AGNEW ::BECK

HEALTH MANAGEMENT ASSOCIATES

Milliman

MEDICAID REDESIGN AND EXPANSION TECHNICAL ASSISTANCE

RFP No. 2015-0600-3077
Proposal for Professional Services from
Agnew : : Beck Consulting, LLC
Health Management Associates
Milliman, Inc.

Submitted to the Alaska Department of Health and Social Services
April 29, 2015

Engage
Plan
Implement

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INTRODUCTION LETTER

April 29, 2015

Janice Neal, Procurement Officer
Alaska Department of Health and Social Services
Division of Finance and Management Services
350 Main Street, Room 6
Juneau, Alaska 99811

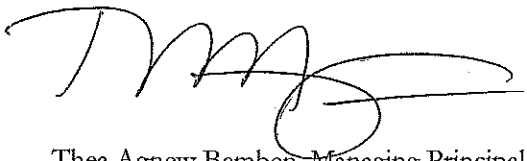
Dear Ms. Neal:

Please find our response to RFP No. 2015-0600-3077 Medicaid Redesign and Expansion Technical Assistance issued by the Alaska Department of Health and Social Services.

Agnew::Beck Consulting qualifies for the Alaska Bidder preference and holds Alaska Business License number 291349. A copy of our Alaska business license is included as an attachment. Members Thea Agnew Bemben and Chris Beck are both residents of the state of Alaska. Our Vendor Tax ID Number is 54-2076437.

By submitting this proposal, we affirm that Agnew::Beck and subcontractors Health Management Associates and Milliman will comply with all provisions and terms in this request for proposals. We do not anticipate any conflicts of interest with this project. This proposal is open and valid for ninety (90) days from the proposal receipt deadline.

Sincerely,



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UNDERSTANDING OF THE PROJECT

Our team brings unparalleled national and local expertise to assist the Alaska Department of Health and Social Services with this critical project. Agnew::Beck, based in Anchorage, Alaska, will lead the engagement with the support of two national firms: Health Management Associates (HMA) and Milliman. Our team understands that this project will recommend a Medicaid expansion and reform strategy and provide technical assistance and support to develop a sustainable Medicaid program for Alaska that meets the State's goals to:

- Optimize enrollee health outcomes and access to care;
- Drive increased value (quality, efficiency, and effectiveness) in the delivery of services; and
- Provide cost containment in Alaska's Medicaid budget.

We will work with the State to develop a strategy that will include potential options and recommendations for alternative Medicaid expansion models and a series of Medicaid reform initiatives. It will include a recommended three-year action plan for implementing the preferred expansion model and reforms. It will also include recommendations for monitoring, evaluating and reporting the results of reforms. The alternative models proposed and tested through this project must be consistent with federal and state regulations, and must maximize the options available to states to make the best use of state and federal resources. We will draw from our team's experience working with other states on Medicaid expansion and reform to inform Alaska's options and selection of a preferred strategy. The result of this collaborative analysis will be a report that draws from analysis of a number of alternative reform strategies that our team, Alaska DHSS leadership and Alaska stakeholders will thoroughly examine. We will deliver this report to DHSS by January 15, 2016; it will include provide a clear description and analysis of the recommended approach for Alaska. During the 2016 legislative session, our team will be available to participate in legislative hearings to explain and educate policy-makers about the recommended approach. During this period, we will also continue to work with DHSS staff to develop a three-year action plan and evaluation plan for the recommended strategy.

The outcome of Medicaid expansion and reform is critical to Alaska's future. How it is structured, who is eligible, how cost savings are identified and implemented, and which services are ultimately available to Alaska's low-income residents, seniors, individuals with disabilities and other eligible recipients are critical to our State's ability to support healthy outcomes and a strong economy for all members of our community. Alaskans have a vested interest in understanding the ideas, challenges, and recommendations related to Medicaid expansion and reform. Informing and engaging the public on the specific ideas and solutions developed as part of this technical assistance contract are critical to successful implementation of reform and expansion. Members of the public can offer valuable insight regarding ways to improve Alaska's Medicaid system. Quality and comprehensive outreach strategies are a key part of our scope of work.

