring on expected impacts, as directed by [State]	Mercer	TBD

SECTION 1915(I) HOME- AND COMMUNITY-BASED SERVICES STATE PLAN OPTION

Section 6086 of the Deficit Reduction Act (DRA) of 2005 created a new state plan (SP) option for home- and community-based services (HCBS). This new option is codified at Section 1915(i) of the Social Security Act. Congress recently made several key changes to the Section 1915(i) SP option as part of the Affordable Care Act (ACA). 1915(i) authority breaks the eligibility links between HCBS programs and institutionalization and allows states to implement HCBS programs without a waiver. In addition to the statutory language, the Centers for Medicare and Medicaid Services (CMS) published proposed rules on the 1915(i) SP option on April 4, 2008 and in two State Medicaid Director letters dated April 4, 2008 and August 6, 2010. Finally, 1915(i) allows states to add medically needy individuals with higher income not otherwise eligible for Medicaid and only offer those individuals the HCBS 1915(i) services without access to the full Medicaid benefit.

This summary will highlight how the 1915(i) compares to 1915(c) waiver. *Note: The original statutory provisions were effective January 1, 2007.*[1]

In many basic respects, the 1915(i) SP option includes similar authorities of a Section 1915(c) waiver. Each has an evaluation process to determine eligibility and an assessment of the need for HCBS.[2] Also, each authority requires that services are delivered in accordance with a plan of care. Each may offer a self-directed option and both require the state to have a quality management program. Both require the state to give health and welfare assurances. Each program excludes payment for room and board. In each type of program, the state may choose not to apply all the usual asset and income rules.

The ACA changes to Section 1915(i) further aligned the SP option with Section 1915(c) waiver authority. First, the original statute limited services under the SP option to those set forth in Section 1915(c)(4)(B); these include case management, homemaker/home health aide, personal care services, adult day health, habilitation, respite, psychosocial rehabilitation services and clinic services for persons with chronic mental illness. However, the ACA does now permit the 1915(i) to offer "such other services requested by the state as the secretary may approve." The extent to which CMS will approve all HCBS services has yet to be tested.

Second, the 1915(i) option originally did not allow a waiver of comparability; so the option had to be available to any Medicaid-eligible person who met state-established needs-based criteria. The new ACA language now allows states to design service packages without regard to comparability to specific, targeted populations for states covering the new optional group eligible for institutional

[1] Iowa was the first state approved to add HCBS under the SP with an approval date of April 5, 2007. Nevada also has an approved 1915(i) SP.
[2] 1915(i) requires an independent assessment; some 1915(c) waivers permit providers to perform assessments.

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CONSULTING. OUTSOURCING. INVESTMENTS.

SECTION 1915(I)
Page 2

levels of care.[3] These states are also permitted to offer services that are different in amount, duration and scope to specific population groups and multiple 1915(i) service packages.

However, the 1915(i) option still has important differences when compared to other options. First, the 1915(i) has more stringent financial eligibility limits than either a Section 1915(j) or a Section 1915(c) program and **is limited to individuals with income up to 150% of the federal poverty level (FPL), unless the individual is eligible for institutional care under an existing 1915(c) waiver or 1115 demonstration**, in which case the state may cover up to 300% of the Supplemental Security Income (SSI) federal benefit rate (FBR). A significant number of individuals who self-direct their services will exceed the 150% income limit, particularly among the group that acquires Medicaid eligibility through a buy-in program. In addition, Section 2402(d) of the ACA creates a new categorical eligibility group for Medicaid benefits. This optional eligibility category allows states, but does not require states, to provide full Medicaid benefits to individuals receiving HCBS services under a 1915(i) state plan amendment. This provision allows states to add an eligibility category for individuals with incomes up to 300% of the SSI FBR (but not exceeding 150% of FPL) that meet the needs-based criteria of 1915(i) and offer this eligibility group the 1915(i) behavioral health-related HCBS services.

Under the 1915(c) waiver, a state may choose to target only a select number of geographical areas; however, based upon the ACA revisions to Section 1915(i), states must cover the entire state under the 1915(i) authority. Further verbal CMS guidance has stated that states are permitted to phase in 1915(i) coverage on date-specific schedules.

Under a 1915(c) waiver, the state may limit the number of individuals that will be served and maintain a wait list. However, with the new ACA changes, states may not limit the number of individuals under the 1915(i) authority. Under 1915(i), the state must project the number of individuals who are expected to be covered under this authority and submit the actual number served each year. If the actual enrollment exceeds the projection, the state may modify the non-financial needs-based eligibility criteria without prior approval by CMS following a 60-day notification process. Existing individuals on the 1915(i) authority must continue to be served through grandfathered eligibility for as long as the state plan HCBS option is authorized.

Under the Section 1915(i) option, the state may not require an institutional level of care for eligibility and must adopt less needs-based criteria for HCBS waivers under the SP (unless using the new authority to cover individuals eligible for institutional level of care up to 300% FBR).

Section 1915(i) permits a state the option of implementing presumptive eligibility for up to 60 days. The presumptive eligibility is only for administrative match and federal financial participation for the evaluation and assessment of the individual's need for services, not the services themselves. CMS states that this is a first step in equalizing the playing field between institutional placements and HCBS placements. Historically, it has been far easier to accomplish the institutional placement.

