NAVIGANT

Proposal for:

Technical Assistance and Program Support for Iowa Medicaid

RFP MED-19-011

Presented to:

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

August 3, 2018

TECHNICAL PROPOSAL **REDACTED**

Presented by:

David Mosley
Managing Director
150 N. Riverside Plaza, Suite 2100
Chicago, Illinois 60606
678.845.7644 Direct | 919.818.9088 Mobile
david.mosley@navigant.com

navigant.com

NAVIGANT

Tab 1 Transmittal Letter and Bid Proposal Security

August 3, 2018

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

RE: RFP No. MED-19-011
Technical Assistance and Program Support for Iowa Medicaid

Dear Ms. Tavegia:

Navigant Consulting, Inc. (Navigant) welcomes and appreciates the opportunity to contribute to the ongoing success of the Iowa Department of Human Services (DHS) and the Iowa Medicaid Enterprise (IME).

We have adhered to your instructions pertaining to the form and content of the proposal and are grateful for the time and thoughtful consideration of those reviewing our submission.

Navigant provides state clients with impactful, actionable insight that they use to design, develop, implement, and improve their Medicaid programs. Navigant has been increasingly called upon to assist states in assessing their programs in the context of new federal guidance and policies and, in some cases, to assist with mitigating systemic issues that have led to withdrawal of health plans, CMS corrective actions, unwanted media attention, and legislative consternation.

There are many firms with healthcare expertise, but Navigant's flexible approach to working with clients sets us apart from others:

1. We provide guidance and insight that is actionable, addressing potential program impacts in the context of the political, fiscal, and regulatory environment as well as developing effective communication strategies to gain buy-in from internal and external stakeholders. We work to understand your program goals and objectives, so we can deliver what you need – not necessarily just what you ask for.
2. We do not make recommendations that simply serve to enrich Navigant by creating a long-term reliance upon our professionals; rather, Navigant professionals are quick to work themselves out of a job and to leave behind state staff that are empowered through formal training, on the job (OTJ) training, and written policies and procedures that automatically update as the laws, codes, and rules cited are expanded or changed.

3. Time and time again, when states have an unexpected crisis or an immediate opportunity with a narrow window, they call Navigant, as they know we will put them first. We draw upon a large bench of subject matter and operational experts with the flexibility to bring in additional support as needed.
4. The staff Navigant proposes is the staff our clients interact with and the staff that gets the work done, as opposed to contractors that propose elite, ivory tower experts who are rarely seen or, when seen, possess neither actionable, implementable insight, nor the "boots on the ground" experience required to motivate staff while leading from within.
5. We often assist our clients in identifying efficiencies and corrections in their federal reporting and state budgeting that have generated several million dollars in savings for the state or drafting reimbursement approaches that likewise have resulted in net gains.

Executive Summary

Our proposal outlines our approach to assisting DHS in addressing the ever-changing Medicaid landscape. With over 200 state laws enacted in 2018, including six in Iowa, plus volumes of new federal laws, rules, and guidance, disruption in Medicaid operations is a given; however, the degree to which such requirements impact your program positively or negatively can be greatly influenced by the trusted, proven, technical experts that stand beside you.

Through annual strategic planning and weekly leadership meetings, Navigant will:

- Bring best-in-class analyses of the issues presented in federal and state policy changes
- Develop options for addressing and implementing changes to state code, contracts, infrastructure and operational needs, etc.
- Reduce redundant efforts and compress approval timelines by offering real-time, in-depth insight into the most current approvals, denials, and guidance issued by regulators
- Develop workplans for implementing selected options or policies
- Provide best practices assessments that will assist DHS in avoiding pitfalls or other challenges due to our proven success in driving best practices and adapting strategies based on the state landscape

NAVIGANT

- Offer you access and support from subject matter experts (SMEs) who have both consulting and industry experience
- Prepare DHS to effectively anticipate, respond to, and engage CMS in a manner that most effectively advocates for your position
- Operate in a manner that acknowledges and readily adapts to changing demands you will have of Navigant because of ever-changing internal and external demands on DHS

Our seasoned project director, Hanford Lin, and our proposed project manager, Christina Koster, will serve as your main points of contact – coordinating the efforts of our healthcare and Medicaid experts to address any need you face. They have worked hand-in-hand with over a dozen Medicaid programs, helping to translate state and federal policies and regulations into operational activities.

We are uniquely positioned to provide Iowa with requested ad-hoc support and expertise as we have done so in several other states including Alabama, Arkansas, Arizona, Colorado, Georgia, Iowa, Illinois, Indiana, Kansas, Kentucky, Louisiana, Minnesota, Mississippi, Nevada, New Hampshire, Pennsylvania and Texas.

In our enclosed proposal, you will find all required proposal elements tabbed as required:

Tab 1 – Transmittal Letter and Bid Proposal Security

Tab 2 – Table of Contents

Tab 3 – RFP Forms

Tab 4 – Bidder's Approach to Meeting Deliverables

Tab 5 – Bidder's Background

We have included the Word version of our proposal on USB key (without signatures and appendices).

In the envelope that follows this Transmittal Letter (original proposal only), we have included our Bid Proposal Security.

Sincerely,

Dave Mosley

David Mosley
Managing Director

Tab 2 Table of Contents

Tab 3 RFP Forms

On the following pages, please find the following executed forms:

- Release of Information Form (RFP Attachment A)
- Primary Bidder Detail and Certification Form (RFP Attachment B)
- Subcontractor Disclosure Forms (RFP Attachment C) – *Navigant intends to complete all work under this contract without the use of subcontractors. As such, we have not included the Subcontractor Disclosure Form in our proposal.*
- Additional Certifications (RFP Attachment D) – *As per RFP instructions, Navigant has not returned a completed Attachment D (Additional Certifications) Form in our proposal.*
- Certification and Disclosure Regarding Lobbying (RFP Attachment E)

[Rest of page intentionally left blank.]

Attachment A: Release of Information

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

Navigant Consulting, Inc. (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.

Navigant Consulting, Inc.
Printed Name of Bidder Organization

Dave Mosley
Signature of Authorized Representative

August 3, 2018
Date

David Mosley
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:	David Mosley, Managing Director
Address:	150 N. Riverside Plaza, Suite 2100, Chicago, Illinois 60606
Tel:	678.845.7644 Direct | 919.818.9088 Mobile
Fax:	312.276.8658
E-mail:	david.mosley@navigant.com
Primary Bidder Detail	
Business Legal Name ("Bidder"):	Navigant Consulting, Inc.
"Doing Business As" names, assumed names, or other operating names:	Not applicable
Parent Corporation Name and Address of Headquarters, if any:	Navigant Consulting, Inc. 150 N. Riverside Plaza, Suite 2100 Chicago, Illinois 60606
Form of Business Entity (i.e., corp., partnership, LLC, etc.):	Corporation
State of Incorporation/organization:	Delaware
Primary Address:	150 N. Riverside Plaza, Suite 2100. Chicago, Illinois
Tel:	919.818.9088 (David Mosley) | 312.583.5700 main
Local Address (if any):	N/A
Addresses of Major Offices and other facilities that may contribute to performance under this RFP/Contract:	150 N. Riverside Plaza, Suite 2100. Chicago, Illinois 60606 1200 19th Street NW, Suite 700, Washington, DC 20036
Number of Employees:	5,900 (FTE) employees
Number of Years in Business:	Approximately 20
Primary Focus of Business:	Consulting
Federal Tax ID:	36-4094854
DUNS #:	022582428
Bidder's Accounting Firm:	KPMG LLP
If Bidder is currently registered to do business in Iowa, provide the Date of Registration:	May 30, 2008 (Reg. No. 363149)
Do you plan on using subcontractors if awarded this Contract? {If "YES," submit a Subcontractor Disclosure Form for each proposed subcontractor.}	
	(YES)(NO)

Request for Confidential Treatment (See Section 3.1)		
Location in Bid (Tab/Page)	**Statutory Basis for Confidentiality**	**Description/Explanation**
Tab 4, p. 20 – 51; Tab 5 p. 65, 68, 71, and 74-79.	These sections of the proposal contain confidential and proprietary information, including trade secrets, of Navigant Consulting, Inc. and shall not be used, disclosed or reproduced, in whole or in part, for any purpose other than to evaluate this proposal, without the prior written consent of Navigant Consulting, Inc. Title in all information contained herein remains at all times with Navigant Consulting, Inc. Unauthorized disclosure will result in competitive harm to Navigant Consulting, Inc. as this information derives economic value, actual or potential, from not being generally known to other persons who can obtain economic value from its disclosure or use and is therefore the subject of efforts that are reasonable under the circumstances to maintain its secrecy or confidentiality.	

Exceptions to RFP/Contract Language	If the bidder objects to any term or condition of the RFP or attached Sample Contract, specific reference to the RFP page and section number shall be made in the Primary Bidder Detail & Certification Form. In addition, the bidder shall set forth in its Bid Proposal the specific language it proposes to include in place of the RFP or contract provision and cost savings to the Agency should the Agency accept the proposed language. The Agency reserves the right to either execute a contract without further negotiation with the successful bidder or to negotiate contract terms with the selected bidder if the best interests of the Agency would be served.

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**
Section 2, Pg. 51	***2.7 Indemnification.*** **2.7.1 By the Contractor.** The Contractor agrees to indemnify and hold harmless the State and its officers, appointed and elected officials, board and commission members, employees, volunteers, and	Pursuant to Contractor's risk management principles, contractor requires that the indemnification obligation be triggered by third party claims only. Contractor also requires a limitation of liability. ***2.7 Indemnification and Limitation of Liability.*** **2.7.1 By the Contractor.** 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	**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 the Proposed Replacement Language is Accepted**
	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 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;	"Indemnified Parties"), from any and all third party 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 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 grossly 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,	

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**
	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	trade dress, mask work, utility design, or other intellectual property right or proprietary right of any third party. **2.7.1.6 Notwithstanding the terms of any other provision, the total liability of Contractor and its subsidiaries, officers, employees and agents for all claims of any kind arising out of this Agreement, whether in contract, tort or otherwise, shall be limited to the total fees paid to Contractor on this engagement. Neither Contractor nor State shall in any event be liable for any indirect, consequential or punitive damages, even if they have been advised of the possibility of such damages.**	

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**
	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.		
Pg. 53	***2.9 Ownership and Security of Agency Information.*** **2.9.7 Subpoena.** In the event that a subpoena or other legal process is served upon the Contractor for records containing Confidential Information, the Contractor shall promptly notify the Agency and cooperate with the Agency in any lawful effort to protect the Confidential Information.	Pursuant to Contractor's risk management principles, Contractor requires that any costs incurred as a result of responding to a subpoena shall be reimbursed by the client. ***2.9 Ownership and Security of Agency Information.*** **2.9.7 Subpoena.** In the event that a subpoena or other legal process is served upon the Contractor for records containing Confidential Information, the Contractor shall promptly notify the Agency and cooperate with the Agency in any lawful effort to protect the Confidential Information. In such event, the State shall reimburse Contractor for its professional fees and expenses (including any reasonable attorneys' fees) incurred in responding to such action.	**N/A**
Pg. 54	***2.10 Intellectual Property.*** **2.10.1 Ownership and Assignment of Other Deliverables.** The Contractor agrees that the State and the Agency shall become the sole	Pursuant to Contractor's risk management principles, Contract requires exclusive ownership of its pre-existing materials. ***2.10 Intellectual Property.*** **2.10.1 Ownership and Assignment of Other Deliverables.** The Contractor agrees that the State and the Agency shall become the sole and exclusive	**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 the Proposed Replacement Language is Accepted**
	and exclusive owners of all Deliverables. The Contractor hereby irrevocably assigns, transfers and conveys to the State and the Agency all right, title and interest in and to all Deliverables and all intellectual property rights and proprietary rights arising out of, embodied in, or related to such Deliverables, including copyrights, patents, trademarks, trade secrets, trade dress, mask work, utility design, derivative works, and all other rights and interests therein or related thereto. The Contractor represents and warrants that the State and the Agency shall acquire good and clear title to all Deliverables, free from any claims, liens, security interests, encumbrances, intellectual property rights, proprietary rights, or other	owners of all Deliverables. The Contractor hereby irrevocably assigns, transfers and conveys to the State and the Agency all right, title and interest in and to all Deliverables and all intellectual property rights and proprietary rights arising out of, embodied in, or related to such Deliverables, including copyrights, patents, trademarks, trade secrets, trade dress, mask work, utility design, derivative works, and all other rights and interests therein or related thereto. The Contractor represents and warrants that the State and the Agency shall acquire good and clear title to all Deliverables, free from any claims, liens, security interests, encumbrances, intellectual property rights, proprietary rights, or other rights or interests of the Contractor or of any third party, including any employee, agent, contractor, subcontractor, subsidiary, or affiliate of the Contractor. The Contractor (and Contractor's employees, agents, contractors, subcontractors, subsidiaries and affiliates) shall not retain any property interests or other rights in and to the Deliverables and shall not use any Deliverables, in whole or in part, for any purpose, without the prior written consent of the Agency and the payment of such royalties or other compensation as the Agency deems appropriate. Unless otherwise requested by the Agency, upon completion or termination of this Contract, the Contractor will immediately turn over to the Agency all Deliverables not previously delivered to the Agency, and no copies thereof shall be retained by the Contractor or its employees,	

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**
	rights or interests of the Contractor or of any third party, including any employee, agent, contractor, subcontractor, subsidiary, or affiliate of the Contractor. The Contractor (and Contractor's employees, agents, contractors, subcontractors, subsidiaries and affiliates) shall not retain any property interests or other rights in and to the Deliverables and shall not use any Deliverables, in whole or in part, for any purpose, without the prior written consent of the Agency and the payment of such royalties or other compensation as the Agency deems appropriate. Unless otherwise requested by the Agency, upon completion or termination of this Contract, the Contractor will immediately turn over to the Agency all Deliverables not previously	agents, subcontractors, or affiliates, without the prior written consent of the Agency. Contractor shall retain sole and exclusive ownership of all rights, title and interest in its work papers, proprietary information, processes, methodologies, know-how and software, including such information as existed prior to the delivery of the Services and, to the extent such information is of general application, anything that it may discover, create or develop during provision of the Services ("Contractor Property"). To the extent the Deliverables contain Contractor Property, State is granted a non-exclusive, non-assignable, royalty-free license to use it in connection with the subject of this Agreement. Without the prior written consent of Contractor, in no event shall Contractor's name be mentioned nor shall Deliverables be disclosed, referenced, used in connection with any offering documents or shared with any third party, except (a) as required by law; (b) as required by any government or regulatory agency with supervisory authority over State; and (c) State's legal advisors and auditors. It is strictly prohibited for the Deliverables to be disclosed, referenced, filed or distributed in connection with the purchase or sale of securities, and in connection with any financing or business transaction.	

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**
	delivered to the Agency, and no copies thereof shall be retained by the Contractor or its employees, agents, subcontractors, or affiliates, without the prior written consent of the Agency.		

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:	Dave Mosley
Printed Name/Title:	**David Mosley, Managing Director**
Date:	**August 3, 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.*)

Navigant intends to complete all work under this contract without the use of subcontractors. As such, we have not included the Subcontractor Disclosure Form in our proposal.

[Balance of page intentionally left blank.]

Attachment D: Additional Certifications

(Do not return this page with the Bid Proposal.)

As per RFP instructions, Navigant has not returned a completed Attachment D (Additional Certifications) Form in our proposal.

[Balance of page intentionally left blank.]

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

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:	Dave Mosley
Printed Name/Title:	**David Mosley, Managing Director**
Date:	**August 3, 2018**

Tab 4 Bidder's Approach to Meeting Deliverables

Understanding and Overall Approach

Redacted

Redacted

Redacted

Redacted

Redacted

Redacted

Redacted

Redacted

Redacted

Redacted

Redacted

Redacted

Redacted

Redacted

Redacted

Redacted

Redacted

Redacted

Redacted

Redacted

Redacted

Redacted

Redacted

Redacted

Redacted

Redacted

Redacted

Redacted

Redacted

Redacted

Redacted

Redacted

Tab 5 Bidder's Background

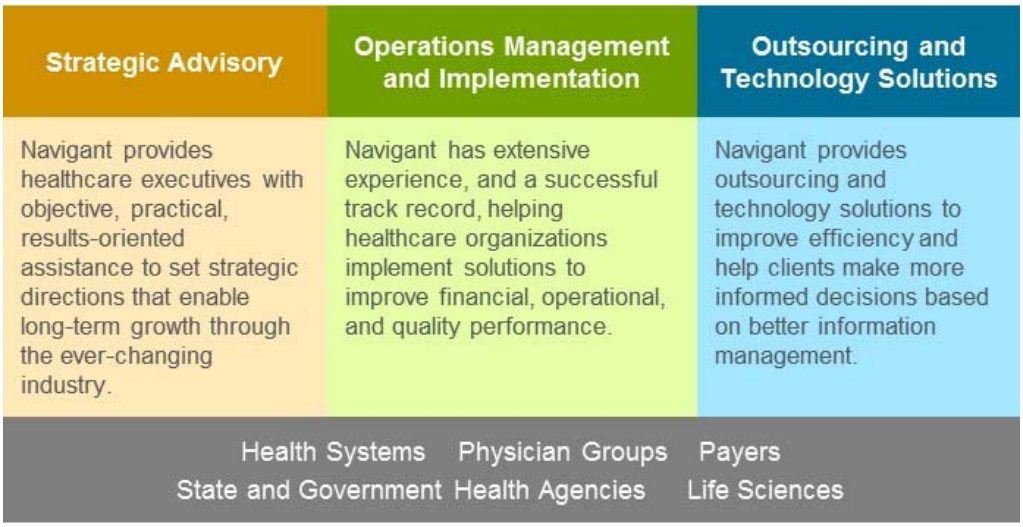
3.2.5.1 Experience

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

Navigant (NYSE: NCI) is a specialized, global professional services firm that applies deep industry knowledge, substantive technical expertise, and an enterprising approach to help clients build, manage, and protect their business interests. With a focus on markets and clients facing transformational change and significant regulatory or legal pressures, the firm primarily serves clients in the healthcare, energy, and financial services industries.

Navigant's healthcare professionals include individuals with experience as public policy experts; hospital, physician practice, life sciences, health plan, Federal and State government, and healthcare operations professionals; finance executives; Actuaries and healthcare analysts; and clinical professionals. Navigant brings together a team of 600 seasoned consulting professionals and industry thought leaders to support clients in designing, developing, and implementing solutions that create high-performing healthcare organizations.

We take a unique interdisciplinary approach to our clients' challenges. This means we work as one team with one goal, leveraging the strengths and expertise of our senior-level consulting professionals in the delivery of integrated solutions. Our primary solutions are in three areas:



Navigant continues to build a strategic platform for payers and providers and supports the development and implementation of solutions and tools that enable our clients to achieve what the Institute for Healthcare Improvement (IHI) calls the "Triple Aim":

- Improve the health of the population.
- Enhance the patient experience of care (including quality, access, and reliability).
- Reduce, or at least control, the per capita cost of care.

We have summarized our specific experience related to the services prescribed in this RFP, in the table below.

Figure 6: Navigant Experience in Task Areas by State

	AL	AR	AZ	CO	GA	IA	IL	IN	KS	KY	LA	MN	MS	NV	NH	PA	TX
Analysis of policy and regulatory changes	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Development of options analyses	✓	✓	✓	✓	✓	✓		✓	✓	✓		✓	✓	✓	✓	✓	✓
Development of workplans	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Assistance with federal authority documents	✓	✓			✓			✓	✓	✓	✓					✓	
Ad-hoc support	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓		✓	✓	✓

Additional details on these key areas our further described below.

Legislative and Regulatory Research and Options Analysis

With the increasing growth in healthcare spending and continued healthcare regulatory changes, federal and state government agencies remain focused on both the quality and value of care. Navigant's State Government Practice works alongside decision-makers in key state and federal agencies to help them transform the delivery and financing of healthcare and other social services. Navigant has worked with Medicaid agencies in many states to support communication and collaboration with legislative bodies and governmental entities. This has included developing recommendations impacting multiple state agencies, creating communication plans, providing trainings on new initiatives and roles of different agencies, and facilitating multi-agency workgroups and committees. We have covered topics ranging from managed care program design to Medicaid reform to provider payment methods.

Our team also has extensive experience providing presentations for interagency meetings to support information sharing and collaboration. We have presented to legislative and executive branch leaders on issues in a majority of states and are familiar with the types of questions and issues that are often raised by these audiences. We have also assisted states to prepare for legislative briefings to provide updates on Medicaid initiatives and Medicaid managed care operations and accomplishments.

We have conducted large implementation and Medicaid managed care redesign projects, where we have supported interagency communication and recommendation development. For example:

- **Alabama.** Navigant created a communication plan for the Alabama Medicaid Agency to support messaging to the Governor's office, state agencies, and other stakeholders as it prepared to implement a new Medicaid managed care program. We also developed training materials to provide updates to state agencies on the key elements of the managed care program and how it impacts each agency and supported the collaboration process between the Alabama Medicaid Agency and the Department of Mental Health to design a care management process.
- **Georgia.** Navigant supported the Georgia Department of Community Health as it implemented a managed care program for children in foster care and children involved in the juvenile justice system. Navigant facilitated the communication process between the Department of Community Health, the Division of Family and Children Services, and the selected MCO throughout the program design and implementation.
- **Illinois.** As part of Illinois' State Innovation Model grant, Navigant facilitated monthly meetings with an Executive Committee composed of State leadership, including developing and distributing meeting materials and presenting information and updates to the committee members. This Executive Committee served as an advisory body and included representatives from numerous state agencies including the Department of Healthcare and Family Services, Department of Aging, Department of Human Services, Department of Public Health, Department of Insurance and the Illinois Health Insurance Exchange. The Executive Committee met on a monthly or bi-monthly basis in-person and via conference call over a 10-month period.
- **Nevada.** Navigant assisted the Nevada Division of Health Care Financing and Policy to evaluate options to modify its current Medicaid managed care program, as required by legislation. As part of this project, we worked with the Division to gather and assess stakeholder feedback and consider the impact of managed care options on various stakeholders, including Governor's office representations, other State agencies, providers, and beneficiaries. We conducted interviews with representatives of key State agencies such as the Division of Public and Behavioral Health, the Division of Child and Family Services, and the Aging and Disability Services Division. We developed a report for the Nevada legislature that provided recommendations regarding managed care expansion based on the results of these analyses and considering the Nevada-specific input from stakeholders.
- **New Hampshire.** Navigant assisted New Hampshire's Department of Health and Human Services in development of an implementation plan in response to SB553 to move their long-term care services to managed care. As part of this effort, Navigant assisted DHHS in developing option assessments and best practice research to support the State's stakeholder efforts and reporting to the SB553 legislatively required workgroup.

Policy Guidance and Development

Navigant has worked with more than 45 Medicaid agencies and dozens of other health and human services agencies across the country on projects across the spectrum of consulting services. Our experience in a diverse mix of projects offers Iowa a team that comes well-versed in national best practices and awareness of both the pressing issues and the menu of solutions states have adopted to address current and anticipated policy changes. When the most recent Managed Care rules were issued, we found that for many of the clients we had been working with and were working with at that time, they were ahead of the curve. Our clients were already looking at or had already adopted robust network adequacy standards, they were already looking at MLR and other financial requirements, they understood the importance of oversight and quality improvement, and they were adopting aggressive measures based on best practices regarding collection and validation of encounter data. These issues did not cause disruption because we had positioned our clients to adopt and consider best practices in advance. We are positioned to offer our clients this best-in-class support as we are deeply familiar with both current policy impacting Medicaid, but also of anticipated change at both a state and national level. Our deep and diverse understanding of all aspects of Medicaid, also positions us to cut through the noise of political and policy changes and simply focus and advise on what works best and how to leverage federal policy to meet your state's needs, versus reacting to changing policy from a position of compliance. We also understand the disconnect that can exist between policy and operations, and we assist our clients in navigating many of the operational and implementation challenges to promote more sustainable outcomes. We help you anticipate the impacts through strategic planning asking key questions including, but not limited to:

- How will this federal/state policy change impact state administrative rules and state plans?
- Will we need to consider a procurement or other contract amendments?
- Will we need to update our waivers?
- Do we need to prepare for a readiness assessment of internal operations and of vendors?
- What operational changes do we need to consider?
- How much will this cost and do we need a budget amendment, or other financing strategies to address this change (e.g., APDs, grants, etc.)?
- Are there timelines for meeting these requirements?
- Are there technology impacts, change orders, etc.?
- Are these substantive changes and do we have a communications strategy to inform and educate key stakeholders?
- Will our rates be impacted?

Our client experience in this capacity includes supporting states such as Pennsylvania, Indiana, Alabama, Kansas, Kentucky, Arizona, New Hampshire and several others.

Some of our experience relevant to the needs outlined in this RFP include:

- **Stakeholder Engagement.** Navigant's large engagements often require significant communication efforts to state leaders, members of legislature, and providers, provider associations, individuals, families, advocates, and others. We have worked alongside states to develop and communicate payment policy, including policy options, fiscal impacts, and policy and budget recommendations. We have facilitated public meetings, focus groups, town hall meetings, webinars, and technical advisory groups as a means to meet with and include affected stakeholders in the process of payment methodology transition. Our team prepares presentations that explain payment methodology and policy adjustments that are targeted for the audience and their level of familiarity with the topic. This fall we will be leading a panel discussion at NASUAD's HCBS conference highlighting our state work with Colorado, Kentucky and Wyoming. In addition, we have recently supported similar efforts in Alabama, Florida, New Hampshire and South Dakota.
- **Discussions with CMS.** Our consultants regularly work with Medicaid programs across the country on projects that require an understanding of and relationship with CMS. We have provided assistance reviewing documentation created by our state clients, assisted with responding to CMS questions during the review process, and assisted with meetings with CMS to further program approval. We help clients write new waiver applications, edit in-process application materials, and negotiate with CMS. Our consultants have strong relationships with CMS staff, and we are experienced in helping our state clients navigate Federal requirements. We assist our clients in navigating CMS discussions regarding CAPs, waiver changes, program design, program readiness, policy interpretation, financial reporting and a host of other needs. We have assisted our clients in such matters in Alabama, Kentucky, Kansas, Louisiana, Arkansas, Georgia and others.
- **Supplemental Payments and Compliance.** Our consultants have assisted with the development of Medicaid Disproportionate Share Hospital (DSH), Certified Public Expenditure (CPE), and supplemental payment programs. We documented the programs' purpose and evolution, the use of Intergovernmental Transfer (IGT) funds, CPEs, and payment methodology. We also evaluated the programs' compliance with the State Plan and Federal UPL regulations, analyzed the distribution of payments among hospitals and the equity of the distributions. We prepare reports of the findings of our evaluation along with our recommended changes in the administration and oversight of the programs.
- **Budget Projections and Policy and Fiscal Impact Analysis.** We have extensive experience conducting a variety of analyses for healthcare payers, including states and health plans. Many of Navigant's projects, whether for the development of FFS systems

or in support of other healthcare payment transformation initiatives or policy development, include significant simulation modeling efforts. We constructed fiscal simulation models using historical claims data that, for example, bundle and/or re-price claims under revised payment methods and rates and estimated the impact and state savings and healthcare system stability from proposed changes. Such modeling allows us to project expected results from the implementation of systems or other policy initiatives and to understand the sensitivity and impacts of alternative policy or system parameters. Navigant's consultants typically prepare payment simulation models in a SAS platform, based on historical FFS paid claims data or MCO encounter data. Using similar modeling techniques and/or our analytics tools, we also help payers and providers identify key unit cost and utilization savings targets and tactics across the care continuum, including emergency room utilization, specialty drugs, and inpatient admissions and days and the impact on hospitals, clinics, and ancillary healthcare providers. Once our models are complete, we help our Medicaid clients to prepare budget projections and related documentation required at both the state and federal levels.

- **State Innovation Models.** Navigant has provided technical assisted to a number of states in support of their State Innovation Model (SIM) initiatives. We assisted the Arizona Health Care Cost Containment System (Arizona Medicaid) with its SIM Application to CMS. We helped the State design the plan for implementation of the infrastructure for integrated care, including consideration of the training required for providers and other stakeholders. We have also worked with Hawaii, Illinois, and the District of Columbia on the development of their SIM design processes, which focused on improving behavioral and physical health integration.

Preparation of State and Federal Documents

Navigant is the premier firm assisting both states and Medicaid managed care health plans throughout the country. Our reports facilitate and foster "real-world" planning – supporting important decision-making processes and effective program management. We are currently working with several states to make recommendations regarding enterprise level, game-changing approaches to managed care that will help these states achieve their Medicaid program goals. We regularly work with Medicaid programs across the country on State Plan Amendment (SPA) and waiver development, renewal, and evaluation projects. Navigant offers experience designing, applying for, implementing, and evaluating Medicaid waiver programs. Our team has extensive experience with various type of waivers, including 1115, 1915(b), and 1915(c) waivers.

We have been involved in most facets of SPA and waiver development, including working with stakeholders to develop program design, developing the cost-effectiveness analyses, writing the applications, negotiating with CMS, conducting evaluations of the waiver programs, and other tasks. We are often called upon to assist with demonstration of Federal compliance and respond to questions from CMS. We regularly help state clients achieve expeditious initial

approvals and modification approvals from CMS. We have provided assistance reviewing documentation created by our state clients, assisted with responding to CMS questions during the review process, and assisted with meetings with CMS to further program approval.

Our consultants continuously research innovations in the waiver process. We are committed to bringing to our clients' attention the latest available options and guiding them through the process as appropriate. This guidance could include the development of work plans, concept papers, and the waiver applications. We understand the critical choices states must make when developing new programs with regard to policy development and planning for the ongoing monitoring of the program.

Navigant's experience with waiver programs, reimbursement based on participant-assessed level of need, and understanding of the nuances of the federal funding requirements for programs such as PACE bring together an outstanding skill set to support the Agency with rate analysis and rate setting for new waiver programs. Navigant's project team has extensive experience completing rate setting work for HCBS waiver programs for **Wyoming, Arizona, Minnesota,** and a number of other states. We also bring program and policy experience with long-term care financing and delivery strategies. Our waiver experience includes, for example, performing cost benefit analyses, evaluation of consumer satisfaction, and assessing compliance with various Federal requirements.

As an example of our experience, Navigant is currently supporting **CMS** in improving oversight of rate setting and financial reporting for Home and Community Based Services (HCBS) waiver programs. For this project, Navigant is serving as a subcontractor to Lewis & Ellis. Our consultants are confirming that states are in compliance with the HCBS assurances as defined in Section 1915(c) of the Social Security Act (the Act), and in the detection and prevention of fraud and abuse in the delivery of personal care and other HCBS services. Developing and conducting trainings is another important aspect of our work, and we have presented with CMS during monthly State Operations & Technical Assistance (SOTA) calls in 2016, including the following webinars "Monitoring Fraud, Waste & Abuse in HCBS Personal Care Services," "Rate Methodology in a FFS HCBS Structure," "Fee Schedule HCBS Rate Setting: Developing a Rate for Direct Service Workers," and "Ensuring Rate Sufficiency: Rate Review and Revision Approaches." As a result of these contracted services, CMS is better equipped to make informed policy decisions and monitor rate setting in these programs, resulting in enhanced program integrity.

As another example of our experience, we recently worked with the State of **Alabama** Medicaid Agency (AMA) to implement a new care delivery model that will improve beneficiary outcomes and address fragmentation in Alabama's Medicaid program. As part of this project, we completed a CMS Section 1115 Demonstration Waiver process related to Medicaid transformation for public notice and public comment. We assisted AMA with drafting the Demonstration Proposal and managing the public comment process (including drafting the public notices, logistics for the public hearings, tracking and compiling the public comments received, summarizing, and addressing the public comments in the Demonstration Proposal and participating in meetings with

stakeholders). We also supported AMA in discussions and negotiations with CMS, including responding to CMS' questions on the Demonstration Proposal. Additionally, we assisted Alabama with their APD request for MMIS changes to support program design and state plan amendments for their Health Home program as it moved under the direction of their RCOs. More recently, we have assisted Alabama with development of their 1915(b) waiver for their Integrated Care Network (ICN) program along with revision of their 1915 (c) waivers.

For the State of **New Jersey**, we completed an independent assessment of New Jersey's Medicaid managed care 1915(b) waiver program for children with special healthcare needs. This assessment was submitted to CMS as part of the State's application to renew its waiver, which was approved. The purpose of the assessment was to evaluate the State's efforts and ability to monitor its waiver program, including access, quality, and cost.

Our consultants also assisted the State of **North Carolina** to conduct an independent evaluation of the "Be Smart" Family Planning Waiver program, operating under an 1115 waiver. The Division of Medical Assistance works directly with the Division of Public Health to administer the Waiver program. Our consultants conducted annual assessments of each of the five years of the waiver to provide analysis of budget neutrality and measure the impact of the waiver on the stated goals of the program.

Navigant assisted the **Massachusetts'** Department of Mental Retardation (DMR) to conduct a comprehensive review and assessment of the Department's approved HCBS waiver. Our consultants facilitated meetings with key DMR staff to establish a vision for the renewed / revised waiver and to review HCBS waiver options. We facilitated meetings with stakeholders regarding the current waiver and proposed changes. We also assisted the DMR Central Office with drafting the HCBS waiver renewal and/or new waiver(s) and obtaining CMS approval for renewal and any new HCBS waiver(s). In addition, we assisted with the development of policy and procedure manuals and the provision of training sessions for DMR staff on the implementation of the renewed and/or new HCBS waiver(s). Our consultants performed an analysis of staffing in the state operated group homes and state operated ICF-MR facilities for purposes of establishing staffing baselines and making recommendations on staffing models.

Support Ongoing Operations of Medicaid and CHIP programs

Navigant has been providing organizational assessment services for more than 30 years. We have assisted the largest Medicaid programs in the nation to effectively and efficiently transition from fee-for-service to a range of managed delivery models and to incorporate various health reform initiatives. As part of these engagements, we have also supported states in determining how to change internal organization and operations to improve effectiveness in administering the changes to their delivery systems. We are also engaged in assisting states to realize improved financial and clinical performance through improved oversight of contractors and more streamlined, data-driven approaches to program administration.

Our experience with complex projects involving organizational assessment, redesign, management, staffing, and training includes our ongoing engagement initiatives in Texas, South

Dakota, Mississippi, Illinois, Alabama, Georgia, Pennsylvania, Washington, Wyoming, and other states. We have provided assistance to CMS, numerous health systems and commercial insurance plans for such engagements. As part of these projects, we have developed project management methodologies and tools, multi-year project plans, and leadership dashboards.

Navigant has significant demonstrated experience in process management and improvement, organizational change, and strategic planning for healthcare transformation initiatives. We work with states to promote transparency, effective communication, coordinated Medicaid operations / administration, and efficient, cost-effective delivery of medically necessary services. Further, it is a cornerstone of our efforts to demonstrate that states can work smarter, often saving administrative costs, to realize performance improvement. Our experience spans state and federal governmental initiatives and those undertaken by private and commercial entities.

Particularly relevant to the scope of this RFP is our work with Medicaid agencies to review and recommend changes to operating and structural models to encourage more efficient and effective business processes. We have worked across all managed care operational areas to develop recommendations for changes in organizational structures, staffing / resource needs and relationships. We have developed organizational charts, communication plans, and inter / intra-agency coordination policies and processes, including identifying opportunities and developing recommendations to help bureaus strengthen and modernize operations and business processes, thereby facilitating a higher return on investment for the State and its citizens. Our recommendations focus on organizational structure and reorganization for maximum efficiency and effectiveness, in addition to the innovative use of technology and analytics, resource deployment and coordination and interaction between agencies.

Compliance with Federal Regulations: Navigant regularly works with states to help them understand federal regulations, CMS rules and policies, and recent or proposed legislative changes. We help program administrators achieve compliance, develop plans for compliance demonstrate compliance. Navigant monitors federal and state healthcare initiatives, regulations and reputable Government and industry information sources to identify potential impacts on our state clients' healthcare programs and operations. Navigant monitors federal regulations that impact our clients and provide assistance to our current clients to help achieve compliance.

***Program Integrity*:** We understand that state programs are required to comply with many regulatory provisions regarding financial and program integrity. These programs are subject to audits by the Secretary of HHS as well as state-level audits and operational reviews, and it is necessary to combat fraud, waste and abuse (FWA) across all systems and operations. Navigant's skills and capabilities are uniquely suited to assist the State in the development and implementation of oversight and program integrity activities to detect and prevent FWA and comply with related State and Federal laws while reflecting the best practices of the public and private market segments.

We have worked with states in the development of the requirements for health plans in formulating their fraud and abuse compliance programs. We have also reviewed health plans' compliance programs and provided guidance regarding areas for improvement.

We have worked with states to understand the issues they face in moving from a FFS environment to a managed care environment – the issues of underutilization and under provision of care versus overutilization and overprovision of care. We have helped these managed care states conduct chart reviews and perform audits. In Mississippi, Navigant supported the Office of Program Integrity as it prepares to enhance its managed care oversight efforts. Navigant conducted a limited review of the Office of Program Integrity to understand policies, activities and business operations in place to monitor and resolve potential fraud, waste and abuse for DOM's managed care program (MississippiCAN). This review included:

- A review of program documentation provided by DOM, including state statutes, program summaries, policies, staffing organization, training resources, and activities related to monitoring program integrity in MississippiCAN
- A review of national and other state Medicaid managed care program integrity effective practices
- Onsite interviews with select Office of Program Integrity staff

As a result of Navigant's review, Navigant prepared a strategic plan for the Office of Program Integrity. Based on feedback from, Navigant subsequently delivered a detailed strategic work plan for the Office of Program Integrity to execute. Navigant facilitated a meeting between the Office of Program Integrity and the Office of Coordinated Care to review roles and responsibilities, and key milestones.

Monitoring and Reporting

After completing the implementation of a new program, states must transition to ongoing monitoring. This is where Navigant's experience differs from that of many consulting firms – we help our clients not only to design new initiatives, but also to execute their initiatives. Our work has also involved analyzing significant amounts of data; facilitating stakeholder meetings; coordinating data collection and conducting on- and off-site reviews of the relevant documentation; and developing recommendations for areas where vulnerabilities or opportunities for improvement are identified.

Over the years, Navigant has supported program monitoring activities for clients in a wide variety of ways. In some cases, we have been engaged to perform the ongoing monitoring activities. In others, we have developed the monitoring procedures and defined the performance standards. We have monitored program and contract compliance, operational performance, financial performance, and quality. We have looked at specific areas of focus such as provider network adequacy, encounter data reporting completeness and accuracy, and payment accuracy. We have measured performance in meeting EPSDT standards, quality standards, reporting requirements, claims processing timeliness, member services response times, and compliance in processing grievances and appeals, to name a few. Our work has involved analyzing actual data files, setting up monitoring databases, developing monitoring procedures and tools, reviewing hardcopy documents and files, conducting interviews and onsite reviews, and validating information via multiple sources.

For both our commercial and Medicaid clients, we have built a wide variety of managed care contractor and information systems monitoring tools. We have built electronic databases to record contract requirements and to collect information from contract monitoring. We generate reports from this system for the executive teams to provide a snapshot of contractor performance at any given point in time.

Navigant was recently retained by a State's Medicaid agency to assist in enhancing its current managed care monitoring infrastructure and processes as it expands its Medicaid managed care programs to incorporate more consumers, new managed care models and an expanded scope of services, including long-term care services. Navigant's work includes the development of internal dashboard reports and related protocols and tools to assess plans' contract compliance, trends in plans and program performance, comparative performance among plans and programs, and actual performance relative to target and benchmark performance levels.

As discussed in our approach section, we have also performed oversight and monitoring in Iowa. Navigant supported a readiness review process and provided additional technical assistance for the ongoing monitoring and proactive management of the MCOs after program implementation. We strategized with the State to establish a thorough and detailed monitoring and oversight reporting process. Navigant assisted with activities such as the creation of an MCO Reporting Manual, reporting requirements, and report templates to collect information in program areas.

Children's Health Insurance Program (CHIP) Expertise

Navigant has in-depth knowledge and expertise of CHIP from both the federal and state perspectives. We have experience working collaboratively with states in understanding the issues and options available under the Deficit Reduction Act, the American Recovery, Reinvestment Act of 2009 (ARRA), and the ACA. Additionally, we are heavily involved in reviewing the recently proposed CHIP managed care regulations issued by CMS and assisting with interpreting the potential impact of these proposed regulations on our state clients.

As previously stated, we have significant experience and understanding of CHIP from our work with both payers and providers. We have worked with states to research the feasibility of expanding CHIP coverage as well as outreach, evaluation, and eligibility contracting strategies and best practices of SCHIP initiatives, and we have developed related Legislative and other reports. We have also assisted in design of managed care initiatives for CHIP, including conducting provider interviews, developing a waiver strategy, assisting with writing legislative rules and SPAs to authorize the program, and assisting with writing MCO and enrollment broker contracts, RFPs, and proposal evaluation criteria.