This project will build from current and previous work that addresses the multiple areas of health care that will be affected by Medicaid expansion and reform including medical care, behavioral health care, and long-term services and supports for seniors and people with disabilities. A recent State-commissioned report by

Evergreen Economics estimated that if the State chooses to expand Medicaid, 41,910 adults will be newly eligible for Medicaid and 20,066 individuals are likely to enroll in FY 2016 (with increasing enrollment projected in subsequent years).[1] Adopting Medicaid expansion will benefit individuals, who will have greater access to coverage for health services; health providers, who will have fewer uninsured patients; and the health system as a whole, by sharpening the focus on integrated care and improving health outcomes for all Alaskans. Providers will have unprecedented opportunities to build systems of care and direct population health initiatives allowing for the management of chronic conditions, and whole-person care versus addressing costly emergent and uncoordinated care. The impact will allow for the attainment of the triple aim: improving the health of Alaskans, enhancing their experience and outcomes, and reducing the state's overall cost of providing care. Additionally, a report prepared by the Alaska Native Tribal Health Consortium estimated that Medicaid expansion would result in $1.2 billion in additional in-state wages and salaries, and $2.49 billion in increased economic activity over the next seven years.[2]

The Patient Protection and Affordable Care Act (ACA) and the subsequent Supreme Court decision regarding this law fundamentally changed its structure by allowing states to choose to expand Medicaid to nearly all individuals under age 65, including non-disabled childless adults, with a Modified Adjusted Gross Income (MAGI) of up to 138 percent of the Federal Poverty Level (FPL). To date, 29 states and the District of Columbia have expanded their Medicaid programs; six states, including Alaska, are considering expansion. Arkansas and four other states (Iowa, Indiana, Michigan, Pennsylvania) have given serious consideration to and/or have already applied to CMS to establish "Private Option" Medicaid expansion models through Section 1115 demonstration waiver authorities. Under a Private Option demonstration, the state provides premium assistance for beneficiaries eligible under the new adult group supporting the purchase of coverage from qualified health plans (QHPs) offered in the individual Health Insurance Marketplace. Individuals eligible for coverage under the new adult group are childless adults ages 19 through 64 with incomes at or below 138 percent FPL. Under this model, the cost of premium assistance is borne in full by the federal government (unless the state is willing and able to contribute funding towards this). Any required Medicaid benefits not offered through the QHPs are provided through the state's existing Medicaid fee-for-service program. Enrollee cost sharing obligations are consistent with both the State Plan and with the cost-sharing rules applicable to individuals with comparable incomes in the Marketplace. Furthermore, some demonstration models incorporate "personal responsibility" features, such as health savings accounts, to encourage healthy lifestyles and preventive care, discourage unnecessary care, and promote the efficient use of constrained healthcare resources.

We believe that Alaska should explore this model as a possibility, with the caveat that success would be heavily dependent on reliable operation of the Health Insurance Marketplace, the availability of QHPs, and the coverage they offer. Because the ACA anticipated that Medicaid expansion would be mandatory, many low-income individuals who would be eligible for Medicaid under expansion are not eligible for advanced

[1] Evergreen Economics. February 6, 2015 Memorandum to Valerie Davidson, Commissioner of AK DHSS, re: Projected Population, Enrollment, Service Costs and Demographics of Medicaid Expansion Beginning FY2016.
[2] Alaska Native Tribal Health Consortium, *Healthier Alaskans Create a Healthier State*. Anchorage, AK, 2013. (A summary document informed by analyses conducted by Northern Economics and the Urban Institute).

premium tax credits (APTCs) to subsidize the cost of buying health insurance in the Health Insurance Marketplace, but are subject to penalties per the individual mandate provision if they do not buy insurance.