[3] CMS SMD letter 10/6/2010 clarifies that the amount, duration and scope of HCBS services may differ only for states that choose to add the new optional eligibility group for individuals with incomes up to 300% SSI FBR.

SECTION 1915(I)
Page 3

Unlike 1915(c), the 1915(i) authority also precludes a state from limiting enrollment based on the cost of care. If the state chooses to target populations, the 1915(i) is approved for five years. States are then able to renew their targeted population-approved 1915(i) SP for an additional five-year period, if federal requirements are met.[4]

[4] The August 6, 2010 SMD letter says that five-year renewal only applies if a state targets services and populations: "If a State chooses to implement this option to provide State plan HCBS to a targeted population(s), the ACA authorizes CMS to approve such a SPA for a five year period. States will be able to renew approved 1915(i) services for additional five year periods if CMS determines, prior to the beginning of the renewal period, that the State met Federal and State requirements and that the State's monitoring is in accordance with the Quality Improvement Strategy specified in the State's approved SPA." This is consistent with the National Governor's Association summary of Mary Sowers and Kathy Poisal (CMS leaders in 1915(i)) statements on the weekly HHS calls):

- There are new opportunities and changes in the ACA to provide HCBS through state plans.
- The new options allow states to target HCBS to particular groups of people, make HCBS more accessible to individuals and improve the quality of HCBS.
- The changes include:
  - States are no longer permitted to limit the number of eligible individuals who receive HCBS or establish a waiting list for state plan HCBS.
  - States can now include a new optional Medicaid eligibility group for individuals less than 300% SSI and eligible under a waiver.
  - States are now able to offer HCBS to specific targeted populations with services that are different in amount, duration and scope.
  - **If targeting services, state plan amendments will be approved for a five-year period and then must be renewed.**
  - States have the ability to add services, in addition to those previously included in their HCBS programs, including assisted medical technology or extended state plan services.

Mercer believes that the statute also applies the five-year renewal if a state elects to phase-in benefits or populations.

SECTION 1915(i)
Page 4

State plan HCBS services option and 1915(c) waivers: Similarities and differences

Feature	Section 1915(c) HCBS waivers	Optional HCBS state plan amendment
Federal approval of benefit	States submit a waiver application with significant detail. Initial waiver approval lasts for three years. Renewals can be for five-year periods.	For approval, states need a state plan amendment that describes the services that will be provided and the target population. 1915(i) programs that target benefits to specific populations or phased-in populations or services are limited to five years, with five-year renewals if CMS requirements met.
Available services/benefits	States have considerable latitude in selecting and specifying the services that are offered through a waiver. §1915(c) of the ACA specifically authorizes the provision of several types of HCBS services. A state may propose to offer other services that are not listed in the statute, subject to CMS approval. Waiver services complement and supplement services that are furnished under the state plan. Waiver services may not duplicate the services that are provided under the state plan, but a waiver may expand upon the amount, duration and frequency of services provided under the state plan.	1915(i) originally permitted only: • Case management • Homemaker/Home health aide • Personal care services • Adult day health • Habilitation • Respite • Psychosocial rehabilitation services and clinic services for persons with chronic mental illness The ACA now permits the 1915(i) to offer "such other services requested by the state as the secretary may approve". The extent to which CMS will approve all HCBS services for populations not eligible for 1915(c) waivers has yet to be tested.

SECTION 1915(i)
Page 5

Feature	Section 1915(c) HCBS waivers	Optional HCBS state plan amendment
Availability	Waivers can be made available on a less-than-statewide basis. Only available for certain target groups.	Must be available on a statewide basis, but may be phased in on date-specific schedule. Individuals must meet needs-based criteria.
Cost neutrality	Must follow cost-neutrality laws and be budget neutral.	Unlike waivers, the program is not subject to cost neutrality.

SECTION 1915(I)
Page 6

Feature	Section 1915(c) HCBS waivers	Optional HCBS state plan amendment
Eligibility criteria	Income cannot exceed 300% of SSI benefit rate – about 222% of FPL. Individuals must require the level of care provided in a hospital, nursing facility or intermediate care facilities for the mentally retarded (ICF/MR). Individuals must be part of a HCBS waiver target group. A state may choose (with the Secretary's approval) the specific criteria to be used to determine whether an individual requires the level of care provided in a hospital, nursing home or ICF/MR.	Individuals' incomes must be below 150% of the FPL, unless the individual is eligible for institutional care under an approved existing 1915(c) or 1115 demonstration, in which case the state may cover up to 300% of the SSI federal benefit rate (FBR). Individuals must meet state-established needs-based criteria, which may take into account the need for assistance with two or more activities of daily living and other risk factors. The needs-based criteria for the HCBS option must be less stringent than the level of care required for an institution (i.e., nursing facility, hospital or ICF/MR). If enrollment exceeds what the state projects, the state may modify the non-financial needs-based eligibility criteria without prior approval by CMS following a 60-day notification process. Existing individuals on the 1915(I) authority must continue to be served through grandfathered eligibility for as long as the state plan HCBS option is authorized.