Navigant assisted the Georgia Department of Community Health (DCH) to analyze and implement strategic options for managing the financing and care of the State's Medicaid and CHIP (PeachCare for Kids™) program which covers nearly 1.7 million members. For this project, we conducted a national environmental scan of Medicaid and CHIP, and of best practices and innovations in commercial health plans. We collected and evaluated ideas for

innovation as well as the financing and delivery of Medicaid and PeachCare for Kids™ benefits. We also assessed the model and structure of Georgia's current Medicaid and PeachCare for Kids™. We assessed and recommended delivery system options for redesign of Georgia's current program to provide Medicaid and PeachCare for Kids™ member's access to quality care. Navigant conducted statewide focus groups with providers, consumers, advocacy groups, legislators, and vendors. We facilitated stakeholder task forces charged with supporting DCH with identify program changes that will result in improved outcomes and cost efficiencies. We prepared a Redesign Strategy Report to present our findings and recommendations to the State. The Report can be found at the following link (scroll down to the "Redesign Strategy Report - Posted January 2012" header): http://dch.georgia.gov/00/channel_title/0,2094,31446711_175210527,00.html.

We have assisted several states with the development, monitoring, and evaluation of a variety of CHIP waivers. We help identify health benefit coverage options that would expand CHIP coverage. Navigant assisted the State of Wyoming's Department of Health in developing a study of options to use a Medicaid or CHIP waiver to expand healthcare coverage. DHS used this study to present coverage expansion options to the legislatively-appointed Wyoming Healthcare Commission and other stakeholders.

We worked with Illinois Medicaid to identify and evaluate a variety of potential program design approaches related to its combined primary care case management and disease management programs. In this role, we worked on the development of a successful §1115(a) waiver application to expand healthcare coverage to parents of children enrolled in the CHIP program in Illinois.

In the State of Mississippi, we assisted with the preparation of the MississippiCHIP Emergency Contract, as well as the RFP and Contract to support the MississippiCHIP reprocurement. As part of this assistance, we prepared all relevant procurement documents and served as Technical Advisor to Mississippi's Proposal Evaluation Committee. We continue to assist with MississippiCHIP contract updates and implementation of the new Managed Care Quality Strategy, which includes MississippiCHIP.

Actuarial Rate Setting and Risk Adjustment Experience

Navigant is fully equipped with an actuarial team and understands the importance of confirming that rates are adequate to cover the financial risk assumed by competing MCOs and so that rates do not result in a benefit to having a disproportionate share of lower-risk enrollees. Our team is familiar with several modern risk adjusters and the statistical biases that can be included in their development. If and as needed, we can blend these perspectives and help confirm or review assumptions. Navigant and its team have provided actuarial work and Medicaid rate setting services in several states. In the sections that follow, we expand on our experience working with status such as Nevada, Washington, and Wyoming.

- **Nevada.** From 2010 to 2015, Annie Hallum assisted Nevada with:
  - Developing Medicaid Managed Care rates including databook preparation, risk score calculation, midyear rate changes, and negotiation support for Nevada's TANF, CHIP, and ACA Expansion populations.
  - Providing waiver support including budget neutrality calculations for Nevada's Behavioral Health program.
  - Developing and analyze its Disease Management programs for FFS populations.
  - Calculating provider enhancement payments for providers.
- **Washington.** From 2011 to 2015, Annie Hallum assisted Washington State with its Managed Medicaid (TANF, CHIP, Foster Care, Children with Special Health Care Needs, ACA Expansion, Blind / Disabled, and SSI enrollees), Basic Health, PACE, and dual integration programs. Key activities included:
  - Developing Medicaid Managed Care rates including databook preparation, risk score model design and calculation, midyear rate changes, health plan negotiations, and CMS responses.
  - Creating and analyzing quality metrics by Managed Care Organization (MCO).
  - Developing capitation rates, negotiating with CMS and health plans, and providing waiver support for the dual eligible integration program.
  - Developing capitation rates, creating a databook, and providing waiver support for an integrated Managed behavioral health and physical health program in a pilot region.
  - Developing PACE UPL certifications.
- **Wyoming.** From 2015 to the present, Navigant has helped Wyoming start and provided actuarial support to its Medicaid Managed Care program for youth with high behavioral healthcare needs. Navigant's team developed and certified Medicaid Managed Care capitation rates, provided 1915b and 1915c waiver support, participated in CMS and health plan negotiations, and provided guidance on developing rate setting methodology, including a risk corridor model. Navigant's team has also certified the PACE UPL rates.

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.

Reference No. 1 | State of Kansas

Project Title	Various Technical Assistance Projects
Project Dates	2010 – Present
Contact	REDACTED

Organizational Assessment of Multiple State Agencies

The Division of Health Care Finance (DHCF) within the Kansas Department of Health and Environment (KDHE) retained Navigant in August 2015 to perform an organizational assessment of the KanCare Medicaid managed care program. KDHE-DHCF contracted with Navigant to analyze the organizational structure and resources needed to effectively administer its programs within a managed care delivery model.

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

Per the client's request, Navigant offered a recommendations report outlining clear, attainable and action-oriented strategies for the agencies to undertake to improve communication efforts, coordination of staff and alignment of the goals for the KanCare program. In addition, Navigant provided a solutions matrix to assist the client in outlining potential strategies and additional considerations to address each issue.

Navigant identified more than 75 issues and provided recommendations pertaining to each for how both agencies could streamline processes / operations, better align resources, and improve communications. After issuing the report, Navigant has been working with the agencies on implementation of recommendations that the State determined would yield the greatest return on their investment.

Since the original assessment, the State has retained Navigant to continue the engagement, assess and implement similar recommendations in other focus areas within the Medicaid agency and sister agencies.

KanCare Corrective Action Plan Support

The Division of Health Care Finance (DHCF) within the Kansas Department of Health and Environment (KDHE) and the Kansas Department for Aging and Disability Services (KDADS) retained Navigant in 2017 to support the development of the State's responses to two Corrective Action Plans (CAPs) issued by the Centers for Medicare & Medicaid Services (CMS) to improve the monitoring and oversight of the State's Medicaid Managed Care program (KanCare).

Navigant assisted in the development the State's CAP responses, which were subsequently approved for implementation by CMS. After approval, Navigant then facilitated bi-weekly discussions with CMS to keep all parties aware of the status of the implementation of over 150 related CAP tasks. The effort is still ongoing, and the State is on track to complete all CAP tasks within the timeframes required by CMS.

Following the approval of CAP implementation, Navigant will also be assisting the State in delivering quarterly reports to CMS to demonstrate how the State is continuing with its ongoing efforts to address the original identified issues CMS raised.

KanCare 1115 Demonstration Support

Navigant supported the Kansas Medicaid Enterprise in developing and securing approval of a one-year extension of the KanCare Section 1115 demonstration, which authorizes the State's Medicaid managed care program KanCare. We assisted the State with drafting the one-year Demonstration Extension application, supported the public comment process, and assisted with discussions with CMS.

Navigant is supporting the Kansas Medicaid Enterprise with the development and submission of a Section 1115 Demonstration Renewal Application, KanCare 2.0. We assisted the State with drafting the Concept Paper, drafting the Demonstration Renewal Application, supporting the public comment process (e.g., draft public notices, prepare public hearing meeting materials, prepare stakeholder engagement materials, respond to written public comments), and finalize the Demonstration Renewal Application for submission to CMS. We are also supporting the State in discussions and negotiations with CMS, including responding to CMS' questions on the Demonstration Renewal Application.

Interim Staffing Support

Navigant provided interim staffing support for key positions within the Kansas Medicaid Enterprise, including:

- Acting Deputy Secretary: Helps to improve agency operations by formalizing and standardizing reporting, monitoring and training processes; improving interagency coordination and communication; and establishing processes for contractor oversight. Also works closely with Agency staff, CMS and contractors to make sure Kansas operates its Medicaid program according to State and Federal requirements.

- Interim Chief Financial Officer: Supports policies, procedures, forms, and best practices to facilitate consistent recording of financial transactions from which statewide financial reporting may be generated and audited.

Information Systems and Data Analysis

Navigant supported the State as they transitioned to a new data analytics tool. We developed executive dashboards, created analysis, and validated data outputs. Navigant also assessed the State's ability to draw down additional dollars for Family Planning.

Uncompensated Care (UC) and Delivery System Reform Incentive Payment (DSRIP)

Navigant is supporting the State to design the UC Pool and DSRIP approach under the State's next 1115 waiver renewal period. As part of this process, Navigant has identified the key action steps related to renewal of the UC Pool and the DSRIP program and has engaged in conversations with CMS regarding the State's options for these initiatives going forward. Navigant is also defining options and related trade-offs for funding the non-Federal share of these pools. Lastly, Navigant is supporting the State in evaluation of options to transition from its DSRIP program to a state-directed payment approach whereby the State requires its managed care organizations to implement designated alternative payment models with contracted providers.

Evaluation of 1115 Demonstration Safety Net Care Pool Financing

Navigant developed a report required by CMS which reviewed the cost of uncompensated care in the state of Kansas and the financing involved with the current Safety Net Care Pools (UC Pool and DSRIP). The report described overall hospital funding and payment for Medicaid recipients enrolled in fee-for-service and managed care, along with uninsured recipients. In the report, Navigant summarized hospital reimbursements from all sources including medical claims, supplemental payment programs, and the Disproportionate Share Hospital (DSH) program. The report also included a summary of funding of the non-Federal share of these reimbursements, from inter-governmental transfers, a provider assessment, and state general revenue.

Reference No. 2 | State of Alabama

Project Title	Medicaid Regional Care Organization (RCO) Implementation
Project Dates	2013 – Present
Contact	REDACTED

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

Over the duration of the project, the Navigant team provided ongoing support in the areas described below.

Waiver Demonstrations

Navigant assisted the AMA with the development and submission of a Section 1115 Demonstration Waiver, which was approved by CMS in February 2016. The Navigant team assisted AMA with drafting the Demonstration Waiver and developing the Special Terms and Conditions. Prior to formal submission of the Demonstration Waiver to CMS, Navigant managed the public comment process, which included cataloguing hundreds of comments and assisting AMA to evaluate and respond to the comments from a diverse range of stakeholders. Navigant also supported AMA in its negotiations with CMS, including developing responses to CMS' questions on the Demonstration Waiver and participating in weekly CMS meetings and periodic in-person negotiations in Baltimore and Washington, D.C.

Waiver Reporting

The Navigant team developed the template for quarterly reports to CMS regarding the Section 1115 Demonstration. The team also supported AMA to develop the report each quarter and develop the annual report. We gathered information and data from AMA team members to complete each report.

Delivery System Reform Incentive Payments (DSRIP)

Navigant assisted AMA to negotiate approval of a DSRIP-like program that would provide incentives to Medicaid providers to implementing projects and achieving quality outcomes. Navigant partnered with AMA throughout this process by supporting staff in weekly calls with CMS. The Navigant team also jointly drafted Special Terms and Conditions (STCs) for the DSRIP-like program with AMA and CMS. The team worked closely with AMA to develop

infrastructure requirements and strategies and approaches that will assist the State in reaching its goals for the Medicaid transformation. We developed the application that providers must complete to apply for funding and hosted webinars for providers and other stakeholders about the DSRIP-like program.

Contract Development

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

Readiness Assessment

Navigant worked with AMA to conduct a readiness assessment of all probationary RCOs (P-RCO's) to ensure compliance with all State and federal requirements. This included desk reviews of each P-RCO's policies and procedures as well as site visits to interview staff, review MMIS systems, and tour facilities. Navigant also facilitated weekly meetings with each P-RCO and AMA to track progress, address questions, and discuss any outstanding issues.

Quality Measures and Incentive Payments

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

Communications Plan

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

Health Homes

AMA operates a Health Home program approved by CMS through Section 2703 of the Affordable Care Act. We assisted AMA to integrate its Health Home program into the broader RCO program. To do so, we assisted in developing and refining AMA's Health Home procurement materials, including a Health Home RFP. One important element of this process was structuring the program so that AMA would continue to receive enhanced federal funding for Health Home services delivered in a managed care environment.

Care Integration

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

Supporting Organizational Change

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

APR-DRGs

We assisted AMA to transition from its current inpatient payment model based on per diem payments to an APR-DRG methodology.

MMIS Assessment

We assisted AMA to identify the changes that would be necessary to the State's MMIS as it transitioned from fee-for-service to a managed care environment. Working within the Medicaid Information Technology Architecture (MITA) framework, we closely collaborated with both AMA and its fiscal agent to document the detailed requirements for the MMIS subsystems. We also

supported multiple Joint Application Development sessions and developed detailed recommendations to support AMA's program and system design decisions related to AMA's delivery system transformation. As MMIS decisions are often tied to larger program design and policy decisions, we coordinated discussion of options between the systems and program administration teams.

HIT / HIE Activities

Navigant provided assistance to AMA to determine what the State wanted to request from CMS to fund HIE in Alabama, which included assisting with a strategic planning and visioning process, developing the federal budget request Implementation-Advanced Planning Document (IAPD), developing draft and final documents, and attending meetings with AMA and with CMS. Navigant conducted the following activities:

- Researched other state HIE initiatives including public health gateways and capacity-building programs, namely for cost and scope details.
- Developed the IAPD submission that reflects the goals from the strategic planning process and builds on funding that was approved by CMS.

Reference No. 3 | Commonwealth of Kentucky

Project Title	Evaluation of 1915(c) Waivers in the State and Operational and Waiver Redesign Assessment
Project Dates	April 2017 – Present (contract extended to June 2019)
Contact	REDACTED

Navigant is currently assisting the Commonwealth of Kentucky Department of Medicaid Services (DMS) to evaluate the six 1915(c) Waivers in the State and perform an operational and waiver redesign assessment. The Commonwealth's waivers provide services to individuals of all ages, including the aging population, with physical, mental, and developmental disabilities as well as individuals with acquired brain injuries. The overall goal of the project is to identify ways to optimize the Kentucky 1915(c) waiver programs, including program oversight and administration, quality of care and service delivery to improve provider, and participant experience.

To provide recommendations in these areas, Navigant reviewed both the current state operations of Kentucky's 1915(c) waiver programs as well as the structure and contents of Kentucky's six 1915(c) waivers. Navigant assessed the following:

1. **Internal Structure and Administration Assessment**: Navigant reviewed the operational processes within the Cabinet for Health and Family Services (the Cabinet) for administering the waivers to identify areas for refinement.
2. **1915(c) Waiver Assessment**: Navigant reviewed the current 1915(c) waivers in Kentucky and assessed program design and waiver content.
3. **Stakeholder Engagement**: As part of this assessment, Navigant facilitated 40 focus groups and reviewed all public comments sent to the DMS public comment inbox.

As a result of this multi-pronged assessment, Navigant developed recommendations for a first phase of HCBS program improvement. These recommendations address the following areas:

- HCBS payment methodology, including a provider rate study, methods to make payment methodologies and rates more consistent across waivers and apply value-based and tiered payment methods.
- Development of more standardized and streamlined approaches to defining waiver services, managing waivers, and executing agency operational workflows.
- Care planning and budgeting, including transition to universal assessment tool and assessment process, and needs-based individual budgeting, and participant directed services.
- Case management, including terms of case manager and support broker contracts, scope of case manager duties and accountabilities, case management tools and training, and oversight.
- Ongoing stakeholder outreach and engagement.

Going forward, Navigant will assist the Commonwealth with the implementation of these recommendations and potentially with future program assessments and improvements.

Letters of reference from the above clients are included starting on page 73.

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.

Navigant has conducted criminal checks on all team members except for Hanford Lin (Director), Tamyra Porter (Director), and Andrea Pederson (Director). For all team members where Navigant has conducted a criminal check, no team member has had a founded child or dependent adult abuse report or been convicted of a felony. For the foregoing team members where a criminal check has not been conducted, Navigant has begun the process of conducting these checks and Navigant will only staff these individuals on the project team upon receipt of each individual's criminal check confirming that the individual has not had a founded child or dependent adult abuse report or been convicted of 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.

On the following pages, please see reference letters that we have procured for several of our most relevant projects.

[Rest of page intentionally left blank.]

Redacted

Redacted

Redacted

Redacted

Redacted

Redacted

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

Not applicable – Navigant intends to complete all work under this contract without the use of subcontractors.

3.2.5.2 Personnel

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

Figure 7: Table of Organization, Overall Project Operations

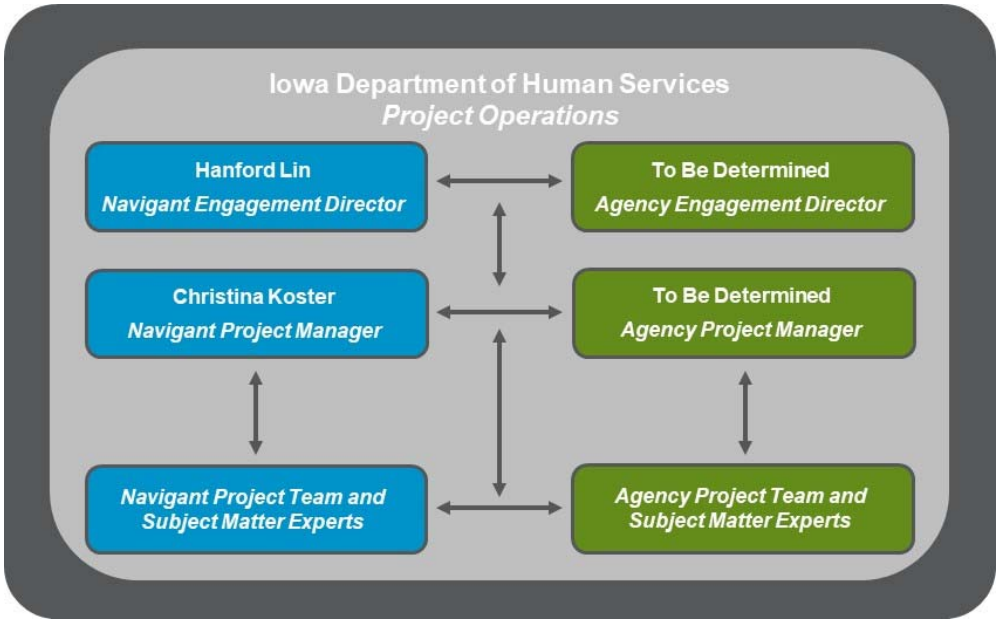
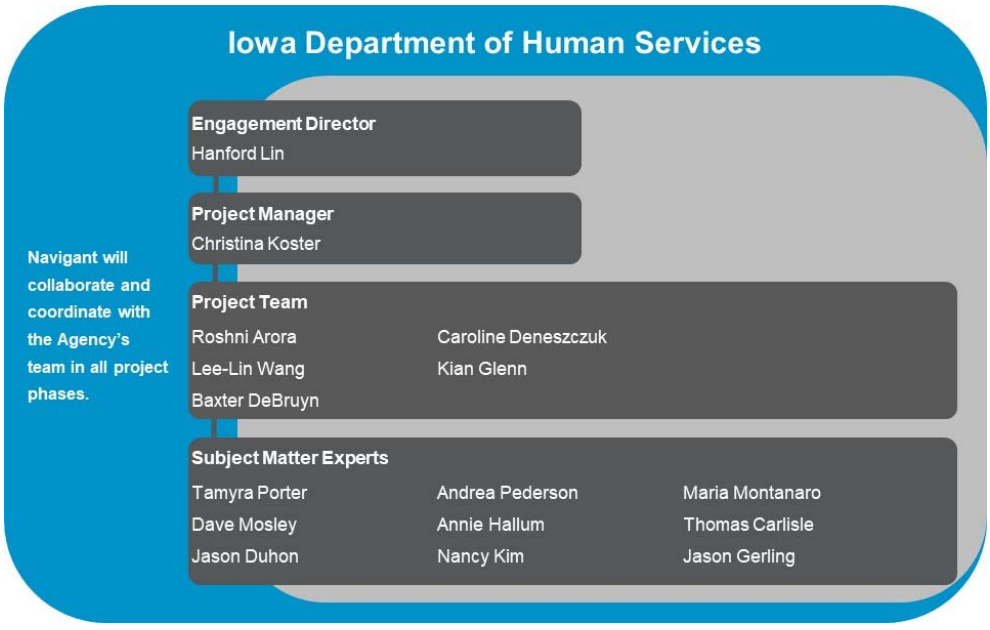


Figure 8: Table of Organization, Navigant Staff to Provide Services under the RFP



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.

In the following table, we have provided Navigant's current Board of Directors and C-Suite Officers. None of these Corporate Personnel will be involved in providing or overseeing the services sought by this RFP.

Executive Officer Name	Title
Julie M. Howard	Chairman & Chief Executive Officer
Stephen R. Lieberman	EVP & Chief Financial Officer
Lee A. Spirer	EVP & Chief Growth and Transformation Officer
Monica M. Weed	EVP & General Counsel
Board of Directors	
Julie M. Howard	
Kevin M. Blakely	
Cynthia A. Glassman, PhD	
Stephan A. James	
Rudina Seseri	
Michael L. Tipsord	
Kathleen (Kate) Walsh	
Jeffrey (Jeff) Yingling	
Randy H. Zwirn	

Supervisory Personnel

Hanford Lin, Director, will serve as ***Engagement Director*** for this work.

Hanford has more than 20 years of experience working with Federal and Medicaid managed care and fee-for-service programs, with an emphasis on quality improvement, program monitoring, and agency operations. He works with Medicaid programs to identify, consider, and implement key healthcare initiatives based on emerging trends, best practices, and federal and state policies and regulations. He helps states develop and operate Medicaid managed care, primary care case management, and fee-for-service delivery systems, from conducting procurement and contracting activities to developing and implementing ongoing operational processes, organizational structures, and tools.

Most recently, Hanford served as Medicaid's Acting Deputy Secretary for the Kansas Department of Health and Environment. In this role, he worked closely with the Governor's Administration, Agency leadership, and frontline staff to understand and develop key program initiatives for Kansas's Medicaid managed care program. He led teams to research and design state policies and programs, including 1915(c) waiver policies, community engagement, 1915(i)-like supported employment, and institutions for mental disease (IMD) exclusions. Operationally, Hanford and his team successfully submitted Kansas's one-year 1115 waiver extension approved by CMS, a five-year 1115 waiver renewal that CMS is currently reviewing, and a corrective action workplan that CMS approved. Hanford is passionate about helping states implement solutions that work within their specific political, programmatic, operational, and fiscal environment.

As Engagement Director, Hanford will ultimately be responsible for the Agency's overall satisfaction with Navigant's work. He will serve as the Agency's main contact and will oversee the development of deliverables to confirm their quality throughout the engagement.

Hanford's resume can be found 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.

The following table provides descriptions of our Project Manager and other Key Project Personnel, and their experience related to this RFP. As requested, we have also provided an estimated allocation of the proposed team members contribution per month based on our experience with other projects and our commitment to provide DHS with both a large bench of seasoned experts and trusted advisors who will offer continuity and consistency throughout this engagement. These estimates are also based on the projections proposed in the cost proposal template. We recognize that the prescribed hours and on sites were proposed estimates and subject to change. We are likewise positioned to expand and contract our commitments and resource allocations to meet your needs. As is the case with many of our contracts, we also anticipate that project needs will also fluctuate over the course of the project with some months and weeks being more extensive than others. Thus, we have presented commitments as estimates and in terms of peak and non-peak contributions.

Name	Relevant Experience	% / Month
Hanford Lin Managing Director ***Engagement Director***	Please see the previous pages for Hanford's experience.	0-5% during non-peak times, up to 25% during peak times
Christina Koster Associate Director ***Project Manager***	Christina Koster is an Associate Director with more than 10 years of experience working with public and private payers and providers, focusing on Medicaid programs. She supports states to design, implement, and operate Medicaid managed care programs. She assists states to develop and obtain CMS approval of federal waivers, including 1915(b) waivers, 1915(c) waivers, and 1115 waivers, to implement changes to their health care delivery systems. Christina is well-versed in federal policy and regulations to help inform states as they undertake Medicaid reform initiatives. She has supported state Medicaid agencies to develop policies and strategies related to the design and implementation of new health care delivery systems, including health homes, care management programs, provider-led health plans and expansion of full-risk managed care models to new populations, services, and geographic areas. Christina has also assisted states to respond to new federal policies impacting Medicaid programs. Christina is an experienced project manager, having led large multi-million and multi-year engagements with more than 20 project staff.	12.5-25% during non-peak times, up to 75% during peak times
Roshni Arora Associate Director ***Project Team***	Roshni has more than 12 years of experience in the healthcare industry working with government-sponsored programs, including Medicaid, Medicare, CHIP, and uninsured programs. Roshni has led engagements specializing in healthcare service delivery system activities. These delivery system engagements include technical support for all phases of program operation, including program design and project planning, financing, implementation, monitoring, and evaluation. Roshni specializes in the design and implementation of Medicaid waiver programs including 1115 waiver demonstrations, 1915(b) waivers, and 1915(c) waivers. For example, she assisted the State of Kansas with drafting the Concept Paper and Section 1115 waiver demonstration renewal application, supported the public comment process (e.g., draft public notices, prepare public hearing meeting materials, prepare stakeholder engagement materials, respond to written public comments), and finalized the 1115 waiver renewal application for submission to CMS. She is	12-25% during non-peak times, up to 100% during peak times

Name	Relevant Experience	% / Month
	also currently supporting the State in discussions and negotiations with CMS, including responding to CMS' questions. She has also worked with Alabama, Georgia, Illinois, Mississippi, Pennsylvania, and West Virginia to design, implement, and enhance management and monitoring approaches for managed care organizations (MCOs) and other state Medicaid agency contractors such as the external quality review organization, fiscal agent, and utilization management vendor. Her work includes the development of procurement materials, such as RFPs and contracts for MCOS; conducting readiness reviews of Medicaid MCOs and developing strategies and processes to assist states with monitoring program performance and driving quality improvement. Finally, Roshni has developed and updated the federally-required Quality Strategy and established performance through metrics such as Healthcare Effectiveness Data and Information Set (HEDIS®), Consumer Assessment of Healthcare Providers and Systems (CAHPS®), National Core Indicators, and other state-generated measures.	
Kian Glenn Managing Consultant ***Project Team***	Kian has spent nine years in the healthcare industry with significant experience assisting states to analyze Federal requirements and identify opportunities to update state plans and Waivers – specifically for managed Medicaid and Home and Community Based Services. She is an expert at reviewing CMS bulletins, notices, letters to State Medicaid Directors, and other states to interpret CMS language and approval patterns and identify recommendations for states on various topics. She's worked with numerous states to facilitate CMS negotiations during waiver or SPA submissions. She also assists states and providers to develop waiver funding strategies, including DSRIP program strategies and state and Federal negotiations to finalize DSRIP Programs. She has experience in integrating physical and behavioral health, implementing advanced primary care models, developing value-based payment methodologies, ongoing monitoring and oversight strategy and stakeholder and communication strategies. She is currently working in Minnesota to assist the Department of Health and Human Services to understand current case management and targeted case management services delivered across the state and identify opportunities to streamline the rate and service definition. Kian uses research and analysis to help clients develop managed care strategy and policy, submit reports to CMS,	0-5% during non-peak times, up to 25% during peak times

Name	Relevant Experience	% / Month
	implement public and private plans, and create new population health methodologies. She has worked on numerous large, complex system transformational projects on both the strategy and implementation side.	
Lee-Lin Wang Managing Consultant ***Project Team***	Lee-Lin has 20 years of experience in health policy research and analysis, fundraising, and program management. She has experience working with local and state governments and public and private entities on healthcare reform issues, Medicaid managed care program design and monitoring, healthcare disparities, strategic planning and reorganization, development and implementation of communications strategies, cross-cultural understanding and collaboration. She supports Medicaid managed care engagements in multiple states; assisting states with the research, development, preparation and review of MCO performance reporting and state Medicaid benchmarking reports in addition to other analyses and presentations related to managed care program design and implementation. She leads teams to develop managed care contractual requirements, conducts reviews for compliance with state and federal legislation, and assesses readiness of both states and MCOs for transition to Medicaid managed care. Lee-Lin assists state departments of human services and Medicaid agencies with assessment and redesign of medical care services delivery for state Medicaid beneficiaries including the elderly and disabled. She has supported review and development of requirements for governance and operations through a statewide integrated care network. She assisted states in restructuring efforts of long-term care supports and services for their respective Medicaid populations. She provides technical assistance, research, and national best practices; develops options analysis, briefings, and state presentation materials and reviews guidance on Federal waiver process for state application. On behalf of a state Medicaid Agency, she facilitated Medicaid managed care contract review and approval by the Centers for Medicare and Medicaid Services (CMS). Lee-Lin is currently working with CMS on reviews of state electronic visit verification (EVV) advanced planning document (APD) submissions, creating the EVV APD review tool, standard operating procedure, report template, and leading the team on conducting the reviews.	12-25% during non-peak times, up to 100% during peak times

Name	Relevant Experience	% / Month
Baxter DeBruyn Senior Consultant ***Project Team***	Baxter has experience in policy assessment, financial review, and data analytics supporting Medicaid, with a focus on HCBS for developmental disabilities, behavioral health, and long-term care. Baxter is skilled in data visualization, having experience with Tableau and data analysis. Baxter has experience reviewing post-payment review methodologies and financial accountability measures in 1915(c) HCBS waiver programs, frequently working directly with CMS to expedite program approval. In addition, he has reviewed and developed 1915(c) performance measures for level of care requirements, provider qualifications, service plan development, health and welfare requirements, and financial accountability. Baxter has also reviewed rate determination methods across the 1915(c) landscape and helped address multiple technical assistance requests pertaining to HCBS-specific topics and Electronic Visit Verification implementation.	12-25% during non-peak times, up to 100% during peak times
Caroline Deneszczuk Senior Consultant ***Project Team***	Caroline specializes in Medicaid waiver policy, stakeholder engagement, program management and operational assessments. Caroline has worked with Kentucky's Cabinet for Health and Family Services on 1915(c) waiver redesign activities including conducting internal operational assessments, updating 1915(c) waiver applications, policy implementation, and stakeholder education and training. Caroline also led reviewing, drafting, and negotiating efforts between Alabama and CMS for its 1915(b)/(c) concurrent waivers. She has provided policy recommendations to CMS regarding 1115 waivers, including improving reporting requirements and adherence to Terms and Conditions. She has also conducted policy and impact analysis regarding multiple subjects including, but not limited to, federal managed care and HCBS rules and policy, case management administration and funding, patient liability determination, and 1915(c) waiting list management.	0-5% during non-peak times, up to 25% during peak times
Tamyra Porter Director ***Subject Matter Expert***	Tamyra has nearly 19 years of experience working on the design, procurement, implementation, readiness, and oversight of Medicaid programs and initiatives in many states, including Alabama, Pennsylvania, Kentucky, North Carolina, Indiana, Mississippi, Texas, Louisiana, New Hampshire, Nevada, the District of Columbia, Maryland, Kansas, Ohio, Iowa, Illinois, and Georgia. Tamyra has worked to develop managed care program options including provider-sponsored, medical homes, full-risk MCOs, PCCM models, and programs that look to fully integrate covered	TBD based on project needs.

Name	Relevant Experience	% / Month
	services and populations including long-term care and behavioral health. Tamyra supports clients in the full life-cycle of program design including waiver support, stakeholder engagement, procurement, and contract development as well as robust development of organizational redesign supported by training and resource development for program oversight, monitoring, and quality improvement.	
Andrea Pederson Director ***Subject Matter Expert***	Andrea has more than 17 years of experience with policy analysis, program assessment and data analysis supporting Medicaid, Medicare and commercial insurers. She has worked extensively in the development, implementation and impact analysis of rate setting methodologies. She directs projects focused on analysis of eligibility, healthcare cost, and paid claims data to provide program evaluation, policy development, reimbursement development, trend analysis, financial impact analysis, and fiscal projections. She supports state clients with Medicaid program design and development, including State Plan Amendments and state rule development. She has extensive project management and leadership experience having directed multi-million dollar engagements. As an area of focus, Andrea uses her years of experience working with states on 1915(c) rate setting, program design, and waiver design to support federal and state clients as a subject matter expert. She currently serves as a director and subject matter expert for the 1915(c) HCBS waiver reviews Navigant conducts for CMS. Her role includes directing the development of trainings for CMS and presenting trainings on nationwide technical assistance webinars alongside CMS.	TBD based on project needs.
Maria Montanaro Director ***Subject Matter Expert***	Maria has extensive executive experience in the health public sector. Prior to joining Navigant, she served as the Director of the Department of Behavioral Health, Developmental Disabilities and Hospitals, where she oversaw Rhode Island's system of care for people living with a serious mental illness, developmental disabilities and drug addiction. She has planned budgets, developed policies, implemented programs and led Medicaid reform initiatives in collaboration with state and industry leaders, insurers, providers, consumers and advocates. During her career, Maria has provided executive management for primary care delivery systems and Medicaid managed care plans. As the Chief Executive Officer of Magellan Healthcare of Iowa, she managed behavioral healthcare for Iowa's Medicaid population from 2012 to 2015. In that role, she was involved in the design and implementation of initiatives in Iowa's Medicaid	TBD based on project needs.

Name	Relevant Experience	% / Month
	program for behavioral health and primary care integration, pay for provider performance and redesign of state services that went into managed care including habilitation services, waiver services in autism and mental health, PMIC services and all inpatient and outpatient behavioral health services. She worked with the State of Iowa and its providers to implement program reforms and initiatives that improved care and lowered costs to Iowa's most vulnerable Medicaid recipients. As the leader of one of Rhode Island's largest integrated medical, dental and behavioral health providers serving Medicaid, Maria led Thundermist Health Center (an FQHC) to nationally recognized excellence in providing advanced, comprehensive primary care to over 40,000 Rhode Islanders. She was instrumental in the establishment of Neighborhood Health Plan of Rhode Island, an award-winning Medicaid HMO and she served as the Chairwoman of its Board for many years. Her pioneering leadership in primary care and Medicaid managed care has given Maria experience and expertise in designing and implementing provider-based initiatives in accountable, integrated system delivery. Throughout her career, she has been invited to testify before Congressional committees and serve on workgroups at CMS, HRSA and SAMSHA, particularly in the areas of PCP transformation, payment reform, integrated behavioral health care and the opioid overdose epidemic. She has direct and practical experience in working on policy development, rate setting and program implementation across the entire spectrum of Medicaid services.	
Dave Mosley Managing Director ***Subject Matter Expert***	Dave leads the State Practice within the Government Value Transformation business unit. His focus is in government healthcare and he maintains exceptional relationships with elected officials, regulators, and industry leaders across the U.S. He provides clients with valuable insight, policy guidance, financial modeling, revenue strategy, and technical assistance while empowering them to realize success in areas such as organizational development, revenue enhancement, finance / budgets, Federal claiming / reporting, institutional reimbursement, rate setting, and audits. Dave is proficient across the breadth and depth of regulatory healthcare as it relates to government agencies, private payers, providers, and beneficiaries. He helps clients evaluate complex regulatory, IT systems, and budgetary and financial matters to provide leaders with concise insight and guidance. He effectively	TBD based on project needs.

Name	Relevant Experience	% / Month
	engages CMS professionals on behalf of, or in concert with, his state clients. Dave brings extensive experience in the Iowa market having consulted relative to topics such as: managed care programs to address revenues associated with sister-agency claiming, compliance / performance assessment, state organizational effectiveness, supplemental payments to facility-based providers, and county / parish health departments.	
Annie Hallum, FSA, MAAA Associate Director ***Subject Matter Expert***	Annie has eight years of experience in healthcare and actuarial consulting for State Medicaid agencies, private insurers, public agencies, and providers. Her Medicaid experience includes Managed Care capitation rate development, Medicaid plan and policy design, Medicaid policy impact analyses, payment transformation design and implementation, and waiver support for 1115, 1915b and 1915c waivers and dual demonstrations. She has also provided policy impact analyses and a review of policy changes for other payors including State Public Employee Benefit plans, State Insurance Commissioners, private insurers, and providers. States in which she has performed this work include Idaho, Nebraska, Nevada, New Mexico, Washington, and Wyoming, among others. She is currently assisting two state Medicaid agencies with independent reviews of their Medicaid Managed Care capitation rates and rate development process. She is also assisting a third state agency with redesigning its dental reimbursement policies and two other states with developing and analyzing policies related to transformation hospital payment systems. Throughout this work she has managed the goals of states, CMS, and MCOs and supported state communications with CMS and other stakeholders.	TBD based on project needs.
Thomas Carlisle, CPA Associate Director ***Subject Matter Expert***	Thomas brings a diverse background to Navigant's Government Healthcare practice. He offers a unique perspective at a time of great change in healthcare having previously served as Chief Financial Officer for the Arkansas Division of Medical Services and more recently as Interim CFO for the Kansas Division of Health Care Finance, which administer each states' Medicaid program. Thomas is a Certified Public Accountant (CPA) and has public accounting experience at a Big Four accounting firm. He has executive leadership in the financial operation of state Medicaid programs, analysis of state and federal legislative policy changes, compliance and monitoring of government healthcare laws, regulations and policies, development and	TBD based on project needs.

Name	Relevant Experience	% / Month
	drafting of State Plan Amendments, and Section 1115 and 1915 Waivers, and audits at the state and provider levels. As Medicaid CFO in Arkansas, Thomas oversaw all finance and reimbursement activities within the State Medicaid Agency. Developed annual operating budget for executive and legislative approval, which included forecasting of existing and new programs based on historical, geographic, demographic and other trends. Thomas was actively involved in Arkansas Medicaid's implementation of the Patient Protection and Affordable Care Act (ACA), including Arkansas' alternative Medicaid Expansion—Private Option. He was also on the leadership team in Arkansas that implemented the State's successful payment reform—Episodes of Care. More recently, Thomas served as the Interim CFO for the Kansas Medicaid program. He oversaw all financial operations of the program, worked closely with the State's leadership team during the 2018 Legislative session, assisted the State in hiring its current Medicaid CFO and in providing training to the new CFO. Over the past several years Thomas has supported Alabama Medicaid with its planning for implementation of new risk-based Medicaid managed care and long-term care programs. In addition to serving the project as a financial subject matter expert, Thomas served as the primary point of contact for Alabama's leadership and helped them manage day-to-day project management and operations including diverse stakeholder and legislative demands. He also led collaboration across multiple sister Agencies including the Division of Developmental Disabilities, Department of Public Health and Department of Mental Health to gather financial and provider-level information for the State's designated state health programs (DSHP). He assisted the State in the development, drafting, submission and gaining of approval of Section 1115 and 1915 Waivers from CMS.	
Jason Duhon Associate Director ***Subject Matter Expert***	Jason is an expert in MMIS design and implementation, having performed similar work for the states of Alabama, Alaska, New Mexico, North Dakota, and others. He has significant experience assisting health plans and government payers with payment methodology assessment, managed care system design and health information technology needs. He has created General System Design (GSD) and Detail System Design (DSD) documentation for MMIS managed care and claims adjudication subsystems to support implementation of applications for a	TBD based on project needs.

Name	Relevant Experience	% / Month
	number of payer clients. He led the analyses of claims, member, provider and other datasets, including currently assisting the Kansas Department of Health and Environment (KDHE) with various analytics related to their Medicaid program. Jason has worked with a variety of state programs on their Medicaid managed care programs including more mature managed care states such as Pennsylvania, Illinois, and Kansas as well as other state programs developing additional managed care infrastructure, such as Alabama. As part of his work with states in conducting readiness assessments of various health plans entering into Medicaid managed care and monitoring the performance of these plans, Jason worked with the following health plans: Centene, BCBS, Molina, AmeriChoice UPMC, and Sentara. Jason has also supported behavioral health engagements over the last several years, documenting the funding flow between a state Department of Mental Health (DMH) and Medicaid Agency, reviewing billing requirements that would allow CMHCs to bill Medicaid for services rendered by allied mental health professionals that are not currently reimbursable under the rehab option. He is also assisting Alabama DMH with Quality Measure analysis, which will eventually be used for Pay-for-Performance (P4P) for their CMHCs. He also performed data analysis on ADMH's available and vacant housing, and presented finding with ADHM to providers and other stakeholders. Jason is assisting with housing needs assessment and evaluating supportive housing services.	
Nancy Kim Managing Consultant ***Subject Matter Expert***	Nancy Kim is a Managing Consultant with more than nine years of experience in the healthcare industry. She focuses on managed care program design as well as home-and community-based services and supports program design. She has worked extensively with state Medicaid programs, assisting with managed care program design, research, and analysis of healthcare policy, strategic planning, and process and performance improvement. She has helped states analyze federal regulations and drafted policy documents to help guide the implementation of program changes. Nancy has also worked with states to implement Nancy is currently assisting with the review of state's 1915(c) waiver applications for the Centers of Medicare and Medicaid Services (CMS) to identify issues related to rate-setting, compliance, quality measures, and fiscal integrity.	TBD based on project needs.