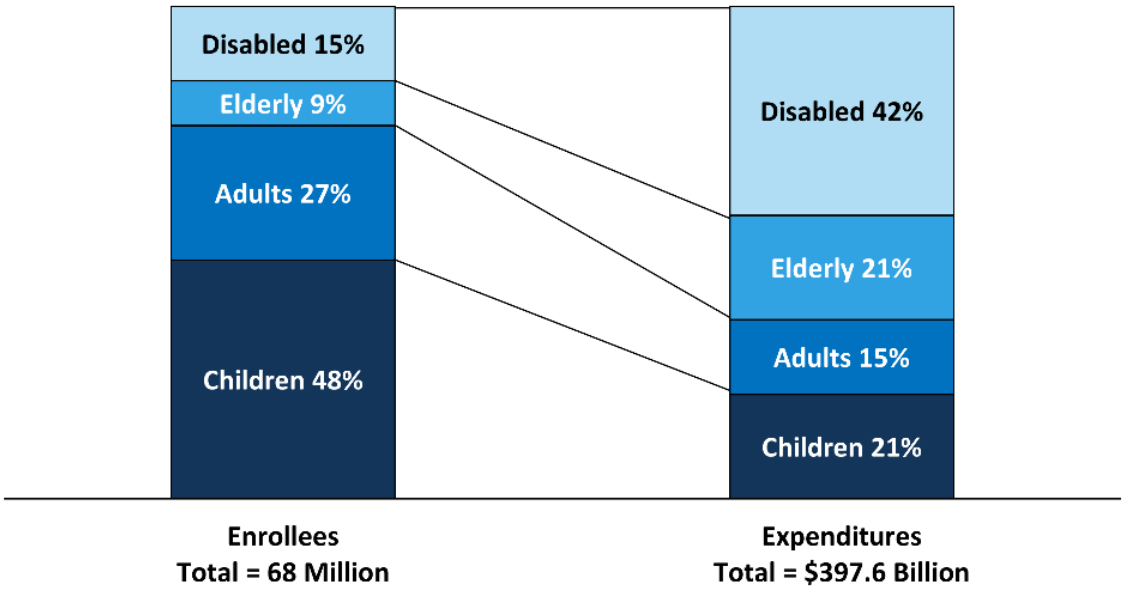
One of the most critical factors in creating projections is the enrollee group, broadly categorized as adult, aged adult (senior), disabled adult or child. Below is Medicaid spending by enrollee type for FY 2011 in the U.S. and Alaska. In all categories, Alaska's spending is far higher than the national average. More important for purposes of creating projections is the relative cost by enrollee category: adults who are not classified as aged or disabled cost, on average, about one-quarter of those who are aged or disabled.

Medicaid Spending Per Enrollee by Group, FY 2011					
State	**Total**	**Aged**	**Disabled**	**Adult**	**Children**
United States	$5,790	$13,249	$16,643	$3,247	$2,463
Alaska	$9,474	$23,321	$28,554	$6,467	$4,720

The disparities are depicted graphically for the United States in the figure below.

Figure 2

Medicaid Enrollees and Expenditures, FY 2011



SOURCE: KCMU/Urban Institute estimates based on data from FY 2011 MSIS and CMS-64. MSIS FY 2010 data were used for FL, KS, ME, MD, MT, NM, NJ, TX, UT, OK but adjusted to 2011 spending levels.

By far the largest group to be added to the Medicaid rolls under the proposed Medicaid expansion would be adults ages 18 to 64. From a State fiscal perspective, the downside of expanding coverage to this population is the additional State funds that will be required as the federal match declines (from 100% in FY 2016 and

reducing to 91.3% beginning in FY 2021).[3] However, as the State is currently using General Funds to support coverage for many non-Medicaid eligible individuals, enrolling these residents in Medicaid will give the State access to Federal matching funds that will reduce the current reliance on General Funds for people getting services now. In addition, as the ACA assumed that states would expand Medicaid and that uncompensated care costs would decrease, the law also reduces Disproportionate Share Hospital (DSH) allotments that have historically helped hospitals support care for the uninsured. The reduction in these funds adds urgency to the need to both reform and expand Medicaid.

On March 17, 2015, Governor Walker submitted a bill for Medicaid expansion to the Alaska Legislature. If approved, DHSS estimates the resulting cost savings to be $6.5 million in FY 2016 through proportional reductions in programs funded by the general fund that currently serve this uninsured population; estimated savings from these offsets hold steady at $3.3 million in FY 2021.[4] Notably, assumptions of cost savings include a $1 million reduction in behavioral health grant dollars in FY 2016, increasing to a $16 million reduction in FY 2021.[5] This amount of lost revenue will not be easy for Tribal and non-Tribal behavioral health providers to absorb, especially at a time when demand for behavioral health services is expected to increase, unless significant capacity-building measures are proactively put into place. Part of this effort includes verifying these offsets and identifying measures to build capacity within the publicly-funded behavioral health system to facilitate reform. We understand that a strong behavioral health system that is capable of meeting increased demand for services enabled by Medicaid expansion, increased private insurance coverage through the individual insurance exchange, efforts for mental health parity, patient-centered medical home and integrated care initiatives is critical to improving health for Alaskans and reducing health care costs.