SECTION 1915(I)
Page 7

Feature	Section 1915(c) HCBS waivers	Optional HCBS state plan amendment
Written individualized plan of care	HCBS waiver services that are approved by the Secretary must be provided according to a written plan of care for each individual. Medicaid law is not specific as to how the evaluation and assessment are conducted.	There must be an independent evaluation and assessment to establish a written, individualized plan of care. Whereas the HCBS waiver law is vague, this statute outlines specific criteria that must be met. For example, there must be a face-to-face evaluation of each individual and an examination of the individual's relevant history and medical records.
Cost sharing and post-eligibility treatment of income	Depending upon the beneficiary's Medicaid eligibility category, a waiver participant may be subject to post-eligibility treatment of income.	Post-eligibility treatment of income only applies to individuals eligible for an approved 1915(c) waiver. The state may require cost sharing for this service, subject to Medicaid's general cost-sharing rules.

BAZELON CENTER FOR MENTAL HEALTH LAW: State Medicaid Policy Choices under the Deficit Reduction Act Provisions Affecting Children and Adults with Mental Disorders, accessed 1/27/2010 at http://www.hcbs.org/files/141/7045/DRA_state_medicaid_policy_choices.pdf

Note: Bazelon chart modified based on ACA statutory changes and SMD 8/6/2010 changes.

SUMMARY OF THE HOME- AND COMMUNITY-BASED SERVICES (HCBS) REGULATIONS (CMS-2249-F; CMS-2296-F)

Publication Date: January 16, 2014
Effective Date: March 17, 2014

The Centers for Medicare & Medicaid Services (CMS) has issued a consolidated final rule for HCBS that impacts 1915(c) waivers, 1915(i) HCBS as a State Plan Amendment, and, for a single provision, 1915(k) Community First Choice. These rules present opportunities for state consideration, as well as requirements for compliance activities.

Executive Summary

The final rule:

- Includes requirements for HCBS settings. For existing programs, states will need to conduct analysis to determine compliance, and where needed, develop a comprehensive transition plan to submit to CMS. This plan requires public notice, must be submitted within a year of the effective date of the provision, sooner for states with waivers with renewals and amendments and may allow for up to a 5-year transition period. CMS will issue additional guidance on how the HCBS setting requirements apply to non-residential settings (day habilitation, for example).
- Provides an opportunity for states to design waivers serving multiple target groups, with added assurance that the waivers continue to meet the needs of all included target groups.
- Finalizes person-centered planning requirements for both 1915(c) waivers and 1915(i) State Plan benefits.
- Sets forth circumstances when retroactive approval dates are possible for amendments for both 1915(c) HCBS waivers and for 1915(i) HCBS State Plan benefits.
- Finalizes the requirements for 1915(i) HCBS as a State Plan Option.
- Includes regulations for 5-year approvals for certain programs serving individuals who are dually eligible for Medicare and Medicaid.
- Includes a provision related to circumstances when a portion of provider payments can be withheld and remitted to a third party on behalf of the provider for health and welfare benefit contributions, training costs, and other benefits customary for employees.

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HOME- AND COMMUNITY-BASED SERVICES – REGULATIONS
Page 2

Overview of Key Provisions

HCBS Setting Requirements

The final rule establishes requirements for HCBS that will apply across HCBS authorities including 1915(c) waivers and 1915(i)/1915(k) State Plan Options. States will need to evaluate their existing HCBS requirements against those in the final regulation and make necessary changes to their programs to come into compliance. For existing 1915(c) and 1915(i) programs, CMS is requiring a transition plan be submitted within a year (sooner for states with waivers with amendments or renewals) of the effective date of the rule, with reasonable timeframes identified for compliance. The transition plan is subject to specific public notice and input requirements. CMS has also indicated that it expects states offering HCBS through 1115 demonstrations to comply with these regulations. As 1115 demonstrations are amended or renewed, states may be required to provide their plans to ensure compliance in a fashion similar to 1915(c) and 1915(i) programs. The regulations add an additional assurance, likely to require state evidence, that these provisions are met. The requirements are as follows.

Settings providing HCBS must have all of the following qualities, and such other qualities as the Secretary determines to be appropriate, based on the needs of the individual as indicated in their person-centered service plan:

1. The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

2. The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.

3. Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.

4. Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

5. Facilitates individual choice regarding services and supports, and who provides them.

6. In a provider-owned or controlled residential setting, in addition to the qualities at §441.301(c)(4)(i) through (v), the following additional conditions must be met:

HOME- AND COMMUNITY-BASED SERVICES – REGULATIONS
Page 3

A. The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For settings in which landlord/tenant laws do not apply, the state must ensure that a lease, residency agreement, or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord/tenant law.

B. Each individual has privacy in their sleeping or living unit:
   i. Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors.
   ii. Individuals sharing units have a choice of roommates in that setting.
   iii. Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

C. Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time.

D. Individuals are able to have visitors of their choosing at any time.

E. The setting is physically accessible to the individual.

F. Any modification of the additional conditions, under §441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:
   i. Identify a specific and individualized assessed need.
   ii. Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
   iii. Document less intrusive methods of meeting the need that have been tried, but did not work.
   iv. Include a clear description of the condition that is directly proportionate to the specific assessed need.
   v. Include regular collection and review of data to measure the ongoing effectiveness of the modification.
   vi. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
   vii. Include the informed consent of the individual.
   viii. Include an assurance that interventions and supports will cause no harm to the individual.