Name	Relevant Experience	% / Month
Jason Gerling Managing Consultant ***Subject Matter Expert***	Jason specializes in program design, implementation and monitoring specific to LTSS and HCBS programs. Past work has included supporting states with strategy development and implementation related to 1915(c), 1915(i), 1915(b)(c) combination, managed LTSS implementation, and other Older Americans Act and CBDG funded programs. As a Gerontologist who has supported program and policy development for aging and disabled populations in multiple states, Jason brings practical insights developed by his years of field work, coupled with his first-hand insights on: case management delivery to the aged, persons with disabilities, persons with behavioral health issues, and individuals with chronic disease, community partnership building and interagency collaboration development. Additional areas he specializes in include stakeholder engagement strategy and implementation, organizational assessment and staff engagement in change initiatives. In addition to his work with state Medicaid, Aging and Disability units, Jason has held roles in a Hospice organization, within one of the nation's largest assisted living and memory care companies, and for one of the nation's largest public housing authorities.	TBD based on project needs.

This team may be complemented by practice leaders and directors, subject matter specialists, nurses, physicians, analytical support staff, and other resources as necessary for the successful achievement of our mutually defined outcomes.

Detailed professional resumes and actuarial certifications for select staff can be found in Appendix A.

Appendix A Resumes of Proposed Navigant Staff

On the following pages, please find full resumes for Navigant's proposed staff, discussed in detail in Tab 4 Section 3.2.5.2 Personnel.

[Rest of page intentionally left blank.]

NAVIGANT

Hanford Lin

Director

hlin@navigant.com
New York, New York
Direct: 646.227.4344

% Time / Month

0-5%* during non-peak times,
up to 25%* during peak times

Professional Summary

Hanford Lin is a Director with Navigant with almost 20 years of experience working with commercial, Medicaid, and Federal healthcare payers, providers, and life sciences companies. quality improvement, value-based purchasing models, fee-for-service and managed care program design and implementation, data analytics and performance management.

Areas of Expertise

- Leads engagements to help states with developing, implementing, and operating Medicaid managed care, primary care case management, and fee-for-service delivery systems, from conducting procurement and contracting activities to developing and implementing ongoing operational processes, organizational structures, and tools.
- As Acting Deputy Secretary for the Kansas Department of Health and Environment – Medicaid, worked closely with Medicaid leadership, Governor's Office and State Legislature to assess, design and implement program initiatives.
- Supports clients to develop processes and strategies for monitoring program performance and driving quality improvement and develops tools to facilitate program monitoring and operations.
- Works extensively with quality and performance measure sets including Healthcare Effectiveness Data and Information Set (HEDIS®), Consumer Assessment of Healthcare Providers and Systems (CAHPS®), Agency for Healthcare Research and Quality (AHRQ), and other National Quality Forum (NQF)-endorsed measures for both physical health and behavioral health.

Professional Experience

Medicaid

- Served as Acting Deputy Secretary for the Kansas Department of Health and Environment – Medicaid (February 2017 through June 2018).

**These estimates are also based on the projections proposed in the cost proposal template. We recognize that the prescribed hours and on sites were proposed estimates and subject to change. We are likewise positioned to expand and contract our commitments and resource allocations to meet your needs. As is the case with many of our contracts, we also anticipate that project needs will also fluctuate over the course of the project with some months and weeks being more extensive than others. Thus, we have presented commitments as estimates and in terms of peak and non-peak contributions.*

NAVIGANT

Hanford Lin

Director

- Developed one-year extension of KanCare (managed care) 1115 demonstration waiver that CMS approved. Leading team to develop KanCare five-year waiver renewal, submitted to CMS in December 2017. Supporting CMS discussions and negotiations for special terms and conditions.

- Advising Medicaid and sister agency (Kansas Department of Aging and Disability Services) leadership, Governor's Office and legislators on key Medicaid program considerations, national best practices on managed care monitoring and performance improvement, policy analysis, and other initiatives.

- Participating in high-visibility, high-priority Medicaid initiatives, including managed care pay-for-performance, implementation of the Kansas Modular Medicaid management information system (MMIS) and decision support system, and eligibility and enrollment process improvement.

- Supporting all aspects of managed care program monitoring, including provider network development for both general and long-term services and supports populations, performance improvement projects, and dashboard and operational reporting.

- Supporting engagements to design, implement, and operate Medicaid managed care programs in states such as Alabama, California, Illinois, Iowa, Mississippi, and Pennsylvania. Project work has involved:

  - Working with senior leadership to develop pay-for-performance and value-based payment programs that incentivize value over volume.

  - Developing reporting templates, dashboards, and other reports to collect and disseminate performance data (quality, operational, and financial) to internal and external stakeholders.

  - Assessing and developing organizational structures, processes, and policies and procedures to promote effective program monitoring and continuous performance improvement.

  - Conducting data analysis to identify performance opportunities and successes and evaluate program effectiveness.

  - Facilitating stakeholder workgroups consisting of agency staff, clinicians, hospital, and health plan executives, consumers, and legislators to identify health plan and program performance measures.

  - Conducting readiness reviews to assess contractor readiness prior to program go-live.

  - Developing and providing feedback on procurement materials, including Requests for Proposals, responses to bidder questions, and proposal scoring tools.

Hanford Lin

Director

  - Training agency staff on subject matter, such as Medicaid and managed care, and skills, such as data analysis and program monitoring.

- Worked with Wyoming Department of Health to evaluate and refine its quality-based incentive program for WYHealth, a primary care case management program. Led a HEDIS® and Quality Measure rate validation study for performance measures calculated by the WYHealth contractor for utilization and care management services.

- Worked with the California Health Care Foundation and California Department of Health Care Services Medi-Cal Managed Care Division to examine the performance of Medi-Cal managed care plans and the factors that may impact performance.

- Assisted a Medicaid health plan with reviewing its HEDIS® data collection and reporting processes for selected HEDIS® measures. Conducted onsite interviews with operational and decision support staff to identify potential risk areas and opportunities for improvement. Developed a process map to illustrate the health plan's systems and processes involved in the rate development process.

- Assisted the Illinois Governor's Office with implementation of its State Innovation Model. Facilitated Quality Measure workgroup sessions to identify and select quality measures used to assess physical health and behavioral health integration.

Federal Initiatives

- Managed project to implement a population health management platform for one of the most successful Pioneer Accountable Care Organizations (ACO) between a national commercial health plan and a leading health system. Worked with executives to document and assess strategic priorities, develop work plans and timelines and prepare project charters. Facilitated meetings to monitor progress and identify and resolve risks for sub-teams tasked with the following: developing the ACO technology solution; locating and ingesting data; implementing the technology in the clinical and care management setting; and developing the Pioneer measures used for CMS reporting.

- Managed a project to assist the Veterans Health Administration (VHA) with developing a Quality Measurement Plan and implementation strategies for two of the VHA's Purchased Care programs, the Fee Program and the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). Conducted interviews, literature review, and additional research to identify current best practices and emerging trends in quality measurement used by commercial healthcare payers, state Medicaid agencies, and other Federal payers.

- Assisted the Department of Defense in assessing the feasibility of HEDIS® accreditation for TRICARE Prime and TRICARE Senior Prime and assisted the Department of Defense with the extraction, analysis, and compilation of healthcare data for use in Joint Commission accreditation of military treatment facilities.

NAVIGANT

Hanford Lin

Director

Litigation Services

- Assisted a State Attorney General's office in response to a class action a(30)(A) lawsuit filed by several disabled Medical Assistance beneficiaries. The lawsuit alleged that the State Medicaid agency did not assure that the Plaintiffs received medically necessary dental care with reasonable promptness and failed to assure that medically necessary dental services were made available to the Plaintiffs in the same amount, duration, and scope as they were provided to other Medical Assistance recipients, among other contentions. The court decided in favor of the State Medicaid agency.

- Assisted Counsel in response to a lawsuit filed by providers. The lawsuit alleged that a health insurance company negotiated improper reimbursement rates and implemented barriers to claims payment.

Health Information Technology

- Managed an assessment of Pennsylvania's existing information technology infrastructure that could be used in implementing a State Health Insurance Exchange. Reviewed the online eligibility and enrollment portal. Conducted in-depth stakeholder interviews with key departments and agencies. Extensively reviewed systems documentation, analyzed potential gaps between current systems, anticipated business requirements, and identified capabilities of other states' and commercial payers' benefit exchanges.

Developmental Disabilities

- Assisted a State Medicaid agency with assessing access to dental services for managed care members with special needs. Compiled and analyzed telephone survey data to evaluate whether health plans could identify and refer members with special needs to appropriate dental services.

- Assisted the Pennsylvania OMAP Division of Quality and Special Needs Coordination with developing a special needs access and availability database to assess and track the accessibility of provider offices to members with special needs. Updated special needs reports to support Commonwealth staff with monitoring each Medicaid health plan's Special Needs Unit performance.

Long-Term Care

- Assisted the Ohio Department of Job and Family Services with identifying and evaluating long-term care rebalancing strategies. Researched unified long-term care budgets, care planning and case management, "single point of entry" and "no wrong door initiatives, and nursing home diversion programs. Surveyed states to identify long-term care best practices and lessons learned.

- Assisted the Pennsylvania Office of Social Programs to clarify and evaluate the current reimbursement system for each of the Bureau of Home- and Community-Based Services' Medicaid waiver programs. Assisted with the potential development of new reimbursement methodologies.

NAVIGANT

Hanford Lin

Director

Other Relevant Experience

- Assisted states such as Alabama and Pennsylvania with strategic planning for their Non-Emergency Medical Transportation (NEMT) programs. Assessed current NEMT model and identified alternative service delivery models. For Pennsylvania, developed a consumer survey to evaluate current transportation services and program performance.

- Assisted a life sciences company with developing an enhanced methodology and forecast model for estimating Medicaid drug rebates. Conducted internal stakeholder workgroup sessions to understand current methodology, historical rebate submissions, and roles and responsibilities. Researched factors that impact Medicaid rebate submissions, such as state Medicaid enrollment, impact of ACA Medicaid expansion, managed care penetration, and 340B changes.

- Assisted a life sciences company with assessing potential opportunities for partnering with quality improvement organizations to improve health outcomes for selected diseases. Determined areas of alignment between the company's product portfolio and quality improvement priorities.

- Conducted a managed care assessment for a national health system. Led team to conduct reimbursement benchmarking analyses to support negotiations with commercial payers. Developed workflows for contract negotiations, revenue reconciliation, and other managed care processes. Worked with corporate and market-level executives to identify appropriate governance structures for collaborative decision-making processes.

- Assisted a national dental benefits provider with developing a pay-for-performance program for its dental providers. Developed options for measuring quality dental performance and scoring and payment distribution methodologies to reward high-performing dentists.

NAVIGANT

Hanford Lin

Director

Work History

Director, Navigant	2016 – Present
Consultant – Associate Director, Navigant	2004 – 2016
Staff Consultant, Tucker Alan Inc.	2003 – 2004
Teaching Assistant – Management Accounting University of North Carolina at Chapel Hill School of Public Health	2001 – 2003
Intern, Tucker Alan Inc.	2002 – 2002
Business Strategy Consultant, The i^4 Consulting Group	2000 – 2001
Healthcare Consultant, Vector Research Inc.	1998 – 2000

Education

Master of Healthcare Administration	University of North Carolina at Chapel Hill, School of Public Health
BA, Public Health – Health Policy and Management	The Johns Hopkins University

Selected Recent Presentations and Publications

- Roshni Arora, Randy Whiteman, and Hanford Lin, "Upcoming Medicaid Managed Care Regulations – How Do You Stack Up?" Navigant Insights, May 2018.
- Hanford Lin, Randy Whiteman, and Roshni Arora, "Provider Network Adequacy Changes in Medicaid Managed Care Final Rule Leave States with Much to Address." Navigant Whitepaper, July 2016.
- California HealthCare Foundation Briefing, "Monitoring Performance: A Dashboard of Medi-Cal Managed Care." Presented at California HealthCare Foundation, December 2013.

NAVIGANT

Christina Koster

Associate Director

christina.koster@navigant.com
Chicago, Illinois
Direct: 312.583.3758

% Time / Month

12.5-25%* during non-peak times, up to 75%* during peak times

Professional Summary

Christina Koster is an Associate Director with Navigant's Government Healthcare Solutions practice. Christina has over ten years of experience working with public and private payers and providers, focusing on state Medicaid programs. She has supported states to design, implement and operate managed care programs.

Areas of Expertise

- Assists states in reforming their Medicaid programs in compliance with state legislation and Federal regulations and provides guidance and support in negotiations with the Centers for Medicare and Medicaid Services (CMS) regarding program funding and regulatory approval
- Supports states in successful development and negotiation for approval of federal funding opportunities, including 1115 Waivers and Delivery System Reform Incentive Payment (DSRIP)-like programs
- Assists in the development of strategies to improve outcomes for complex populations, including behavioral health integration for individuals with mental health and substance use conditions, at both the payer and provider levels
- Has experience managing large projects, including serving as the project manager for a multi-million, multi-year engagement

Professional Experience

Medicaid Reform

- Assisted a healthcare provider consortium in a complex strategic planning process to determine organizational goals and strategic options to respond to changes in the Federal healthcare environment; used the Kepner-Tregoe decision-making methodology to work with healthcare executives to identify priorities.

**These estimates are also based on the projections proposed in the cost proposal template. We recognize that the prescribed hours and on sites were proposed estimates and subject to change. We are likewise positioned to expand and contract our commitments and resource allocations to meet your needs. As is the case with many of our contracts, we also anticipate that project needs will also fluctuate over the course of the project with some months and weeks being more extensive than others. Thus, we have presented commitments as estimates and in terms of peak and non-peak contributions.*

NAVIGANT

Christina Koster

Associate Director

- Supported the Kansas Department of Health and Environment in the development of an extension for the KanCare Section 1115 demonstration. Drafted the extension application to meet the Federal transparency and public notice requirements, compiled documentation of compliance with the KanCare Special Terms and Conditions, supported meetings with CMS and provided guidance regarding public notice and public hearing requirements.

- Facilitated the development and submission of the Alabama Medicaid Agency's (AMA's) Section 1115 demonstration proposal to implement a provider-led managed delivery model. Drafted content, managed the Federally required public comment process, negotiated with CMS and assisted the State in reviewing and operationalizing the demonstration's Special Terms and Conditions as required by CMS. The approved demonstration includes Designated State Health Program (DSHP) funding and over $300 million in Transition Pool funding to assist in the State's Medicaid transformation. Transition Pool funding is similar to a DSRIP program.

- Assisted AMA is developing amendments for its Section 1115 demonstration. Developed the amendment in accordance with the Special Terms and Conditions and supported AMA to respond to CMS questions regarding the proposed amendment.

- Managed an engagement to support Illinois with its State Innovation Model design process, which was focused on strategies to improve the delivery of behavioral health services provided through the Department of Healthcare and Family Services, the Division of Mental Health and the Division of Alcoholism and Substance Abuse. Assisted the State with the evaluation of health transformation strategies, stakeholder engagement and workgroup facilitation and development of a State Health Innovation Plan (SHIP). Regularly provided guidance to leadership from the Governor's Office and the Department of Public Health.

- Conducted a meta-analysis and qualitative reviews to evaluate the impact that initiatives to implement patient-centered medical homes (PCMHs) have had on access, quality and cost as well as to better understand the barriers to achieving PCMH.

Medicaid Managed Care

- Supported AMA to design and implement a managed care under which AMA would pay risk bearing, provider-based regional care organizations (RCOs) on a capitated basis to provide the full scope of Medicaid benefits, including primary, acute, behavioral, maternal and post-acute services.

    - Assisted the State to develop the protocols for providers to receive Transition Pool funding, educate stakeholders, develop application materials and instructions and comply with Federal requirements. Helped the State to develop the process for evaluating performance milestones and metrics and link Transition Pool payments to process and outcome achievements.

NAVIGANT

Christina Koster

Associate Director

- Assisted with the development and implementation of AMA's statewide Health Home program, authorized under Section 2703 of the Affordable Care Act, to provide case management and care coordination services to approximately 300,000 individuals with chronic conditions in Alabama. Developed and refined Health Home procurement materials and readiness assessment materials.
- Assisted AMA to develop managed care contract requirements related to enrollment and enrollee services, provider network and services, covered services and care coordination. Developed contract language in accordance with State laws, administrative rules and Federal regulations.
- Led the development of a Federally required managed care quality strategy for AMA, including quality goals and objectives, program effectiveness and quality measures, monitoring approach and major quality initiatives.

- Led a project to assist the Nevada Division of Health Care Financing and Policy to evaluate options for modifying its Medicaid managed care delivery system. Considered options such as expanding the current managed care program to new geographic areas and populations (e.g., individuals who are aged, blind or disabled). Evaluation considered the impact of managed care models on the State's supplemental payment programs and the impact of managed care on special populations including those with behavioral health issues, children receiving foster care and children involved in the juvenile justice system. Conducted over 30 focus groups and town hall meetings regarding the proposed delivery system recommendations.

- Assisted Georgia's Department of Community Health with design, implementation and ongoing operations of Medicaid managed care programs. Led the development of monitoring materials and readiness review tools for the implementation of managed care for children in foster care and adoption assistance and youth in juvenile justice. Co-led the development of the operational design of a value-based purchasing program and the development of a value-based purchasing manual to guide State and managed care organization (MCO) operations.

- Supported the Pennsylvania Department of Public Welfare with various activities to support its Medicaid managed care program. Developed a learning institute for the Department to train approximately 400 staff and contractors on Medicaid, health reform topics, leadership and operations. Assisted with development of a value-based purchasing program to encourage performance improvement on program goals.

- Served as the key point of contact for a multi-year project with West Virginia's Bureau for Medical Services for the design and administration of a mandatory managed care program. Managed daily contact with the client, contracted MCOs and other vendors, conducted ongoing evaluation of MCO performance, developed provider network standards, evaluated provider networks, prepared annual MCO contract updates, created 1915(b) waiver renewal applications and coordinated with CMS to obtain approval of the applications.

NAVIGANT

Christina Koster

Associate Director

- Assisted the Texas Health and Human Services Commission in evaluating the readiness of 17 health plans to participate in Texas' Medicaid and Children's Health Insurance Program managed care programs. Reviewed provider and member materials and internal policies and procedures to identify the operational and provider network readiness for each MCO. Conducted site visits and interviews with MCO staff.

Behavioral Health

- Assisting TennCare with its Patient Centered Medical Home and Health Link (behavioral health home) programs. Developing content for conferences, collaboratives, and webinars to promote practice transformation. Responsible for a team of five coaches who provide one-on-one coaching to practices to support practice transformation.

- Assisted Illinois to develop strategies to improve physical health and behavioral health integration, including behavioral health homes, data sharing options for behavioral health providers, behavioral health self-management programs and supportive housing services for individuals with behavioral health needs. Prepared for and facilitated dozens of stakeholder workgroups to develop recommendations for enhancements to the behavioral health delivery system.

- Supported interagency efforts between AMA and the Alabama Department of Mental Health to develop policies around behavioral health care coordination for RCOs. Facilitated meetings with the Alabama Department of Mental Health to answer questions about how the Section 1115 demonstration will impact the Department.

Long-term Care

- Assisting AMA with the design and implementation of an Integrated Care Network program, authorized by State legislation, to cover individuals in need of long-term care services in a nursing facility or home- and community-based setting. Provided guidance to AMA leadership regarding Medicaid long-term care program design options and supported stakeholder meetings. Developed a concept paper to summarize program design decisions and seek input from stakeholders. Created an administrative rule on network adequacy standards for the program.

- Assisted Georgia's Department of Community Health with the development of a Request for Proposals for a Medical Coordination Program, to provide medical coordination services to Medicaid members who are aged, blind or disabled.

- Worked with the Illinois' Bureau of Managed Care to develop and implement a new monitoring approach for the Integrated Care Program, a Medicaid managed care program for seniors and persons with disabilities. Led the development of business processes, databases and standard

operating procedures to support contract monitoring. Trained staff on managed care and use of monitoring tools.

- Assisted a Medicaid long-term care MCO in readiness activities to implement a managed long-term care product in a new market. Led development of member and provider materials and policies and researched policy options.

Other Relevant Experience

- Led an analysis of the Medicare Part D benefit for the Pharmaceutical Research and Manufacturers of America. Estimated the number of Medicare beneficiaries with comprehensive drug coverage by various factors. Analyzed year-to-year changes in Part D plan premiums, deductibles and benefit designs. Researched the Department of Veterans Affairs' experience in negotiating prices and analyzed the coverage of the Department's national formulary as compared Part D plan formularies.

- Wrote an assessment for a commercial insurer on the needs of consumers in its service. The final report contained state-level profiles outlining major socio-economic, health status and health care delivery strengths and weaknesses.

Work History

Associate Director, Navigant	2015 – Present
Managing Consultant, Navigant	2013 – 2015
Project Manager, University HealthSystem Consortium	2011 – 2013
Consultant, The Lewin Group	2005 – 2009

Education

M.H.S.A., Health Management and Policy	University of Michigan
B.S.P.H., Health Policy and Administration	University of North Carolina

Selected Recent Presentations and Publications

- "State Trends in Behavioral and Physical Health Integration" Florida's Premier Behavioral Health Conference; Orlando, Florida; August 6, 2015.

NAVIGANT

Roshni Shah Arora

Associate Director

roshni.arora@navigant.com
Washington, DC
Direct: 713.646.5021

% Time / Month

12-25%* during non-peak times, up to 100%* during peak times

Professional Summary

Roshni Arora is an Associate Director with Navigant Healthcare and has more than 11 years of experience in the healthcare industry working with government-sponsored programs, including Medicaid, Medicare, CHIP, and uninsured programs. Roshni has led engagements specializing in healthcare service delivery system activities. These delivery system engagements include program design, implementation, monitoring, operations, organizational readiness, as well as care management, network adequacy, and federal and regulatory compliance.

Areas of Expertise

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

Professional Experience

Federal Initiatives

- Led an engagement for a large national health plan (Part C, Part D, Medicare-Medicaid) to overhaul existing policy infrastructure to develop a comprehensive set of policies addressing Medicare and

**These estimates are also based on the projections proposed in the cost proposal template. We recognize that the prescribed hours and on sites were proposed estimates and subject to change. We are likewise positioned to expand and contract our commitments and resource allocations to meet your needs. As is the case with many of our contracts, we also anticipate that project needs will also fluctuate over the course of the project with some months and weeks being more extensive than others. Thus, we have presented commitments as estimates and in terms of peak and non-peak contributions.*

Medicare-Medicaid products. Tasks included policy life cycle management design, development of a policy template, policy research and development, and procedure review. The policy research and development component incorporated a review of all relevant regulatory frameworks, including federal and state regulations, federal and state guidance, and contracts with government purchasers. At the conclusion of the project, led the review and update of over 400 policies.

- Through a multi-year contract with the Agency for Healthcare Research and Quality (AHRQ), coordinated and provided onsite and individualized technical assistance to 17 states for selected areas of interest related to Medicaid care management.
  - Facilitated peer-to-peer learning across the states through in-person meetings and web conferences on topics such as program design, procurement, measurement, evaluation, communications, and continuous quality improvement. Developed resources such as issue briefs and a technical assistance website for states.
  - Designed and coordinated a day-long session at the National Academy for State Health Policy conference to disseminate lessons learned about Medicaid care management.
  - Developed a toolkit, “Designing and Implementing Medicaid Disease and Care Management Programs: A User’s Guide.”
- Developed network adequacy criteria used by CMS for evaluating Medicare Advantage applications. Established criteria requirements and exceptions, documented detailed business requirements for automating review and evaluation of application data, and drafted communication materials.
- Supported CMS in the development of the Medicaid and CHIP Program System (MACPro) by designing standardized templates for the 1937 Benchmark State Plan Amendment to facilitate consistent state reporting and streamline review, resulting in a more streamlined, efficient, and transparent process and data for state partners and researchers.
- Assisted in the development of a Medicaid managed care oversight guide to facilitate CMS review of Medicaid managed care programs. Managed a scan of existing Medicaid managed care contractual requirements and identifying best practices.

Medicaid Reform

- Assisted the District of Columbia to engage public and private sector stakeholders in developing the District’s proposal for innovative payment and service delivery models. Tasks include data collection and research, stakeholder engagement, meeting facilitation, development of policy recommendations,

financial modeling, and communications activities. Developing the District's State Health System Innovation Plan (SHIP) that the District will submit to CMS.

- Conducted a study for the Association of Community-Affiliated Health Plans (ACAP) to identify the benefits and challenges associated with leveraging Medicaid safety net health plans for health reform.

Medicaid Managed Care

- Supported engagements to design, implement, and operate Medicaid managed care programs in states such as Alabama, Kansas, Illinois, Mississippi, Pennsylvania, and West Virginia. Project work has involved:
  - Supported the evaluation of program design considerations through research, analysis, and stakeholder engagement.
  - Supported the management and oversight of Medicaid managed care for long-term services and supports (LTSS).
  - Supported the development of 1115 waiver demonstration, including preparation of application materials and participating in CMS discussions and negotiations.
  - Developed reporting templates, dashboards, and other reports to collect and disseminate performance data (quality, operational, and financial) to internal and external stakeholders.
  - Supported quality improvement and performance monitoring, including development and update of the federally-required Quality Strategy and establishing performance through metrics such as Healthcare Effectiveness Data and Information Set (HEDIS®), Consumer Assessment of Healthcare Providers and Systems (CAHPS®), and other state-generated measures.
  - Assessed and developed organizational structures, processes, and policies and procedures to promote effective program monitoring and continuous performance improvement.
  - Conducted data analysis to identify performance opportunities and successes and evaluate program effectiveness.
  - Facilitated stakeholder workgroups consisting of agency staff, providers, and health plan executives, and consumers to identify health plan and program performance measures.
  - Conducted reviews of state agency and health plan to assess readiness prior to program go-live.
  - Developed and provided feedback on procurement materials, including Medicaid managed care organization contracts, Requests for Proposals, responses to bidder questions, and proposal scoring tools.
  - Trained agency staff on subject matter, such as Medicaid and managed care, and skills, such as data analysis and program monitoring.

NAVIGANT

Roshni Shah Arora

Associate Director

- Supported strategic planning for senior leadership from the Florida Agency for Health Care Administration's Division of Medicaid to prioritize activities in 2017-2020. Led interviews with senior leaders to understand their role, activities and approach for oversight, monitoring, and performance management, and ongoing challenges. Facilitated strategic planning session using a decision-making framework to prioritize agency activities and establish goals for 2017-2020 to achieve short- and long-term program goals.

- Managed daily project operations for a technical assistance contract with West Virginia's Bureau for Medical Services, which included serving as the primary point of contact with the client, contracted MCOs, CMS, and other vendors. Supported the State with expansion of managed care to include SSI beneficiaries and new services (e.g., behavioral health, dental, and pharmacy services). Prepared the 1915(b), quality strategy, and other supporting documentation to obtain federal authority for program changes. Provided strategic support for implementation activities such as phased-expansion schedule, stakeholder communications, and supported readiness reviews.

- Provided assistance to the Georgia Department of Community Health to develop and implement a value-based purchasing model for select Georgia Medicaid managed care programs. Designed a collaborative process with vendors, identified key priority areas, developed an incentive payment model, and prepared performance measurement specifications.

- Provided recommendations for combining New York's Medicaid managed care contract for the special needs plan (SNP) program for Medicaid-eligible individuals with HIV/AIDS into the mainstream Medicaid managed care program contract. As a result, the State adopted a single managed care contract for these programs, facilitating contract oversight and vendor monitoring.

- Assisted multiple Medicaid MCOs in responding to state Requests for Proposals to participate in mandatory Medicaid managed care programs. Reviewed health plan policies and procedures, interviewed health plan staff and executives and drafted responses to RFP questions.

Medicaid Performance Management

- Performed an assessment of Mississippi's Medicaid managed care program to improve operational and program performance. The assessment focused on the areas such as monitoring and oversight, data analytics, enrollment, quality management, and care management.

- Supporting engagements to assess and improve program integrity functions in Alabama, Mississippi, Texas, and West Virginia. Project work has involved:
    - Assessing organizational structure and processes to improve critical processes, especially in the context of increased managed care enrollment.

NAVIGANT

Roshni Shah Arora

Associate Director

  - Building agency program integrity capacity through the development of policies and procedures and staff trainings.
  - Developing strategic work plans to prioritize agency activities.
  - Developing reporting templates to collect contractor data for program integrity activities.

- Provided consultation on organizational structure and development to the Illinois Bureau of Managed Care to identify operational and structural efficiencies. Facilitated strategic planning to determine priorities to enhance the Bureau's oversight of current and new programs. Proposed recommendations for organizational realignment to increase functional efficiency.

- Conducted an analysis for Arizona to identify potential cost savings that would minimize adverse impacts on the health status of Arizona Health Care Cost Containment System (AHCCCS) beneficiaries. For each proposed area, identified and estimated the projected cost savings and identified advantages and the potential for adverse effects on the target population, exacerbation of related chronic conditions, cost shifting to other covered services, and delayed access to care.

- Provided technical assistance to West Virginia on overall quality improvement, program monitoring, and oversight. Reviewed all MCO deliverables and prepared a quality dashboard to highlight key issues. Coordinated with the State's EQRO to identify interventions to improve performance.

- Led the collection and analysis of information of Medicaid primary care case management (PCCM) programs, including beneficiary access, cost-sharing, and associated disease management and care management components, for New York to use in considering a future PCCM program as an alternative to full-risk managed care in rural areas. Evaluated beneficiary access to primary care and specialist providers in New York's Medicaid managed care program through conduct of focus groups.

- Assessed the performance of Connecticut's HUSKY Program, a capitated Medicaid managed care to compare the policy alternatives of retaining HUSKY versus adopting a "managed fee-for-service" model of coverage for the Connecticut Association of Health Plans.

- Developed an independent assessment of New Mexico's managed care program, Salud!, and behavioral health managed care programs, assessing access, quality, and cost-effectiveness.

Other Relevant Experience

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

NAVIGANT

Roshni Shah Arora

Associate Director

Work History

Associate Director, Navigant	2018 – Present
Managing Consultant, Navigant	2012 – 2018
Consultant, The Lewin Group	2006 – 2012

Certifications, Memberships, and Awards

Navigant Most Outstanding Leadership Collaboration 2015-2016

Client Focus Award, OptumInsight Consulting

Education

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

Selected Recent Presentations and Publications

- "Upcoming Medicaid Managed Care Regulations — How Do You Stack Up?," (multiple co-authors), Navigant Consulting, Inc., May 2018.
- "Provider Network Adequacy Changes in Medicaid Managed Care Final Rule Leave States with Much to Address," (multiple co-authors), Navigant Consulting, Inc., July 2016.
- "Coordination Between Medicaid Health Plans and Marketplace QHPs," (multiple co-authors), Navigant Consulting, Inc., April 2014.

NAVIGANT

Kian Glenn

Managing Consultant

kian.glenn@navigant.com
Minneapolis, Minnesota
Direct: 312.251.5912

% Time / Month
0-5%* during non-peak times,
up to 25%* during peak times

Professional Summary

Kian Glenn, a Managing Consultant with Navigant Healthcare, has six years of experience with a focus on research and analysis to help clients develop managed care strategy, implement public and private plans, and create new population health methodologies.

Kian Glenn has experience assisting states and providers to develop Delivery System Reform Incentive Payment (DSRIP) Program strategies; including state and Federal negotiations to finalize DSRIP Programs. She also has experience in integrating physical and behavioral health, implementing advanced primary care models, developing value-based payment methodologies, financial modeling, strategy and development, Knox-Keene licensing, managed care program design, risk-sharing and capitation methodologies, physician incentive design, CAHPS survey design and implementation, project management, worksite wellness and telemedicine. Kian has assisted some of the largest U.S. health insurers and healthcare start-ups test innovative models. She advised hospitals and providers on reimbursement and population health strategies. She has worked on numerous large, complex system transformational projects on both the strategy and design side.

Professional Experience

Medicaid Managed Care

- Assists the Alabama Medicaid Agency to implement a new care delivery model to improve Medicaid beneficiary outcomes using risk-bearing, provider-based regional care organizations (RCOs). Assists in weekly discussions with CMS to achieve Section 1115 Demonstration Waiver approval, including demonstration funding strategy and design (e.g., Designated State Health Programs – DSHP, Transition Payments, and DSRIP). Aligns demonstration funding goals and objectives with provider-level models that integrate physical and behavioral health, address chronic disease, and advance primary care models across the State.
- Also for the Alabama Medicaid Agency, conducts regulatory, environmental and market analysis to understand operational implications of policy design. Supported development and execution of a communication plan to manage the perception of Alabama Medicaid and inform stakeholders of transition to RCOs. Assisted in integration of physical and behavioral health, advanced primary care models, managed care contracting strategy and Agency staff reorganization and training.

**These estimates are also based on the projections proposed in the cost proposal template. We recognize that the prescribed hours and on sites were proposed estimates and subject to change. We are likewise positioned to expand and contract our commitments and resource allocations to meet your needs. As is the case with many of our contracts, we also anticipate that project needs will also fluctuate over the course of the project with some months and weeks being more extensive than others. Thus, we have presented commitments as estimates and in terms of peak and non-peak contributions.*

NAVIGANT

Kian Glenn

Managing Consultant

Other Relevant Experience

- Assisted the State of Nebraska, Division of Developmental Disabilities with rate development as it redesigned its home- and community-based services (HCBS) waivers. Reviewed proposed service definitions based on unbundling of current services, led in-person discussions with State staff to define waiver service assumptions for rate setting, including the use of payment tiers, staffing ratios, wages and other model assumptions. Developed rate model and fiscal impact analyses, and presented findings to State staff and stakeholders during webinars and in-person meetings. Reviewed waiver application submission and correspondence from CMS, and assisted with responses to CMS requests.
- Supported the State of Illinois' State Innovation Model (SIM) strategy with a focus on integrating physical and behavioral health through advanced primary care models. Responsibilities included: identifying federal funding opportunities for the State to pursue, researching and drafting whitepapers on integration models and funding strategies, interviewing staff and identifying current processes, gap analysis, project management of work plan and associated tasks, stakeholder engagement strategy, drafting of State Health System Innovation model sections. Also: developed managed care organization (MCO) performance reports and dashboards for the State of Illinois Department of Healthcare and Family Services.
- Collaborated with New York's largest primary care based Preferred Provider System (PPS). Assisted in completing the PPS and project DSRIP applications and still performs quarterly reporting tasks. Other support included evaluation of state application requirements, with subsequent gap analysis to identify critical strategic, cultural, market, organizational, clinical, operational, and financial capabilities, and positioning to continue the PPS' development as a Patient Centered Medical Home (PCMH). The application writing and submission included collection, integration and revision of work products across teams, development of an integrated point of view (including stewardship and management), and content management and application process control across work teams. The PPS was among the top five DSRIP applicants and published in international news.
- At the Minnesota Department of Health, developed a strategic plan for a state health department to implement the clinical portion of the Community Transformation Grant from the Centers for Disease Control and Prevention (CDC). As a result, the health department assisted primary care clinics across the State to improve preventive health practices to reduce chronic disease.
- Assisted a large health services company with the integration strategy of various newly acquired physician practices across the country. Led cross-functional teams to develop actuarial, clinical, network and operational models to support risk-sharing agreements to assist new acquisitions to better manage the care of patients. Created market-level reports to identify strategic opportunities for new acquisitions.
- Developed strategy and initial implementation of an onsite health and wellness strategy for a Fortune 20 company to address high needs employees. Strategy included an onsite clinic at the flagship office

NAVIGANT

Kian Glenn

Managing Consultant

featuring a mid-level provider, dietitian, and health coach and benefits concierge. Based on claims data, employees with high risk were targeted and provided with a personalized and integrated experience. Onsite clinic created savings and employee retention so valuable that it has been replicated at more than 15 sites within three years.

Work History

Managing Consultant, Navigant	2014 – Present
Consultant, Optum (UnitedHealth Group)	2012 – 2014
Healthcare Coordinator / Principal Planner, Minnesota Department of Health	2012
Analyst, Optum (UnitedHealth Group)	2009 – 2012
Associate Consultant, Carlson Consulting Enterprise	2008 – 2009

Certifications, Memberships, and Awards

Corporate Citizenship Award Recipient, Navigant Consulting, Inc.

NAVI Award Recipient, Navigant Consulting, Inc.

Super Hero Award Recipient, Optum

Emerging Leaders Program Participant, Optum

Heroh! Award Recipient, Optum

Education

Bachelor of Science – Finance and International Business	University of Minnesota Carlson School of Management

NAVIGANT

Lee-Lin Wang, MSW, MBA

Managing Consultant

lee-lin.wang@navigant.com
Chicago, Illinois
Direct: 312.583.2104

% Time / Month

12-25%* during non-peak times, up to 100%* during peak times

Professional Summary

Lee-Lin Wang is a Managing Consultant with Navigant Healthcare and has 20 years of experience in program management and evaluation, research, and health policy analysis. She is experienced working with Federal, state, and local governments and public and private entities on healthcare reform issues, Medicaid managed care program design, contracting, readiness review and monitoring, healthcare disparities, strategic planning, and cross-cultural understanding and collaboration.

Areas of Expertise

- Leads development and review of state Medicaid managed care contracts in consideration of compliance with state and Federal regulations, often in coordination with multiple stakeholders.
- Supports states with conducting and managing readiness reviews and monitoring the ongoing compliance of managed care organizations.
- Assists state Medicaid agencies and other organizations in the development, design, and evaluation of healthcare staff training.
- Supports work on multi-year, multimillion dollar engagements and guiding timely completion and demonstrable value of complex engagements.

Professional Experience

Federal Initiatives

- Supporting the Centers for Medicare & Medicaid Services (CMS) collection and review of state home and community-based services (HCBS) 1915(c) waiver applications, renewals, and amendments for compliance with federal and state regulations.

- Assisted the CMS and the Center for Consumer Information and Insurance Oversight (CCIIO) with activities related to the Outreach and Collections for the Transitional Reinsurance Program. Supported identification and outreach efforts of entities required to contribute towards stabilizing premiums in the individual market.

**These estimates are also based on the projections proposed in the cost proposal template. We recognize that the prescribed hours and on sites were proposed estimates and subject to change. We are likewise positioned to expand and contract our commitments and resource allocations to meet your needs. As is the case with many of our contracts, we also anticipate that project needs will also fluctuate over the course of the project with some months and weeks being more extensive than others. Thus, we have presented commitments as estimates and in terms of peak and non-peak contributions.*

NAVIGANT

Lee-Lin Wang, MSW, MBA

Managing Consultant

- Supported the Consumer Operated and Oriented Plan (CO-OP) Program of CMS and CCIIO on the creation of qualified nonprofit health insurance issuers in multiple states. Drafted market research profiles, provided technical and administrative support, and conducted onsite visits to states to determine readiness for operations and compliance with state and Federal regulations.

Medicaid Reform

- Assisted with survey development, analysis, and evaluation for North Carolina's Family Planning Waiver and provided recommendations to increase enrollment with Waiver services and support continuity of enrollee participation in annual screenings.

- Provided internal Navigant assistance and collateral development of Federal Healthcare Reform implications and needs for appropriate state positioning and preparedness for compliance with Medicaid provisions of the Patient Protection and Affordable Care Act of 2010.

Medicaid Managed Care

- Serving as project manager for the Arkansas Department of Health Services' (DHS) reorganization of five Divisions into the newly created Division of Provider Services and Quality Assurance (DPSQA). Assisting DPSQA with the evaluation of personnel reallocation, review and promulgation of policies including streamlining incident and accident, and compliant policies across CMS 1915(c) waivers. Supporting contract reviews and assessment, and provider education, support, and training.

- Assisted the Arizona Department of Corrections with procurement review and evaluation between two potential healthcare vendors. Developed comparison analysis of vendors' proposed staffing plans and considerations for further assessment.

- Assisted the Alabama Medicaid Agency (Agency) on the statewide transition to risk-based, community-led, regional care organizations (RCOs) to coordinate the healthcare of the State's Medicaid beneficiaries in each of five designated regions in the State.

  - Led development of a risk-based contract for use between the Agency and RCOs. Worked with the Agency and CMS on contract language revisions and final contract approval and execution.
  - Assisted the Agency with conducting readiness assessments of eleven RCOs to determine their respective readiness to provide services to Medicaid beneficiaries in accordance with the RCO contract and State and Federal regulations. Developed review criteria, interview questions, onsite review schedules and agendas, and risk mitigation strategies. Drafted final Readiness Assessment report for submission to CMS.
  - Managed the development and implementation of healthcare related trainings for Agency employees.