To find cost savings without reducing quality of care for Alaskans, it is critical for the project team to understand the health care needs and cost drivers of the populations who will be included in the newly-eligible group, as well as the State programs that currently serve these individuals. It will also be critical to understand and assess additional revenue opportunities that may exist for Alaska. Our consultant team holds this expertise and offers a strong local team leader, Agnew::Beck, who has extensive experience with Alaska health planning across a range of sectors. We have teamed with Health Management Associates (HMA), national experts in Medicaid expansion and reform strategies and federal Medicaid financing authorities, and with Milliman's nationally-recognized actuarial expertise to identify costs and savings associated with change.

Our strong local lead will give our team insights into and a grasp of the unique Alaska environment, the key players in the project, and issues that a standalone national firm would not bring to bear. For example, a critical factor in Alaska's Medicaid expansion and reform efforts is the State's current budget situation. According to a recently-released analysis of the State budget by a Commonwealth North fiscal study group: between 2004 and 2014, the State's operating budget grew by 105 percent, from $2.1 billion in general funds in FY 2004 to $4.4 billion in FY 2014.[6] While the budget more than doubled in a decade, inflation increased

[3] Evergreen Economics. February 6, 2015 Memorandum to Valerie Davidson, Commissioner of AK DHSS re: Projected Population, Enrollment, Service Costs and Demographics of Medicaid Expansion Beginning FY 2016.

[4] Alaska Department of Health and Social Services. *The Healthy Alaska Plan: A Catalyst for Reform. Healthy Alaskans – Healthy Economies – Healthy Budgets*. February 2015.

[5] Ibid.

[6] Commonwealth North Study Report. February 2015. *The State's Operating Budget; Critical Crossroads, Choices, and Opportunities*.

by 30 percent and Alaska's population increased by 11 percent. During this same 10-year period Alaska's oil production steadily declined from 932,000 barrels per day in 2005 to 547,000 barrels per day in 2014. The recent crash of oil prices expedited a long-overdue conversation about the growth and long-term sustainability of Alaska's budget, which relies primarily on oil revenues. Because Alaska does not have an income tax like most other states, the benefits of increased economic activity from Medicaid expansion to the State from state tax revenue cannot be considered as a potential offset for the costs of expansion.

As Alaska's Governor and Legislature contemplate how best to navigate the current deficit, health care costs are a major challenge, and a valuable opportunity. Alaska's health care system is one of the most expensive in the nation. The high cost of health care in Alaska illustrates the need for wholesale transformation of our health care system, not just Medicaid. The State's FY15 budget included $1.6 billion for health care, $703 million of which is designated for Medicaid.[7] Reforming Alaska's Medicaid Program to achieve the ACA's triple aim of increased quality, reduced costs, and improved access to care while reducing the State's share of Medicaid costs are the key goals for Medicaid expansion and reform efforts, and have the potential to catalyze transformation of the entire health care system.

We understand that for many reasons time is of the essence. We believe that the project demands a team that can hit the ground running. We further understand that in order to be effective, the team must have deep knowledge of local systems; experience working with Tribal and non-Tribal providers across the spectrum of medical care, behavioral health, and long-term services supporting seniors and individuals with physical and developmental disabilities; national expertise in Medicaid expansion and reform; and objective actuarial analysis to carefully understand the costs and benefits of different alternatives. Our team brings all of this expertise to the task.

This project will require an understanding of the various options for Medicaid reform that have been discussed in Alaska, and are being analyzed or pursued through other projects. Together, our team has firsthand knowledge and experience in most of these initiatives that positions us to provide an unparalleled caliber of technical assistance. The table on the following page describes the understanding our team has gained through our experiences with these initiatives.

Medicaid Reform Advisory Group Recommendations	**Team Experience and Understanding Gained**
Development of a person-centered case management program	Agnew::Beck recently delivered an expedited stakeholder engagement process and system design to comply with CMS regulations for conflict-free case management for all recipients of Home and Community-based Services funded by Medicaid. Conflict-free case management is a key component of person-centered service planning and delivery.

[7] Ibid.