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G. Settings that are not Home- and Community-Based. HCBS settings do not include the following:
   i. A nursing facility.
   ii. An institution for mental diseases.
   iii. An intermediate care facility for individuals with intellectual disabilities.
   iv. A hospital.
   v. Any other locations that have qualities of an institutional setting, as determined by the Secretary. Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS will be presumed to be a setting that has the qualities of an institution unless the Secretary determines through heightened scrutiny, based on information presented by the state or other parties, that the setting does not have the qualities of an institution and that the setting does have the qualities of HCBS.

Requirements for Transition Plans

Within the final rule, CMS provides requirements for states to develop transition plans related to compliance for HCBS settings. Importantly, the timeline for transition plans for ALL HCBS waivers and State Plan benefits operating in the state is implicated by the first renewal or amendment submitted within a year of the rule's effective date (see bold text below). Specifically, the rule at 42 CFR 441.301(c)(6) stipulates that:

A. States submitting new and initial waiver requests must provide assurances of compliance with the requirements of this section for HCBS settings as of the effective date of the waiver.

B. CMS will require transition plans for existing section 1915(c) waivers and approved State Plans providing HCBS under section 1915(i) to achieve compliance with this section, as follows:
   i. For each approved section 1915(c) HCBS waiver subject to renewal or submitted for amendment within one year after the effective date of this regulation, the state must submit a transition plan at the time of the waiver renewal or amendment request that sets forth the actions the state will take to bring the specific waiver into compliance with this section. The waiver approval will be contingent on the inclusion of the transition plan approved by CMS. **The transition plan must include all elements required by the Secretary; and within one hundred and twenty days of the submission of the first waiver renewal or amendment request the state must submit a transition plan detailing how the state will operate all section 1915(c) HCBS waivers and any section 1915(i) State Plan benefit in accordance with this section. [Emphasis Added]** The transition plan must include all elements including timelines and deliverables as approved by the Secretary.

ii. For states that do not have a section 1915(c) HCBS waiver or a section 1915(i) State Plan benefit due for renewal or proposed for amendments within one year of the effective date of this regulation, the state must submit a transition plan detailing how the state will operate all section 1915(c) HCBS waivers and any section 1915(i) State Plan benefit in accordance with this section. This plan must be submitted no later than one year after the effective date of this regulation. The transition plan must include all elements including timelines and deliverables as approved by the Secretary.

C. A state must provide at least a 30-day public notice and comment period regarding the transition plan(s) that the state intends to submit to CMS for review and consideration, as follows:
   i. The state must, at a minimum, provide two (2) statements of public notice and public input procedures.
   ii. The state must ensure the full transition plan(s) is available to the public for public comment.
   iii. The state must consider and modify the transition plan, as the state deems appropriate, to account for public comment.

D. A state must submit to CMS, with the proposed transition plan:
   i. Evidence of the public notice required.
   ii. A summary of the comments received during the public notice period, reasons why comments were not adopted, and any modifications to the transition plan based upon those comments.

E. Upon approval by CMS, the state will begin implementation of the transition plans. The state's failure to submit an approvable transition plan as required by this section and/or to comply with the terms of the approved transition plan may result in compliance actions, including but not limited to deferral/disallowance of Federal Financial Participation.

Person-Centered Planning Requirements

The final rule also finalizes requirements for person-centered process and plan content for individuals receiving HCBS. There are some very minor differences in the language between the requirements for HCBS waivers and HCBS State Plan services reflecting minor statutory differences and regulatory content. In almost all aspects, however, the requirements are identical. Importantly, the person-centered plan must address any modifications that impact the HCBS characteristics of a setting, establishing specific expectations and monitoring when individuals' plans require a deviation from those HCBS setting requirements. The requirements are as follows:

A. Person-Centered Planning Process.
   The individual will lead the person-centered planning process where possible. The individual's representative should have a participatory role, as needed and as defined by the individual, unless State law confers decision-making authority to legal representative. All references to individuals include the role of the individual's representative. In addition to

HOME- AND COMMUNITY-BASED SERVICES – REGULATIONS
Page 6

being led by the individual receiving services and supports, the person-centered planning process:

i. Includes people chosen by the individual.
ii. Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions.
iii. Is timely and occurs at times and locations of convenience to the individual.
iv. Reflects cultural considerations of the individual and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with § 435.905(b) of this chapter.
v. Includes strategies for solving conflict or disagreement within the process, including clear conflict-of interest guidelines for all planning participants.
vi. (vi) Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person-centered service plan, except when the state demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS. In these cases, the state must devise conflict of interest protections including separation of entity and provider functions within provider entities, which must be approved by CMS. Individuals must be provided with a clear and accessible alternative dispute resolution process.
vii. Offers informed choices to the individual regarding the services and supports they receive and from whom.
viii. Includes a method for the individual to request updates to the plan as needed.
ix. Records the alternative home and community-based settings that were considered by the individual.

B. The Person-Centered Service Plan.

The person-centered service plan must reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports. Commensurate with the level of need of the individual, and the scope of services and supports available under the state's 1915(c) HCBS waiver, the written plan must:

i. Reflect that the setting in which the individual resides is chosen by the individual. The state must ensure that the setting chosen by the individual is integrated in, and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.
ii. Reflect the individual's strengths and preferences.