Lee-Lin Wang, MSW, MBA

Managing Consultant

  - Supported drafting Alabama Medicaid Administrative Code Rules to implement the RCO program.

- Assisted with the Iowa Department of Human Services, Iowa Medicaid Enterprise (IME)'s readiness reviews of four selected MCOs for the IA Health Link program. Conducted desk and onsite reviews of each MCO's ability to provide high quality, accessible care to Iowa Medicaid beneficiaries. Assisted with drafting final reports that documented findings and recommended mitigation steps for identified deficiencies.

- Supported Pennsylvania in the development of an e-Learning Institute for State employees, provided recommendations for course content, timing, and roll-out. Managed the transformation of PowerPoint presentations into individual web-based training sessions, facilitated review, and edit of course content along three course tracks: Medicaid 101, Health Reform and Special Topics, and Leadership Development. Developed corresponding knowledge checks and resource guides for the e-Learnings.

- Conducted desk reviews of Coordinated Care Organizations' (CCOs) ability and readiness to provide services for the Mississippi Division of Medicaid's Coordinated Care Program called Mississippi Coordinated Access Network. Assessed alignment with requirements from the CCO contract and Request for Proposals (RFP). Determined for each operational area if the materials submitted satisfied contract requirements. Identified follow-up items related to any deficiencies found and identified questions to ask during pre-site and on-site reviews.

Government Payment Transformation

- Led the development of the Wyoming Medicaid Benchmarking Study, an annual report analyzing Medicaid fee schedules for various services. The report serves as a reference and planning document with comparisons to other state Medicaid reimbursement rates, commercial fees, and Medicare reimbursement. Researched Wyoming current and historical payment methodology, analyzed expenditure data, and presented options for future reimbursement directions.

- Provided Massachusetts's Delivery Model Advisory Committee with research and analysis of Medicaid service delivery systems and fee schedules to evaluate MassHealth, the State's Medicaid program. Assisted in development of a briefing book, summaries of interviews with representatives from various state Medicaid programs, and recommendations of innovative Medicaid payment and delivery system models and design features.

- Assisted the Illinois Department of Healthcare and Family Services with potential modifications to the Medicaid fee-for-service inpatient prospective payment system (IPPS). Assisted in development of evaluation criteria for reimbursement system re-design. Researched utilization of Resource Utilization Groups within the national landscape for nursing facility reimbursement.

NAVIGANT

Lee-Lin Wang, MSW, MBA

Managing Consultant

Medicaid Performance Management

- Assisted the Iowa Department of Human Services, Iowa Medicaid Enterprise (IME) with development of a performance report for the State Legislature of the IA Health Link program's participating MCOs' first quarter performance. Provided review and data analysis of submitted monthly and quarterly data reports for contract compliance and assessment of care provided to members.

- Assisted the Pennsylvania Department of Public Welfare (DPW) with updating performance reports of outcomes for MCOs participating in the HealthChoices program. Reviewed the Department's data repository and performance profile reports developed from HEDIS® and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) data from the National Committee for Quality Assurance. Assisted with review and recommendations for the Department's Annual Report, Consumer Guide and other publications.

- Assisted the Illinois Department of Healthcare and Family Services with development of monitoring tools and standard operating procedures for tracking and evaluation of MCO performance reporting.

Health Information Technology

- Supported the District of Columbia Department of Health Care Finance's design, planning and implementation of its State Medicaid Health Information Technology Plan (SMHP). Assisted in the development of provider and hospital surveys.

- Assisted the Pennsylvania DPW Office of Medical Assistance Programs with health information technology efforts including the design, development and implementation of its SMHP and Implementation Advanced Planning Document (IAPD). Assisted with evaluation of the eHealth Pod Pilot to increase secure data exchange among long-term care and behavioral health providers with other provider partners.

Long-term Care

- Assisting the Alabama Medicaid Agency with assessment and redesign of medical care services delivery for the State's elderly and disabled Medicaid beneficiaries. Supporting review and development of requirements for governance and operations through a statewide integrated care network. Providing recommendations for defining, tracking, and trending critical incident events for the State's 1915(c) HCBS waivers.

- Assisted in restructuring efforts of long-term care supports and services for a state Medicaid population. Provided technical assistance, research, and national best practices. Developed options analysis, briefings, and state presentation materials. Reviewed guidance on Federal waiver process for state application.

NAVIGANT

Lee-Lin Wang, MSW, MBA

Managing Consultant

Health Insurance Studies

- Provided assistance to the North American Medical Management (NAMM) of Illinois – an Aveta Company – to create Regional High Performance Networks (HPN) for Chicago. Applied cost analysis model to analyze 13 hospital claims data against a peer grouping. Assessed each hospital's potential cost savings on a per case basis, potentially avoidable one-day admissions, avoidable emergency room visits, and avoidable readmissions. Assisted in development of a hospital shared savings model. Conducted research on MCOs to assist development of competitive market assessments and strategic recommendations.

Other Relevant Experience

- Designed and convened multiple Chicago city-wide listening sessions for research and assessment of racial and ethnic disparities related to access to breast health screening and treatment. Assisted in the development and publication of report addressing quality improvements and reducing disparities in breast cancer mortality in Metropolitan Chicago.

- Assessed health conditions and standards of incarcerated and formerly incarcerated girls in Chicago. Provided policy and programmatic recommendations on the health of incarcerated girls to the Illinois Department of Juvenile Justice.

Work History

Managing Consultant, Navigant	2011 – Present
Graduate Assistant, Center for Supply Chain Management and Logistics University of Illinois at Chicago	2010 – 2011
Teaching Assistant, Department of Managerial Studies University of Illinois at Chicago College of Business Administration	2010
Consultant, Metropolitan Chicago Breast Cancer Task Force Sinai Urban Health Institute	2007, 2009
Program Director, Illinois Women's Health Coalition and Senior Policy Analyst, Health and Policy Research Group	1996 – 2007

Certifications, Memberships, and Awards

Beta Gamma Sigma

Member, Women's Leadership and Mentoring Alliance (WLMA)

Member, Project Management Institute (PMI) Chicagoland Chapter

NAVIGANT

Lee-Lin Wang, MSW, MBA

Managing Consultant

Education

M.B.A., Entrepreneurship, Marketing, and Management	Liautaud Graduate School of Business University of Illinois at Chicago
M.S.W., Health Policy	University of Pennsylvania School of Social Policy & Practice (formerly the School of Social Work)
A.B., Political Science	Bryn Mawr College

NAVIGANT

Baxter DeBruyn

Senior Consultant

baxter.debruyn@navigant.com
Washington, D.C.
Direct: 202.481.7377

% Time / Month

12-25%* during non-peak times, up to 100%* during peak times

Professional Summary

Baxter DeBruyn is a Senior Consultant in the Value Transformation practice at Navigant. Baxter has experience in healthcare consulting, policy assessment, financial review, and data analytics supporting Medicaid, with a focus on home- and community-based programs for developmental disabilities, behavioral health, and long-term care. Baxter is skilled in data visualization, having experience with Tableau and data analysis.

Areas of Expertise

- Reviewing post-payment review methodologies and financial accountability measures in 1915(c) HCBS waiver programs.
- Reviewed and developed 1915(c) performance measures for level of care requirements, provider qualifications, service plan development, health and welfare requirements, and financial accountability.
- Data compilation and analysis using Tableau.
- Development and implementation of business continuity plan to meet conflict-free case management requirements.

Professional Experience

CMS 1915(c) Rate Reviews

- Reviewed 1915(c) home- and community-based waivers for rate sufficiency and financial integrity. Assessed the completeness and reasonableness of the states submitted documents. Reviewed state waiver documents to provide assessment to CMS for follow-up with states. Aided in the development of training and resource materials used to educated state Medicaid programs.

**These estimates are also based on the projections proposed in the cost proposal template. We recognize that the prescribed hours and on sites were proposed estimates and subject to change. We are likewise positioned to expand and contract our commitments and resource allocations to meet your needs. As is the case with many of our contracts, we also anticipate that project needs will also fluctuate over the course of the project with some months and weeks being more extensive than others. Thus, we have presented commitments as estimates and in terms of peak and non-peak contributions.*

NAVIGANT

Baxter DeBruyn

Senior Consultant

Conflict-Free Case Management

- Aided in the development of a business continuity plan delivered to the State of Colorado to ensure Community Centered Boards (CCBs) followed new conflict of interest requirements. Presented the business continuity plan to both state employees and provider agencies in separate trainings.

Data Analysis

- Collected relevant post-payment review, rate, cost, and performance measure data for 1915(c) waiver applications and CMS-372(s) reports. Compiled data and developed Tableau dashboards visualizing various analyses for CMS including specific analysis regarding appendix data, regional cost comparison, and the adequacy of state performance measures. Developed recommendations for CMS based on data visualizations, and depicted these conclusions using Tableau Stories.

- Collected personal care services data for 1915(c) waiver applications utilized in an annual PCS data report submitted to CMS.

- Compiled and analyzed data from a nationwide survey for states to report the status of their Electronic Visit Verification (EVV) programs. Visualized this data using Tableau, which was used to display recommendations and best practices in two NASUAD trainings delivered by CMS and Navigant.

Work History

Consultant, Navigant	2016 – Present

Education

Bachelor of Arts, Public Health Studies	Johns Hopkins University

NAVIGANT

Caroline Deneszczuk, MPH

Senior Consultant

caroline.deneszczuk@navigant.com
Washington, D.C.
Direct: 202.973.3277

% Time / Month

0-5%* during non-peak times,
up to 25%* during peak times

Professional Summary

Caroline Deneszczuk is a Senior Consultant with Navigant's Government Health Solutions practice, specializing in health policy research, project management, and data analysis. Caroline has significant experience working with government entities and legislative groups to conduct research and support health reform initiatives. Her areas of focus are health insurance coverage and access, healthcare demonstrations and waiver policy, dual eligible individuals, end-of-life care, home- and community-based settings, program operations, and evaluation. She has served in positions in Washington, D.C. that have afforded her a deep understanding of Federal health regulations and reform in the United States.

Caroline has performed reviews of Federal regulations, guidelines, standards and recommendations related to Medicare, Medicaid, State Children's Health Insurance Programs (SCHIP), and other Federal and state programs, and worked as a liaison to congressional offices, the Congressional Budget Office, the Department of Health and Human Services, state officials, and health advocacy groups.

Areas of Expertise

- Analysis of healthcare policy issues and development of reports, issue briefs, and other deliverables.
- Healthcare program redesign including the waiver approval process, conducting readiness reviews, and site visits to assess health plan readiness to serve Medicaid members and development of standard operating procedures for future monitoring and operations.
- Facilitation and training of elected officials, healthcare executives, and other stakeholders on state and Federal policy-related issues and the healthcare delivery system.
- Expertise in stakeholder engagement through developing, scheduling, and conducting stakeholder interviews, focus groups, and surveys.

Professional Experience

**These estimates are also based on the projections proposed in the cost proposal template. We recognize that the prescribed hours and on sites were proposed estimates and subject to change. We are likewise positioned to expand and contract our commitments and resource allocations to meet your needs. As is the case with many of our contracts, we also anticipate that project needs will also fluctuate over the course of the project with some months and weeks being more extensive than others. Thus, we have presented commitments as estimates and in terms of peak and non-peak contributions.*

NAVIGANT

Caroline Cay Deneszczuk

Senior Consultant

Federal Initiatives

- Provided subject matter expertise to the Centers for Medicare and Medicaid Services (CMS) regarding Medicare and the Dual Eligible population. Assisted CMS is implementing healthcare demonstrations for this population through the Financial Alignment Initiative. Aided in the readiness review of contracted health plans and the ensuing implementation and monitoring of the demonstration in Washington, Colorado, Texas, New York, and California.

- Assisted in the qualitative and quantitative evaluation of federal healthcare innovation grants awarded by the Centers for Medicare and Medicaid Innovation (CMMI). Planned and conducted site visits for seven awardees and performed analysis on this data collection. Led the drafting process for quarterly and annual reporting requirements throughout the evaluation. Provided research and knowledge regarding home- and community-based services, assisted living and independent living facilities, end-of-life care policy, and palliative care policy.

Medicaid Reform

- Aided Wyoming to identify gaps and provide recommendations to improve the State's Adult Protective Services system and improve communication and collaboration across agencies, advocates, the judicial system, and business leaders that serve vulnerable adults.

- Aided in the development of the State Innovation Model (SIM) Plan in Washington, D.C. Led stakeholder engagement efforts through conduct of consumer interviews and focus groups, provider surveys, and assisting in advisory committee and workgroup activities. Led research and drafting efforts of several sections of the State Healthcare Innovation Plan (SHIP) including the environmental scan, stakeholder engagement, and building connections between social and medical services.

- Served as the assistant project manager for a Federal 1115 waiver demonstration management and evaluation project. Provided policy and evaluation recommendations to CMS regarding Medicaid 1115 waivers throughout the United States. Aided CMS and states in improving reporting requirements and adherence to Standard Terms and Conditions (STC). Reviewed quarterly and annual reports of providers participating in the Delivery System Reform Incentive Payment (DSRIP) program. Determined providers' achievement of milestones necessary for performance payment in the DSRIP program.

Medicaid Managed Care

- Managed teams in conduct of readiness reviews of Medicaid managed care organizations in Texas, New York and California, and well over 30 plans. Led staff through the readiness review process by providing training, guidance, and expertise. Planned, staffed, and conducted desk reviews and site

visits to all three states and led discussions on care coordination, appeals and grievances, and staffing.

- Leading drafting of the Alabama Medicaid Agency(AMA) Managed Care Quality Strategy and establish a framework for collecting and analyzing quality data to reflect managed care organization and state performance.

Medicaid Performance Management

- In collaboration with subject matter experts within Navigant and Alabama Medicaid Agency, develop standard operating procedures regarding program governance, key staffing roles, monitoring of subcontractor agreements, and provider certification to collaborate with the State.

- Led efforts to monitor and evaluate the performance of managed fee-for-service demonstrations in Washington State and Colorado. Developed all annual reports to CMS regarding process and outcomes measures reported by the states. Selected the questions and administered a demonstration-specific CAHPS survey during each year of the monitoring and evaluation effort.

Long-term Care

- Assisting the Alabama Medicaid Agency with its planned transition to managed LTSS delivery system (expected implementation October 2018). Responsibilities include leading the development of the Section 1915(b) and 1915(c) Medicaid waiver applications, developing a concept paper for public comment, and analyzing results of a survey of LTSS consumers, caregivers, providers, and advocates.

- Assisting Colorado with streamlining case management service delivery and redesigning reimbursement methodology for the State's ten 1915(c) home- and community-based services waivers. Researching and interviewing case management experts to determine best practices that offer choice in case management providers, eliminate conflicts of interest, establish a framework for fair reimbursement, and increase provider capacity.

Other Relevant Experience

- Assisted Navigant's Healthcare Revenue Cycle practice to support healthcare systems implement and refine coding and billing procedures using Epic Software®. Worked with the University of Texas Medical Branch (UTMB) to conducted research and devise strategies and procedures to prevent claim denials and avoidable write-offs. Provided weekly training to coding and billing staff at UTMB and produced policy and procedure documents for long-term software management.

- Developed and conducted training of survey staff on how to approach, conduct and record responses from Medicaid enrollees regarding their experiences in the healthcare system. Analyzed and

NAVIGANT

Caroline Cay Deneszczuk

Senior Consultant

interpreted the data collected by survey staff to develop healthcare reforms for the District of Columbia's State Healthcare Innovation Plan.

- Served as Monitoring Task Lead for a Financial Alignment Initiative Operation Support Contract.
- Served as awardee cohort lead for the Health Care Innovation Award Evaluation: High-Risk and Complex Patient Populations Project, at NORC at the University of Chicago.
- As Health Policy Fellow for a congressman's office, assisted in drafting legislation regarding a single-payer system, primary care workforce reform and gaps in Medicare / Medicaid coverage.
- Performed research related to legislative trends for aging individuals, in the areas of managed care, caregiving, health insurance exchanges dual eligible, and Medicaid waiver programs.

Work History

Senior Consultant, Navigant	2015 – Present
NORC at the University of Chicago	2013 – 2015
Office of Congressman Jim McDermott	2012– 2013
American Association for Retired Persons	2011 – 2012

Education

Masters of Public Health, Health Policy	The George Washington University
Bachelors of Science, Psychology	The Ohio State University

Selected Recent Presentations and Publications

- Lupu, D., Deneszczuk, C., Leystra, T., McKinnon, R., and Seng, V. (December, 2013). Few U.S. Public Health Schools Offer Courses on Palliative and End-of-Life Care Policy. Journal of Palliative Medicine. 16(12); 1582-7.

NAVIGANT

Tamyra Porter

Director

tporter@navigant.com
Washington, DC
Direct: 202.973.3138

% Time / Month
TBD based on project needs.

Professional Summary

Tamyra has nearly 17 years of experience working on the design, procurement, implementation, readiness, and oversight of Medicaid programs and initiatives in many states including Alabama, Pennsylvania, Kentucky, North Carolina, Indiana, Mississippi, Texas, Louisiana, New Hampshire, Nevada, the District of Columbia, Maryland, Kansas, Ohio, Iowa, Illinois, and Georgia. Tamyra has worked to develop managed care program options including provider-sponsored, medical homes, full-risk MCOs, PCCM models and programs that look to fully integrate covered services and populations including long-term care and behavioral health. Tamyra supports clients in the full life-cycle of program design including waiver support, stakeholder engagement, procurement and contract development as well as robust development of organizational redesign supported by training and resource development for program oversight, monitoring and quality improvement.

Areas of Expertise

- Assists states with evaluating program design options to better manage their Medicaid programs including waiver development, procurement and contracting, and developing internal infrastructure to monitor and drive quality improvements.
- Assists states with addressing reform and innovation to better manage long-term care programs including stakeholder engagements, development of quality measures, waiver support, and cost analyses.
- Develops and manages various readiness assessment and oversight tools for Medicaid managed care oversight
- Provides strategic consultation in program design assisting states in exploration of new model options including Medicaid ACO, provider-sponsored health plans, health homes, etc.
- Develops and deploys solutions to improve the use of Health Information Technology and data analytics assisting states in their goals for transparency and accountability through dashboards and other technology solutions

NAVIGANT

Tamyra Porter

Director

Professional Experience

Medicaid Managed Care

- Supported and directed various aspects of program design and implementation. Roles in this area have included concept paper development, internal stakeholder facilitation, development and drafting of waiver applications (1915 b and c, as well as 1115), updating and drafting state plans and developing and reviewing budget neutrality calculations. Tamyra has also assisted states in coordination and meeting with CMS to usher through the waiver approval process. Supported New Hampshire, Kentucky, Pennsylvania and Alabama in these aspects of program design implementation.

- Directed and supported the development of procurement and reprocurement tools, including state administrative code development, RFPs, proposal evaluation resources, and contracts. Provided support with an eye towards ongoing operations and oversight incorporating principles of value-based purchasing. Provided such support for Pennsylvania, Mississippi, Georgia and Alabama for full-risk managed care programs, provider-sponsored managed care programs, EPCCM programs, Enrollment Broker contracts, EQRO contracting, Pharmacy Benefits Managers, Specialty Pharmacy contracting, ADA compliance audits, and public outreach campaigns.

- Directed and supported the development of various readiness review tools for a variety of state Medicaid managed care programs including Indiana, Pennsylvania, Mississippi, Alabama, and Iowa. Has assisted in training state and contracted staff in the use of designed tools and providing ongoing support and dashboarding of readiness tools throughout the readiness process. Served as a subject matter expert with emphasis on systems readiness, network adequacy, reporting, long-term care, and special needs populations. As a subject matter expert, she participates and leads desk reviews and participates in site visits related to the readiness process. Worked with states to leverage the readiness efforts as a seamless transition to ongoing monitoring, including evaluation and assessment of national and local Medicaid health plans such as Centene, Amerigroup, United, AmeriHealth Mercy, Molina, and also provider-sponsored entities who have partnered with groups such as Blue Cross Blue Shield, Sentara, Viva, and others.

- Works with a variety of states to evaluate and support their monitoring and oversight of state programs. Worked on targeted efforts to evaluate provider network access and availability, ADA accessibility, care management evaluations, compliance with grievances and appeals, and maternity care programs. Worked with state clients in multi-year engagements and one-time GAP analyses to develop Monitoring Boot Camp trainings, provide automated tools to facilitate monitoring, provide oversight documentation, and develop reporting requirements and tools to read and aggregate vendor reporting for state dashboarding and oversight. Her approach to monitoring includes the use of existing resources and development of automated tools to more efficiently document and complete

oversight functions. Has directed the development of various tools that have been created to support state agencies in all aspects of program operations. Provides support through entire software development process including development of UAT, user guides, and training, whether directing the development for clients or working as the business analyst for the client and interfacing with state-staffed developers.

- Directed an engagement for Texas Health and Human Services Commission to support compliance with Corrective Action Orders specific to the Consent Decree in *Frew v. Hawkins* and mandate to provide adequate supply of healthcare providers. Conducting robust series of provider network adequacy tests which she has leveraged in assisting other states in the development of network adequacy requirements and related reporting and analytics to monitor ongoing compliance with access standards.

- Assisted states in the development or renewal of their state quality strategy. Worked with Pennsylvania, Mississippi, and Alabama in crafting the quality strategy as a foundational component of their overarching approach to value-based monitoring and oversight and as a means of aligning state program goals and objectives with the national quality strategy. Led efforts to engage stakeholders in identifying and adopting quality measures for their state programs and in turn assisting the state in the operational reporting, data collection and analyses of these measures.

Medicaid Performance Management

- Conducted various reviews of internal state oversight functions and provided technical assistance and recommendations for performance improvements in several states including Indiana, Pennsylvania, Texas, Alabama, Mississippi, Louisiana, and North Carolina. Provided clients with various technical, customized database solutions to better track and document monitoring activities, report on these functions and improve oversight. Recommended monitoring review steps, sources for obtaining required data and guides for measuring and evaluating performance. Developed detailed standard operating procedures to support the ongoing monitoring efforts and transitioned these tools to the assigned staff for ongoing use. Provided detailed training manuals and conducted classroom trainings to support staff in these efforts. The monitoring tool also connects compliance decisions to contractor performance reporting.

- Designed and directed the development of a state training institute to assist clients in program transitions from fee-for-service to managed care and to provide ongoing staff development resources. Directed the development of various e-learning solutions to be packaged and hosted on state platforms or hosted for our state clients.

NAVIGANT

Tamyra Porter

Director

Long Term Care

- Assisting states in their design and development of program reforms for their long-term care programs. Working with state clients to develop concept papers, stakeholder engagement efforts, waivers and state plan modifications. Coordinating efforts with legislative mandates and affiliated workgroups. Assistances also includes payment transformation and leveraging managed care designs to transition to alternative payment models. Recent efforts have focused on provider-led initiatives where provider groups would gradually assume risk for the long-term care population. Serves as a subject matter expert on LTSS issues on projects for Iowa readiness reviews, Kentucky program design, Kansas and others while directing program design projects for Alabama and New Hampshire.

- Assisted Pennsylvania's Bureau of Home and Community Based Services (HCBS) with ongoing analysis of its current Individual Service Planning and service plan approval process. Assisted the Commonwealth in evaluating process for automating the service planning and approval process. Conducted research and support for the evaluation of uniform needs assessment tools to aid in the development of individualized budgets for HCBS waiver services. Expanded this research to include a full spectrum of public welfare services including the critical services for dual eligibles and those who may qualify for long-term care and support.

- Researched and developed a bed-needs study for Ohio. Compared the number of nursing facilities available across the state to occupancy rates and unused beds for each area of the State. Compared findings with trends in nursing home usage in other states, as well as nationally, in context to recent Federal requirements related to rebalancing and nursing home transitions. Prepared summary reports and presented findings to Ohio's Office of Jobs and Family Services.

- Developed and conducted a training institute for HCBS waiver providers and service planners to fulfill training requirements for enrollment as a qualified provider with the Commonwealth of Pennsylvania.

- Provided initial support for an automated audit tool to assist state clients in their quality improvement and audit functions of HCBS providers.

Government Payment Transformation

- Assisted North Carolina with an evaluation of its Medicaid Disproportionate Share Hospital and supplemental payment programs. Revised the State's model that calculates Disproportionate Share Hospital or supplemental payments. Assisted with the payment calculations. Analyzed the validity of hospital-reported data used in calculating interim payments and in final cost settlement. Trained State staff in the use of the model.

NAVIGANT

Tamyra Porter

Director

- Assists states in moving monitoring programs to that of compliance to align with more robust development of value-based purchasing (VBP) concepts. Facilitates planning sessions related to program goals and outcomes, data analytics to support benchmark data as well as to guide ongoing performance evaluation. Instrumental in the development of Quality Strategies and tools to support the state's aims for value-based purchasing and program oversight. Provides assistance in the operational assessments to determine strength and capacity of internal resources to execute VBP goals. Assisted with these efforts in Mississippi, Pennsylvania, and Alabama while providing some project consultation in Illinois.

- Assisted Alabama with various aspects of its quality withhold program and related exercise in developing quality measures with the states Quality Assurance Committee, coordination with the Medicaid Quality Strategy, and coordination with the RCO's Provider Standards Committee.

Medicaid Reform

- Serves as a liaison between state staff and CMS in the development of state waiver programs (1115), corrective action plans or other program design considerations. Assists senior state health and human services officials a state to identify and develop major reform initiatives including reforms to Medicaid, social services, reforms required under the ACA and other public welfare benefits. Develops options, white papers, presentations, talking points, and meeting and training materials to facilitate the decision-making process. Assisted states including Pennsylvania and Alabama through various wavier development exercises and discussions with CMS.

Health Information Technology

- Assisted the States of Pennsylvania, Kansas, Maryland, and the District of Columbia in the design and planning for the Medicaid HIT provider incentive payment program. Assisted in the development of various planning sessions and the drafting of the SMHP for CMS review and approval. For the District of Columbia, assisted in the drafting of a statement of work the District would use to procure support for the ongoing operations of its incentive program.

- Directed engagements related to encounter data requirements and validation. Projects have included development of contract requirements, evaluation of readiness, assistance with encounter data production testing. Developed various encounter data studies to look at timeliness and completeness and determine opportunities for efficiencies and other studies comparing HEDIS scores for administrative measures comparing results from encounter data calculations to audited HEDIS reports.

- Developed MCO contract requirements related to promoting use of HIT by providers requiring adoption and use for inclusion in provider networks for certain high-volume provider types.

NAVIGANT

Tamyra Porter

Director

- Assisted states in considering data warehousing requirements for potential procurements to support better use of data gathering, storage and reporting.

Healthcare Compliance

- Assisted on various healthcare litigation projects related to billing disputes. Evaluated all aspects of claims life cycle to determine billing errors and to quantify related damages. Evaluated claims for inpatient, outpatient, pharmacy and durable medical equipment (DME).

Work History

Director, Navigant	2016 – Present
Associate Director, Navigant	2006 – 2016
Manager, Navigant	2004 – 2006
Manager, Tucker Alan Inc.	1999 – 2004
Web Developer, University of North Carolina Hospitals Assistant to the Chair of Obstetrics and Gynecology	1998 – 1999

Education

Bachelor of Science in Public Health, Health Policy and Administration with Highest Honors	University of North Carolina at Chapel Hill, School of Public Health

Selected Recent Presentations and Publications

- "Innovative Approaches to Measuring Outcomes for HCBS Participants" NASUAD (2016)
- "Moving the Outcomes Needle – Integrating the Dually Eligible" NASUAD (2016)
- "Improving Your Purchasing Power – Procurement Opportunities" HSFO (2016)
- "Monitoring the Shift to Managed Care. Why is Monitoring Important?" World Congress Medicaid Managed Care Summit Presentation (2012)
- Readiness Review Trainings – Commonwealth of Pennsylvania Bureau of Managed Care Operations (Spring 2012)
- Monitoring Boot Camp - Commonwealth of Pennsylvania Bureau of Managed Care Operations (Fall 2012).

NAVIGANT

Andrea Pederson

Director

andrea.pederson@navigant.com
Seattle, Washington
Direct: 206.292.2569

% Time / Month
TBD based on project needs.

Professional Summary

Andrea is a Director with Navigant and has more than 16 years of experience in the healthcare industry. Her range of knowledge includes policy analysis, program assessment, and data analysis supporting Medicaid, Medicare, and commercial health insurers, with a focus on home- and community-based programs for developmental disabilities, behavioral health, and long-term care. She has worked extensively in the development, implementation, and impact analysis of rate setting methodologies.

Areas of Expertise

- Supports the Centers for Medicare and Medicaid Services (CMS) and state clients with development and review of 1915(c) home- and community-based waiver applications and program development, with a focus on service reimbursement rate development.
- Has extensive experience assisting clients with long term services and supports issues, including behavioral health.
- Directs projects focused on analysis of eligibility, healthcare cost and paid claims data to provide program evaluation, policy development, reimbursement development, trend analysis, financial impact analysis, and fiscal projections.
- Supports state clients with Medicaid program design and development, including State Plan Amendments and state rule development.
- Has extensive project management and leadership experience having directed multi-million dollar engagements.

Professional Experience

Federal Initiatives

- Assisting the Centers for Medicare and Medicaid Services (CMS) with the review of 1915(c) home- and community-based services Medicaid waiver applications, renewals and amendments. Directed the development of detailed review tools to assess the completeness and reasonableness of state waiver documents submitted to CMS. Reviewing state waiver documents and providing assessment to CMS for follow-up with states. Developing training materials relevant to HCBS program development that CMS will use to educate states. Present trainings during national CMS webinars.

NAVIGANT

Andrea Pederson

Director

Medicaid Reform

- Assisting the State of Wyoming in conducting an independent evaluation of its Section 1115 Family Planning Waiver. Preparing analyses and reports to assess the success of the Waiver. Assisted the North Carolina Division of Medical Assistance in conducting a five-year independent evaluation of the "Be Smart" Family Planning Waiver program, operating under a Section 1115 waiver. After the initial five years, North Carolina converted the waiver to state plan services.
- Assisted in developing a Rural Health Care Model for the Wyoming Health Care Commission. Developed recommendations and implementation strategies for Wyoming to enact as its rural healthcare model.

Government Payment Transformation

- Directs the multi-year contract with the State of Wyoming to perform on-going maintenance and analysis of the State's Medicaid reimbursement programs. Annually prepares work plans and budgets to outline the planned tasks for the contract year. Responsible for the day-to-day correspondence with Wyoming State staff and the timely response to all requests.
  - Performs reimbursement analysis that includes: inpatient prospective payment system, outpatient prospective payment system, disproportionate share hospital payments, upper payment limits, and intergovernmental transfer payments.
  - Organizes and facilitates provider stakeholder meetings.
  - Leads research and analysis of policy issues that includes: reimbursement methodologies, healthcare acquired conditions (HCACs), ICD-10, and State Plan Amendments.
- Directs the multi-year engagement with the State of California to analyze Medicaid school-based services provided by local educational agencies to special education children. Supporting California in the transition to a Random Moment Time Study (RMTS) as a component of the State's reimbursement methodology for school-based services. Participating in a technical assistance group with several key stakeholders on the design, evaluation, and eventual implementation of RMTS for California's school-based services program.
- Assisting the State of Wyoming with several supplemental payment programs for acute care hospitals. Currently, assisting with CMS approval for a provider tax for in-state, private hospitals. Revised Wyoming's disproportionate share hospital payment calculation. Drafted State plan language to describe the new methodology, which was approved by the CMS for fiscal year 2009. Developed an intergovernmental transfer based supplemental payment program that was approved by CMS and continue to assist with payment calculations on an annual basis.
- Assisting the State of Wyoming with its annual upper payment limit calculations for inpatient and outpatient hospital, physician, clinics, ICF/DD, PRTFs, and IMDs. Collecting cost reports and claims data and developing models to test the upper payment limit for each service type.

NAVIGANT

Andrea Pederson

Director

- Assisted a state Medicaid agency with a pilot project to assess the feasibility of implementing bundled payments for pneumonia, chronic-obstructive pulmonary disease (COPD), maternity and newborn services. Due to shifting priorities, state postponed further analysis.
- Assisted the State of Wyoming with an evaluation of its Medicaid reimbursement methodologies for the transition to ICD-10. Determined mapping of ICD-9 diagnosis and procedure codes to ICD-10 equivalent. Estimated impact of transition on impacted reimbursement methodologies.
- Assisted a large state hospital association with an analysis of hospital costs and reimbursement to support discussions as the state implements a new inpatient hospital APR-DRG payment system. Analyzed hospital cost reports, allowable costs and cost-to-charge ratios, as well as detailed claims data. Developed an analysis of the impact of the new payment system on the state's children's hospitals to support the children's hospital association's reimbursement discussions with the state Medicaid agency.
- Conducted assessments of payment methodologies for the State of Wyoming Medicaid's inpatient hospital payment system to determine whether the State should consider a transition to a payment system based on Diagnosis-Related Groups (DRGs); the State chose to continue to use a level-of-care per discharge reimbursement approach. Also, assess Wyoming's Outpatient Prospective Payment System on an annual basis using a report card to summarize the payment system's performance against nine performance measures.
- Assisted the State of Wyoming to develop payment methodologies for: outpatient hospital through a Medicare-like outpatient prospective payment methodology, inpatient rehabilitation, physician services through a Resource-Based Relative Value Scale (RBRVS), Rural Health Clinics, and Federally Qualified Health Centers. Analyzed claims data and cost report data, developed preliminary rates, and budget impact estimates. Navigant assists the State to review the outpatient, physician, Rural Health Clinic, and Federally Qualified Health Center rates each year.

Medicaid Performance Management

- Conducted an in-depth study of Wyoming's Medicaid program to assess the appropriate use of the emergency room (ER). Developed an approach to analyze ER utilization, and the services obtained there by Medicaid recipients. Analyzed ER conditions with high utilization, recipients who were high ER utilizers and key "drivers" of high utilization. Provided recommendations to conduct frequent monitoring of recipients with disproportionally high ER utilization (four or more times in a 12-month period), specifically to provide targeted education and offer a medical home provision. As implementing these recommendations, the State has realized reductions in ER utilization and the per member per month cost of ER visits and is implementing a medical home model.
- Assisted in the review of the California Department of Corrections' healthcare policies and procedures. Compared policies and procedures with national standards for accreditation to assess whether these policies and procedures conformed to the standards. Assisted the Department in drafting policies and procedures to meet standards.

NAVIGANT

Andrea Pederson

Director

- Assisted a hospital with comprehensive billing reviews of inpatient, outpatient, and physician services. Collected claims data; selected sample for review; coordinated resources between the hospital and coding reviewers; wrote final reports that summarized findings and recommendations for each review, and discussed results with the client. Reviews led to multi-day trainings of hospital staff by Navigant consultants.
- Assisted a New York agency to evaluate its methodology in reimbursing staff for required residential costs. Researched Federal and State regulations, reviewed agency's practices and posed questions to the New York Office of Mental Retardation and Developmental Disabilities. Provided the client with an opinion about current practices for claiming staff residential costs as part of Medicaid claiming.
- Assisted multiple hospital systems in comprehensive billing reviews of selected inpatient and outpatient services. Reviewed payment methodologies, used SAS programming to analyze claims data and create summaries of patient claims and estimated potential overpayments. Provided the analysis results in reports to clients.
- Assisted the State of Florida in a claims accuracy review. Assisted with the collection of recipient data through development of recipient surveys and coordinated the mailing of surveys. Developed a database to track survey responses and analyze data.

Litigation Services

- Provided litigation support for several managed care litigation matters. Reviewed claims detail records, claims payment, capitation payments, Federal regulations, and contract documentation to inform expert report. Conducted claims data analysis. Prepared report and supporting exhibits as findings summary. Submitted expert report to client.
- Provided litigation support to a state regarding access to services for Medicaid recipients. Analyzed more than one million claims detail records using SAS programming. Developed summary reports for use by Counsel.
- Provided litigation support to an insurer regarding patentability of a healthcare system. Reviewed patent's claims, researched major claims processing and healthcare practice management information systems operated by public and private payers and summarized research for use by Counsel.

Behavioral Health

- Directing a behavioral health rate study for the Wyoming Department of Health to examine costs and payments for mental health and substance abuse services provided through community mental health centers, substance abuse treatment centers and independent behavioral health providers. Providing recommendations for improvements to billing practices, rate development and stakeholder outreach. The State is in the process of reviewing recommendations.

NAVIGANT

Andrea Pederson

Director

- Continue to assist the Wyoming Department of Health with the collection and analysis of cost report data and development of reimbursement rates for psychiatric residential treatment facilities that participate in the Medicaid program and residential treatment centers and group homes that participate with the Departments of Family Services and Education. Conducted seven years of cost report collections and developed recommendations for provider peer group rates. Continue to update project website to communicate project status and to facilitate the distribution of cost report collection materials. Develop cost-based rate recommendations for the biennium budget.
- Directed our contract with the State of Hawaii for its State Innovation Model (SIM) design grant. Collaborated with the Governor's Office, with involvement from the Medicaid agency and community stakeholders, to develop a statewide strategy for the integration of behavioral health within primary care. Coordinated teams, including four subcontractors, to provide subject matter expertise in behavioral health integration delivery and payment models, technical assistance and research, stakeholder engagement assistance, a SIM evaluation plan, and the final SIM report—the State Health Innovation Plan. Assisted the State with development of a Behavioral Health Integration Blueprint, which will be used to describe and promote the adoption of three evidence-based behavioral health practices by primary care providers.
- Provided the Texas Health and Human Services Commission (HHSC) and Department of State Health Services (DSHS) with technical assistance relative to the development of uniform statewide payment rates for substance abuse services for adults and children. Directed the development, distribution, and collection of a provider survey to gather data about the costs to provide substance abuse services in Texas. Reviewed the results of the analysis and used the data and information as a basis for developing model assumptions and cost-based rates for residential and outpatient services, including opioid treatment services. Worked closely with DSHS staff to develop an approach to rate setting that accomplished its objectives.
- Assisted the State of Wyoming in establishing a cost report and rate development process for psychiatric residential treatment facilities participating in the Medicaid program and residential treatment centers and group homes participating with the Wyoming Department of Family Services and the Wyoming Department of Education. Conducted five phases of cost report collections and developed recommendations for provider rates. Prepared data for rate analysis and recommendations to inform Department budgeting. Assisted the Departments with gathering provider feedback and reported provider comments in a final report for the Wyoming Legislature. Facilitated a technical advisory group that included participants from the State and healthcare providers to discuss cost reporting. Based on provider comments, developed allowable cost rules, and uniform cost accounting guidelines to improve provider reporting of costs. The providers used these new rules and guidelines to complete the most recent collection of costs and uniformly agreed that the rules and guidelines were helpful.
- Assisted the California Department of Mental Health with identifying options to reduce state costs for mental health services while maintaining or enhancing the current quality of those services. Evaluated the risks and rewards of applying for, implementing, and maintaining a home- and community-based

services (HCBS) waiver for mental health services for children. Researched other states' HCBS waivers and alternative approaches to using an HCBS waiver. Prepared a white paper for the Department to use to brief the legislature about the project. Formed a stakeholder work group to discuss the community mental health needs of children. Interviewed states currently operating HCBS waivers for children to identify best practices for California to consider. Developed final recommendations for options to reduce costs for mental health services for children.

- Assisted the State of Illinois, Departments of Public Aid and Human Services, Division of Mental Health with analysis of mental health programs and crisis screening for children and adults. Developed a cost analysis model to analyze agency mental health and Screening Assessment and Support Services programs and to compare Illinois to other states. Produced an independent report of the cost analyses for mental health and Screening Assessment and Support Services programs for the Illinois legislature and Governor's office. Worked with a technical advisory group consisting of representatives from sample agencies, provider associations, and State departments to gather advice throughout the cost analysis process. Developed updated financial report instructions and modified the State's current financial data collection tool to accommodate provider feedback and collect additional service unit detail.
- Assisted the Ohio Department of Alcohol and Drug Abuse Services in development of a fee schedule for alcohol and substance abuse services. Analyzed cost report and shadow claims data, produced potential rates for the fee schedule, and produced a model for evaluation of fee schedule options.

Developmental Disabilities

- Managed rate development for home- and community-based waivers in Nebraska, Arizona, Wyoming and Illinois. These projects require expertise and advisement on rate setting methodology for 1915 (c) waivers to develop rates that would be accepted by CMS. Project work involves:
    - Lead rate development for redesign of home- and community-based waivers.
    - Review of proposed service definitions based on unbundling of current services or creation of new services
    - Design, distribute and review cost and wage survey of providers; conduct provider trainings for cost and wage surveys.
    - Research and identify other publicly available sources of cost and wage data.
    - Facilitate in-person and webinar discussions and meetings with state decision-makers, technical advisory groups, focus groups, providers and various stakeholders.
    - Develop rate model and fiscal impact analyses.
    - Review waiver application submissions and correspondence from CMS, and assist with responses to CMS requests for additional information.