Initiation of a comprehensive payment reform working group	Through a recent grant writing engagement sponsored by the Alaska Mental Health Trust Authority (The Trust) for Alaska's e-Health Network, Agnew::Beck gained understanding of the current status, timelines, and challenges faced in onboarding additional entities to the state's health information exchange, as well as the systems changes necessary to ready Alaskan health and behavioral health providers for value-based payment and person-centered case management.
Contracting for pharmacy services and for waiver assessments	HMA has recent and extensive experience assisting states with the design, analysis, development, implementation, operation and evaluation of waivers. Recent projects include the South Dakota Disabilities Waiver, in which HMA supported development of a new algorithm for determining an individual's service level and individual budget allocation; Illinois' 1115 Waiver, in which HMA helped the state consolidate nine home and community-based services waivers, development of the behavioral health services expansion, and identification of CNOM/DSHP and DSRIP requests to CMS; and Maryland's 1115 Waiver, in which HMA led the design, development, and implementation of a waiver to move Maryland hospitals towards value-based health reform while eliminating the risk of violating the cost test by replacing the outdated test with one that is more relevant to the current realities.
Investigation of 1915(k) state plan options	Agnew::Beck worked on three initiatives related to this recommendation: in 2011, for DHSS, A::B worked with stakeholders to develop the Recommendations for a Strategic Plan for Long Term Care in Alaska, which included the 1915(k) as a recommendation; A::B provided technical support to Senior and Disabilities Services for its internal division strategic plan where the 1915(k) was also discussed; most recently in 2014, A::B facilitated Alaska's Roadmap to Address Alzheimer's and Related Dementia, which included this recommendation.
Implementation of a care coordination program for controlling overutilization of hospital emergency room services by high-risk Medicaid beneficiaries	From HMA's role as a technical assistance provider to the National Governors Association (NGA) "Policy Academy" aimed toward developing state-level capacity to support super utilizers, our team understands the super-utilizer population in Alaska, as well as care management and delivery models to address the unique needs of this cohort. HMA has in-depth experience working with states, safety-net providers, delivery systems, and health plans in the design, implementation, and evaluation of care coordination programs and integrated models of care for complex populations.
Home and Community-Based Service improvements for seniors and Alaskans with disabilities to comply with CMS requirements for person-centered planning and conflict-free services	From Agnew::Beck's recent engagement providing technical assistance for conflict free case management initiative, the team has gained intimate familiarity with the issues and helped generate the recommendations for conflict-free case management likely to be adopted by DHSS.

Investigation of methods of refinancing Medicaid waivers through 1915(k) state plan options	HMA worked with the Campaign for Oregon Seniors and People with Disabilities, an alliance of organizations representing business, labor, consumers and other Oregon stakeholders, to complete a review of Oregon's long-term care delivery system and identify options newly available to states under the ACA to fund home and community-based services. HMA 's analysis and report was instrumental in encouraging the state of Oregon to secure approval for services authorized under Section 1915(k) of the Social Security Act (Community First Choice).
Coordinating with the Alaska Tribal health system to increase community resources and strengthen systems of care across the state	Agnew::Beck has worked with Tribal health organizations in every region of Alaska over the past two decades to conduct business planning, feasibility analysis, program development, facility development, funding and service coordination. A::B's breadth of experience with Tribal health organizations, as well as experience with non-Tribal health organizations, supports the team's understanding of the opportunities to improve coordination between these two health systems to improve health outcomes and cost efficiencies. Currently, Agnew::Beck is completing the Alaska Behavioral Health Systems Assessment, which includes an in-depth analysis of the challenges and opportunities facing the publicly-funded behavioral health system.
Strategic planning led by the Alaska Mental Health Trust and the DHSS Division of Behavioral Health to develop sustainable housing resources integrated with behavioral health and other Medicaid services	Agnew::Beck's work as technical assistance providers to The Trust and engagements with many organizations across the state provides the team with firsthand knowledge of the progress and challenges Alaskan's communities face in addressing supportive housing needs. Specifically, Agnew::Beck has developed business plans, fiscal analyses and successful funding applications to develop supportive housing in multiple communities around Alaska, including RurAL CAP's Karluk Manor in Anchorage and an Alaska adaptation of the California SHIELDS model serving homeless families in need of substance abuse treatment. In a survey conducted by Agnew::Beck in November 2014 of the Division of Behavioral Health treatment and recovery grantees, providers ranked supportive housing as the number one gap in Alaska's behavioral health continuum of care.[8]
Collaboration with the Alaska Primary Care Association on a Patient-Centered Medical Home project	Agnew::Beck assisted a grant applicant to apply for and secure funding through the Patient-Centered Medical Home (PCMH) project; this process helped the team learn firsthand the challenges this private practice faced in its journey toward achieving PCMH in Alaska. Agnew::Beck has conducted an analysis of Medicaid billing barriers to PCMH and generally monitored the efforts of the PCMH project as it is an important initiative for many of our Alaskan clients.