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iii. Reflect clinical and support needs as identified through an assessment of functional needs.
iv. Include individually identified goals and desired outcomes.
v. Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports. Natural supports are unpaid supports that are provided voluntarily to the individual in lieu of 1915(c) HCBS waiver services and supports.
vi. Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed.
vii. Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her. At a minimum, for the written plan to be understandable, it must be written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with § 435.905(b) of this chapter.
viii. Identify the individual and/or entity responsible for monitoring the plan.
ix. Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation.
x. Be distributed to the individual and other people involved in the plan.
xi. Include those services, the purpose or control of which the individual elects to self-direct.
xii. Prevent the provision of unnecessary or inappropriate services and supports.
xiii. Document that any modification of the additional conditions, under paragraph (c)(4)(vi)(A) through (D) of this section, must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:
   a. Identify a specific and individualized assessed need.
   b. Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
   c. Document less intrusive methods of meeting the need that have been tried but did not work.
   d. Include a clear description of the condition that is directly proportionate to the specific assessed need.
   e. Include a regular collection and review of data to measure the ongoing effectiveness of the modification.
   f. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
   g. Include informed consent of the individual.
   h. Include an assurance that interventions and supports will cause no harm to the individual.

C. Review of the Person-Centered Service Plan.
The person-centered service plan must be reviewed, and revised upon reassessment of functional need as required by § 441.365(e), at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual.

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Timing for Retroactive Amendments for 1915(c) or 1915(i)

For 1915(c) waivers, retroactive amendments to the beginning of the waiver year are possible only for non-substantive amendments. Substantive changes include, but are not limited to, revisions to services available under the waiver including elimination or reduction of services, or reduction in the scope, amount, and duration of any service, a change in the qualifications of service providers, changes in rate methodology or a constriction in the eligible population. Similar provisions for 1915(i) permit modifications to the benefit to be made effective retroactive to the first day of a fiscal year quarter, or another date after the first day of a fiscal year quarter, in which the amendment is submitted, unless the amendment involves substantive change. Amendments with substantive changes may only take effect on or after the date when the amendment is approved by CMS and must be accompanied by information on how the state will ensure minimal adverse impact on individuals impacted by the change.

Additional Changes to Section 1915(c) HCBS Waiver Provisions

The final rule includes a number of important changes to the HCBS waiver provisions:

- The final rule provides states the option to combine in one waiver the existing 3 waiver targeting groups identified in § 441.301: (1) Aged or disabled, or both; (2) Mentally retarded or developmentally disabled, or both; (3) Mentally ill. Additional reporting requirements are included for 372 annual reports for waivers serving multiple target groups.

- The rule sets forth requirements related to person-centered processes and plans of care, including deliberate incorporation of elements related to HCBS.

- The rule clarifies timing of amendments and public input requirements when states propose modifications to HCBS waiver programs and service rates, as well as the circumstances under which retroactive amendments are permissible.

- The rule provides CMS with enforcement tools to ensure state compliance with the statutory provisions of section 1915(c) of the Act. These rules are quite broad and may include moratorium on enrollment, withholding of Federal Financial Participation or "other corrective strategies as appropriate to ensure the health and welfare of waiver participants."

- Requirements for person-centered plans of care that document an individual's choice of a HCBS from among options that meet the individual's needs. CMS will provide additional guidance on these elements.

State Plan HCBS (1915(i))

The final rule outlines the optional State Plan benefit (1915(i)) to furnish HCBS State Plan services that will enable a state to design and tailor Medicaid services to better accommodate individual needs. The most significant changes within the final rule (as compared to the proposed) include the refinements to the HCBS requirements, and additional clarfication/modification to the person-centered process and planning provisions.