NAVIGANT

Andrea Pederson

Director

- Assisted the State of Colorado, Office of Community Living, with the development of a conflict-free case management implementation plan for submission to the Colorado Legislature, Joint Budget Committee in response to House Bill 15-1318. Examined the impact of conflict-free case management on its Community Care Boards related to the State's developmental disabilities waivers. Developed a financial survey and detailed documentation request to gather information from the Community Care Boards about their operations and costs. Oversaw the review of submitted data and documentation and conducted on-site visits to five Community Care Boards. Presented a proposed CFCM implementation plan at five community stakeholder meetings (four in-person meetings and one webinar) to collect input on the options for implementation and potential impact of each option and summarized the comments in a report.
- Assisted the North Dakota Department of Human Services, Division of Developmental Disabilities, with the final phase of implementing the new cost-based rate methodology for select developmental disabilities services. Directed the development of detailed service descriptions and recommendations for the necessary changes to North Dakota's Administrative Code to reflect the new rate methodology and services. Developed recommendations for changes to the provider contract to comply with changes to the Administrative Code. Directed the development of a detailed Provider Manual and updated Medicaid waiver documentation and State Plan documents for the new rate system implementation.
- Assisted the Washington Department of Social and Health Services to perform an independent review and analysis of the Developmental Disability Administration's Supported Living Program; specifically, this work included a critique of their reimbursement methodology and a report that included suggestions for improvement. Led a review of data, reports, and documentation regarding the Supported Living Program's function and reimbursement methodology. Interviewed State staff and mapped key processes to better understand the existing infrastructure. Conducted interviews and research of other state's programs similar to Washington's Supported Living Program. Drafted a report assessing the Supported Living Program, drawing comparisons to similar programs in other states and provided recommendations to the State.
- Assisted the Illinois Department of Human Services Division of Developmental Disabilities to comply with a legislative mandate to develop a work group and final report on the scope of nursing services for the Division's community integrated living arrangement program. Assisted the Division with facilitating work group meetings; collected data regarding providers' use of nurses at community integrated living arrangement using a survey; researched nursing wage rates in Illinois and nationally and interviewed providers about the services that nurses provide. Developed the final report with recommendations regarding nursing ratios and wage rates that the work group presented to the Department of Human Services and the Illinois legislature and Governor's office. The work group leaders, consisting of providers and advocates, used the report to lobby the legislature for the additional funding to raise nurses wages at community integrated living arrangement settings.

NAVIGANT

Andrea Pederson

Director

- Assisted the Illinois Department of Human Services Division of Developmental Disabilities to develop its strategic plan for state fiscal years 2007 through 2011 and the related work plan for state fiscal year 2007. Attended meetings to discuss the goals and outcomes the Division wanted to achieve with the strategic plan and work plan. Assisted the Division with designing and finalizing the format of the plans that are now posted on the Division's website. The Division used the strategic plan and work plan to develop tasks that respond to strategic plan goals.

Long-term Care

- Assisted the Wyoming Department of Health with a cost and rate study for its long-term care and assisted living facility 1915(c) waiver services. Directing the collection of cost and wage information from service providers through a customized survey tool. Evaluated available data for the development of transparent models to be used for rate determination, including Bureau of Labor Statistics wage data. Facilitated provider technical advisory groups to discuss cost and wage data, model assumptions and rate setting issues. Developed independent rate models for both waivers and assisted with waiver application submission and request for additional information from CMS. Both waivers were approved by CMS.
- Assisted the Illinois Bureau of Long-Term Care in the determination of which nursing facility residents have a mental illness, and of those residents, which have medical diagnoses or conditions requiring long-term nursing home care. Analyzed two sets of information submitted by nursing homes: resident-level Minimum Data Set assessment data and facility-level On-line Survey Certification and Reporting data. Summarized results of analysis on a facility basis, provided profiles of selected residents, and created a facility roster and sample lists of residents for use by the Bureau of Long-Term Care. Transitioned SAS programming to the State for use in conducting the same analyses in the future.

Health Insurance Studies

- Assisted the State of Wyoming in evaluating Wyoming's current Health Insurance Premium Payment program. Developed a concept paper that compared Wyoming's program to other states' programs, identified areas for improving enrollment, and recommended short-term and long-term goals for Wyoming. The State will use the concept paper to consider their options for short-term improvements to the program and will evaluate how best to move forward.

Other Relevant Experience

- Use SAS programming to manipulate and analyze large datasets. Familiar with Oracle databases. Performed statistical analyses and produced reports for numerous projects.

NAVIGANT

Andrea Pederson

Director

Work History

Director, Navigant	2004 – Present
Manager, Tucker Alan Inc.	2000 – 2004
Senior Analyst, Information Resources	1998 – 2000

Education

Bachelor of Science	University of Wisconsin, Madison

Selected Recent Presentations and Publications

- "Monitoring Fraud, Waste & Abuse in HCBS Personal Care Services" Division of Long Term Services and Supports, Disabled and Elderly Health Programs Group – Centers for Medicare and Medicaid Services (February 2016)
- "Rate Methodology in a FFS HCBS Structure" Division of Long Term Services and Supports, Disabled and Elderly Health Programs Group – Centers for Medicare and Medicaid Services (March 2016)
- "Fee Schedule HCBS Rate Setting: Developing a Rate for Direct Service Workers" Division of Long Term Services and Supports, Disabled and Elderly Health Programs Group – Centers for Medicare and Medicaid Services (July 2016)
- "Ensuring Rate Sufficiency: Rate Review and Revision Approaches" Division of Long Term Services and Supports, Disabled and Elderly Health Programs Group – Centers for Medicare and Medicaid Services (November 2016)
- Navigant Healthcare Policy Briefing: *Physical and Behavioral Health Integration – Considerations for Health Care Payers and Policy Makers, Part 1: Making the Case for Behavioral Health Integration* (December 2016)

NAVIGANT

Maria Montanaro, MSW

Director

maria.montanaro@navigant.com
Direct: 312.583.5820
Mobile: 401.258.8746

% Time / Month
TBD based on project needs.

Professional Summary

Maria Montanaro is a Director within Navigant's Healthcare Practice. She has extensive executive experience in the health sector. Prior to joining Navigant, she served as the Director of the Department of Behavioral Health, Developmental Disabilities and Hospitals, where she oversaw Rhode Island's system of care for people living with a serious mental illness, developmental disabilities and drug addiction. She has planned budgets, developed policies, implemented programs and led Medicaid reform initiatives in collaboration with state and industry leaders, insurers, providers, consumers and advocates. She led Rhode Island's statewide response to its opioid overdose epidemic.

During her career, Maria has provided executive management for primary care delivery systems and Medicaid managed care plans. As the Chief Executive Officer of Magellan Healthcare of Iowa, she managed behavioral healthcare for Iowa's Medicaid population. As its CEO, Maria led Thundermist Health Center to nationally recognized excellence in providing advanced, comprehensive primary care to over 35,000 Rhode Islanders. She was instrumental in the establishment of Neighborhood Health Plan of Rhode Island, an award-winning Medicaid HMO. Maria's has been at the forefront of innovation in healthcare delivery system transformation, including the early pioneering of chronic disease management, patient centered medical homes, EHR adoption, facilities redesign, payment reform, outcome measurement, ACOs, Medicaid redesign and integrated models of behavioral health/primary care. Throughout her career, she has been invited to testify before Congressional committees and serve on workgroups at CMS, HRSA and SAMSHA, particularly in the areas of PCP transformation, payment reform, integrated behavioral health care and the opioid overdose epidemic.

Maria's most recent past professional affiliations include: The Rhode Island Governor's Task Force on Opioid Overdose (Co Chair), Neighborhood Health Plan of Rhode Island (Board President), Rhode Island Public Expenditures Council (Trustee), The Rhode Island State Improvement in Medicare and Medicaid (SIM) Steering Committee, and the Advisory Board of the AAFP-Robert Graham Center for Policy Studies in Family Medicine.

Areas of Expertise

- **Executive Leadership/Organizational Development:** Guides boards and senior leadership in strategic planning, growth management, organizational turn around, mergers and acquisitions. Specializes in HRSA funded Community Health Centers, and SAMSHA funded Community Mental Health Centers, including expertise with Federal program regulations and performance expectations. Guides entrepreneurial (or distressed) organizations with turn around plans, federal relationships, mergers, acquisitions

NAVIGANT

Maria Montanaro, MSW

Director

- **Medicaid Reform Policy/Program Development:** Provides expertise in the development of Medicaid waivers, payment reform initiatives, innovation program development and implementation.

- **Payment Reform/ACO Development:** Guides state officials, insurers and provides in the formation of ACO payment systems, including use of benchmark outcome measures, client attribution methodologies, provider engagement strategies, incentive payments, contract negotiations and collaborative partnerships. Specializes in Medicaid and Medicare ACOs, Long Term Care payment reform, vertically integrated ACOs and integrated primary care based ACOs.

- **HMO/Medicaid Managed Care Executive Leadership:** Provides expertise to HMOs, insurers and Medicaid agencies in need to executive leadership guidance, strategy development, partnership development, provider relation strategies and strategies for new market/product development. Specializes in assisting plans with strategy for entering Medicaid Managed Care markets or serving new Medicaid managed care populations, such as long-term care and special needs populations.

- **Ambulatory Care Management/Facility Design:** Provides expertise in ambulatory care practice staffing structure, flow and facility design to support productivity and clinical practice transformation.

- **Primary Care Practice Transformation and Integrated Care:** Assists Provider groups with the planning, design and implementation of practice transformation initiatives in primary care, specifically patient centered medical homes, integrated behavioral health and medical care programs, programs aimed at addressing social determinants of health and programs aimed at training providers to more effectively manage chronic pain in the primary care setting. Assists practices in evaluating readiness, selecting or designing curricula for practice transformation, establishing the tools for transformation (such as IT tools, practice coaches, care coordination staff), establishing the measures for progress through transformation and the effectiveness of the transformed system. Assists practices in hard wiring transformational change into the structure of the organization. Assists practices in creating sustainable funding for transformation through pay for performance incentives and bundled or risk based payment structures.

- **FQHC Executive Management**: Guides Boards and Executive staff of growing or distressed community health centers. Leads evaluation, planning and growth or turn around strategies including merger, acquisition, federal regulatory programmatic compliance, grant writing, organizational/operational improvement, executive recruiting and temporary executive leadership.

Relevant Experience

- Decades of experience providing executive leadership to large community based, integrated primary care practices and health plans successfully managing triple digit growth, organizational innovation, program and site expansion, mergers and acquisitions.

NAVIGANT

Maria Montanaro, MSW

Director

- Designed and implemented patient-centered integrated health home programs for adults living with serious mental illness in two state Medicaid programs, covering thousands of lives and producing meaningful costs savings over a three-year period.
- Worked on Medicaid cost savings and redesign at the State level in two states, including population based approaches as part of the State's SIM and DSRP projects.
- Worked on the development of numerous Medicaid waivers for special populations including dual eligible populations, DD and LTSS services and MH and addiction services.
- Led negotiations on P4P initiatives for several large practices. Developed ACO shared savings programs for advanced PCMH large group practices.
- Developed ACO payment initiatives for public sector and commercial health plans.
- Development of risk stratified, data driven strategies to managed care for the most vulnerable and seriously ill populations
- Participated in the founding and development of two Medicaid managed care insure companies, and participated in the strategic growth and development of the plans and their entry into emerging markets.
- Led award winning out-patient ambulatory care facility design for several community health centers.

Work History

Director, Navigant	2017– Present
Director, Rhode Island Department of Behavioral Health, Disabilities and Hospitals	2015 – 2017
CEO, Magellan Behavioral Care of Iowa	2012 – 2015
CEO, Thundermist Health Center, Rhode Island	1997 – 2011

Certifications, Memberships and Awards

Harvard Business School – Strategic Perspectives in Non-Profit Management, SE NE Alumni Fellowship

Rhode Island Foundation Non-Profit Leadership Fellowship

Rhode Island Business News – Woman of Achievement Award

YWCA's Rhode Island Businesswoman of the Year Award

Education

M.S.W./Health Policy, Planning and Administration	University of Illinois, Champaign-Urbana
B.S. Education / Physical Education/Health	University of Massachusetts, Amherst

NAVIGANT

Wm. David Mosley, MBA

Managing Director

david.mosley@navigant.com
Suwanee, Georgia
Direct: 919.818.9088

% Time / Month
TBD based on project needs.

Professional Summary

Dave is a Managing Director with Navigant Healthcare. Prior to joining Navigant, he served as a partner with a national CPA firm for nine years, where he focused exclusively on the success of government healthcare leaders. He has served two governors; been employed as a city manager; directed the financial operations, claims processing systems, rate setting, and audit functions of a state's $14 billion Medicaid program; and addressed complex budget and financing issues for states across the Nation.

Dave leads the State Practice within the Government Value Transformation business unit. His focus is in government healthcare and he maintains exceptional relationships with elected officials, regulators, and industry leaders across the Nation. He provides clients with valuable insight, policy guidance, financial modeling, revenue strategy, and technical assistance while empowering them to realize success in areas such as organizational development, revenue enhancement, finance / budgets, Federal claiming / reporting, institutional reimbursement, rate setting, and audits.

Areas of Expertise

- Proficient across the breadth and depth of regulatory healthcare as it relates to government agencies, private payers, providers, and beneficiaries.
- Managed care procurement, contracting, and oversight for Medicaid programs.
- Negotiating with federal agencies to expand funding, abate penalties, introduce legislation, and favorably interpret guiding regulations.
- Evaluating complex regulatory, IT systems, and budgetary and financial matters to provide leaders with concise insight and guidance.

Professional Experience

Medicaid Managed Care

- Consulted with state clients including Kansas, Iowa, Texas, Nevada, Mississippi, Tennessee, South Carolina, Massachusetts, Alabama, and Louisiana on managed care programs to address revenues associated with sister-agency claiming, compliance / performance assessment, state organizational effectiveness, supplemental payments to facility-based providers, and county / parish health departments.

NAVIGANT

Wm. David Mosley, MBA

Managing Director

- Implemented risk assessment and/or audit programs to address administrative and medical loss ratio data provided to states by Medicaid managed care organizations (MCO) in states including South Carolina and Nevada.
- Conducted an actuarial audit for the Minnesota Department of Human Services.
- With the Governor's Office, addressed Legislative reporting requirements for new, statewide, MCO program through direct meetings with elected leaders, written correspondence, and discussions with Medicaid leaders.
- Provide guidance and counsel state leaders addressing Medicaid managed care transition in states including Nebraska, Mississippi, New Mexico, Georgia, Minnesota, Nevada, Arkansas, and Florida.
- Assessed and provided guidance on reorganization of state staff, new protocols, revised processes, and communication strategies in states including, but not limited to South Carolina, Mississippi, Nevada, and Kansas.

Government Payment Transformation

- Served as CFO for $14 billion Medicaid program serving 1.3 million beneficiaries and 65,000 providers. Created first long-term financial forecasting model incorporating State revenues and Medicaid spending. Successfully addressed more than $1.2 billion in potential Federal deferrals attributable to regulatory compliance matters. Drafted new administrative code, provider tax policies, Federal reporting guidelines, and inter-agency agreements. Created budget and financial documents for legislature, governor, and regulators.
- Consulted on the design, development, implementation and/or audit of Medicaid funding initiatives including intergovernmental transfers (IGT), certificates of public expenditure (CPE) and provider tax / assessments for Alabama, Mississippi, Nevada, Texas, South Carolina, Kansas, Tennessee, Colorado, and Louisiana.
- Served as a subject matter expert on the state plan design, implementation, impact, and/or operational compliance of Disproportionate Share Hospital (DSH) and Upper Payment Limit (UPL) hospital payment in Texas, Massachusetts, North Carolina, South Carolina, Colorado, New Hampshire, Alabama, Arkansas, Oklahoma, and Tennessee.
- Evaluated State per member per month (PMPM) payments to primary care physicians (PCP), regional networks, and centralized operations for Community Care of North Carolina.
- Designed changes and implemented new Federal funds budgeting, claiming, and reconciliation processes for the States of Alabama and Arkansas. Efforts included the resolution of certification issues associated with prior CMS-64 Reports, supporting documentation, operational procedures, and sister agency claiming.

NAVIGANT

Wm. David Mosley, MBA

Managing Director

Medicaid Performance Management

- Worked for the University of Massachusetts to facilitate the integration of the Commonwealth's accounting system into the required, quarterly Federal reporting for Medicaid (CMS-37 and CMS-64). During the reconciliation of the CMS-64 reports, discovered $60 million that CMS had erroneously double-charged the Commonwealth, and recovered those dollars. Also audited DSH payments to Medicaid hospitals through the University of Massachusetts.

- Led operational assessment and/or reengineering efforts to improve operational efficiency in several states including Nevada, Louisiana, Kansas, Arkansas, North Carolina, and Mississippi.

Health Information Technology

- Directing an engagement with the Kansas Department of Health and Environment to provide administration and oversight support for the Medicaid Electronic Health Record Incentive Program.

- Assisted Massachusetts to incorporate its accounting system into an electronic reporting / claiming system.

- Served as a subject matter expert on the audit of the design, development, and implementation (DDI) of MMIS system for North Carolina and Texas.

- Conducted assessments of MMIS operations for Indiana and Mississippi.

- Served as expert in support of litigation focusing on MMIS system procurements and DDI.

Other Relevant Experience

- Effectively engaged CMS professionals on behalf of, or in concert with, state clients to address OIG audit findings, CMS financial management reviews (FMR), state plan amendments (SPA), and new legislative / regulatory requirements.

- Successfully advocated for clients' positions with Federal regulators to abate more than $1 billion in proposed disallowances and/or recoupments.

- City Manager for a full-service municipality which provided water, sewer, airport, fire, police, public works, and other services for city, county, and San Carlos Reservation residents. Doubled the city's size through annexation efforts. Ended deficit spending pattern. Received extensions on Federal grants to expedite and complete backlogged projects. Initiated public / private ventures between the city, state, and private entities. Negotiated new benefits and compensation programs for all employees.

NAVIGANT

Wm. David Mosley, MBA

Managing Director

- Led statewide business and economic development efforts for a state. Evaluated business recruitment incentive programs. Developed university-based technology commercialization practices. Negotiated public / private contracts. Conducted economic impact assessments.

Work History

Managing Director, Navigant	2012 – Present
Partner, Clifton Larson Allen	2009 – 2012
Director of Finance, North Carolina Division of Medical Assistance	2006 – 2009
CEO, Nationally Accredited Science Museums	2003 – 2006
City Manager, City of Globe, Arizona	2001 – 2003

Certifications, Memberships, and Awards

American Economic Development Council, Elected Member

Red Cross Service Award

American Hospital Association

International City / County Managers Association

Association of Human Services Finance Officers

Education

Master of Business Administration, Organizational Development	Auburn University
Bachelor of Science, Finance	Auburn University
Certificate in Public Policy	Arizona State University
Certificate in Public Management	University of Arizona

Selected Recent Presentations and Publications

- Mosley, W., Portman, S. *Under Pressure: Reimbursement Challenges Affecting Pediatric Services.* Webinar presented by the American Health Lawyers Association (AHLA), March 2018.
- Cited Contributor: *MACPAC (Medicaid and CHIP Payment Access Commission) Report To Congress on Medicaid and CHIP, March 2016.*
- Mosley, W. David, “Medicaid managed care organizations face strict compliance requirements.” *Compliance Today*. August 2012.

NAVIGANT

Wm. David Mosley, MBA

Managing Director

- "Why Audit MCOs?" National Association for Medicaid Program Integrity (NAMPI) 2011 Conference; Denver, Colorado; August 15, 2011.
- Invited speaker for the National Association for Medicaid Program Integrity (NAMPI) to address key risk components, audit protocols, return on investment and institutionalization of performance / compliance monitoring attributable to Medicaid managed care procurement and ongoing operations.
- Invited speaker to Health Care Compliance Association (HCCA) regarding regulatory compliance, risk assessment and auditing of Medicaid MCOs.
- Invited speaker to Association of Human Services Finance Officers (HSFO) on the impact of ongoing changes in Congressional / CMS requirements associated with the DSH audit rule.
- Invited speaker on MMIS risk assessments and auditing for NAMPI and the Association of Human Services Finance Officers (HSFO).

NAVIGANT

Annie Hallum, FSA, MAAA

Associate Director

annie.hallum@navigant.com
Seattle Washington
Direct: 206.302.4060

% Time / Month
TBD based on project needs.

Professional Summary

Annie is an Associate Director with Navigant, a Fellow of the Society of Actuaries, and a Member of the American Academy of Actuaries. She has eight years of experience in healthcare and actuarial consulting. Her range of knowledge includes rate setting, plan design, payment analysis, and evaluating fiscal impacts for State Medicaid agencies, Medicare Advantage plans, and commercial health insurers.

Areas of Expertise

- Has consulted Medicaid agencies, private payors, and providers in a wide range of actuarial analyses including Medicaid capitation rate setting, commercial individual, small group, large group premium development, and employer self-funding projections
- Has extensive experience assisting state clients with Medicaid program design and pricing, including Managed Care rate setting, Upper Payment Limit (UPL) analysis, disease management program development, and evaluation of the impact of programmatic changes on fiscal budgets
- Has consulted state Medicaid agencies on fiscal impacts, cost effectiveness, and rate setting methodology of Managed Care programs
- Has extensive knowledge in programming (SAS and R), financial mathematics and economics, statistics, probability, and federal health and disability programs
- Has experience in using patient classification tools such as 3M's All Patient Refined-Diagnosis Related Groups (APR-DRG) grouper, commercial, Medicare, and Medicaid risk adjusters and episode groupers to assess and evaluate patient, provider, and payer risk

Professional Experience

Federal Initiatives

- Assisted CMS to develop training tools for states looking to create tiered provider payments rates home- and community-based services (HCBS) waiver services. Involved using statistical theory to propose sound rate setting methodology.

Medicaid Reform

- Assisting two state Medicaid agencies with independent reviews of their Medicaid Managed Care rate setting process and assumptions. Involves reviewing the rate development process, models, and

assumptions as requested by the State and making recommendations for program or rate setting improvements.

- Assisted the State of Washington and State of Nevada in creating Medicaid Managed Care rates for its TANF, SCHIP, ABD, and Medicaid Expansion populations. Analyzed detailed claims and enrollment data, utilization and unit cost trends, and payment rates for specific services (such as Applied Behavioral Analysis for children with developmental disabilities). Involved developing sound rate setting methodology to properly account for the underlying risk of each population and identifying best practices for ensure financial performance, efficiency, and overall program quality.

- Assisted the State of Nevada with the development and evaluation of two disease management programs for its Medicaid FFS population. Involved litigation support for a previous program which showed negative results and development and evaluation of a replacement program. Development included determining appropriate quality benchmarks, setting targets for quality, determining appropriate conditions for eligibility, and developing appropriate savings incentives for the disease management vendor.

Government Payment Transformation

- Assisting the State of Nebraska with the development and implementation of an outpatient EAPG payment model, transition from a cost-based payment system. Developing a prospective payment model using EAPGs to bend the cost curve relative to the current cost-based payment methodology.

- Assisted the State of Washington in a pilot program to integrate the Medicaid and Medicare Dual Eligible services under one capitation rate. Involved considering the feasibility, evaluating the potential fiscal effects, developing rate projections, advising the state on its implementation plan, and assisting in negotiations with CMS and insurers.

- Assisted a state Public Employee Benefits program with implementing bundled payments. Analyzed detailed claims data and provider quality data as measured by rates of complication in setting the episode rates.

Litigation Services

- Provided litigation support for a hospital involved in a lawsuit regarding a person with developmental disabilities. Estimating the cost of a life care plan for the person and analyzing the potential impact of Medicaid eligibility on the costs.

Behavioral Health

- Assisting the State of Wyoming in maintenance and evaluation of their 1915(b)/(c) waiver High Fidelity Wraparound program for children with behavioral healthcare needs. Evaluating rate

sufficiency and monitoring the contractor performance with regards to quality of service, provider supply, and other program quality metrics.

- Assisted the State of Nevada in the development of an 1115 waiver to provide expanded services to youth with high behavioral care needs. Analyzed claims data, evaluated the opportunity for fiscal savings, and completed the cost effectiveness documentation for the program.

- Assisted the State of Washington in developing a pilot program to integrate Behavioral Health and Medical costs under one contract. Included developing the rate setting methodology and setting an integrated premium rate, providing feedback on their implementation plan, and working with several state agencies and insurers to implement the program.

Health Insurance Studies

- Assisted a provider-owned health insurer looking to evaluate provider quality within its HMO network to develop an EPO network. Monitored costs and quality by provider and assessed patient risk attributed to each provider.

- Advised a provider-owned health insurer looking to enter Managed Medicaid on the potential profitability for their health insurance business as well as the reimbursement rates for the providers.

- Advised an organization of Skilled Nursing Facilities starting a new venture as a Medicare Advantage insurer. Evaluated market opportunities and potential penetration. Developed rates and advised on market growth strategies in later years.

- Assisted a Medicaid Managed Care Organization in bidding in a competitive procurement process. Developed rates, monitored experience as compared to initial projections, and evaluated risk scores.

Long-term Care

- Assisted the State of Washington and State of Wyoming in determining an Upper Payment Limit for their PACE population. Analyzed detailed claims data of comparable populations, risk scores, provider performance, and trends.

Actuarial Skills Experience

- Assisted a Professional Employer Organization with improving their health insurance program. Projected healthcare cost changes due to augments to benefit package combinations, anti-selection between insurers and plan offerings, and ACA mandated changes. Estimated potential cost impacts of implementing a Disease Management program and identified patient conditions to target for the program.

- Assisted a Professional Employers Organization with refining its unemployment insurance and workers' compensation insurance lines. Created an unemployment insurance algorithm and underwriting model

Annie Hallum, FSA, MAAA

Associate Director

using Monte Carlo simulation to maximize profit via client placement into different unemployment risk entities. Refined the workers' compensation underwriting model for enhanced risk selection.

- Assisted several health insurers and a Professional Employer Organization with estimating and monitoring reserves. Involved analysis of healthcare claims and premiums data to set Incurred but Not Reported Reserves and premium reserves and an analysis of workers' compensation claims data to develop claims reserves.

- Assisted a large health insurer in provider rate negotiations by comparing their fee schedules to other commercial data and to Medicare and Medicaid payment rates. Evaluated results to develop priorities for the negotiation team.

- Assisted a health plan and their opining actuary with preparing and reviewing Statements of Actuarial Opinion.

Work History

Associate Director, Navigant	2017 – Present
Consulting Actuary, Milliman, Inc.	2013 – 2015
Insurance and Underwriting Analyst, Proservice Hawaii	2012 – 2013
Associate Actuary, Milliman, Inc.	2009 – 2012

Certifications, Memberships, and Awards

Fellow of the Society of Actuaries

Member of the Academy of Actuaries

Education

Bachelor of Arts, Mathematics and Economics	University of Washington
Bachelor of Sciences, Statistics	University of Washington

NAVIGANT

Thomas Carlisle, CPA

Associate Director

thomas.carlisle@navigant.com
Suwanee, Georgia
Direct: 501.993.7700

% Time / Month
TBD based on project needs.

Professional Summary

As an Associate Director with Navigant, Thomas brings a diverse background to the Healthcare Consulting Practice. Thomas offers a unique perspective at a time of great change in healthcare having served as Chief Financial Officer (CFO) for Arkansas' Division of Medical Services, which administers the State's Medicaid program. Thomas was actively involved in Arkansas Medicaid's implementation of the Patient Protection and Affordable Care Act (ACA), including Arkansas' alternative Medicaid Expansion—Private Option. He was also on the leadership team for Arkansas that implemented the State's successful payment reform—Episodes of Care. Additionally, he has extensive executive leadership, corporate finance, acquisition, and publishing experience with a Fortune 500 company, business experience as owner of a national franchise, and public accounting experience at a Big Four accounting firm. Thomas is a Certified Public Accountant (CPA).

Areas of Expertise

- Hands on experience directing and implementing all financial aspects of the ACA at the state-level, including successful implementation of Medicaid Expansion under an 1115 Waiver.
- State-level experience leading financial implementation of payment reform using episodes of care model.
- Experience working with and reporting to Fortune 500-level Executive Committees, State Legislatures, Governor's Office, and Executive Teams.
- Experience in implementing Managed Care at the state level, including responsibility for all financial aspects of state's 1115 Waiver, negotiations with Centers for Medicare and Medicaid Services (CMS), and participation in state-level strategy.
- Extensive experience in managing large organizations as Chief Financial Officer and Chief Executive Officer including Fortune 500 divisions and state Medicaid programs.
- Experience in auditing healthcare providers and hospitals at a Big Four accounting firm, including Blue Cross Blue Shield and Medicare Cost Reports.

NAVIGANT

Thomas Carlisle

Associate Director

Professional Experience

Medicaid Managed Care

- Currently working with the State of Alabama to implement a new care delivery model that will improve beneficiary outcomes and address fragmentation in Alabama's Medicaid program. Program development utilizes designated state health program (DSHP) funding and delivery system reform incentive program (DSRIP) methodologies.

Other Relevant Experience

- Served as Chief Financial Officer at the Arkansas Department of Human Services – Division of Medical Services. Managed $6 billion+ Medicaid program, Arkansas' largest agency. Responsible for accounting and budgeting, human resources, reimbursement, and administrative units of division.

- Oversaw all Finance and Reimbursement function within State Medicaid Agency in Arkansas. Developed annual operating budget for executive and legislative approval, which included forecasting of existing and new programs based on historical, geographic, demographic, and other trends. Responsible for monthly budget analysis to identify variances within programs that could indicate under-utilization or access to care issues, as well as over-utilizations or consumption. Responsible for reporting Medicaid program finance results to Legislative Oversight Committees.

Work History

Associate Director, Navigant	2014 – Present
Chief Financial Officer, Arkansas Department of Human Services – Division of Medical Services	2010 – 2013
President and Owner, 360 Design Corporation	2001 – 2009
Time Inc. / Southern Progress Corporations / Leisure Arts	1984 – 2000
Vice President and General Manager, Leisure Arts, Inc.	
Director of Finance (CFO), Southern Progress Corporation	
Manager of Corporate Planning, Southern Progress Corporation	
Assistant Controller / Controller, Oxmoor House, Inc.	
Staff Auditor / Senior Auditor, Ernst & Young	1980 – 1983

NAVIGANT

Thomas Carlisle

Associate Director

Certifications, Memberships, and Awards

Alabama and Arkansas Society of CPAs

Finance Chairman and Board of Directors, Habitat for Humanity of Pulaski County

President and Board of Directors, Executive Networking Organization

President and Board of Directors, Downtown Civitan Club

Beta Alpha Psi, National Accounting Honors Fraternity

Eagle Scout and God & Country Awards, Boy Scouts of America

Education

Bachelor of Science – Business Administration in Accounting	Auburn University

NAVIGANT

Jason Duhon

Associate Director

jason.duhon@navigant.com
Suwanee, Georgia
Direct: 678.845.7635

% Time / Month
TBD based on project needs.

Professional Summary

Jason Duhon is an Associate Director within Navigant's Government Healthcare Solutions practice and has more than 17 years of experience leading initiatives to modernize healthcare information systems. Jason has significant experience developing applications for Medicaid Management Information System (MMIS), including claims adjudication, payment processing, and reference data maintenance. Jason has also assisted government payers with process audits, payment transformation, behavioral health transformation, and data analytics.

Areas of Expertise

- Facilitates enhancements to Medicaid Management Information Systems (MMIS) by evaluating system capabilities, developing requirements, configuring data, testing, and implementation activities. Served as liaison between policy and technical teams, translating policy decisions into technical requirements.
- Effectively addresses complex managed care encounter issues by analyzing voluminous encounter data to improve adjudication, reporting, and monitoring of encounter claims.
- Experience assisting states with many facets of behavioral health care program design and financing.

Professional Experience

Medicaid Managed Care

- Assisted the State of Alabama with transitioning their MMIS from a fee-for-service (FFS) delivery system to a managed care environment. Worked with State staff to develop a strategy for the design and implementation of a managed care model, building on the infrastructure of the existing MMIS. Collaborated closely with both the Alabama Medicaid Agency (AMA) and its fiscal agent to document the detailed requirements to the following subsystems: claims adjudication, claims payment, claims reporting, benefit plan, prior authorization, managed care, member, provider, reference, and federal reporting. Supported Joint Application Development, Detailed System Design, and data configuration sessions and developed detailed recommendations to support AMA's program and system design decisions for delivery system transformation.

NAVIGANT

Jason Duhon

Associate Director

- Performed managed care readiness reviews for Regional Care Organizations (RCOs) for the State of Alabama and Iowa.

- Led review of a state's managed care encounter adjudication practices. Recommended strategies for improving managed care encounter claim performance.

Behavioral Health

- Led joint review of policy with Alabama Department of Mental Health (ADMH) and AMA for transition to managed care. Documented existing and future business processes. Developed managed care contract language to help maintain access to care for behavioral health services, including indigent populations. Developed contract language for care coordination between Community Mental Health Centers (CMHCs) and managed care entities. Developed methodology for determining the state match owed by ADMH for Medicaid services. Evaluated strategies for care for members committed to psychiatric facilities while also in managed care. Analyzed and recommended methodology for billing for Substance Abuse and Mental Illness co-occurring members. Currently assisting ADMH with Quality Measure analysis, which will eventually be used for Pay-for-Performance (P4P) for their CMHCs. Working to develop billing requirements that would allow CMHCs to bill Medicaid for services rendered by allied mental health professionals that are not reimbursable under the rehab option. Performed data analysis on ADMH's available and vacant housing, and presented finding with ADHM to providers and other stakeholders. Assisting with housing needs assessment and evaluating supportive housing services.

Health Information Technology

- For the State of Alabama, conducted an analysis to determine the feasibility of procuring a Third Party Administrator (TPA) to process encounter claims for managed care providers. This analysis included estimating the state's cost for procuring a TPA versus implementing the encounter processing in their current MMIS alongside their FFS claims. Analyzed the potential federal matching percentage for both approaches to estimate the total financial impact to the State. Evaluated the impact of accountability, control, risks, and impact to state and federal reporting. The State used this analysis to determine the best strategy for encounter claims processing.

- For the State of Alabama, assisted with defining the technical requirements for the Enrollment Broker and for developing Request for Proposal (RFP) for vendor selection. Presented technical requirements to Enrollment Broker vendor prior to implementation.

- Served as Subject Matter Expert (SME) and Project Lead for more than 12 years on MMIS development and maintenance teams, supporting claims adjudication, payment, and managed care subsystems. Created design documents for 65 of the 80 adjudication related processes on Enterprise Healthcare project, a Medicaid Information Technology Architecture (MITA) aligned MMIS—including creating deliverables of high- and low-level design documents, including process flows, use cases,

business rules catalogs, user interface specifications, report specifications, and testing matrices. Created all design specifications for capitation and encounter processing for the Managed Care subsystem in the Health Enterprise MMIS. Also served as a maintenance team lead for over five years for the claims and certain managed care processes, such as capitation creation, capitation adjudication, and encounter processing.

- Assisted the State of New Hampshire with Benefit Plan, Reference, Managed Care and Claims Adjudication design and configuration. Created General System Design (GSD) and Detail System Design (DSD) documentation and claims adjudication to support implementation of new Health Enterprise claims processing application. Acted as lead data analyst of claims dataset to model migration to new pricing algorithms for a new MITA-aligned payer-side healthcare claims processing system. Designed dynamic auditing functionality—specifically created new dynamic, parameterized duplicate checking, and utilization review adjudication components—for adjudication subsystem.

- Assisted the State of North Dakota Division of Medicaid with the design of Claims Adjudication with editing, pricing, and auditing application design and configuration. Developed an analysis of system requirements to generate GSD and DSD documentation of claims adjudication application.

- Assisted the State of New Mexico Division of Medicaid with a number of design and implementation issues over several years. Routinely analyzed dataset of more than 10 million claims to determine historical impact. Designed, developed, implemented, and tested application changes and created summary reports.

Federal Initiatives

- Assisted the US Department of Veterans Affairs (VA) with assessing the Non-VA Care Program, which pays more than $5.5 billion for Veterans healthcare at non-VAMC facilities. Reviewed technology, processes, and procedures for Non-VA Care program nationally. Along with Grant Thornton, issued a report of finding and recommendations to congress for improving VA payment accuracy and timeliness to providers.

Litigation Services

- Led assessment for a state Attorney General's office of their vendor’s healthcare claims adjudication system for litigation matter. Reviewed the vendor contract and provided guidance on additional Service Level Agreements (SLAs), based upon national best practices. Team reviewed defect logs, IV&V reports, technical documentation, User Acceptance Testing (UAT) plan, and data produced by the system as part of the system assessment. Our team reviewed materials produced by the vendor to assess the likelihood of federal certification and evaluated the roadmap for implementing deferred items as part of the system review. We also provided guidance on the Corrective Action Plan submitted to the state by the vendor.

NAVIGANT

Jason Duhon

Associate Director

Government Payment Transformation

- Assisted the State of Florida Agency for Health Care Administration with transition from a per diem based inpatient claim payment system to an APR-DRG based prospective payment system. Performed pricing simulations using SAS programming language and performed comparisons of historical payment amounts to projected APR-DRG payment amounts.

- Assisted several Blue Cross and Blue Shield Plans evaluate avoidable cost, capitation rates, physician variation, and other analytics. Certain projects also partnered with large physician or hospital organizations in the Blues' service area. Performed simulations using SAS programming language and performed comparisons of claim datasets between the payer and provider claim datasets to identify cost savings and other opportunities.

- Performed Upper Payment Limit (UPL) analysis for Florida, Illinois, and Kentucky, analyzing the impact of Medicaid payment across several years of claims data. Analysis included extracting and summarizing multiple years of HCRIS data, projecting Medicare payments for Medicaid claims, and trending multiple years of claims forward to current year.

Work History

Associate Director, Navigant	2012 – 2017
Healthcare Claims Adjudication Subject Matter Expert, Xerox	2000 – 2012

Education

Bachelor of Business Administration in Management Information Systems	University of Georgia

NAVIGANT

Nancy Kim, MPH, PMP

Managing Consultant

nancy.kim@navigant.com
Los Angeles, CA
Direct: 213.670.3229

% Time / Month
TBD based on project needs.

Professional Summary

Nancy Kim is a Managing Consultant with Navigant. She has more than eight years of experience in the healthcare industry and focuses on managed care program design and implementation and the adoption and implementation of HIT. She works extensively with state Medicaid programs, assisting with managed care program design, research, and analysis of healthcare policy, strategic planning, and process and performance improvement. Nancy also has assisted with reviewing state's 1915(c) waiver applications for the Centers of Medicare and Medicaid Services (CMS) to identify issues related to rate-setting, compliance, quality measures, and fiscal integrity.

Areas of Expertise

- Directs projects focused on managed care program design, including conducting readiness reviews and monitoring process improvement
- Supports states with conducting procurement and contracting activities for contractors such as managed care organizations, enrollment brokers, and care management entities and for services such as medical management and utilization review, pharmacy benefit management, and specialty pharmacy
- Supports states with monitoring the implementation of health information technology and working with the Centers for Medicare and Medicaid Services (CMS) to create Implementation Advance Planning Documents (IAPDs)
- Experience in reviewing Home and Community-Based Services (HCBS) program compliance against federal and state rules and regulations, including the review of 1915(c) waiver applications for a variety of states

Professional Experience

Medicaid Managed Care

- Provided support to state Medicaid clients, including Iowa, Georgia, Mississippi, and Alabama in assessing readiness for transition to Medicaid managed care, including development of the readiness review tool, standard operating protocols, instructional guides, and trainings delivered to staff.

Nancy Kim, MPH, PMP

Managing Consultant

Assisted with onsite reviews of managed care organization's readiness to go-live with the program. In addition, assisted with integrating and assessing the implementation of new Medicaid Managed Care rules for the Alabama Medicaid Agency and Arizona Health Care Cost Containment System.

- Assisted the Alabama Medicaid Agency (Agency) on the statewide transition to risk-based, community-led, regional care organizations (RCOs) to coordinate the health care of the State's Medicaid patients in each region. Assisted in drafting the risk-based contract to be used between the Agency and RCOs. Assisted with drafting Alabama Medicaid Administrative Code Rules to implement the regional care organization program.

- Assisted various state Medicaid clients with the development of procurement materials, such as Request for Proposals, responses to vendor questions and proposal evaluation criteria, and reviewing proposals from potential vendors.