[8] Conducted as part of the Alaska Behavioral Health Systems Assessment and available online at: http://dhss.alaska.gov/dbh/Documents/CAC/2014winter/AKBH-SystemsAssessmentProviderSurveyResults.pdf See slides 15 + 16.

DHSS and ANTHC Healthy Alaskans 2020 partnership	Agnew::Beck regularly works with Alaska communities to leverage data from Healthy Alaskans 2020 and is intimately familiar this new and valuable resource for community health improvement efforts across Alaska. A::B has worked with multiple public health programs in DHSS that work to address and prevent chronic disease: Tobacco Prevention and Control, Obesity Prevention and Control, Heart Disease and Stroke Prevention, Substance Abuse Prevention and Suicide Prevention.

We know that the project team will be expected to bring national experience and expertise to bear as the State seeks to understand the various reform mechanisms used successfully in other states and weigh potential fiscal and service impacts in Alaska. Alaska has many hard-to-serve populations, as the state's geographic and cultural diversity presents unique challenges to health care delivery. In addition to the ability to expand Medicaid to individuals with incomes of up to 138 percent of FPL (133 percent with a five percent income disregard), the ACA and earlier legislation created a number of new Medicaid authorities that states are using to restructure their systems. Because many of these new authorities target older adults and individuals with disabilities, they offer states mechanisms to target reforms at their most costly populations.

As part of our approach, the project team will consider and include the identification and discussion of Medicaid financing authorities and options available to meet Alaska's Medicaid expansion and reform goals as well as the requirements, flexibilities and limitations for each of the various waivers and recommended options. For example, Section 1332 of the ACA permits states to apply for innovation waivers to implement state-specific health reform approaches that vary from certain ACA requirements. Section 1332 waivers may serve as a long term system redesign option allowing Alaska to redesign their Medicaid and health care delivery system in an innovative way that meets ACA requirements for affordability, comprehensiveness of coverage, and budget neutrality.

Throughout the contract, we will provide status reporting on our activities, document decisions made, produce reports of findings of data and fiscal analysis, and produce materials to educate stakeholders on regulatory parameters, options, recommendations, and their implementation and operational considerations. (*See Task 6 for further discussion of our proposed approach to stakeholder engagement.*) In addition to the formal review and approval of deliverables, we expect that throughout the project, members of the Project Team and DHSS client team will engage in informal idea sharing. DHSS can expect to benefit from our team's knowledge of health reform initiatives across the country, and our team can expect to receive preliminary feedback on candidate reform scenarios to help narrow the field for inclusion in the final report.

To identify feasible approaches to Medicaid reform, it will be necessary to look at other services funded by the State that could be better funded through Medicaid or other sources. Building from our team's experience, we have already identified the following opportunities that should be investigated as part of this project and, if feasible, incorporated into the resulting business plan:

- **Alaska's General Relief program**: This program pays for adults who require emergency housing and support, using State general fund dollars. The regulations for this program specify that the individual must be placed into an assisted living home; however, the State does not provide any

intake assessment or case management to individuals on General Relief. Another complication is that this program managed in part by Senior and Disabilities Services (SDS) and in part by the Division of Behavioral Health, with no clear structure for communication between two divisions or a rational process for assessing or providing case management to the individuals served by this program. This results in some program participants receiving case management from a behavioral health provider, while others, despite having behavioral health or complex needs, not receiving case management because they entered General Relief through SDS or another channel. In addition, the General Relief program requires the individual to pay all but $100/month of his or her income to the program, which eliminates the incentive to seek employment when or if they are able to do so.

In 2013, Agnew::Beck conducted a telephone survey for the Division of Behavioral Health of all the individuals in assisted living who had at any time received behavioral health services, to assess whether the individual could move into independent housing. The survey found that many of these residents believed they could move into a more independent setting, but the lack of care coordination left them with little support to achieve this move. Additionally, Karluk Manor, a Housing First project in downtown Anchorage, serves individuals in the same population as those living in assisted living homes on General Relief. Karluk Manor provides independent, supportive housing with services paid for by Medicaid billing. It is possible that General Relief dollars could purchase more appropriate services for more people, allowing them greater autonomy and choice, if those dollars could be spent at Karluk Manor rather than in small assisted living homes; however, current regulation does not allow this. This is an example of the type of reform that should be considered in the overall scheme of Medicaid expansion.