HOME- AND COMMUNITY-BASED SERVICES – REGULATIONS
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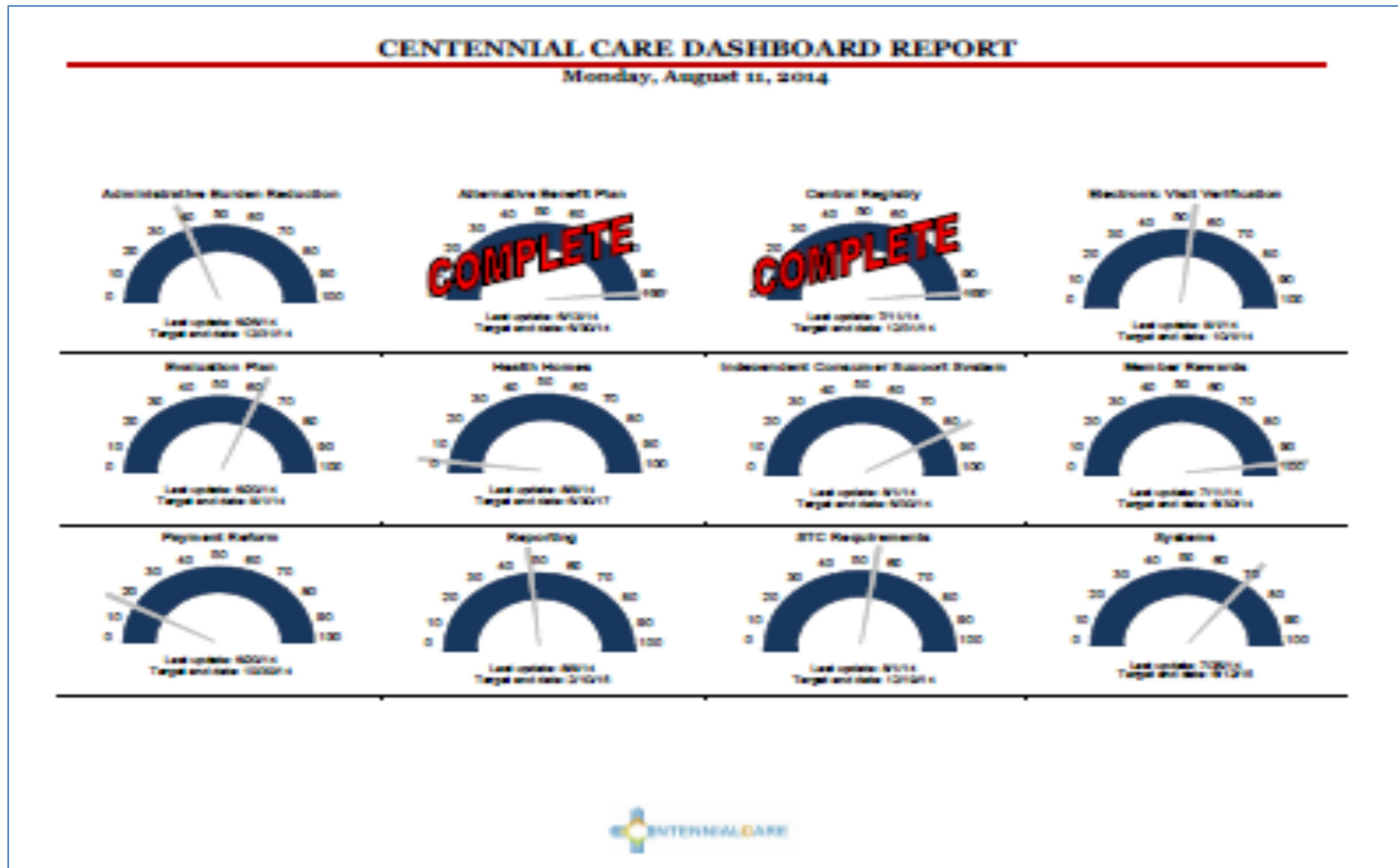
In addition to provisions related to HCBS and person-centered planning requirements, the rule establishes requirements related to eligibility, services, operation, and administration (including conflict-free requirements), quality and oversight, reimbursement, and reporting.

5-year Duration for Waivers

The final rule amends Medicaid regulations consistent with the requirements under Section 2601 of the ACA which adds section 1915(h)(2) to the Social Security Act to provide authority for a 5-year duration for certain demonstration projects or waivers under sections 1115, 1915(b), 1915(c) or 1915(d), when the waiver programs provide medical assistance to individuals who are dually eligible for Medicare and Medicaid. The statute defines a dual eligible as: "an individual who is entitled to, or enrolled for, benefits under part A of title XVIII, or enrolled for benefits under part B of title XVIII, and is eligible for medical assistance under the state plan under this title or under a waiver of such plan." This authority will be provided at the Secretary's discretion and only to those waivers meeting programmatic and financial expectations.

Exception to Payment Rules

The final rule provides additional limited exception to the requirement that payment for services must be made directly to the individual practitioner providing a service when the Medicaid program is the primary source of reimbursement for a class of individual practitioners. The exception will allow payments to be made to other parties to benefit providers by ensuring workforce stability, health, welfare, and trainings and provide added flexibility to the state. This is a provision that arises especially in states utilizing public authorities for the organization and/or employment of direct support professionals, often for self-directed service arrangements. This will allow the state to pay a portion of the rate to cover health benefits, training, and similar costs.


CENTENNIAL CARE DASHBOARD REPORT
Monday, August 11, 2014
COMPLETE
COMPLETE

CENTENNIAL CARE DASHBOARD REPORT

Tuesday, July 30, 2013

Countdown (in business days)			
ONSITE READINESS PHASE I	GO/NO GO DECISION	MEMBER OPEN ENROLLMENT	GO-LIVE
AUG 12, 2013	SEPT 11, 2013	OCT 15, 2013	JAN 1, 2014
10	31	54	105

COUNTDOWN FOR DELIVERABLES TO CMS					
MCO CONTRACT TO CMS	INDEPENDENT CONSUMER SUPPORT SYSTEM TO CMS	REVISED QUALITY STRATEGY TO CMS	READINESS REVIEW MATERIALS TO CMS	TRANSITION PLAN FOR 1915(C) WAIVERS TO CMS	EVALUATION PLAN TO CMS
AUG 30, 2013	SEPT 10, 2013	OCT 10, 2013	NOV 1, 2013	NOV 1, 2013	NOV 8, 2013
24	30	52	67	67	72

Accomplishments

- ✓ Group 3 reports sent to MCOs for review. Comments due on August 7
- ✓ Part 1 of Behavioral Health training completed.