- Developed materials and trained agency staff in areas such as Managed Care 101, Federal waivers, conduct of readiness reviews, Accountable Care Act reforms, and conduct of contract monitoring and oversight.

- Assisted the Pennsylvania Office of Medical Assistance Programs (OMAP) with assessing opportunities for organizational improvement, including clarification of Bureau roles and functions, communication of OMAP vision and goals, and staff training. Conducted interviews with both internal stakeholders and other states to understand "current state" capabilities, identify gaps, solicit recommendations, and identify best practices.

Health Information Technology

- Provided Kansas Department of Health and Education design, development, and implementation support of its Medicaid EHR Provider Incentives Auditing Program. Led work on the successful completion of the State auditing document, which outlined the development of the workflow and process for auditing the incentive program including provider application, eligibility and payment, oversight and program, integrity, and review.

- Assisted the Commonwealth of Pennsylvania in implementing an eHealth Pod Pilot Program to provide technical assistance to stimulate collaboration between healthcare providers who serve a high volume of behavioral health and long-term care Medicaid recipient through the implementation of Continuous Care Documents (CCD). Developed various tools, such as provider checklists and FAQ documents, to assist providers with implementation of CCDs.

- Assisted several states, including Kansas and Pennsylvania, with their Medicaid EHR Incentive Programs such as drafting SMHPs and Advanced Planning Documents and developing communications strategies and program implementation plans. Developed landscape assessments,

which required the review of statewide EHR adoption and factors influencing adoption such as average office size, office location (rural versus urban), connections to hospitals, presence of an EHR adoption network, and funding.

- Served as task lead for a project to develop tools and resources for public and population health that assist the Regional Extension Centers (RECs) in supporting providers seeking to achieve meaningful use of electronic health records. Key tasks include: conducting stakeholder interviews and drafting case studies and best practice documents; developing various tools and resources on public health departments' role in health IT, including syndromic surveillance; and conducting environmental scans.

- Served as task lead for a project which assessed how health IT can be used as a tool to improve access to quality oral healthcare for children enrolled in Medicaid and CHIP. A central component of this study included convening an expert panel with various stakeholders and providing actionable recommendations. Key tasks include: conducting a literature review; drafting sections and reviewing the background paper; giving a presentation on access to oral health care for Medicaid and CHIP enrollees at the panel meeting; synthesizing recommendations from the meeting; drafting and reviewing the final report; managing day to day project activities and the project budget; and leading calls and meetings with the client.

- Conducted a study for the Office of the National Coordinator for Health Information Technology (ONC) to assess the availability and use of open source products and licenses by safety net health care providers, such as Federally Qualified Health Centers (FQHCs). This research resulted in a report to Congress, submitted to ONC in September 2010. Specific contributions include conducting a literature review, participating and leading stakeholder interviews and case studies, drafting and reviewing the final report, and presenting findings to various HHS agencies and conferences.

Long-term Care

- Assessed state's compliance with federal and state regulations related to the 1915(c) applications, including identifying issues and gaps in the waiver application. Developed and created trainings for CMS to provide guidance in completing 1915(c) applications, including related rate-setting methodologies, identifying potential HCBS quality and oversight measures, and ensuring fiscal integrity.

- Assisted the Illinois Department of Healthcare and Family Services with its design plan for the Balancing Incentive Program, a federal grant to help states rebalance their long-term services and supports (LTSS) delivery systems. Provided project planning, guidance, and technical assistance related to federally mandated structural changes that affect multiple State agencies, including the design of a "no-wrong door" system of LTSS entry points and mitigation of conflict from LTSS case management processes. Assisted the State with the development of a uniform assessment instrument to be used for multiple LTSS populations.

NAVIGANT

Nancy Kim, MPH, PMP

Managing Consultant

- Researched Medicaid Long Term Care Managed Care Programs for the State of Mississippi's Department of Medicaid's effort to resign their Long-Term Care Program. Synthesized state program information into profiles to assist the state in making a decision regarding Long-Term Care.

Other Relevant Experience

- Assisted with a study for the Department of Health and Human Services Assistant Secretary for Planning and Evaluation (ASPE) to evaluate how public health financing in states. This project required in-depth case studies of seven states to assess how different states are approaching the financing of public health and preventative services.

- Supported the Centers of Medicare and Medicaid (CMS) in a study to support the national EPSDT workgroups. This included conducting a comprehensive review of EPSDT services and patient-centered medical home models in each of the 50 states and the District of Columbia.

- Provided project officer assistance on programmatic and technical issues to Health Center Controlled Networks looking to adopt, implement, or upgrade health IT systems.

- Conducted a study on evaluating and using patient satisfaction and HCAHPS as tool for quality improvement in hospitals.

Work History

Managing Consultant, Navigant	2013 – Present
Senior Consultant, Navigant	2012 – 2013
Senior Research Analyst, NORC at the University of Chicago	2010 – 2012
Public Health Analyst, Department of Health and Human Services	2009 – 2010

Certifications, Memberships, and Awards

Project Management Professional Certification

Education

B.S.Ed., Social Policy	Northwestern University
M.P.H., Health Policy and Administration	Yale School of Public Health

NAVIGANT

Nancy Kim, MPH, PMP

Managing Consultant

Selected Recent Presentations and Publications

- Goldwater, J.; Kwon, N.; Nathanson, A.; et al. (2013). The Use of Open Source Electronic Health Records within the Federal Safety Net. Journal of American Medical Informatics Association, 0; 1-5.
- Goldwater, J., Kwon, N., Nathanson, A., et.al. (2013). Open Source Electronic Health Records and Chronic Disease Management. Journal of American Medical Informatics Association, 0; 1-5.
- Wild, D.; Kwon, N.; Dutta, S.; Tessier-Sherman, B.; Woddor, N.; Sipsma, H.; Rizzo, T.; Bradley, E. (2011).Who's Behind an HCAHPS Score? Joint Commission Journal of Quality and Patient Safety, 37(10), 461-468.
- "Quality Oral Health Care in Medicaid through Health IT: Background Report. Report to the Agency for Healthcare Research and Quality (co-authored with Cheryl Austein Casnoff, Lisa Rosenberger, Nancy Kwon, and Hilary Scherer). January 2011. Available at: http://www.norc.org/PDFs/QualityOralHealthCareMedicaid%5B1%5D.pdf
- Using Open Source Health IT for Chronic Disease Management. Academy Health, Seattle, WA. July 2011. Available: http://www.academyhealth.org/files/2011/monday/kwon.pdf

NAVIGANT

Jason S. Gerling

Managing Consultant

jason.gerling@navigant.com
Atlanta, Georgia
Direct: 4046023477

% Time / Month
TBD based on project needs.

Professional Summary

Jason Gerling is a Managing Consultant with Navigant's Government Healthcare Services practice. Jason has more than 10 years of professional experience building successful LTSS and case management models that improve opportunities for aging in place, and enhance collaboration between social services sectors including health, human services, and housing. He has a keen ability to build partnerships and engage external partners both in program management, technical assistance, and training roles. He is committed to improving upon current systems to accommodate changes in the needs of older Americans, while developing cost-efficient and creative ways to serve aging and disabled individuals and their caregivers.

Areas of Expertise

- Develops and optimizes long-term services and supports programs for older, disabled and special needs populations, with emphasis on home-and community-based delivery models.
- Optimizes and reforms Medicaid 1915 (c) waiver and Older American's funded models, including operational assessment and inter-agency consolidations.
- Designs and delivers case management and care coordination services including person-centered care, options counseling, crisis intervention and integrated management models across disability types, including development and provision of professional coaching and training.
- Implements comprehensive stakeholder engagement with consumers, service providers, consumer advocates and members of the public.
- Leads formation of inter-agency partnerships and community collaboratives aimed at integrating home and community based services, behavioral health and affordable housing services.

Professional Experience

Federal Initiatives

- Designed and managed implementation of the Community Living Program in Oneida County, New York, an early pilot implementation of participant-directed service delivery using Older American's Act funding from the U. S. Administration on Aging.

NAVIGANT

Jason S. Gerling

Managing Consultant

- Spearheaded and managed New York's first operational Veterans-Directed Home and Community Based service program – establishing a revenue generating relationship between an area agency on aging and the Syracuse VA Medical Center to extend person-centered planning and participant-directed services to the Veteran population.

Long-Term Care

- Assisted Kentucky with assessment and re-design of its 1915 (c) waiver system, including completion of an operational assessment and inter-agency workflow re-design, developing and facilitating internal and external stakeholder engagement platforms, and providing subject matter expertise on HCBS and case management monitoring and quality framework.

- Supported Alabama with transition of its Medicaid funded LTSS services to a provider-sponsored, managed delivery system, playing a significant role in design and execution of a comprehensive public stakeholder strategy including facilitation of dozens of public meetings, design and analysis of a public survey, and development of external reports and correspondence. Additionally, provided subject matter expertise on home-and community-based case management design and led inter-agency sessions between the Medicaid agency and sister 1915 (c) designated operating agencies.

- Participated in the re-design of Florida's nursing home reimbursement system to a prospective payment model for the State of Florida, helping to develop and execute a stakeholder engagement strategy, and providing clinical and operational expertise in the development of the state's first quality incentive program tied to payment.

- Completed a study of Wyoming's statewide system for prevention and response to abuse, neglect and exploitation (ANE) of vulnerable adults, assisting Wyoming Medicaid by designing and facilitating a series of interviews with key agencies and professionals, culminating in the delivery of a recommendations report identifying mechanisms to enhance prevention and intervention of ANE, and enhance inter-departmental communication so that the state could meet critical incident reporting to the Centers for Medicare and Medicaid Services.

Behavioral Health

- Performed initial assessments of statewide community mental health centers for the Tennessee's Bureau of Tenncare, assisting with curriculum development for their primary care transformation project intended to deliver multimodal practice training and coaching services to CMHCs as they shifted to an integrated Health Home model.

- Convened and facilitated a multi-disciplinary coalition of housing and mental health providers to establish local pathways for collaboration, in partnership with Emory Healthcare's Fuqua Center for Late Life Depression and LeadingAge Georgia.

NAVIGANT

Jason S. Gerling

Managing Consultant

- Appointed to Board of Georgia's Institute on Aging, past coalition member for Atlanta Area Coalition on Aging & Mental Health, Advisory Board member Emory Fuqua Center for Late Life Depression, active member Piedmont Care Transitions Work Group, active member Fulton Crisis Collaborative.

Other Relevant Experience

- Single-handedly designed and implemented a case management model offering housing stabilization case management and service network referral to elderly and disabled adults residing within the Atlanta Housing Authority's Housing Choice Voucher program portfolio. The program reported 89% housing stabilization rates amongst households served in FY14 reporting. Additionally, grew the agency's network of non-contract service provider network significantly, nearly tripling the number of aligned agencies and programs with cross referring relationships to the Authority's Human Development Services.

- Designed and implemented a training and development curriculum for the Atlanta Housing Authority's portfolio of public housing high-rises for the elderly and disabled, delivering training and technical assistance to more than a dozen resident service coordinators over a year, covering nearly 2,000 tenants.

- Provided subject matter expertise to the Atlanta Housing Authority in the design of procurement requirements for Resident Service program implementation prior to release of a multi-year public procurement for property management and development organizations.

- Served as Director of Sales at two Sunrise Senior Living properties – Webb Gin and Johns Creek, maintaining and increasing census by 10% through effective internal sales, including through an executive leadership transition. Conducted external business development – developing and sustaining positive community relationships within the aging services network.

- Managed admissions for a Hospice provider, including educating patients and families about Hospice, completing insurance verifications, leading multidisciplinary care team meetings, and monitoring documentation compliance in clinical documentation.

- Delivered person centered planning and options counseling training to clinical staff, providing representation at statewide conferences in New York, and in multimedia training projects designed by Boston College's National Center for Participant Directed Services.

- Delivered Medicaid and Older American's Act funded case management services, information and referral to a case load of 150 individuals with high success rate in development of community based long-term care plans – including floating assistance for coworkers and other geographic teams.

NAVIGANT

Jason S. Gerling

Managing Consultant

- Served as interim Director of an AARP-model volunteer bill payer program, and its organizational representative payee agreement with the Social Security Administration.
- Developed policies and procedures for a non-profit organizational Representative Payee Program, designing and delivering compliance training to program staff and volunteers.

Work History

Managing Consultant, Navigant	2017 – Present
Senior Consultant, Navigant	2016 – 2017
Program Manager - Aging Well Services, Atlanta Housing Authority	2013 – 2016
Director of Sales, Sunrise Senior Living	2011 – 2013
Admissions Coordinator, Odyssey Hospice	2010 – 2011
Program Coordinator, Oneida County Office for the Aging and Continuing Care	2010 – 2011
Case Management Consultant, Family Services for the Mohawk Valley, Bill Payer Program	2008 – 2009
Case Manager, Oneida County Office for the Aging and Continuing Care	2007 – 2009

Certifications, Memberships, and Awards

Barbara A. Romano Memorial Award for Excellence in Gerontology, 2007

Past Member, Sigma Phi Omega National Gerontological Honor Society

Education

Master of Science – Gerontology, Management of Aging Services Track	University of Massachusetts
Bachelor of Arts – Psychology (*Magna Cum Laude*), Specialist in Aging Certification	Canisius College

NAVIGANT

Jason S. Gerling

Managing Consultant

Selected Recent Presentations and Publications

- "Integrating Housing and Behavioral Health Supports: Taking a Pilot to Scale" – National Association of Area Agencies on Aging Annual Conference. August, 2017
- Gerling, Jason and Walton, Betsy. "State Considerations for Provision of Support Services to Affordable Housing Tenants." (White paper). October, 2016.
- **"**Leveraging Aging and Social Services to Stabilize Tenancy in Affordable Housing" – National Home and Community Based Services Conference. August, 2016
- "The Crossroads of Housing and Healthcare" – National Aging in Place Council Annual Meeting. December, 2015
- **"**Ethics of Responding to Self-Neglect: Opening the Conversation" – Atlanta Area Coalition on Aging and Mental Health: 2015 Building Workforce Competency Conference. September, 2015.

Appendix B Sample Work Documents

Select examples of Navigant's work product are listed and included here. We will make others available upon request and leverage resources to provide efficiency in our approach to meeting Iowa's needs:

Issue Briefs and Best Practices Research

- Thought Leadership:
  - *Upcoming Medicaid Managed Care Regulations — How Do You Stack Up?* https://www.navigant.com/insights/healthcare/2018/upcoming-medicaid-managed-care.
  - *Provider Network Adequacy Changes in Medicaid Managed Care Final Rule Leave States with much to Address* https://www.navigant.com/~/media/WWW/Site/Insights/Healthcare/2016/HC_NetworkAdequacy_TL_0616.pdf.
  - *MCO Claims Data Critical to CMS and State Oversight of Medicaid Program* https://www.navigant.com/-/media/www/site/insights/healthcare/2016/encounter-whitepaper-final.pdf.
- LTSS Issue Briefs (included in the pages that follow):
  - Commonwealth of Kentucky, Department of Medicaid Services 1915(c) Waiver Assessment – Summary of Natural Supports Policies for Select States.
  - Commonwealth of Kentucky Department of Medicaid Services 1915 (c) Waiver Assessment – Summary of Federal HCBS Monitoring and Oversight Requirements.
  - Commonwealth of Kentucky, Department of Medicaid Services 1915(c) Waiver Assessment – State Comparison: Concurrent Delivery of Hospice and Home and Community Based Services (HCBS).
  - Alabama Medicaid – Waiver QA Requirements and Recommended Practices.
- **Speaker List:** *http://www.worldcongress.com/events/HW18037/speakers.cfm.*

Options Assessments and Recommendations Reports

As many of these are public documents, produced on behalf of our state clients, we have provided links to these reports for your review, as needed:

- *New Hampshire – SB553 workgroup presentation*: https://www.dhhs.nh.gov/sb553/documents/sb-553-ltss-options-080917.pdf.

- *Nevada – Options Assessment for Medicaid:* http://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Pgms/LTSS/MCE/Draft_Nevada_Delivery_System_Report_010317.pdf.
- *Nevada – Recommendations cited within larger context of Nevada reform:* https://www.kff.org/report-section/putting-medicaid-in-the-larger-budget-context-an-in-depth-look-at-three-states-in-fy-2017-and-fy-2018-nevada/.
- *Washington DC – SIM (State Innovation Model) Options Analyses:* https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/Payment%20Model_Dec%2017_Navigant%20Slide%20Deck.pdf.
- *Kansas – DSRIP Report Assessment:* *https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ks/KanCare/ks-kancare-uc-dsrip-rpt-09142017.pdf.*

Stakeholder Input and Assessments

- *Alabama – Integrated Care Network FAQs postings:* *http://medicaid.alabama.gov/documents/5.0_Managed_Care/5.2_Other_Managed_Care_Programs/5.2.4_ICNs/5.2.4_ICN_FAQ_Probationary_Certification_9-7-17.pdf.*
- *Commonwealth of Kentucky Cabinet for Health and Family Services – Assessment of 1915(c) Home and Community-Based Services Waivers – Summary of Phase One Recommendations:* *https://chfs.ky.gov/agencies/dms/Documents/TownHallsSummaryofRecommendationsFINAL.pdf.*

Sample Project Workplans

Sample project workplans are included in the pages that follow.

NAVIGANT

HEALTHCARE

PROVIDER NETWORK ADEQUACY CHANGES IN MEDICAID MANAGED CARE FINAL RULE LEAVE STATES WITH MUCH TO ADDRESS

HANFORD LIN
Director
Government Healthcare Solutions
646.227.4344
hlin@navigant.com

RANDAL WHITEMAN
Associate Director
Government Healthcare Solutions
215.832.4450
rwhiteman@navigant.com

ROSHNI ARORA
Managing Consultant
Government Healthcare Solutions
713.646.5021
roshni.arora@navigant.com

navigant.com

About Navigant

Navigant Consulting, Inc. (NYSE: NCI) is a specialized, global professional services firm that helps clients take control of their future. Navigant's professionals apply deep industry knowledge, substantive technical expertise, and an enterprising approach to help clients build, manage and/or protect their business interests. With a focus on markets and clients facing transformational change and significant regulatory or legal pressures, the Firm primarily serves clients in the healthcare, energy and financial services industries. Across a range of advisory, consulting, outsourcing, and technology/analytics services, Navigant's practitioners bring sharp insight that pinpoints opportunities and delivers powerful results. More information about Navigant can be found at navigant.com.

Navigant reviewed Medicaid managed care contracts for 30 of the 45 states with comprehensive risk-based managed care.[1] Our goal was to identify potential changes that states must make to meet the new regulations.

CMS released the Medicaid and CHIP Managed Care Final Rule to "modernize Medicaid managed care regulation to reflect changes in the usage of managed care delivery systems."[2] As a result of the final rule, states will need to update their managed care contracts and supporting documentation to address new regulations regarding provider network adequacy and beneficiary access to services. To truly improve access, however, states must also evaluate their methodologies for developing network adequacy requirements, processes for monitoring provider networks, exceptions, and enforcement tools.

According to CAHPS Health Plan Survey data, only 54% of adults and 59% of children enrolled in Medicaid health plans in 2015 reported that it was often easy to access needed care and schedule appointments with specialists as soon as needed.[3]

The final rule establishes new requirements formalizing provider network adequacy standards for Medicaid managed care programs, which will become effective July 1, 2018.

1. States without comprehensive risk-based managed care include: Alaska, Connecticut, Maine, Montana, and South Dakota. *Source*: Kaiser Family Foundation, *Medicaid Enrollment in Comprehensive Risk-Based Managed Care*, 2014, http://kff.org/medicaid/state-indicator/medicaid-enrollment-in-comprehensive-risk-based-managed-care/.
2. Centers for Medicare and Medicaid Services, *Medicaid and Children's Programs: Medicaid Managed Care: CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability. Federal Register 81, no. 88* (May 6, 2016): 27497, https://federalregister.gov/a/2016-09581.
3. Agency for Healthcare Research and Quality, CAHPS Health Plan Survey Database Health Plan Comparative Data, https://cahpsdatabase.ahrq.gov/CAHPSIDB/Public/about.aspx

We reviewed contracts to determine:

- Compliance with the new CMS regulations relative to network adequacy (42 CFR 438.68 and 438.207) in four key areas:
  - Time and Distance Standards
  - Exceptions to Provider Network Standards
  - Required Elements for Provider Network Establishment
  - Provider Network Documentation
- Monitoring approaches the states rely on to enforce access requirements

While other regulatory sources may include network adequacy requirements (e.g., state Medicaid and insurance regulations, accreditation organization guidelines, policy guidance from CMS and states), Navigant reviewed risk-based contracts because they are the primary Medicaid managed care arrangement used to enforce program requirements and hold contractors accountable.

Overall, states will need to develop or build upon existing network adequacy standards for provider types where there are not already defined standards and develop monitoring approaches and policies for exceptions. Although states have until July 2018 to comply with the regulations, we recommend that states begin to analyze population-specific data and leverage existing network standards (e.g., Medicare Advantage, Qualified Health Plans) to meet the new regulations as soon as possible. States will be challenged by competing internal agency priorities, tightening budgets, and finite resources to analyze and determine the accuracy and appropriateness of set standards.

Key findings from Navigant's analysis of state Medicaid managed care contracts include:

1. **Most states will need to develop time and distance standards for additional provider types**. Although approximately half (53%) of state contracts include time and distance standards for at least one required provider type, only two state contracts contained time and distance standards for each of the seven provider types specified in the new regulations.

2. **Nearly every state must delineate specific time and distance standards for adults and children related to the following provider types: primary care providers (PCPs), specialists, and behavioral health**. Only four state contracts (13%) currently include breakouts for adult and child time and distance standards for the select provider types.

3. **States should formalize approaches for overseeing exceptions to standards**. Only three states (10%) include contract provisions that meet all of CMS's requirements for monitoring exceptions. While states may already use these approaches in internal processes and state regulations, states should also specify them in contracts to enhance the ability to enforce exceptions.

4. **Given the elevated focus on network adequacy, states should evaluate their current monitoring and oversight practices**. States will need to improve the rigor of network adequacy analyses, better leverage data analytics, and enhance reporting to determine if there is appropriate access to services. When identifying deficiencies, states will need the tools and the willingness to enforce corrective action plans, sanctions, and penalties.

TIME AND DISTANCE STANDARDS

CMS's new regulations require that states develop time (minutes) and distance (miles) network adequacy standards for the following provider types:

1. PCP (adult and pediatric)
2. Behavioral health (adult and pediatric)
3. Specialist (adult and pediatric)
4. OB/GYN
5. Hospital
6. Pharmacy
7. Pediatric dental
8. Additional provider types that promote state objectives

The final rule specifies that network adequacy requirements include both time and distance standards for selected Medicaid providers.[4]

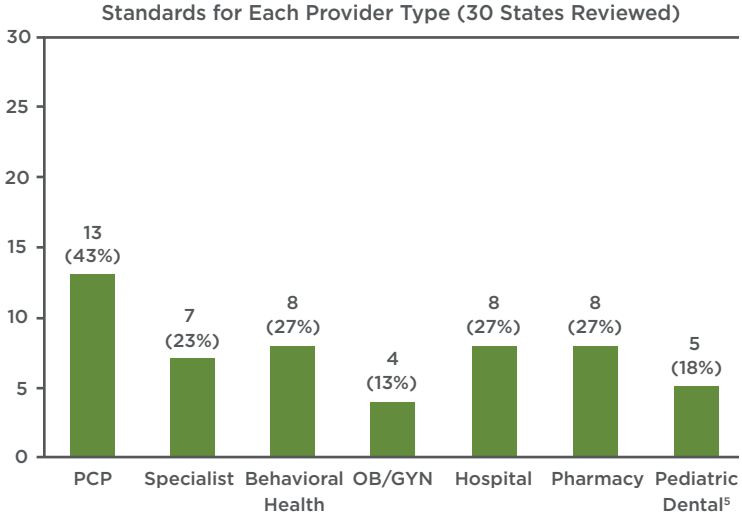
4. Managed Care, 42 C.F.R. § 438.68 (b).

NAVIGANT RESEARCH INDICATES:

- Only two states (7%) include time and distance standards for all seven specified provider types in their contracts
- Only 16 states (53%) include both time and distance standards for at least one of the provider types

States retain the flexibility to develop their own unique time and distance standards for various geographic regions rather than follow specified national standards. To date, most states include time and distance standards in their managed care contracts to some extent. Our research indicates that 27 state contracts (90%) include a time or distance standard for at least one of the required provider types. However, only two states (7%) have both time and distance standards for all seven specified provider types. As shown in the chart below, states most frequently include time and distance standards for PCPs, and most frequently fail to include them for OB/GYN providers.

Count of State Contracts that Include Time and Distance Standards for Each Provider Type (30 States Reviewed)



The final rule also requires states to delineate time and distance standards for both adults and children for three provider types: PCPs, behavioral health, and specialists. We found that approximately one in three states (32%) include both adult and child breakouts for any provider type, and only four states (14%) meet the new requirements for all required provider types.[5]

EXCEPTIONS TO PROVIDER NETWORK STANDARDS

CMS acknowledges that local patterns of care, such as a lack of providers in a given region, may require a contractor to seek an exception to the established provider network standard. Federal regulations require that, to the extent a state permits an exception, states must:[6]

- Specify in the contract the standard for evaluating the exception;
- Base the standard, at a minimum, on the number of healthcare professionals in that specialty practicing in the service area; and
- Outline how the state will monitor enrollee access to providers in networks that operate under an exception and report to CMS annually.

73% of states grant exceptions to provider network standards.

Only **10%** of states included contract provisions meeting all of CMS's requirements listed above.

While some states may already use these approaches in their internal exceptions and monitoring processes, states should also specify these elements in contracts to enhance their ability to enforce exceptions and hold managed care organizations accountable for meeting requirements.

REQUIRED ELEMENTS FOR ESTABLISHING PROVIDER NETWORK STANDARDS

CMS requires that states consider nine elements when developing network adequacy standards and establishing provider networks. Although CMS does not require inclusion of these elements in contracts (i.e., states can also include these in other documentation outside of the contract), states generally require contractors to consider these elements, and thus should consider including them in their risk-based contracts. No state included all nine of the required elements in its managed care contracts.

5. Two contracts examined covered population ages 21 and over only, thus would not be required to delineate adult and child breakouts for time and distance standards. Therefore, the total contracts examined for this section of the analysis was 28 instead of 30.
6. Managed Care, 42 C.F.R. § 438.68 (d) 1-2 (2016).

CMS REQUIRED ELEMENTS FOR ESTABLISHING NETWORK STANDARDS	NUMBER OF STATE CONTRACTS CONTAINING ELEMENTS (30 STATES REVIEWED)
1. Anticipated enrollment	24 (80%)
2. Expected utilization of services	23 (77%)
3. Characteristics and healthcare needs of specific populations	25 (83%)
4. Numbers and types of network providers required	24 (80%)
5. Numbers of network providers not accepting new Medicaid patients	22 (73%)
6. Geographic location of network providers and enrollees, considering distance, travel time, and transportation	29 (97%)
7. Ability of network providers to communicate with enrollees in their preferred language	18 (60%)
8. Ability to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for enrollees with disabilities	25 (83%)
9. Availability of triage lines or screening systems, as well as the use of telemedicine, e-visits, and/or other evolving and innovative technological solutions	1 (3%)[7]

Additional State Considerations

- How does the state assess the impact of provider network standards and provider outreach?
- Do Medicaid contractors classify provider types consistently?
- How does the state assess population healthcare needs?
- How does the state or contractor assess Americans with Disabilities Act and language accessibility at provider offices?
- How does the state monitor provider panel status and size across contractors?
- What are the state's policies for allowing exceptions, and how will those exceptions be monitored?
- Do the state's reimbursement guidelines account for telemedicine?

As a result of the growing Limited English Proficiency (LEP) population and to comply with CMS regulations, many states should require that contractors consider the ability of providers to communicate with LEP enrollees in the development of provider networks. In particular, 12 state contracts (40%) do not include provisions requiring network standards to account for a provider's ability to communicate with LEP enrollees. Federal Medicaid managed care regulations previously required consideration of LEP in enrollee communication. As a result, most states already have a starting point for compliance. The new regulations now require this consideration when developing network adequacy standards.

As of 2012, people with LEP made up 12% of the Medicaid population, but as the ACA continues to expand Medicaid coverage, we anticipate that the number of enrollees with LEP will likely grow.[8]

Only one state contract (3%) addressed the consideration of triage lines, telemedicine and other technology solutions in the development of network adequacy requirements. Given the expansion of Medicaid managed care to rural areas in many states, contractors will increasingly rely on technology-related solutions to improve access to care and thus should consider this when developing network adequacy standards.

PROVIDER NETWORK DOCUMENTATION

CMS's new regulations codified practices that states commonly use to verify appropriate enrollee access. A majority of states (83%) require contractors to submit documentation to demonstrate that their networks provide access to an appropriate range of services and are sufficient in terms of mix and geographic distribution.

7. Fourteen states (47%) encourage MCOs to use telemedicine to improve access to care; however, only one state specifically indicated that these elements are to be considered in the development of network adequacy standards.

8. Robert Wood Johnson Foundation, *State Estimates of Limited English Proficiency (LEP) by Health Insurance Status*, 2014, http://www.rwjf.org/en/library/research/2014/06/state-estimates-of-limited-english-proficiency--lep--by-health-i.html

In addition, states must also require documentation in special situations such as:[9]

- At the time a contractor enters into the contract with a state;
- Annually; and
- Anytime there is a significant change in the contractor's operations that would affect the adequacy and capacity of services (e.g., changes in benefits and service area or enrollment of a new population).

States must publish network adequacy standards clearly on their website and make them available at no cost to enrollees with disabilities in alternate formats or through auxiliary aids and services.[10]

Although most states already follow this practice and may request reports from contractors at any time, 19 states (63%) do not have explicit requirements that contractors must submit documentation in all of the required circumstances. Specific conditions under which states may request this detailed reporting would reduce ambiguity and clarify contractor expectations.

NETWORK ADEQUACY REPORTING

States routinely require geographic access maps, provider addition/deletion reports, and enrollee surveys to monitor MCO provider networks.

WHAT'S NEXT? ACTIONS SPEAK LOUDER THAN WORDS...

Most states will need to update their managed care contract language and related state requirements (e.g., regulations, policy, and reporting manuals) to fully comply with the new network adequacy requirements, particularly with regard to time and distance standards and the exceptions process. Adding related contract requirements is only a small fraction of the work that is needed. States must also develop and document appropriate methodologies for determining these network adequacy requirements. For example, how will states decide when a 30-minute/30-mile versus a 60-minute/60-mile requirement is appropriate? When and how should requirements differ by physician type and specialty? How will policies and requirements vary for adults and children? Will there be exceptions, and if so, how will they be implemented and monitored?

Ready for 2018?

To prepare for the new regulations, states should consider:

1. What information do we need to assess our current service network adequacy and standards?
2. How can we leverage existing data analytics to verify our methodology for developing provider network standards?
3. What does the data say about the need for exceptions?
4. How can we strengthen our processes and tools to more effectively monitor compliance with provider network standards?
   - How do we monitor exceptions?
   - What feedback and support do we provide to contractors?
   - Are internal monitoring processes comprehensive enough to identify potential problems?
   - Have we issued any corrective action plans related to network adequacy?
5. How "compliant" is the program's overall network with adequacy standards across contractors?
   - Where do we have gaps and how can we address them?
   - How will the External Quality Review Organization validate network adequacy for the Medicaid managed care program?
6. How do our enrollees choose providers?
   - Do contractors require enrollees to select a primary care physician or clinic?
   - Is choice limited due to appointment availability?

9. Managed Care, 42 C.F.R. § 438.207(c) (2016).
10. Managed Care, 42 C.F.R. § 438.68(e) (2016).

For more information about state-specific findings or for further assistance with your Medicaid managed care program, including provider network development, please contact Hanford Lin (hlin@navigant.com) or Randal Whiteman (rwhiteman@navigant.com).

About Navigant Government Healthcare Solutions

Navigant's Government Healthcare Solutions (GHS) advisors work with healthcare decision makers in key state and federal agencies, supporting government clients with advice on service delivery, financing, and operations. Our consultants collaborate with experts from all areas of our healthcare practice, giving our government clients access to thought leaders in the healthcare industry, and providing valuable insight into the challenges facing payers and providers.

NAVIGANT

PAYER / PROVIDER CONSULTING

BETSY WALTON
Director
Government Healthcare Solutions
312.583.5705
betsy.walton@navigant.com

JASON DUHON
Associate Director
Government Healthcare Solutions
678.845.7635
jason.duhon@navigant.com

navigant.com

About Navigant

Navigant Consulting, Inc. (NYSE: NCI) is a specialized, global professional services firm that helps clients take control of their future. Navigant's professionals apply deep industry knowledge, substantive technical expertise, and an enterprising approach to help clients build, manage and/or protect their business interests. With a focus on markets and clients facing transformational change and significant regulatory or legal pressures, the Firm primarily serves clients in the healthcare, energy and financial services industries. Across a range of advisory, consulting, outsourcing, and technology/analytics services, Navigant's practitioners bring sharp insight that pinpoints opportunities and delivers powerful results. More information about Navigant can be found at navigant.com.

MCO CLAIMS DATA CRITICAL TO CMS AND STATE OVERSIGHT OF MEDICAID PROGRAM

INTRODUCTION

In April 2016, Centers for Medicare & Medicaid Services (CMS) finalized the Medicaid Managed Care Rule,[1] which includes new requirements for collection, validation and reporting of encounter claims. These requirements have a wide-ranging impact on states and managed care organizations (MCOs). Originally proposed in April 2015, these new regulations indicate the increased importance of encounter claims reporting for CMS.

The importance of timely, accurate and complete encounter data has grown significantly since the passage of the Affordable Care Act (ACA) in March 2010:

- Medicaid enrollment has increased by 27 percent, adding more than 16 million covered lives to the program. The majority of these new enrollees are receiving benefits from risk-based MCOs.[2]
- Currently, more than 60 percent of all Medicaid beneficiaries are enrolled in comprehensive, risk-based managed care.[3]
- Premium payments to MCOs providing comprehensive services to Medicaid beneficiaries exceed $161 billion dollars, and account for 34 percent of all Medicaid spending.[3,4] For states, CMS and health plans, encounter claims are the best source of information to understand how these billions of dollars are being spent.

Not surprisingly, CMS, states, legislators and other stakeholders have an increased interest in obtaining timely and accurate services and outcomes information related to MCO coverage of Medicaid beneficiaries.

1. Medicaid Managed Care Rule released in CMS-2390-F, which updated 42 CFR Parts 431, 433, 438, 440, 457 and 495.
2. Total Monthly Medicaid and CHIP Enrollment. (n.d.). Retrieved August 05, 2016, from http://kff.org/health-reform/state-indicator/total-monthly-medicaid-and-chip-enrollment/
3. Medicaid Managed Care Enrollment and Program Characteristics, 2014 Retrieved August 05, 2016 from https://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/medicaid-managed-care/downloads/2014-medicaid-managed-care-enrollment-report.pdf
4. Total Medicaid MCO Spending. (n.d.) Retrieved August 05, 2016 from http://kff.org/other/state-indicator/total-medicaid-mco-spending/

The Medicaid Managed Care Rule mandates that states report encounter claims timely, accurately and completely through the Transformed Medicaid Statistical Information System (T-MSIS), which states use to report member and claims data to CMS. CMS indicates that states with deficient encounter data are at risk of losing federal matching funds. Although CMS has had the ability to withhold matching funds when states fail to report encounter data since at least 2010, it has not used this authority.[5] In addition, states have often not enforced their own contracts with MCOs in collecting timely, accurate and complete encounter data. The Office of the Inspector General has been critical of all parties because of the lack of quality encounter data, recommending greater penalties for non-compliance.

The Medicaid Managed Care Rule demonstrates that CMS is increasing scrutiny of encounter data and indicates that CMS is more likely to withhold federal matching funds for non-compliant encounter data in the future. This brief discusses the major regulatory changes related to encounter data, reporting in the Medicaid Managed Care Rule, how states can better monitor and improve the quality of their encounter data and the importance and benefit of having timely, accurate and complete encounter data.

In the Medicaid Managed Care Rule, CMS defines enrollee encounter data as "the information relating to the receipt of any item(s) or service(s) by an enrollee under a contract between a State and a MCO, PIHP, or PAHP".

WHAT IS ENCOUNTER DATA USED FOR?

Medicaid, like other payers in the private sector, are data-driven. The primary data points within any Medicaid agency are eligibility and claims data. Without timely, accurate and complete encounter data, state Medicaid agencies cannot perform effective oversight, review or monitoring of their managed care programs.

Encounter data provides detailed information regarding the services provided to Medicaid beneficiaries who receive their services on a capitated basis from managed care organizations. Encounter data are the primary record of the services for which states and the Federal government pay billions of dollars. Without timely, accurate and complete encounter data, states cannot demonstrate to CMS, state legislators and other stakeholders how much they are spending, for whom they are spending and the results of that spending.

In addition to addressing the basic questions of who is getting care at what price, and how much providers are receiving to deliver that care, there is significant value in states collecting accurate and complete encounter data. Encounter data facilitates capitation rate setting, risk adjustment, the evaluation of MCO quality and cost performance, the contribution of value-based purchasing, care management, behavioral health and physical health integration activities, program integrity and policy development. In other words, encounter data allows states to provide better care and determine appropriate payment for that care. Other activities that are supported by encounter data are described in Table 1.

5. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, Final Rule,§ 1903(i)(25).

Table 1. State Agency Encounter Data Activities

ENCOUNTER DATA ACTIVITY	STATE USAGE	STATE IMPACT WHEN ENCOUNTER DATA DEFICIENT
Federal reporting	Reporting utilization to CMS per federal regulations	Withhold of federal matching funds by CMS
Capitation rate setting	Actuaries use encounter data to calculate capitation rates each year; correctly calculated rates promote "beneficiary access to quality care, efficient expenditure of funds and innovation in the delivery of care"[6]	Potential under- or overstatement of capitation rates
Service verification, utilization patterns and access to care	Review member utilization and analyze members' ability to access care; assess network adequacy	Lack of insight on member's ability to access care and overall quality of care
Evaluate healthcare quality and outcomes	Calculate quality measures to understand MCO quality	Inability to drive managed care quality improvement
Evaluate MCO performance	Evaluate MCO's outcomes, such as evaluating avoidable emergency room (ER) usage, avoidable hospitalizations and readmissions and other performance metrics	Missed opportunity to drive performance goals with MCOs. For example, some states assign a higher percentage of members to better performing MCOs
Hospital and other provider rate setting	Setting prospective rates or performing retrospective cost settling	Under- or over-statement of provider rates
Budgeting	Identifying types of services and types of providers reimbursed through the Medicaid program	Inability to determine how state funds are being used, and report to Legislatures
Program Integrity (Fraud, Waste, Abuse)	Program integrity analysis such as beginning preliminary investigations, reviewing utilization spikes and analyzing outliers	Lack of ability to completely track Fraud, Waste and Abuse across all Medicaid spending
Other state goals	Other goals such as risk adjustment, value-based purchasing and policy development	Inaccurate or incomplete information available to inform policy and other decisions

6. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, Final Rule, Setting Actuarially Sound Capitation Rates for Medicaid Managed Care Programs (CFR §§438.2, 438.4, 438.5, 438.6, and 438.7).

WHAT ARE THE MAJOR NEW RULES THAT AFFECT ENCOUNTER REPORTING?

CMS finalized three requirements relating to encounter claims in the Medicaid Managed Care Rule:

1. §438.818 Enrollee Encounter Data
   - States are at risk for having federal match for MCO capitations withheld when they provide inaccurate or incomplete encounter data to CMS.
   - States must submit claims via T-MSIS.[7]
   - If CMS notifies a state that its encounter data is deficient, the state must work to rectify the data. If it cannot, "CMS will take appropriate steps to defer and/or disallow federal financial participation (FFP) on all or part of an MCO, PIHP or PAHP contract in a manner based on the enrollee and specific service type of the noncompliant data."[8]
2. §438.242 Health Information Systems
   - The state's information system must be able to ensure that encounter claims data are timely, accurate and complete.
   - The MCOs possess a Management / Health Information System that can process, collect and maintain data related to the MCO's management and oversight of its enrollees, such as utilization, claims, grievances and appeals, and disenrollment.
3. §438.66 State Monitoring Requirements
   - The state must have a monitoring system for managed care programs.
   - The state must collect data and use it to improve its managed care programs.
   - The state must assess readiness for each manage care entity.
   - The state must report yearly to CMS on each managed care program.

WHAT METHODS DO STATES USE TO ENSURE TIMELINESS, ACCURACY AND COMPLETENESS OF MCO DATA SUBMISSION?