- **Assisted living and skilled nursing care in rural communities**: Because the assisted living rate is not tiered by individual acuity and not based on a realistic assessment of costs to provide care in rural communities, Tribal Health organizations and other Tribal entities have not been able to feasibly operate assisted living facilities. As a result, Tribal organizations and rural health organizations have opted to provide skilled nursing instead of assisted living because it is more financially feasible. The cost to the State to house individuals in skilled nursing is much higher than assisted living, even if the rate were increased. This results in a situation where, as a stakeholder in the recent long-term care strategic planning process stated, "many of the individuals who are in skilled nursing in a rural community would be housed in assisted living if they lived in Anchorage." This is an example of an opportunity to identify strategies to re-balance the long term care delivery system and develop additional home and community based options and infrastructure to allow individuals to maintain their independence in the least restrictive setting possible, and to save public funds in the process.
- **Supports for individuals with dementia**: Because the system does not incentivize providers to develop Memory Care assisted living programs some individuals with dementia who are difficult to care for in assisted living homes are being cared for at Alaska Psychiatric Institute (API), at a high daily rate. Memory Care assisted living is provided mainly by Alaska Pioneer Homes, a good use of this unique and highly subsidized program, but also very costly. It is possible that a payment structure could be developed to incentivize Tribal, non-profit and for-profit health providers to develop and operate Memory Care assisted living facilities at a much lower cost than the Pioneer Homes. This would help meet the consumer demand statewide for the service while relieving the State from the

cost burden of directly and exclusively providing this service. In addition, the State could employ different Medicaid options to provide supports for people with dementia. Many of these individuals are not currently eligible for a 1915(c) waiver because they do not meet the nursing facility level of care (LOC). The State has the option to change this LOC, which would allow individuals to be eligible for waiver services. DHSS is considering pursuing both the 1915 (k) and the 1915(i) State Plan HCBS options, and our team would be ready to coordinate with that process, as needed.

- **Payment Assistance at Alaska's Pioneer Homes.** An additional opportunity for Pioneer Homes is the Payment Assistance program available for Alaskans who cannot pay the full cost of care at these facilities. Currently individuals are not required to apply for the Medicaid Home and Community Based Waiver prior to qualifying for Payment Assistance. It is possible that some applicants and residents at the Pioneer Home could qualify for the waiver, which would reduce the amount of general fund dollars required to pay for the cost of care at Pioneer Homes.
- **Payment for Behavioral Health Treatment Services:** Another area to examine, building from the Alaska Behavioral Health Systems Assessment being conducted by Agnew::Beck for The Trust and its partners, is how behavioral health treatment services are funded. Currently, many treatment services are grant-funded. While the Division of Behavioral Health has made great strides towards provider accountability and tying payment to performance, more work is needed to ensure that the considerable funding spent on treatment services results in improved behavioral health for Alaskans. Substance use treatment services are chronically under-resourced in Alaska, in part because many individuals who require treatment are not eligible for Medicaid and do not have private insurance. The ACA requires Medicaid and private insurance plans to cover behavioral health services at parity with medical services. If, as was intended, Medicaid expansion and more integrated care occur in conjunction with the increase in the number of Alaskans who can get private health insurance, we should see a significant increase in the number of Alaskans who require substance use treatment and have resources to pay for it. To effectively meet this demand, providers need to increase capacity, improve efficiency, and optimize Medicaid billing practices. The State can lead this process by developing an accountable and results-oriented payment system that allows and incentivizes providers to deliver quality care to more people.
- **Barriers to integration of primary care and behavioral health**: Multiple billing structures within Medicaid for behavioral health services and the multiple divisions within DHSS that oversee portions of the Medicaid program create complexity that results in inefficiencies and inequities. We have identified a suite of issues as we worked with organizations and at the system level to understand barriers to integration of primary care and behavioral health. It will be necessary to integrate payment structures that fund these services to achieve the vision of a behavioral health service delivery system that is available and accessible to all Alaskans. Currently, medical providers use one of a number of billing structures to access Medicaid and, depending on which they use, the regulations for providers to deliver and bill for a particular service may be different. For example, if a Licensed Clinical Social Worker is employed at a Federally Qualified Health Center (FQHC) s/he can provide and bill for a much broader array of mental health services than s/he would be able to provide and bill for at a non-FQHC primary care clinic, even with similar patient populations at both clinics. From the patient or client perspective, this limits the availability and quality of care depending on which setting the patient enters. From the provider perspective, this limits the extent to which a particular