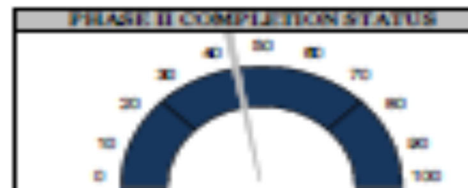
Upcoming Tasks

- ☐ 7/30 – Conduct behavioral health training 2
- ☐ 7/31 – Provide State with decision on use of current Value-Added codes and Encounter Form beginning 1/1/2014
- ☐ 8/1 – State drafts alternative benefit plan package & eligibility SPA
- ☐ 8/2 – Submit draft rules to workgroup for review and final feedback
- ☐ 8/2 – Schedule Presumptive Eligibility Determiner trainings

CENTENNIAL CARE DASHBOARD REPORT

Tuesday, July 30, 2013

High Level Progress Chart



Task	Percent Complete	Start Date	Target End Date
Phase I Tasks - Waiver Development and Contract Procurement			
CMS Approval: Waiver and STCs	100%	[illegible]	[illegible]
Phase II Tasks - Implementation and Readiness Review			
State Meetings With MCOs	54%	[illegible]	[illegible]
MCO Trainings	99%	[illegible]	[illegible]
CMS Approvals	11%	[illegible]	[illegible]
Workgroups			
Admin Burden Reduction	29%	[illegible]	[illegible]
Alternative Benefit Plan	17%	[illegible]	[illegible]
Care Coordination	77%	[illegible]	[illegible]
Coding	[illegible]	[illegible]	[illegible]
Health Homes	[illegible]	[illegible]	[illegible]
LOC	[illegible]	[illegible]	[illegible]
Member Education & Communications	[illegible]	[illegible]	[illegible]
Member Rewards	54%	[illegible]	[illegible]
Quality	[illegible]	[illegible]	[illegible]
Reporting	[illegible]	[illegible]	[illegible]
Rules	[illegible]	[illegible]	[illegible]
School-Based Health Care	27%	[illegible]	[illegible]
Self Direction	51%	[illegible]	[illegible]
Systems	[illegible]	[illegible]	[illegible]
Readiness Review	[illegible]	[illegible]	[illegible]
MCO Enrollment	0%	[illegible]	[illegible]
Transition Plan	73%	[illegible]	[illegible]
Evaluation Plan	0%	[illegible]	[illegible]

C

APPENDIX C: LETTERS OF REFERENCE

Mercer provides the following Letters of Reference from the following state clients:

- State of Delaware Health and Social Services
- State of Louisiana Department of Health and Hospitals
- State of Ohio Department of Medicaid

DELAWARE HEALTH AND SOCIAL SERVICES
DIVISION OF MEDICAID & MEDICAL ASSISTANCE

TELEPHONE: (302) 255-9500

July 27, 2018

Mary Tavegia
Iowa Medicaid Enterprise
100 Army Post Road Des Moines, Iowa 50315

Dear Ms. Tavegia:

Mercer Health & Benefits LLC (Mercer) has indicated they intend to respond to Request for Proposal (RFP) MED-19-011 for Technical Assistance and Program Support for Iowa Medicaid. Mercer has requested this letter of reference to fulfil the requirements of the RFP.

Mercer has provided consulting services, including policy consulting, to our agency for more than a decade. Relative to the services requested by the Iowa Department of Human Services, examples of Mercer's assistance include:

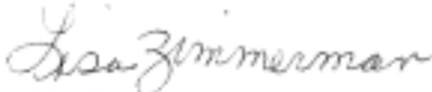
- Support for the design, development, CMS negotiations and implementation of amendments to our Diamond State Health Plan 1115 Waiver.
- Development of State Plan Amendments and assisted with CMS negotiations for topics such as Delaware's alternative benefit plan and behavioral health benefits.
- Policy support for the development and approval of Delaware's section 1915(i)/1915(b) Pathways to Employment Program and Delaware's 1915(i)-like PROMISE behavioral health program implemented through our 1115 waiver.
- Analysis of the impact of the proposed rule and final Medicaid managed care regulation and leading DMMA workgroups on the implementation of the rule.
- Conducting the Medicaid/CHIP Mental Health Parity analyses.
- Supporting the development and approval of Delaware's HCBS Transition Plan, consistent with the HCBS final rule.
- Providing MCO procurement and contract assistance.
- Assisting with the development of stakeholder materials and presentations.
- Advising DMMA on CMS expenditure and waiver reporting for CMS compliance.
- Developing targeted program review summaries and reports, such as an assessment of the CMS SUD 1115 waiver option and a "landscape" assessment of Delaware's behavioral health program.
- Providing ongoing, ad-hoc policy assistance as needed.

P.O. BOX 906 • NEW CASTLE • DELAWARE • 19720

Mercer is our trusted partner in the success of Delaware's Medicaid and CHIP Programs. We are pleased with the services Mercer provides and appreciate their insights, recommendations, and assistance in improving our Medicaid program.

Please do not hesitate to contact me by telephone at (302) 255-9535 or by email at Lisa.Zimmerman@state.de.us for further information.