As a first step to satisfying CMS's requirements for collecting accurate and complete encounter data from MCOs in a timely fashion, states must implement oversight mechanisms to monitor the encounter data they receive. States can independently monitor encounter data performance or engage an External Quality Review (EQR) organization to review encounters.[9] For states engaging an EQR, CMS asserts that EQR "…annual validation alone is probably not adequate."[9] CMS also advises that if states are not using an EQR, they must "…ensure that there is sufficient analytic rigor in the chosen method."[10]

Methods that states use to ensure encounter data quality related to each of three requirements include those outlined in Table 2; we recommend states use some, if not all, of these methods:

When a state finds a MCO's encounter data deficient, the state should work with the MCO to correct issues that result in less than timely, complete and accurate encounter data reporting. Many states write sanctions into contracts to incentivize encounter data compliance. However, some states experienced poor encounter performance when contractual sanctions were too light or when states did not perform strict oversight.

7. Technically, the rule requires encounters to be "submitted in the format required by the Medicaid Statistical Information System or format required by any successor system to the Medicaid Statistical Information System", but T-MSIS is the successor to MSIS. See section, "How Is CMS Measuring Timeliness, Accuracy and Completeness?" which describes T-MSIS.
8. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, Final Rule, CFR §438.242 and §438.818, Discussion of Public Comments.
9. Encounter data validation is an optional activity for an EQR per Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, Final Rule, CFR §438.358, Discussion of Public Comments.
10. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, Final Rule, CFR §438.242 and §38.818, Discussion of Public Comments.

Table 2. Methods for Monitoring and Enforcng Encounter Quality

REQUIREMENT	METHOD TO ENSURE QUALITY
Timeliness	Using the X12 standard 837, states may use the difference between the MCO payment date and stated date of receipt to calculate the timeliness of claims submissions.[11] Alternatively, if that data is not available, states ask the MCOs to generate specific reports regarding the payment date of encounters.
Accuracy	States determine accuracy either prospectively or retrospectively. Prospectively, they can process claims through their Medicaid Management Information System (MMIS), applying a subset of the Fee-For-Service edits and audits, to determine if the claim contains accurate information. If inaccurate, states deny or reject the encounter claim and ask the MCO to fix and resubmit that encounter. Alternatively, states can retroactively review the encounter data, generally through the use of sampling, and determine accuracy and further follow up actions.
Completeness	States compare historical utilization program-wide to utilization as reported in the encounter data for an MCO and across MCOs. States compare financials to encounter data to measure completeness. States can also use audits to determine encounter completeness.

Other methods to assess encounter data quality exist, and it is incumbent upon each state to confirm its mix of policy, procedures and oversight methods for that purpose. One particular area in which states should provide additional scrutiny is MCO sub-capitated services. This has long been a troublesome area for MCOs and states, and CMS calls attention to this area in the Medicaid Managed Care Rule discussion. MCOs have less direct control of these encounters since these claims often are not submitted directly to the MCO for payment (i.e., the MCOs have some of the same challenges the states have in terms of getting timely, accurate and complete encounter data). Consequently, sub-capitated encounter reporting may be problematic and take longer to address. States should consider requiring additional contract requirements for MCOs' sub-capitated arrangements.

MCOs may "sub-capitate" a portion of the services for which they are at-risk to another entity. Under a sub-capitated arrangement, the MCO contracts with another entity, for example, a behavioral health managed care plan, to provide a defined set of services at risk.

A number of other steps can help with accuracy validation. Specifically, states may wish to consider detailed of strategies, such as:

- Use the Medicaid Management Information System (MMIS) to improve encounter accuracy—States can "shadow price" encounter claims at Medicaid Fee-For-Service rates (i.e., determine what payments would have been had they been paid Fee-For-Service) to leverage the existing state infrastructure for improving accuracy at a claim level—the state's MMIS adjudication engine. But when doing so, states will need to carefully consider how to apply MMIS processing rules to encounters. For example:
  - MCOs may pay for services beyond that of Medicaid. These services typically will not have a rate in the MMIS. States must decide how to handle these encounter line items.
  - Not all FFS edits should be dispositioned for encounter claims. For example, FFS Prior Authorization (or Service Authorization) edits should not be disposed for encounters.
- Focus on provider data reported on encounters to enhance encounter accuracy—Deriving the correct Medicaid provider number from the submitted National Provider Identification numbers (NPIs) has proven challenging for both FFS and Encounter claims for many state agencies. State agencies' mapping of NPIs to Medicaid provider identification numbers is often complex and requires special attention to ensure accuracy in associating claims payment to service providers.
- Track duplicate claims separately—Certain states choose to track accuracy issues and duplicative claims independently (having separate contract Service Level Agreements for each). This allows states to focus on improving the quality of encounter claims while also monitoring issues with duplicate encounter submissions.

11. Claims should be sent to the state electronically. The 837I, 837P and 837D are the national standard format for reporting medical claims information.

CMS collects eligibility, enrollment, program, utilization and expenditure information through Medicaid and Statistical Information System (MSIS). States provide CMS with data quarterly. Transformed-MSIS (T-MSIS) replaces MSIS, and it allows CMS to collect additional files and data elements.

HOW IS CMS MEASURING TIMELINESS, ACCURACY AND COMPLETENESS?

CMS considers encounter claims submissions compliant only when states report timely, accurate and complete data through the T-MSIS. Even if states collect encounter data correctly from MCOs, CMS may still assign penalties if the states do not report their encounter data correctly via T-MSIS. CMS states, "We agree that states' effort to collect complete and accurate data from managed care plans is distinct from their MSIS/T-MSIS submissions. However, we are limited in our ability to accept and/or evaluate encounter data outside of MSIS/T-MSIS."[12]

The Medicaid Managed Care Rule also requires states to dedicate proper resources to their T-MSIS development stating, "...some states have not or could not make the investment of resources previously to comply with MSIS/T-MSIS requirements; as proposed and finalized, §438.818 will require them to make that investment".[12]

T-MSIS is the successor to MSIS as the system used by states to report member, claims and other data to CMS. T-MSIS requires states to submit four claim files: Inpatient, Long-Term Care, Outpatient and Prescription Drugs, along with other non-claim files.[13] 310 unique fields (e.g., member, provider, diagnosis, procedure code, etc.) exist among these four files. For T-MSIS validation:

1. CMS first administers an automated review of claims data. Within T-MSIS, many of the rules verify that the dates are logical, submitted values match T-MSIS valid values, and other low-level data integrity validations.[14]
2. CMS performs an additional validation of the submitted data, and CMS engaged an external contractor to conduct subsequent validation to ensure integrity within and among files.

Under MSIS, even if CMS accepted the file, it did not mean that CMS considered the data to be timely, accurate or complete.[15] The Medicaid Managed Care Rule does not specifically define what "accurate" means to CMS. CMS states it expects to release additional guidance.

WHAT CHANGES ARE MCOS LIKELY TO SEE AS A RESULT OF THE MEDICAID MANAGED CARE RULE?

MCOs can expect tighter contracts, greater oversight and monitoring, and an increased focus on encounter reporting. They can expect states to develop more robust processes and procedures for monitoring MCO performance. Several states have already imposed penalties on contracted MCOs for failure to provide timely, accurately and complete encounter reporting. While CMS has not typically withheld state matching funds for deficient encounter performance in the past, CMS has indicated it will use these sanctions to obtain encounter data in the near future. In July 2015, the Office of the Inspector General recommended that "CMS use its authority to withhold appropriate Federal funds from States that fail to submit encounter data to MSIS until those States report encounter data as required."[16] CMS agreed with this recommendation. Additionally, the Medicaid Managed Care Rule details the methodology CMS would use to determine the amount to withhold.[17]

States need to carefully consider their future contract language surrounding encounters. Typically, if a state includes sanctions in the MCO contract for failure to accurately report encounter claims, the sanctions are not at the magnitude of the state's Federal Medical Assistance Percentages (FMAP). For example, one state sanctions MCOs if its encounter accuracy and completeness falls below 98 percent. For every percentage point under 98 percent, the state penalize an MCO 0.25 percent of their capitation rate. In other words, if an MCO does not report encounters, the state's maximum sanction would be 24.5 percent, whereas CMS's maximum penalty would be the state's FMAP rate (50 percent to 74.63 percent depending on the state).[18] Navigant anticipates that states will add contract language that shifts federal penalties to MCOs for noncompliant encounter reporting. At present, many states push federal penalties to vendors with MMIS and other contracts—expect states to follow this model during their next MCO contracting period.

12. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, Final Rule, CFR §438.242 and §438.818, Discussion of Public Comments.
13. The four claims files were reported under MSIS along with an eligible file. T-MSIS adds TPL, Managed Care and Provider files. States must report both encounter and fee-for-service claims.
14. T-MSIS document "7 - t-msis v1_1 to v2_0 validation rules comparison- 2015-11-24" includes the validation rules.
15. CMS presentation on T-MSIS data quality shows that accepted files have gaps in the data: http://www.mesconference.org/wp-content/uploads/2012/08/monday_tmsis_gorman.pdf
16. Not All States Reported Medicaid Managed Care Encounter Data as Required. July 2015, Office of the Inspector General.
17. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, Final Rule, CFR §438.242 and §438.818, Discussion of Public Comments: "We interpreted the statute as providing for a per-enrollee disallowance for a failure to report enrollee encounter data. We believe it is more accurate to calculate the deferral and/or disallowance amount based on the enrollee and the specific service type of the non-compliant data. Using this methodology, only the portion of the capitation payment attributable to that enrollee for the service type of the non- compliant data would be considered for deferral and/or disallowance. For example, if the non-compliant encounter data is for inpatient hospital services, then only the inpatient hospital portion of the capitation payment for that enrollee would be subject to deferral and/or disallowance. We proposed that any reduction in FFP would be effectuated through the processes outlined in §430.40 and §430.42."
18. Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier. (n.d.). Retrieved August 05, 2016, from http://kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/

If CMS does withhold matching funds to states for MCO capitation payments when timely, accurate and complete encounters are not submitted, most states will likely be more aggressive in taking steps to mitigate their risk. Not only are they more likely to pass down financial penalties, but they are also more likely to consider the long-term viability of MCOs that are out of compliance. MCOs that have mastered the encounter data submissions process will be in a more favorable position with states upon contract renewal or re-procurement.

CMS's maximum penalty for encounter claim deficiency would be the state's Federal Medical Assistance Percentages (FMAP) rate (ranging from 50% to 74.63%) for capitations.

The Medicaid Managed Care Rule stipulates the methodology CMS would use to disallow matching funds: "For example, if the non-compliant encounter data is for inpatient hospital services, then only the inpatient hospital portion of the capitation payment for that enrollee would be subject to deferral and/or disallowance"

WHAT'S NEXT?

CMS indicated it will be providing states and MCOs further guidance about encounter "accuracy," beyond the rules established for T-MSIS. Current CMS rules require that "…states submit all of the data elements required by MSIS / T-MSIS, for all of the services, for all of the enrollees enrolled in the states' managed care plans".[19]

While CMS works to define accuracy, states can begin to evaluate their managed care contract requirements for the future. Most new regulations will be enforced for contracts beginning after July 2017 and July 2018.[20] Clear contract requirements and dedicated state staff monitoring and enforcing encounter submissions are key components of an overarching encounter quality strategy. The most important time to mitigate risk is prior to the start of a contract; states should begin review of Service Level Agreements for encounter data reporting well in advance of new contracts with MCOs. States should contractually incentivize MCOs through sanctions and incentives to promote proper encounter reporting.

Independent of the finalized rules, there is significant value for states to collect timely, accurate and complete encounter data. States will likely review their processes and procedures for encounter data collection in preparation of CMS's additional guidance. If states have not yet done this, they may wish to consider dedicating proper resources to ensuring encounter data quality and T-MSIS reporting. As managed care has become a significant portion of most Medicaid programs in recent years, Medicaid policy making must include an understanding of the types of services and providers reimbursed by the Medicaid MCOs.

19. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, Final Rule, CFR §438.242 and §438.818, Discussion of Public Comments.

20. CFR §438.818 - No later than rating period for contracts starting on or after July 1, 2018.
CFR §438.242 - No later than rating period for contracts starting on or after July 1, 2017.
CFR §438.66(a)-(d) - No later than rating period for contracts starting on or after July 1, 2017.
CFR §438.66(e) (Annual program report) - Rating period for contracts that start after the release of CMS guidance.

NAVIGANT

HEALTHCARE

UPCOMING MEDICAID MANAGED CARE REGULATIONS – HOW DO YOU STACK UP?

By Roshni Arora, Randy Whiteman, and Hanford Lin

It has been almost two years since the Centers for Medicare & Medicaid Services (CMS) released its Medicaid and CHIP Managed Care Final Rule in 2016. With several key milestones coming up on July 1, 2018, and July 1, 2019, we prepared a cheat sheet to help states stay on track with upcoming requirements and timelines.

Rather than following a "check the box" compliance approach, states should develop an overall compliance strategy that aligns with the Medicaid managed care program design specific to the state to drive value from the program.

Navigant is currently supporting many states in these efforts and is available to assist your state to comply with CMS' Medicaid managed care regulations.

We will continue to update this cheat sheet for states, as we anticipate changes from CMS when they conduct a full review of the managed care regulations and issue a proposed rule in August of 2018.

REQUIREMENT	STATE STEPS TO COMPLY WITH REGULATION
No later than rating period for contracts starting on or after July 1, 2018	
Managed Care Quality Strategy (§438.340)	• Draft new or revise managed care quality strategy to incorporate newly required components such as: – Transition of care policy – Plan for reducing health disparities – Quality metrics and performance targets • Make strategy available for public comment and obtain input from the State's Medical Care Advisory Committee, beneficiaries and other stakeholders • Evaluate strategy effectiveness at least every 3 years • Update strategy with new or modified external quality review (EQR) activities (See EQR requirements below) • Post strategy on state website
External Quality Reviews (§438.350, §438.354, §438.356, §438.358, §438.360, §438.362, §438.364)	• Revise external quality review organization (EQRO) contracts to include: – Annual review of each managed care organization (MCO) – Inclusion of federal EQRO qualifications – All mandatory EQR-related activities (e.g., validation of performance improvement projects, compliance reviews, performance measurement evaluation, network adequacy review) – Optional EQR-related activities – Preparation of an annual technical report – Validation of MCO network adequacy • Post EQRO reports on state website
Provider Network Access (§438.68, §438.206, §438.207)	• Develop time and distance standards for new provider types, including home and community-based services • Formalize provider network exceptions process • Update MCO contracts to reflect updated provider network access standards
Provider Screening and Enrollment (§438.602(b), §438.608(b))	• Modify MCO contracts to require all network providers enroll with the state as Medicaid providers • Implement new or revise provider screening and enrollment processes to include required program integrity elements

No later than rating period for contracts starting on or after July 1, 2018	
Beneficiary Support System (§438.71)	• Identify the extent that the following beneficiary support system services are already provided to members: – Choice counseling – Assistance for members in understanding managed care – Assistance for members using or expressing a desire to receive long-term services and supports • Modify existing vendor (e.g., enrollment broker, fiscal agent) contracts to include all required services • Prepare request-for-proposals to contract with new vendors or identify state agency resources to provide required beneficiary support system services
No later than rating period for contracts starting on or after July 1, 2018	
Continued Services to Members (§438.62)	• Develop a plan for providing Medicaid services to members in the event of MCO contract termination • Prepare a transition of care policy during a transition from the fee-for-service program to an MCO, or vice versa for at-risk members
Actuarial Soundness (§438.4(b)(3), §438.4(b)(4), §438.7(c)(3))	• Confirm sufficiency of actuarially sound capitation rates to meet provider network access standards and care coordination requirements • Tailor capitation rates for each rate cell under the contract
Encounter Data (§438.818)	• Develop and implement plan for validating encounter data for accuracy and completeness • Modify managed care contract requirements for encounter data submissions and validation • Enhance procedures and processes to submit required encounter data to CMS
April 25, 2019 (No later than 3 years from the date of a final notice published in the Federal Register)	
Managed Care Quality Rating System (§438.334)	• Adopt the Medicaid managed care quality rating system developed by CMS; • Design an alternative Medicaid managed care quality rating system, using high-level steps such as: – Identify performance indicators to include in quality rating system – Obtain public input on the proposed quality rating system – Submit quality rating system to CMS for approval
No later than rating period for contracts starting on or after July 1, 2019	
Annual Report (§438.66(e))	• If state elects to mandate a minimum medical loss ratio, work with actuary to confirm that capitation rates would allow MCOs to achieve a medical loss ratio of at least 85%
No later than one year from the issuance of the associated EQR protocol	
Network Adequacy (§438.58(b)(1)(iv))	• States must begin conducting the mandatory EQR activity to validate compliance with network adequacy requirements
No earlier than the issuance of the associated EQR protocol	
Plan Rating (§4383.58(c)(6))	• States must begin conducting the optional EQR-related activity to assess the quality rating of MCOs.

CONTACTS

ROSHNI ARORA
roshni.arora@navigant.com
+1.713.646.5021

RANDY WHITEMAN
rwhiteman@navigant.com
+1.215.832.4450

HANFORD LIN
hlin@navigant.com
+1.646.227.4344

About Navigant

Navigant Consulting, Inc. (NYSE: NCI) is a specialized, global professional services firm that helps clients take control of their future. Navigant's professionals apply deep industry knowledge, substantive technical expertise, and an enterprising approach to help clients build, manage, and/or protect their business interests. With a focus on markets and clients facing transformational change and significant regulatory or legal pressures, the firm primarily serves clients in the healthcare, energy, and financial services industries. Across a range of advisory, consulting, outsourcing, and technology/analytics services, Navigant's practitioners bring sharp insight that pinpoints opportunities and delivers powerful results. More information about Navigant can be found at **navigant.com**.

healthcare@navigant.com

linkedin.com/company/navigant-healthcare

twitter.com/naviganthealth

Commonwealth of Kentucky, Department of Medicaid Services
1915(c) Waiver Assessment

Summary of Natural Supports Policies for Select States

For the purposes of this document, Navigant assumes the term Natural Supports refers to family, friends and other unpaid supports in the community, who provide support to a waiver participant to assist them with meeting their health, social and/or other community-based needs.

State	Service Category	Allowable Categories of Natural Supports *(Eligible for Payment for Care Rendered)*	Non-Allowable Categories *(Ineligible for Payment for Care Rendered)*
Alabama [1]	Personal Care	Personal care services can only be provided by qualified waiver provider	Personal care services performed by family members will not be reimbursed
Arkansas [2]	Personal Care	• Personal care services can be provided by qualified relatives only if they are approved by the department first • All qualifications and standards must be met before the relative can be approved as a paid service provider	• Payment will not be made to an adoptive or natural parent, step-parent, legal representative or legal guardian of a person under 18 • Payments will not be made to a spouse or a legal representative for a person over the age of 18
Indiana [3]	Attendant Care	Attendant Care services can only be provided by a qualified Attendant Care Provider	Services will not be reimbursed to legal guardians, child, spouses, attorneys, or health care representatives

[1] Alabama 0001.R07.00 1915 (c) Waiver Application, Appendix C-2 (2014), https://medicaid.alabama.gov/documents/6.0_LTC_Waivers/6.1_HCBS_Waivers/6.1.5_Intellectual_Disablities_Waiver/6.1.5_ID_Waiver_Renewal_10-30-14.pdf
[2] Arkansas 0188.R05.00 1915 (c) Waiver Application, Appendix C-2 (2016), http://humanservices.arkansas.gov/ddds/ddds_docs/AR.0188.R05.00_(Effective_09-01-2016).pdf
[3] Indiana 007.03.05 1915 (c) Waiver Application, Appendix C-2 (2017), https://www.in.gov/fssa/files/FSW.pdf

Summary of Natural Supports Policies for Select States

For the purposes of this document, Navigant assumes the term Natural Supports refers to family, friends and other unpaid supports in the community, who provide support to a waiver participant to assist them with meeting their health, social and/or other community-based needs.

State	Service Category	Allowable Categories of Natural Supports *(Eligible for Payment for Care Rendered)*	Non-Allowable Categories *(Ineligible for Payment for Care Rendered)*
Iowa [4]	Attendant Care	Services can be provided by relatives	Services will not be reimbursed to legally responsible individuals, parents of minors, spouse or a legal representative
Kansas [5]	Personal Care	Personal care services and enhanced services can be provided by relatives	Personal care cannot be provided by parents of minors and spouses
Mississippi [6]	Personal care	• Personal care services can be provided by qualified family members that are not legally responsible for the individual • Family member must be employed by a Medicaid approved agency that provides personal care services, must meet provider standards and must be deemed competent to perform the required tasks	Services cannot be reimbursed to legally responsible individuals, such as parents and guardians of minor and spouses

[4] Iowa 0299.R04.01 1915 (c) Waiver Application, Appendix C-2 (2016), https://dhs.iowa.gov/sites/default/files/BI%20waiver%20%28CMS%20Approved%29.pdf
[5] Kansas 0304.R04.01 1915(c) Waiver Application, Appendix C-2 (2016), https://www.kdads.ks.gov/docs/default-source/CSP/HCBS/PD/physical-disability_application-for-1915(c)-hcbs-waiver_-ks-0304-r04-01---jan-01-2016.pdf?sfvrsn=0
[6] Mississippi 0272.R04.01 1915(c) Waiver Application, Appendix C-2 (2012), https://medicaid.ms.gov/wp-content/uploads/2014/03/Elderly-Disabled-Waiver.pdf

Summary of Natural Supports Policies for Select States

For the purposes of this document, Navigant assumes the term Natural Supports refers to family, friends and other unpaid supports in the community, who provide support to a waiver participant to assist them with meeting their health, social and/or other community-based needs.

State	Service Category	Allowable Categories of Natural Supports *(Eligible for Payment for Care Rendered)*	Non-Allowable Categories *(Ineligible for Payment for Care Rendered)*
Missouri [7]	Personal Care	Personal services can be reimbursed to the family member that was picked by Planning Team	Services cannot be provided by parent and guardian of minors, spouses and power of attorney
North Carolina [8]	Personal Care Homemaker/Chore	• Services may be furnished by the legally responsible individual under the state's provision of extraordinary care • All In-home Care services can be provided by a relative or legally responsible individual if they are an employee of an In-Home Care Agency or Home Health Agency • Personal care services may be performed by a spouse, parent, step-parent, child, sibling, or other relative if the waiver recipient is over the age of 18	Personal care services may not be provided by parents, step-parents or a significant other of a waiver recipient under the age of 18

[7] Missouri 0178.R06.00 1915(c) Waiver Application, Appendix C-2 (2016), https://dmh.mo.gov/dd/progs/waiver/docs/compwaiverapplication.pdf
[8] North Carolina 028.01.00 1915(c) Waiver Application, Appendix C-2 (2016), https://ncdma.s3.amazonaws.com/s3fs-public/documents/files/1915c-HCBS-Waiver-Application-2015.pdf

Summary of Natural Supports Policies for Select States

For the purposes of this document, Navigant assumes the term Natural Supports refers to family, friends and other unpaid supports in the community, who provide support to a waiver participant to assist them with meeting their health, social and/or other community-based needs.

State	Service Category	Allowable Categories of Natural Supports *(Eligible for Payment for Care Rendered)*	Non-Allowable Categories *(Ineligible for Payment for Care Rendered)*
Ohio [9]	Personal Care	Personal care services can be provided by relatives and family members if they are qualified to provide these services	• Services cannot be provided by legally responsible individuals and spouses • Services cannot be provided by parents and legal guardians of minors
Tennessee[10]	Personal Care Respite	• Respite and personal care services can be provided by relatives only if they are licensed by the State and meet the same standards as other providers • Services may be furnished by the legally responsible individual under the state's provision of extraordinary care	• Personal care services cannot be reimbursed to spouses • Personal care services cannot be provided by parents or custodial grandparents of a minor

[9] Ohio 0231.R04.01 1915(c) Waiver Application, Appendix C-2 (2015), http://dodd.ohio.gov/IndividualFamilies/ServiceFunding/Documents/IO%20Approved%20Waiver%20Amendment%207_15.pdf

[10] Tennessee 1915(c) Waiver Application, Appendix C-2, https://www.tn.gov/assets/entities/tenncare/attachments/StatewideWaiver.html

Summary of Natural Supports Policies for Select States

For the purposes of this document, Navigant assumes the term Natural Supports refers to family, friends and other unpaid supports in the community, who provide support to a waiver participant to assist them with meeting their health, social and/or other community-based needs.

State	Service Category	Allowable Categories of Natural Supports *(Eligible for Payment for Care Rendered)*	Non-Allowable Categories *(Ineligible for Payment for Care Rendered)*
West Virginia[11]	Respite Transportation Personal Care	• Services may be furnished by the legally responsible individual under the state's provision of extraordinary care • Respite services can be provided by any qualified relative as long as they do not reside in the home with the waiver recipient • Transportation can be provided by any qualified relative/legal guardian if they meet the qualifications	Respite services cannot be provided by spouses and legal guardians

[11] West Virginia 1915(c) Waiver Application, Appendix C-2 (2015), http://www.dhhr.wv.gov/bms/Programs/Documents/IDD%20Waiver/Waiver%20and%20reports/IDDW%202015.pdf

Commonwealth of Kentucky Department of Medicaid Services
1915 (c) Waiver Assessment
Summary of Federal HCBS Monitoring and Oversight Requirements

Introduction:

As part of the comprehensive 1915 (c) HCBS waiver assessment, Navigant is reviewing the Department of Medicaid Services' (DMS) monitoring and oversight process to identify ways to improve these functions, including restructuring options that would enhance oversight. Navigant reviewed federal HCBS regulations for 1915 (c) state waiver programs to summarize monitoring and oversight requirements. Additionally, Navigant researched how states internally identified as having strong HCBS financial oversight, distribute oversight activities outlined by Center for Medicare and Medicaid Services (CMS) in the 1915 (c) waiver application. This brief summarizes our findings and can be used as a resource while reviewing and re-organizing monitoring functions within DMS, in an effort to centralize quality and program oversight functions.

A. Quality Improvement Strategy and 1915(c) Waiver Assurances:
CMS requires each state to have a Quality Improvement Strategy (QIS) outlining how the state's waiver program will meet waiver assurances. The QIS should include activities and processes related to discovery and remediation, such as who will conduct the discovery and remediation and its frequency. These activities generate information regarding compliance, potential problems and individualized corrective actions. This information can be analyzed and used to measure the overall system in meeting waiver assurances. To comply with federal Home and Community Based Services (HCBS) requirements, states must provide evidence that these assurances are being met in their 1915(c) waivers.

Table 1 outlines the waiver assurances and the correspondent sub-assurances that CMS requires states to implement in their 1915 (c) waiver programs:

Table 1: Waiver Assurances and Sub-Assurances:[1]

Waiver Assurance	Description of Assurance:	Sub-Assurances
Health and Welfare	State must show that it has created an effective system assuring waiver participants' health and welfare	• Have a system in place that identifies, addresses and finds ways to prevent abuse, neglect, exploitation and death • Have an incident management system in place that resolves these incidents and prevents future incidents • Use or prohibition of restrictive interventions are followed in State policies and procedures • Establish overall health care standards and monitors those standards based on the

[1] Modifications to Quality Measures and Reporting in 1915(c) Home and Community-Based Waiver, Center for Medicaid and Medicare Services, March 2014. Available online: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/downloads/3-cmcs-quality-memo-narrative.pdf

Commonwealth of Kentucky Department of Medicaid Services
1915 (c) Waiver Assessment
Summary of Federal HCBS Monitoring and Oversight Requirements

Waiver Assurance	Description of Assurance:	Sub-Assurances
		responsibility of the service provider as stated in the approved waiver
Financial Accountability	State must design and implement an adequate system for ensuring financial accountability of the waiver program	• Provide evidence that claims are coded and paid in accordance with the reimbursement methodology specified in the approved waiver • Provide evidence that rates remain consistent with approved rate methodology throughout the five-year waiver cycle
Service Plans	State demonstrates it has designed and implemented a system for reviewing the adequacy of service plans for waiver participants	• Address all members' assessed needs (including health and safety risks) and personal goals • Update or revise service plans annually or if the participant's needs change • Deliver services in accordance with the service plan, including the type, scope, amount, duration and frequency specified in service plan • Provide participants a choice of waiver services and providers
Qualified Providers	State must design and implement a system to assure that all waiver services are provided by qualified providers	• Verify that providers initially and continually meet required licensure and/or certification standards and follow other standards prior to providing waiver services • Monitor non-licensed/non-certified providers to assurance adherence to waiver requirements • Implement policies and procedures for verifying that training is provided in compliance with State requirements and approved waiver
Level of Care	States must have processes and instruments, that are specified in their waiver, in place to evaluate and reevaluate a waiver participant's level of care (LOC) consistent with the level of care provided in	• Evaluate LOC of all applicants • Apply processes and instruments described in the approved waiver appropriately and according to approved description to determine initial participant level of care

Waiver Assurance	Description of Assurance:	Sub-Assurances
	hospitals, nursing facilities, or ICF/ID-DD	
Administrative Authority	The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities	*No Sub-assurances indicated*

B. Provider Certification and Monitoring Process:[2]

Summary of Federal Expectations for Provider Credentialing:[3]

A state Medicaid agency must screen all initial provider applications based on a categorical risk level of either limited, moderate, or high. If a provider falls within more than one risk level, they are assigned to the highest risk level. To assign the appropriate risk level, the state Medicaid agency should examine its Medicaid program to determine which of these providers types present an increased risk of fraud, waste or abuse to its Medicaid program. The state Medicaid agency has the discretion to make its own risk level determinations concerning these provider types. Additionally, CMS recommends states use payment trends to identify high risk provider types and activities when establishing these parameters. Table 3 outlines the required steps a state Medicaid agency must take to properly designate a provider to a categorical risk levels:

Table 3: Categorical Risk Levels Requirements for New Provider Applications

Categorical Risk Level	Required Steps
Limited Categorical Risk	• Verify that provider meets any applicable federal or state requirements • Conduct license verifications, including state licensure verifications • Conduct database checks on a pre- and post-enrollment basis to ensure that the provider continues to meet the enrollment criteria for their provider type

[2] Monitoring and Compliance with Home and Community Based Requirements, Center for Medicare and Medicaid Services, March 2016. Available online: https://www.medicaid.gov/medicaid/hcbs/downloads/hcbs-monitoring-slides.pdf

[3] Subpart C 455.450: Screening Levels for Medicaid Providers, Electronic Code of Federal Regulations. Available online: https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=1d07ebcbbc995d0c39e5c38e4288ef9e&mc=true&n=sp42.4.455.e&r=SUBPART&ty=HTML

Moderate Categorical Risk	• Perform the 'limited' screening requirements described above • Conduct on-site visits
High Categorical Risk	• Perform the 'limited' and 'moderate' screening requirements • Conduct a criminal background check • Require submission of a set of fingerprints

The state Medicaid agency must adjust the categorical risk level of a provider from "limited" or "moderate" to "high" when any of the following situations occur:

- CMS imposes a payment suspension on a provider based on credible allegation of fraud, waste, or abuse. The provider's risk remains "high" for 10 years beyond the date of the payment suspension
- A prospective provider is found to have an existing state Medicaid plan overpayment.
- The provider has been excluded by the department's Office of the Inspector General (OIG) or another state's Medicaid program within the previous 10 years.
- The state Medicaid agency or CMS, in the previous 6 months, lifted a temporary moratorium for the provider and a provider that was prevented from enrolling based on the moratorium applies for enrollment as a provider at any time within six months from the date the moratorium was lifted.

Monitoring Compliance:

CMS requires states to establish a monitoring process in their QIS to ensure they are complying with federal HCBS requirements and tracking their QIS progress. CMS recommends that state have two types of monitoring processes in place, monitoring implementation of remedial actions and monitoring to ensure ongoing compliance.

Monitoring Implementation of Remedial Actions:

In the monitoring implementation process, states are responsible to ensure both the state and providers comply with federal HCBS program requirements. Additionally, states must establish a process to track and monitor provider's remedial actions. Once a provider reports the completion of their remedial actions, the state must verify their compliance by using existing oversight resources such as licensing and certification agencies.

Monitoring to Ensure Ongoing Compliance:

States are required to conduct ongoing assessments of provider's compliance status of HCBS requirements. CMS recommends states use existing infrastructure and processes to monitor these requirements. However, existing tools may need to be updated to reflect the new settings requirements established in 2014. Examples of monitoring tools include site visits, licensing and/or certification reviews, case manager reviews and provider self-assessments. Additionally, the state must have state actions in place to bring non-compliant settings back into compliance. If a site is found to be out of compliance, the state must report the assessment results to the

provider, identify areas of noncompliance and require the setting to implement corrective action plans to remedy these areas of noncompliance.

C. Fiscal Surveillance and Utilization Review Control Program:[4]

State Medicaid agencies are required to implement a statewide surveillance and utilization control program that safeguards against unnecessary or inappropriate use of Medicaid services and against excess payments. Additionally, states must have adequate policies in place for performing effective pre-payment and post-payment reviews to limit improper payments. States are required to have post-payment review process that allow them to develop and review beneficiary utilization profiles, provider service profiles and identify exceptions so that the agency can correct misutilization practices of beneficiaries and providers.

D. Federally Defined Role of Program Integrity Units:[5]

Program integrity units are designed to ensure that federal and state funds are being used appropriately in the delivery of services and prevent fraud, overpayment and waste from taking place. When designed and maximized, program integrity units ensure eligibility decisions are correct, and monitor prospective and enrolled providers meet federal and state participation requirements. States use several tools to identify and address fraud and abuse in their program, such as conducting audits and investigations of suspected fraud and abuse. Some states contract outside entities to handle their Medicaid claims and utilization reviews but states are still responsible for conducting program integrity activities that address provider enrollment, claims review and case referrals. Federal Medicaid regulations require all state agencies to:

- Collect and verify basic information on providers
- Maintain a claims processing and information system – MMIS
- Operate a Surveillance and Utilization Review System (SURS)
- Have methods for identifying and investigating suspected fraud cases
- Refer potential fraud cases to law enforcement

CMS has a range of program integrity activities to oversee and support states' Medicaid program integrity units. The Deficit Reduction Act of 2005 provided CMS significant funding and responsibility for Medicaid program integrity. In accordance with the Deficit Reduction Act, CMS contracts with Medicaid Integrity Contractors (MICs) to review the actions of Medicaid providers, and audit provider's claims to identify overpayments. The state, with the guidance from CMS, determine the role of MICs in the state's auditing process. CMS encourages states to use collaborative audits but it is not required. In some states, MICs conduct the entire audit; in other states, MICs are used to supplement state resources by providing medical review staff and other resources. Additionally, the Affordable Care Act required CMS to expand their Recovery Audit Contractors (RACs) to help in the identification of overpayment in state Medicaid program.

---

[4] Subpart C, Part 245: Utilization Control, Electronic Code of Federal Regulations. Available online: https://www.ecfr.gov/cgi-bin/text-idx?SID=efb60d5b075b0e241cf5fe85e1395c97&mc=true&node=pt42.4.456&rgn=div5#se42.4.456_11

[5] Annual Summary Report of Comprehensive Program Integrity Reviews, Center for Medicare and Medicaid Services, Center for Program Integrity, June 2014. Available online: https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/2013pisummary.pdf

States are required to contract with RACs and pay the RACs a contingency fee for identification of overpayments.

Conclusion

Upon review of federal guidance, coupled with the review of other state's 1915 (c) monitoring practices and assignment of monitoring activities, leveraging DMS' Program Integrity unit to support billing review and financial oversight for 1915 (c) waiver is an appropriate step. A review of other 1915 (c) waivers from other states reported to have strong financial oversight capabilities, shows it is not uncommon for program integrity units to have responsibilities related to a state's HCBS programs. DMS should continue to explore how to optimize utilization of their in-house PI unit to support the Division of Community Alternatives, as the department proceeds with centralizing monitoring and oversight functions from sister operating agencies back to DMS, the department with foremost accountability to CMS as the single state Medicaid agency.

Commonwealth of Kentucky, Department of Medicaid Services
1915(c) Waiver Assessment
State Comparison: Concurrent Delivery of *Hospice* and *Home and Community Based Services (HCBS)*

Issue

The Kentucky Department of Medicaid Services requested information on other States' approaches to concurrent delivery of Medicaid funded hospice services and 1915 (c) HCBS waiver services. Current Kentucky regulations disallow Medicaid enrollees from receiving hospice and HCBS services simultaneously, due to potential duplication of service, including case management and personal care services. Stakeholders, including waiver participants, HCBS case management providers and Hospice providers have expressed concern that this rule is detrimental to Hospice appropriate waiver participants, who are required to choose between the palliative healthcare model, and the more robust availability of personal care offered on HCBS waivers.

Summary of Hospice Service and CMS Guidance

Medicaid hospice is a state plan service which includes services provided to individuals with terminal medical prognosis. Eligibility for hospice services requires that the individual complete a written election to enroll with a hospice provider. The individual must acknowledge waiving other Medicaid services for curative treatment of the condition. The selected hospice provider must obtain a physician certification confirming terminal prognosis and authorizing hospice services as necessary for end of life care. The individual may elect to terminate hospice services at any time and resume other Medicaid covered services including curative care.

Individuals enrolled in hospice, and Home and Community-Based Services (HCBS) waivers may elect to receive HCBS services that are not duplicative of services provided in a hospice setting in coordination with hospice services. States have implemented policies and procedures to improve care coordination and limit duplication of services for individuals receiving blended hospice and HCBS. Four states, Mississippi, Ohio, North Carolina and Minnesota outlined in the table below require coordination efforts between HCBS waiver and the hospice team in the development of the individual's Plan of Care (POC). Additionally, the case manager or hospice provider must assume the responsibility of managing the individual's services and additional documentation may be required monitor delivery of services.[1]

Conclusion

Based on a review of federal and state guidance related to the blending of Medicaid Hospice and home and community based waiver services, states have implemented processes to foster the delivery of HCBS services that are not available to individuals in a hospice setting. States rely heavily on coordination among hospice and HCBS providers and thorough documentation during service delivery to avoid duplication. Additional safeguards may be necessary to ensure that duplication of services does not occur, including, training of hospice and HCBS staff and conducting of ad hoc audits. Duplication of service concerns can be mitigated sufficiently to allow for provision of HCBS waiver services and hospice care simultaneously, to meet the personal care and end of life care needs of participants with a terminal prognosis.

[1] *Hospice Benefits, Available at: https://www.medicaid.gov/medicaid/benefits/hospice/index.html*

Commonwealth of Kentucky, Department of Medicaid Services
1915(c) Waiver Assessment
State Comparison: Concurrent Delivery of *Hospice* and *Home and Community Based Services (HCBS)*

Table 1: State Requirements for Administering Hospice and HCBS concurrently

State	Service Limitations	Coordination Activities (*Hospice and HCBS*)
Mississippi[2]	• Hospice benefits must be fully utilized prior to waiver service utilization in instances of potential duplication. Department of Medicaid (DOM) will conduct retrospective reviews of waiver and hospice services.	• The hospice provider and HCBS waiver case manager/support coordinator must have a person-centered planning conference regarding the joint hospice plan of care (POC) and HCBS waiver plan of services and supports before concurrent services can start. • The hospice provider is considered the primary provider and is required to manage the joint hospice POC and HCBS waiver plan of services and supports when a person is receiving both hospice and HCBS waiver services. • The POC must clearly outline services, entity responsible for providing services (Hospice/HCBS) and frequency. • Each HCBS service must be accompanied by documentation stating why the service is not covered under hospice.
Minnesota[3]	• No limitations identified	• The hospice provider must notify the case manager in writing of the member's election of hospice and the anticipated start date. 1) The hospice staff will assume lead responsibility for collaboration with the HCBS case manager and invite the case manager to participate in the hospice interdisciplinary care team meetings for a member receiving HCBS. 2) The hospice staff must document the collaboration and forward the documentation within eight calendar days of the effective date of hospice services. • Collaboration may be by telephone, fax, email, or a face-to-face visit. Include documentation in the member's hospice record.