Sincerely,



Lisa Zimmerman
Deputy Medicaid Director
Division of Medicaid & Medical Assistance
Delaware Department of Health and Social Services

John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Department of Health and Hospitals
Office of the Secretary

July 31, 2018

Mary Tavegia
Iowa Medicaid Enterprise
100 Army Post Road Des Moines, Iowa 50315

Dear Ms. Tavegia:

Mercer Health & Benefits LLC (Mercer) has indicated they intend to respond to Request for Proposal (RFP) MED-19-011 for Technical Assistance and Program Support for Iowa Medicaid. Mercer has requested this letter of reference to fulfil the requirements of the RFP.

Mercer has provided policy-consulting services to the Louisiana Department of Health (LDH) for more than a decade. Mercer's policy consultants have provided us with policy, state plan, waiver, financing, and CMS compliance assistance as Louisiana began statewide-managed care in 2012, integrated physical and behavioral health managed care in 2015, Medicaid expansion in 2016 and our substance use disorder 1115 Waiver in 2018. Our long-standing engagement with Mercer's policy consultants, which includes Meredith Mayeri, Dianne Heffron and Michele Walker, support our institutional knowledge and staff development; providing an extension of our own policy resources with flexibility and responsiveness, playing key roles in minimizing CMS questions and issues during waiver and SPA negotiations.

Relative to the services requested by the Iowa Department of Human Services, examples of Mercer's assistance include:

- Support for the design, development, CMS negotiations and implementation of the Greater New Orleans Community Health Connections 1115 Waiver.
- Assistance with the design, development and implementation of the Coordinated System of Care behavioral health program.
- Drafting State plan and waiver amendments for integrated physical and behavioral health care in 2015
- Assistance with the development and approval of Louisiana's alternative benefit plan SPA for Medicaid expansion in 2016.
- Technical assistance with the Medicaid/CHIP Mental Health Parity analyses.
- Advising LDH on CMS expenditure and waiver reporting for CMS compliance.

Bienville Building • 628 N. Fourth St. • P.O. Box 629 • Baton Rouge, Louisiana 70821-0629
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An Equal Opportunity Employer

Mary Tavegia
7/31/18

- Supporting the application, budget neutrality and CMS negotiations for Louisiana's SUD 1115 waiver approved in February 2018.
- Policy support for Medicaid financing and capitation rate setting.
- Providing ongoing, ad-hoc policy assistance as needed.

We value the policy and technical assistance services Mercer provides and appreciate their insights, recommendations, and assistance in improving our Medicaid program.

Please do not hesitate to contact me by telephone at (225) 342-9240 or by email at Jen.Steele@la.gov for further information.

Sincerely,

Jen Steele
Medicaid Director
Louisiana Department of Health

July 24, 2018

Mary Tavegia
Iowa Medicaid Enterprise
100 Army Post Road Des Moines, Iowa 50315

Dear Ms. Tavegia:

Mercer Health & Benefits LLC (Mercer) has indicated they intend to respond to Request for Proposal (RFP) MED-19-011 for Technical Assistance and Program Support for Iowa Medicaid. Mercer has requested this letter of reference to fulfil the requirements of the RFP.

Mercer currently provides consulting services to our agency and has done so for seven years. Relative to the services requested by the Iowa Department of Human Services, Mercer provides:

- Technical assistance to the Ohio Department of Medicaid (ODM) regarding policy development of State initiatives. For example, Mercer recently assisted the State in developing an 1115 waiver application to implement a legislative mandated work and community engagement requirement for our Medicaid expansion population. Mercer assisted in program design, drafted the Section 1115 Demonstration Waiver application, drafted the public notices, developed stakeholder documents and facilitated public forums to fulfill the federal public transparency requirements, and is currently supporting ODM in the ongoing CMS negotiations regarding waiver approval.
- Technical assistance and drafting of federal authority documents. Mercer assisted our agency in drafting our 1915(b)/1915(c) Waiver to implement our My Care program (Integrated Care Delivery System – Dual demo). Mercer also assisted us in drafting and obtaining approval of our Section 1915i waiver to support our State as we transitioned from a 209(b) State to 1634 status. Mercer is currently assisting our agency in drafting an 1115 Substance Use Disorder (SUD) waiver application. In this capacity, Mercer is also providing policy guidance that will impact program operations.
- Assistance in drafting state-specific document for program implementation. For example, Mercer assisted our agency in developing talking points and other documents used to communicate with providers and other interested stakeholders as we redesigned Ohio's Community Medicaid behavioral health benefit. In addition, Mercer continued to assist ODM as we responded to federal, providers, and other stakeholders' inquiries regarding program changes.
- Assistance as a technical resource to ODM staff as we plan and implement policy and programmatic changes to our Medicaid and CHIP programs. Mercer participates in regular calls with our staff, develops agenda, and facilitates meetings to support clear communications between staff and Mercer team members.

Please do not hesitate to contact me by telephone at 614-752-4252 or by email at Ogbe.Aideyman@medicaid.ohio.gov for further information.

Sincerely,

Ogbe Aideyman
Bureau Chief of
Health Plan & Policy

50 W. Town Street, Suite 400
Columbus, Ohio 43215
medicaid.ohio.gov

An Equal Opportunity Employer and Service Provider

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