[2] *Mississippi Medicaid, Guidance for providing concurrent services for both hospice and home and community based waiver services*. Available at: https://medicaid.ms.gov/guidance-for-providing-concurrent-services-for-both-hospice-and-home-and-community-based-waiver-services/
[3] *Minnesota Department of Human Services, Hospice Services. Available at: https://www.dhs.mn.gov/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=ID_008997*

Commonwealth of Kentucky, Department of Medicaid Services
1915(c) Waiver Assessment
State Comparison: Concurrent Delivery of *Hospice* and *Home and Community Based Services (HCBS)*

State	Service Limitations	Coordination Activities (*Hospice and HCBS*)
North Carolina[4]	• Hospice aide and PCS aide hours CANNOT overlap. Medicaid payments for PCS provided to an individual also receiving hospice services, regardless of the payment source, must be supported by documentation in the medical record of both providers. [5] • Hospice and PCS aides must be instructed that if they arrive at the home and the other aide is there they should report this to their respective agency and leave the home. Any changes in scheduling for either agency will be reported to the other to avoid duplication of services at the same time.	• The hospice agency shall coordinate its hospice aide and homemaker services with the prior approved personal care services required to meet the beneficiary's needs. • If PCS services are in place prior to hospice admit, the hospice agency will contact the PCS provider to coordinate the plan of care and scheduling of services. • If Hospice is in place prior to the PCS request, the hospice agency will submit the Hospice-PCS Coordination Form (DMA-3165) to NC DMA to indicate the service gap necessitating the addition of PCS. • Once PCS is authorized, the hospice agency will contact the PCS provider to coordinate the plan of care and scheduling of services. • The hospice agency will submit the Hospice Aide Plan of Care to the PCS provider. • The Hospice and PCS provider will develop a plan of care (POC) in coordination with the patient, the caregiver and each other. • The coordinated POC must clearly specify aide tasks with frequency of services by each provider to ensure that the beneficiary's daily needs are met without duplication of services. • Hospice is responsible for communicating with other providers to ensure that coordination of care occurs. • Hospice must conduct a thorough interview process at admission to identify all other Medicaid or other state and/or federally funded program providers of care – applies to Medicaid and dually eligible beneficiaries.

[4] *North Carolina Division of Medical Assistance: Medicaid and Health Choice, Hospice: Clinical Coverage policy.:3D. Available at: https://files.nc.gov/ncdma/documents/files/3D_1.pdf*
[5] *Coordination of Hospice & Personal Care Services (PCS). Available at: https://files.nc.gov/ncdma/documents/files/Hospice-PCS-Coordination-Presentation-2015-12.pdf*

State	Service Limitations	Coordination Activities (*Hospice and HCBS*)
		• Communication to coordinate care will be documented in each provider's medical record
Ohio[6]	The individual's certain Medicaid services are waived for the duration of hospice care if services, 1) Are provided by a hospice other than the hospice designated by the individual, unless provided under arrangement made by the designated hospice; 2) Are related to the curative treatment of the terminal condition for which hospice care was elected or a related condition, except for the individual under age twenty-one; or, 3) Are equivalent to hospice care such as non-waiver services provided through home health and private duty nursing services.	• Hospice care program and HCBS case manager must develop a coordinated plan of care regarding the Medicaid recipient's terminal illness. • The hospice must provide services to a waiver individual in accordance with a comprehensive plan for the concurrent provision of waiver services by waiver and hospice providers. The administrating agency of the waiver or its designee shall assist in the coordination of care by: 1) Reviewing and approving the comprehensive plan for the concurrent provision of waiver services by waiver and hospice providers; 2) Resolving any issues resulting from the comprehensive plan for the concurrent provision of waiver services by waiver and hospice providers; 3) Resolving any issues of interpretation when implementing the requirements in this chapter; and; 4) Applying any exceptions to the requirements of this chapter on a case-by- case basis.

[6] *5160-56-04 Hospice services: provider requirements. Available at: http://codes.ohio.gov/oac/5160-56-04*

Appendix: State Regulations for Hospice and Eligibility Criteria

State	Federal Regs.	State Regs.	Hospice – Eligibility Criteria
Mississippi	***42 CFR 418.21 - Duration of hospice care coverage - Election periods*** (1) An initial 90-day period; (2) A subsequent 90-day period; or (3) An unlimited number of subsequent 60-day periods. (b) The periods of care are available in the order listed and may be elected separately at different times. ***42 CFR 418.22 - Certification of terminal illness*** The hospice must obtain the written certification before it submits a claim for payment. ***Exceptions*** 1) certification within 2 calendar days, after a period begins, it must obtain an oral certification within 2 calendar days and the written certification before it submits a claim for payment	***MS Admin Code Title*** *23, Part 205, 208*[7]	• Medicaid beneficiary must be certified as being terminally ill with a life expectancy of six (6) months or less, and there must be a documented diagnosis consistent with a terminal stage of six (6) months or less. The beneficiary/legal representative must sign and file an Election Statement with the hospice.
Minnesota		***Minnesota Admin Rule:*** *9505.0297 Hospice Care Services*[8]	• Member must be: Eligible for MA (Medicaid) or MinnesotaCare Certified as terminally ill by the medical director of the hospice, or a physician member of the interdisciplinary group, and the member's attending physician, if he or she has one. Has filed an election statement with the selected hospice, and if dual eligible, with both Medicare and Medicaid.
North Carolina		**Amended Date: January 1, 2016** *Medicaid and Health Choice Hospice Services Clinical*	• Beneficiary must be enrolled in either North Carolina Health Choice (NCHC) or North Carolina Medicaid Program.

[7] *Mississippi Medicaid, Provider Reference Guide for Part 205, Available at: https://medicaid.ms.gov/wp-content/uploads/2014/01/Provider-Reference-Guide-205.pdf*
[8] *Minnesota Administrative Rule: 9505.0297: Hospice Care Services, Available at: https://www.revisor.mn.gov/rules/?id=9505.0297*

State	Federal Regs.	State Regs.	Hospice – Eligibility Criteria
	2) Certifications may be completed no more than 15 calendar days prior to the effective date of election. 3) Recertification may be completed no more than 15 calendar days prior to the start of the subsequent benefit period **Public Law 111–148, Sec. 2302. Concurrent Care for Children**	*Coverage Policy No.: 3D*[9]	
Ohio		***Changes to state regulation became effective 10/1/2017*** *(1) 5160-56-02 Hospice Services: Eligibility and Election Requirements*[10] *(1) 5160-56-04 Hospice Services: Provider Requirements*	• Certification of the terminal illness on behalf of the individual, obtained in accordance with 42 C.F.R. 418.22. The individual has a hospice plan of care initiated, pursuant to paragraph (F) of this rule - The individual's acknowledgment that the attending physician was the individual's choice.

[9] *North Carolina Division of Medical Assistance: Medicaid and Health Choice, Hospice: Clinical Coverage policy.:3D. Available at: https://files.nc.gov/ncdma/documents/files/3D_1.pdf*
[10] *5160-56-02 Hospice services: eligibility and election requirements. Available at: http://codes.ohio.gov/oac/5160-56-02v1*

Alabama Medicaid

Waiver QA Requirements and Recommended Practices

November 29, 2017

This document summarizes CMS requirements pertaining to quality assurance activities for 1915(c) waivers, and provides examples of recommended practices associated with the Agency's current quality assurance activities and quality assurance activities that are not currently in place (e.g., monitoring waiver assurance performance measures). Navigant used the CMS *1915(c) Home and Community-Based Waiver Instructions, Technical Guide, and Review Criteria* as the primary source to identify CMS requirements. However, it is important to note that CMS also requires states to comply with their approved 1915(c) waivers, which further detail how states will administer and oversee 1915(c) waiver programs. Although Navigant has not incorporated Alabama-specific requirements from Alabama's 1915(c) waivers into this document, the Agency must be able to demonstrate that the functions and procedures in its approved 1915(c) waivers are being followed to comply with CMS requirements.

Quality Assurance Activity	CMS Requirements	Recommended Practices
Waiver Assurance Performance Measures	• A State's Quality Improvement Strategy (QIS) must address the following waiver assurances and sub-assurances as a prerequisite[1] o Administrative authority (1 assurance) o Level of care (1 assurance, 2 sub-assurances) o Qualified providers (1 assurance, 3-sub-assurances) o Service plan (1 assurance, 4 sub-assurances) o Health and welfare (1 assurance, 4 sub-assurances) o Financial accountability (1 assurance, 2 sub-assurance) • A Medicaid agency may delegate QIS activities to other parties, however the Medicaid agency must: o Be the party to delegate the activities in the QIS o Receive the monitoring, remediation, and system improvement reports that pertain to meeting assurances o Perform its own monitoring of all delegated activities • A State should measure performance against the assurances no less than annually • CMS "strongly urges" states to have a solid sampling approach to the assurance evidence it collects • A State's continuous quality improvement process must consist of:	• Clearly identify which agency is responsible for measuring each waiver assurance performance measure and the schedule for discovery, remediation, and improvement o The primary agency (e.g., operating agency) should conduct discovery, remediation, and improvement activities for each waiver assurance performance measure quarterly, unless there is evidence that measure performance has been consistent over time and therefore may be measured on a less frequent basis (e.g., annually) o The Agency's Quality Assurance team should hold quarterly meetings with representatives from each of the operating agencies to review performance on the waiver assurance performance measures, identify remediation strategies and corrective action plans (if needed) and discuss other quality issues pertaining to the waivers • Have data collection tools for each waiver assurance performance measure; typically data collection tools should include instructions, definitions of terms and items, and protocols for data collection and data recording • Develop an electronic tool to aggregate, summarize, and report data • Develop and produce management reports that cover the waiver assurance performance measures at a minimum; managers and

[1] CMS Application for a 1915(c) Home and Community-Based Waiver Instructions, Technical Guide, and Review Criteria. January 2015.

Quality Assurance Activity	CMS Requirements	Recommended Practices
	o **Discovery**: monitoring and data collection activities that identify whether and to what extent the State addresses compliance with the assurances o **Remediation**: activities designed to correct identified problems at the individual, provider or system level o **Improvement**: a State must implement quality improvement projects (QIP) when the performance indicator falls below a threshold of 86%, unless the state provides justification accepted by CMS that a QIP is not necessary[2]	other stakeholders should review these reports on a regular basis to monitor key indicators and identify areas for improvement or further investigation • Consider assigning responsibility for reviewing waiver assurance categories to individual members of the Agency's Quality Assurance team (e.g., one team member reviews all level of care and service plan assurances across 1915(c) waivers)
Additional Quality Performance Measures	• There is no Federal requirement for additional quality performance measures, however CMS states that a State's QIS can extend to aspects of waiver operations that are critical in achieving the waiver's purpose and meeting the expectations of waiver participants and stakeholders[3]	• Identify additional HCBS quality measures beyond the waiver assurance quality measures to evaluate outcomes • Use a combination of structural, process, and outcome performance measures to drive improvement • The National Quality Forum has identified measure concepts associated with HCBS measure domains that the Agency could consider for additional quality measurement activities;[4] could also consider measures identified by the ICN Quality Assurance Committee
Retrospective Reviews	***Related to Level of Care waiver assurance category*** • Level of care must be re-evaluated no less frequently than annually • Re-evaluation of level of care may be performed at any time due to a change in a person's condition or service needs[5]	*None identified at this time*
Case Management Reviews	***Related to Service Plan waiver assurance category*** • While the waiver operating agency or other entities may approve service plans as part of day-to-day waiver operations when authorized by the Medicaid agency, the	• The Agency should continue to review a sample of service plans on a quarterly basis • The Agency should develop a policy that outlines its approach to determining sample sizes across all quality assurance activities.

[2] CMS. Modifications to Quality Measures and Reporting in 1915(c) Home and Community-Based Waivers. March 12, 2014. Available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/3-CMCS-quality-memo-narrative.pdf.
[3] CMS Application for a 1915(c) Home and Community-Based Waiver Instructions, Technical Guide, and Review Criteria. January 2015.
[4] National Quality Forum. Quality in Home and Community-Based Services to Support Community Living: Addressing Gaps in Performance Measurement. September 2016. Available at: file:///C:/Users/ckoster/Downloads/hcbs_final_report%20(1).pdf.
[5] CMS Application for a 1915(c) Home and Community-Based Waiver Instructions, Technical Guide, and Review Criteria. January 2015.

Quality Assurance Activity	CMS Requirements	Recommended Practices
	Medicaid agency must retain responsibility for service plan approval and at a minimum must review at least a sample of service plans retrospectively or employ other methods that ensure that plans have been developed in accordance with applicable policies and procedures and plans ensure the health and welfare of waiver participants • The Medicaid agency must exercise oversight of service plans on a routine and periodic basis. • When this oversight is conducted through an in-depth review of a sample of service plans, the State must specify the basis for the size of the sample, how frequently retrospective review is conducted, the methods for conducting the review, and the persons or entities who conduct the review	This policy should also include details regarding when an additional sample should be pulled based on identified deficiencies.
Informal Conference Reviews	• There is no Federal requirement for 1915(c) grievance and complaint systems under which waiver participants can seek resolution of problems or issues with the services that they receive and/or have been authorized to receive • States must provide waiver recipients the opportunity to request a Medicaid Fair Hearing[6]	*None identified at this time*
Critical Incident Reports	***Related to Health and Welfare waiver assurance category*** • The State must indicate which agency or agencies is responsible for overseeing the operation of the incident management system o When this responsibility is not carried out directly by the Medicaid agency and/or the operating agency, the State must indicate how the information and findings from oversight activities are communicated to the Medicaid agency and/or the operating agency by the state agency (or agencies) responsible for oversight o It is critical that the Medicaid agency and/or the operating agency play an active role in the oversight of the operation of the incident management system	• The Agency should audit the operating agencies conduct of the critical incident review and follow-up process for all waivers • The State should have a centralized, automated system and process to track and trend critical incidents and update incident records • The State should have audit protocols to verify if all critical incidents are being reported • The Agency should assign specific staff responsibility for tracking and trending critical events across the waiver programs for continuous quality improvement and should have policies and procedures that identify the role of the recipient, provider, Medicaid agency, and other state agencies in the critical incident process

[6] CMS Application for a 1915(c) Home and Community-Based Waiver Instructions, Technical Guide, and Review Criteria. January 2015.

Quality Assurance Activity	CMS Requirements	Recommended Practices
	• System-wide oversight methods should include gathering information about types of incidents, participant characteristics, providers, how quickly reports are reviewed and investigated, how promptly follow-up takes place, the results of investigations, and whether participants are informed of the investigation results *Note: Restrictive interventions are also addressed in the Health and Welfare waiver assurance category. The Agency must have effective oversight processes to monitor the use of restraints, seclusion, and restrictive interventions across the 1915(c) waivers.*	
On-site Reviews	***Related to Provider Qualifications waiver assurance category*** • There is no Federally-required schedule for the re-verification of provider qualifications[7] o In the case of some types of providers (e.g., personal assistants), a state may provide that provider qualifications are only re-verified as necessary o Irrespective of the schedule that is employed to re-verify provider qualifications, the state has the responsibility to ensure that providers meet the qualifications for each service on an on-going basis	• Verify provider enrollment process and confirm proper oversight to provider qualifications; conduct a small sample audit of 10 – 15 provider records per waiver to verify protocols are followed • Determine which HCBS providers receive an on-site visit from operating agencies or other state agencies o Determine what is covered during these on-site visits o Determine visit frequency • Align with ongoing monitoring of HCBS settings required by CMS to ensure compliance with Federal regulations • Based on comprehensive list of HCBS on-site visits that occur, determine: o Gaps in provider on-site visits o Any duplication of efforts in on-site visits • Ensure coordination between the licensing/ credentialing entity, investigative entity and quality assurance entity • Potential provider types for additional on-site reviews include: o Provider types that account for high volume of HCBS services (either in terms of dollars or quantity of visits/services) o Provider types in settings that could be isolating (services named in Alabama waiver systemic reviews that are offered in disability-specific settings)

[7] CMS Application for a 1915(c) Home and Community-Based Waiver Instructions, Technical Guide, and Review Criteria. January 2015.

Quality Assurance Activity	CMS Requirements	Recommended Practices
		▪ Adult day health centers (ACT, E&D) ▪ Day habilitation (LAH, ID) ▪ Prevocational services (LAH, ID) ▪ May also consider residential habilitation
Inter-Agency Agreements	• When waiver administrative and operational functions are performed by other entities on behalf of the Medicaid agency, the Medicaid agency should have a formal, written document expressly delegating the functions to be performed, and the Medicaid agency must supervise the performance of these functions o The agreement between the Medicaid agency and the operating agency must be sufficiently detailed so that it clearly delineates those activities, functions and responsibilities that the Medicaid agency delegates to the operating agency and the responsibilities of the operating agency in carrying out those functions. The agreement may span the operation of more than one waiver so long as operating agency responsibilities for each waiver are clearly delineated	• The State should clearly delineate in Memorandums of Understanding (MOU) the roles and responsibilities of the Agency vs. the operating agencies; the MOU should also indicate how often the Agency will review and update the MOU
Operating Agency Policies and Procedures	***Related to Administrative Authority waiver assurance category*** • Any rules, regulations and policies that govern how the waiver is operated must be issued by the Medicaid agency rather than by the operating agency o In issuing rules, regulations and policies that affect the waiver, the Medicaid agency may incorporate by reference rules, regulations and policies that have been adopted by the operating agency o The operating agency may not independently promulgate rules, regulations and policies that have a material effect on the provision of waiver services and how waiver processes are conducted[8]	• The Agency should develop a process whereby operating agencies submit to the Agency for review and approval any new policies, procedures, tools, etc. used to carry out waiver responsibilities or that impact waiver services o On an annual basis, the operating agencies should attest that there have not been any changes to these policies, procedures, tools, etc., o Any time there is a significant change, the operating agencies should submit the policies, procedures, tools, etc. for review and approval

[8] CMS Application for a 1915(c) Home and Community-Based Waiver Instructions, Technical Guide, and Review Criteria. January 2015.

Quality Assurance Activity	CMS Requirements	Recommended Practices
Operating Agency Reviews	***Related to Administrative Authority waiver assurance category*** • The Medicaid agency will conduct or arrange for the periodic assessment of the performance of other entities in conducting waiver administrative and operational activities to ensure that the waiver is operated in accordance with the approved waiver and applicable Federal requirements[9]	• The Medicaid agency oversight may be exercised in a variety of ways, including providing that the operating agency track and periodically report to the Medicaid agency its performance in conducting operational functions • The Agency should establish clear and strong lines of communication with the operating agencies • Each operating agency review should sufficiently cover activities and functions that the Agency has delegated to the operating agency
Meetings	• There is no Federally-required schedule for meetings	• The Agency's Quality Assurance team should meet weekly to discuss status of audits and address any key findings or issues • Hold quarterly meetings with representatives from the Agency's Quality Assurance team and representatives from each of the operating agencies to review performance on the waiver assurance performance measures, identify remediation strategies (if needed) and discuss other quality issues pertaining to the waivers • Information on waiver assurance performance measures should be shared with stakeholders (e.g., through Long Term Care workgroup meetings, Medical Care Advisory Committee meetings, posted on the Agency's website)
Recipient Surveys	• There are no Federal requirements for recipient surveys	• Consider replacing AMA's recipient surveys (REOMBs (Recipient explanation of Medicaid benefits)) and its TA waiver survey with the National Core Indicators-Aging and Disabilities (NCI-AD) survey. o The NCI survey is already used by Department of Mental Health for the intellectual and developmental disabilities waiver and the living at home waiver and could continue to lead this process. o To have a central source for the remaining waivers, the Agency should lead the process for the NCI-AD survey, coordinating with the operating agencies as necessary

[9] CMS Application for a 1915(c) Home and Community-Based Waiver Instructions, Technical Guide, and Review Criteria. January 2015.

Quality Assurance Activity	CMS Requirements	Recommended Practices
Annual Report Form CMS-372	• Annually prepare and submit the Form CMS-372 to CMS	• The Agency should monitor waiver utilization and expenditures on an ongoing basis and submit amendments as necessary, if the number of waiver participants is significantly greater than the number estimated in the approved waiver and/or if waiver expenditures exceed those estimated in the approved waiver • The Agency should have a process to initiate corrective actions if it appears it is at risk of meeting the cost neutrality assurance

Year	XX	20XX												20XX												20XX												20XX												20XX										
Month	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11
Project Kickoff																																																												
Task A - Project Kickoff and Initial Project Planning																																																												
Objective 1 Program Planning and Design																																																												
Task A - Provide assistance for the preparation of Federal Waiver and State Plan Amendment submissions, modifications and renewals; and preparation of corresponding state rules associated with the new delivery system.																																																												
Task B - Assist in the preparation and formatting of reports, surveys, brochures, and newsletters.																																																												
Objective 2 Managed Care Development and Support																																																												
Task A - MMIS-Related Activities																																																												
Task B - Third Party Administrator																																																												
SbTsk 1 - Provide research and analysis relating to the release of an RFP for a third party administrator for managed care.																																																												
SbTsk 2 - Assist in RFP Development for a third party administrator.																																																												
SbTsk 3 - Support the RFP Preproposal Conferences.																																																												
SbTsk 4 - Support the RFP evaluation process.																																																												
Task C - Provide assistance for the Managed Care contracting process.																																																												
Task D - Provide support for Health Information Exchange (HIE) activities.																																																												
Objective 3 Program Monitoring and Data Analysis																																																												
Task A - Data base technical support																																																												
Task B - Assist with training related to contract monitoring.																																																												
Task C - Assist with development of monitoring work plans and updates.																																																												
Task D - Assist with the development of program transition steps for changes to the Medical Assistance delivery system.																																																												
Task E - Support general research and data analyses.																																																												
Task F - Assist with readiness reviews.																																																												
Task G - Assist the Agency in analyzing Provider Network adequacy.																																																												
Objective 4 Quality Management Analysis and Support																																																												
Task A - Assist with development and preparation of reporting Formats.																																																												
Task B - Provide technical assistance and/or staff training related to data analysis that supports Quality Management reporting and monitoring functions.																																																												
Task C - Provide technical assistance related to database development, modification and maintenance.																																																												
Task D - Provide technical assistance related to the development of monitoring and reporting tools.																																																												
Task E - Assist and/or provide staff, training and development.																																																												
Objective 5 Program Management and Infrastructure Development																																																												
Task A - Assist the Agency with the preparation, design and formatting of reports and publications.																																																												
Task B - Develop program management work plans.																																																												
Task C - Analyze and recommend improvement to program operations.																																																												
Task D - Provide technical assistance in subject matter meetings.																																																												
Objective 6 Technical Assistance and Consultant Services Contract Management																																																												
Task A - Prepare for and participate in the Monthly Budget Status Meetings.																																																												
Task B - Manage monthly budget.																																																												
Task C - Contract Responsibilities.																																																												

1. At the State's discretion, hours can be shifted among proposed team members, including members of the expert panel. Similarly, Navigant can make available other members of our Healthcare practice to support and advise the State, as needed, and the State can shift hours from proposed consultants to other consultants.
2. Navigant will provide the State 15 business days for review of all draft deliverables, per the requirements set forth in the RFP.
3. The allocation of consultant hours reflected herein are based on our best estimate at this time.
4. Hours for kickoff meeting are reflected under Objective 6, Task A.

MISSISSIPPI DIVISION OF MEDICAID

Mississippi Division of Medicaid
Healthcare Delivery Systems Consultant

Project Work Plan by Month

Description	Status	Month													Comments
		20XX			20XX										
		Oct	Nov	Dec	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	
Task 1: Conduct Project Management															
Conduct ongoing project management	Ongoing														
Develop detailed project plan	Ongoing														
Conduct status meetings with DOM	Ongoing														
Task 2: Assist with Strategic Planning															
Strategic Planning Discussions with DOM	In Process and Ongoing														
Task 3: Assist with MississippiCAN															
Support MississippiCAN Reprocurement and Contract Negotiations															
Provide Technical Assistance in CCO Proposal Review	Complete														
Attend Oral Presentations and Assist with Contract Negotiations	Complete														
Update Contract	Complete														
Prepare Value-Based Purchasing Measures	On Hold														
Assist with Conduct of MississippiCAN Compliance/ Readiness reviews															
Prepare Readiness Review Tool	Complete														
Conduct of Desk Review	Complete														
Conduct of On-Site Review	Complete														
Preparation of Summary of Findings and Corrective Action Plans	Complete														
Review and Update Contract Standards, and Performance Measures and Targets	In Process														

MISSISSIPPI DIVISION OF MEDICAID

Mississippi Division of Medicaid
Healthcare Delivery Systems Consultant

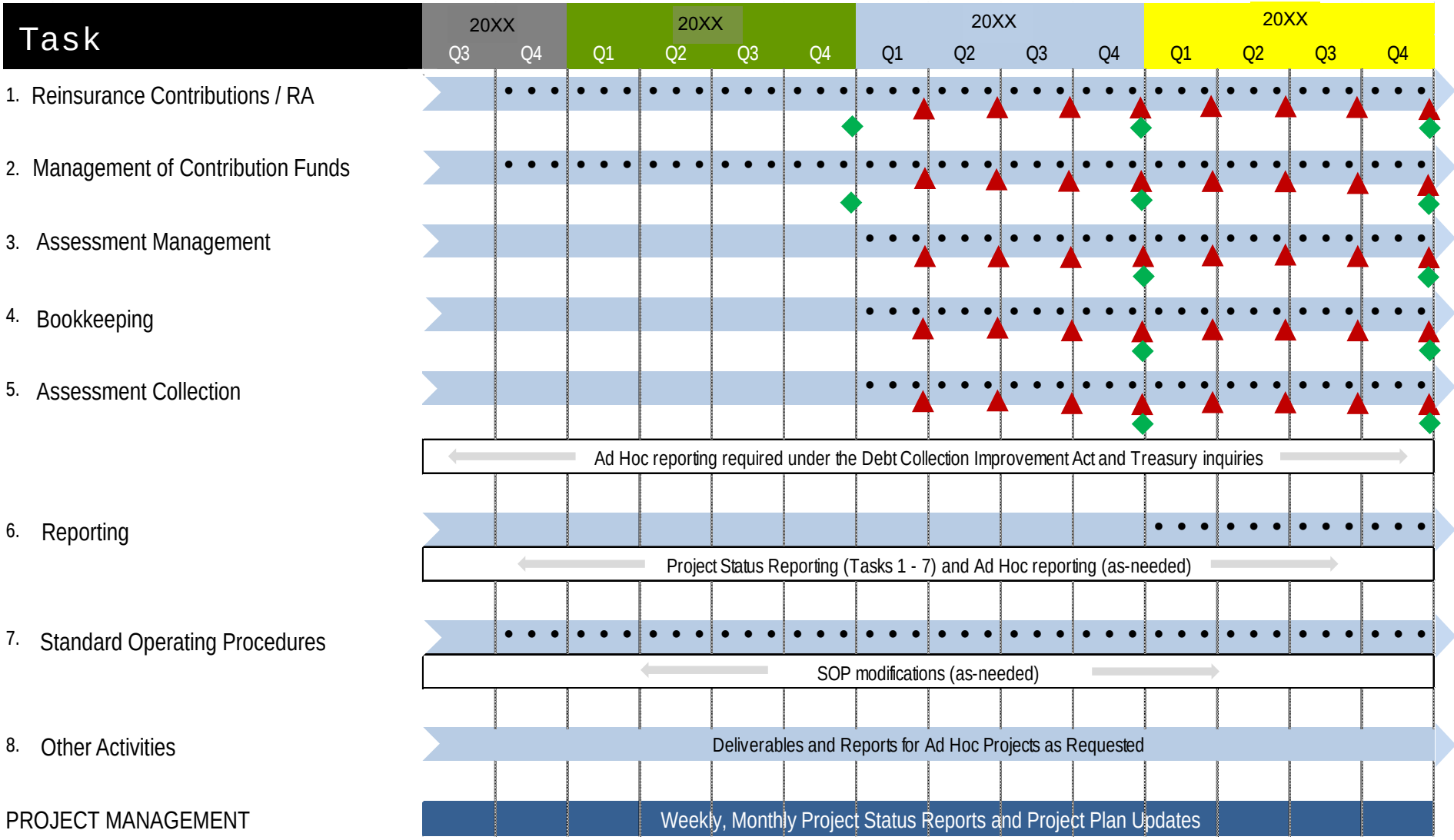
Description	Status	Month													Comments
		20XX			20XX										
		Oct	Nov	Dec	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	
Assist with Conduct of Ongoing Monitoring Activities	Ongoing														
Conduct of Parallel Report Reviews	Ongoing														
Review Audit/Review Methodologies	Ongoing														
Participate in Monitoring Meetings with CCOs	Ongoing														
Support MississippiCAN Quality Initiatives and Ongoing Monitoring	Ongoing														Ongoing as requested
Quality Task Force and Leadership Meetings															
Participate in QTF and QLT Meetings	Ongoing														
Review updates to Quality Strategy	Ongoing														Ongoing as requested
Provide guidance on requested topics	Ongoing														As requested
Develop MississippiCAN Reporting Manual	Complete														
Develop definitions for reports in new contract	Complete														
Meet with CCOs to discuss new reporting requirements and performance measures	Complete														
Develop MississippiCAN Standard Operating Procedures	In Process														
Update Existing Monitoring Tracking Tool based on Changes for New Contract	In Process														
Task 4: Assistance with Other Delivery Systems															
Prepare CHIP Emergency Contract	In Process														

MISSISSIPPI DIVISION OF MEDICAID

Mississippi Division of Medicaid
Healthcare Delivery Systems Consultant

Description	Status	Month													Comments
		20XX			20XX										
		Oct	Nov	Dec	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	
Task 5: Conduct Research and Data Analysis (Tentative)															
Develop "State of the Program" Report	Complete														
Document eligibility/enrollment decision rules	Complete														
Collect data feeds (e.g., enrollment, inpatient, hospital outpatient, professional, provider, ancillary)	Complete														
Develop quarterly data load	Not Started														Timeframe TBD
Develop core enrollment measures, analysis, and trending report	Not Started														Timeframe TBD
Conduct encounter data validation	Not Started														Timeframe TBD
Report on Ongoing Activities and Initiatives of CMS About Healthcare Delivery Systems	Ongoing														Ongoing
Task 6: Assist with Staff Development															
Conduct staff trainings for Office of Coordinated Care	Complete														
Task 7: Executive Support															
Assistance not requested at this time.															

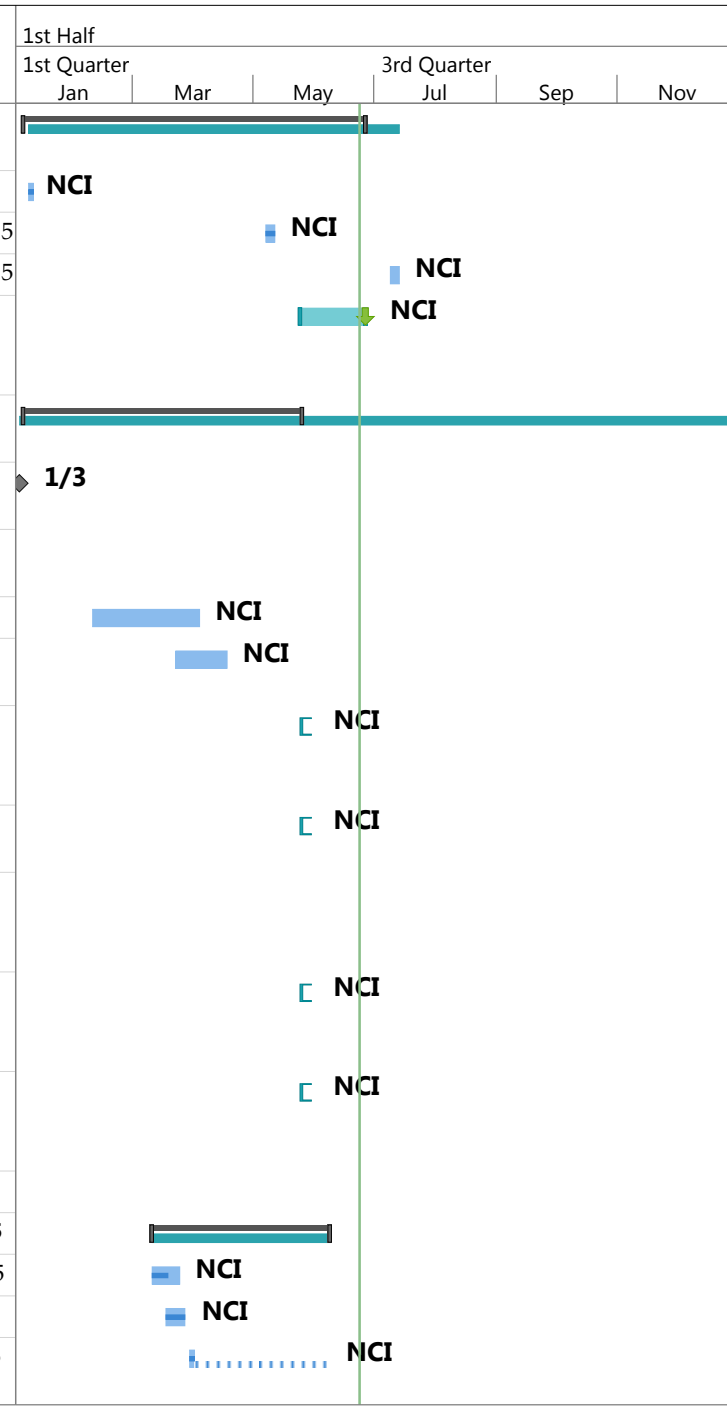
Overview of Proposed Timeline and Schedule of Deliverables



LEGEND: ● Monthly Status Reports* ▲ Quarterly Status Reports* ◆ Annual Status Reports*

*Reports will be Task-specific and will differ based upon Task. Each report will comply with agreed upon form and content. Activities completed to date will impact the robustness of the data reflected in the report as invoicing and collection activities ramp up over time.

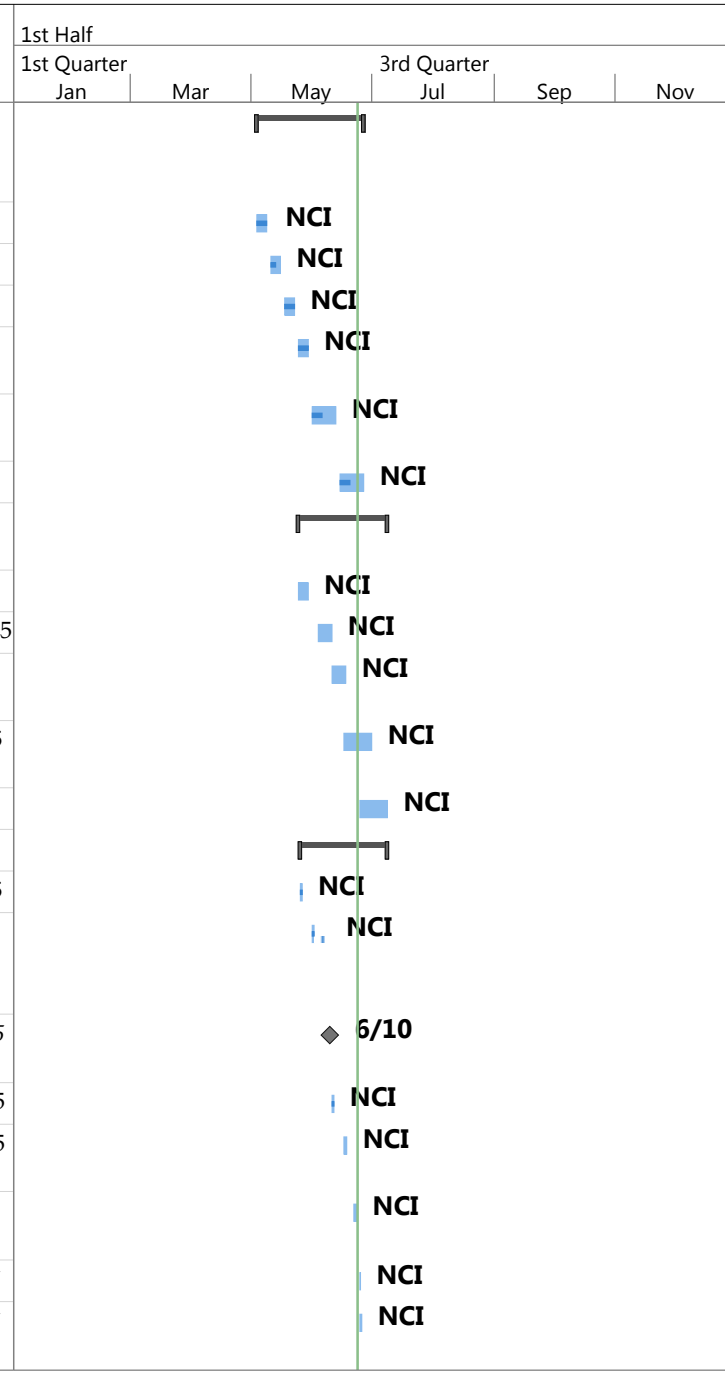
ID	Task Name	Start	Finish
1	**Analytics and Reporting Environment (Load/Maintain)**	**Mon 1/5/15**	**Fri 6/26/15**
2	Quarterly Data Refresher	Wed 1/7/15	Fri 1/9/15
3	Quarterly Data Refresher	Thu 5/7/15	Mon 5/11/15
4	Quarterly Data Refresher	Thu 7/9/15	Mon 7/13/15
5	CHIP Encounter Data Submission (see separate workplan)	Mon 5/25/15	Fri 6/26/15
6	**MMR/Encounter Data Validation**	**Mon 1/5/15**	**Mon 5/25/15**
7	MMR Reporting Template Finalized	Sat 1/3/15	Sat 1/3/15
8	CCOs begin using new template	Thu 12/31/15	Thu 12/31/15
9	MMR/Encounter Validation	Mon 2/9/15	Fri 4/3/15
10	Encounter Data Validation Report (Q115)	Mon 3/23/15	Fri 4/17/15
11	Encounter Data Improvement Recommendations (Q115)	Mon 5/25/15	
12	Encounter Data Validation Report (Q215)	Mon 5/25/15	
13	Encounter Data Improvement Recommendations (Q215)		
14	Program CMS Adult Core Measures into iMMRS (see separate workplan)	Mon 5/25/15	
15	Program CMS CHIPRA Core Measures into iMMRS (see separate workplan)	Mon 5/25/15	
16	Ad Hoc Analysis		
17	**Claims Lag Analysis**	**Wed 3/11/15**	**Mon 6/8/15**
18	Design Study	Wed 3/11/15	Tue 3/24/15
19	Run Analysis	Wed 3/18/15	Fri 3/27/15
20	Generate Report/QC Report	Mon 3/30/15	Mon 6/8/15



Project: MS Work Plan
Date: Wed 6/24/15

Task		Manual Summary Rollup	
Split		Manual Summary	
Milestone		Start-only	
Summary		Finish-only	
Project Summary		External Tasks	
Inactive Task		External Milestone	
Inactive Milestone		Deadline	
Inactive Summary		Progress	
Manual Task		Manual Progress	
Duration-only			

ID	Task Name	Start	Finish
21	**Encounter Data: Cost/Allowable Charge Analysis**	**Mon 5/4/15**	**Fri 6/26/15**
22	Select the study topics	Mon 5/4/15	Fri 5/8/15
23	Define the study questions	Mon 5/11/15	Fri 5/15/15
24	Select the study variables	Mon 5/18/15	Fri 5/22/15
25	Define the population or sample	Mon 5/25/15	Fri 5/29/15
26	Analyze and Interpret Study Results	Mon 6/1/15	Fri 6/12/15
27	Report Results to the State	Mon 6/15/15	Fri 6/26/15
28	**Potentially Preventable Hospitalizations**	**Mon 5/25/15**	**Wed 7/8/15**
29	Define the study questions	Mon 5/25/15	Fri 5/29/15
30	Select the study variables	Thu 6/4/15	Wed 6/10/15
31	Define the population or sample	Thu 6/11/15	Wed 6/17/15
32	Analyze and Interpret Study Results	Wed 6/17/15	Tue 6/30/15
33	Report Results to the State	Thu 6/25/15	Wed 7/8/15
34	**Network Adequacy**	**Tue 5/26/15**	**Thu 7/9/15**
35	Define the study questions	Tue 5/26/15	Tue 5/26/15
36	*Provide data environmental assessment to DOM for selection*	*Mon 6/1/15*	*Tue 6/9/15*
37	*Receive approval from DOM to proceed*	*Wed 6/10/15*	*Wed 6/10/15*
38	Select the study variables	Thu 6/11/15	Thu 6/11/15
39	Analyze and Interpret Study Results	Wed 6/17/15	Thu 6/18/15
40	*Prepare first draft for internal review*	*Mon 6/22/15*	*Tue 6/23/15*
41	*Team Debrief*	*Thu 6/25/15*	*Thu 6/25/15*
42	*Incorporate Navigant team feedback*	*Thu 6/25/15*	*Thu 6/25/15*



Project: MS Work Plan
Date: Wed 6/24/15

Task		Manual Summary Rollup	
Split		Manual Summary	
Milestone		Start-only	
Summary		Finish-only	
Project Summary		External Tasks	
Inactive Task		External Milestone	
Inactive Milestone		Deadline	
Inactive Summary		Progress	
Manual Task		Manual Progress	
Duration-only			