credentialed position is employable, and the extent to which it is possible to offer integrated services, even when the provider recognizes that their patients would benefit from behavioral health services. At the administrative level, Healthcare Services, Behavioral Health, Public Assistance, and Senior and Disabilities Services separately implement various Medicaid programs, which sometimes results in a lack of integration and coordination. This leads to, for example, different case management models for different settings, only some of which are billable; for the consumer, this may mean a duplication of service that does not provide effective case management. This system has led to different data management and billing systems for different portions of the Medicaid program: for example, Behavioral Health and Healthcare employ separate codes, documentation requirements, and data management systems. If a primary care clinic wants to offer integrated services, it means maintaining dual-billing and documentation systems.

These are a few examples of issues to be examined during this process to guide development of an improved Medicaid system that enhances access to services and incentivizes high-quality care at sustainable price points.

The technical assistance activities undertaken through this contract will take into account the needs and costs of different populations and require broad stakeholder engagement. The success of the project depends upon significant coordination and support from DHSS, The Trust, care providers, and other stakeholders. Possible challenges our team may face include: the inherent challenge in communicating complex concepts about complex systems; securing and working with State of Alaska data sets to model change scenarios; potential resistance to change from providers and legislators; the politically-charged, high-profile nature of this endeavor; and, the very expedited schedule that this RFP requires. We will work closely with DHSS and its partners throughout the project to address challenges as they arise, and our team has a strong record of successfully navigating multi-faceted Medicaid redesign, transformation and expansion initiatives.

As we develop options for Medicaid expansion and reform, each initiative will be evaluated on both an outcome and financial basis. There are always trade-offs between initiatives, and relying on an actuarially sound financial model will ensure the stakeholders understand the range of financial implications. Actuaries are accustomed to building models from multiple data sources, which form the backbone of any changes to the healthcare system. Because data quality will affect the validity and reliability of results, actuaries pay close attention to data issues. Healthcare data almost always has known or unknown limitations. Milliman has developed normative models that will help identify data issues that need to be addressed. An actuarially sound financial model ensures that projections are based on reasonable assumptions, and are not overly optimistic or pessimistic.

The second phase of this project will conclude with the development of a three-year action plan and an evaluation plan for the recommended reforms. Agnew::Beck is very skilled at implementation planning and will ensure that DHSS has a clear road map for implementation at the conclusion of this project. HMA will lead the development of the evaluation plan drawing from extensive experience in metrics development and evaluation. The goal of performance measurement, including the use of dashboards, is to identify agreed-upon goals among key stakeholders, and provide a clear view of the performance of the alternative Medicaid program across carefully constructed indicators. Dashboard indicators will allow state policy makers,

legislators, and other stakeholders to better understand how health systems are changing in response to reforms and provide critical data to identify and address opportunities for improvement.

Health information will be the backbone of a reformed, sustainable health system. Providers and payers need reliable data about system performance to spur the transformation. Consumers need accessible data to inform their health care choices. We will work with stakeholders to develop and implement a plan for developing a set of dashboards to promote accountability and drive quality improvement. This will include focusing on measures that matter most to stakeholders and require true transformation and integration (e.g., avoidable hospitalizations). This will also include access measures to ensure that transformation reaches its intended recipients in an equitable manner. These measures will reveal gaps between patient needs and the current health care system, and point to access improvements that the system must make. This process will provide a basis for real-time, practical evaluation of progress being made and inform future policies and programs. There is a high degree of interdependence between this work and analysis of delivery system reform options.

Narrative in the **Methodology and Management Plan** describes our proposed steps to complete the project's deliverables, drawn from firsthand experience providing technical assistance to other states that have successfully undertaken similar efforts. Attention to quality, timeliness, deadlines, cultural competency, and flexibility are paramount to this work. We recognize that the results will be used by the State, The Trust and its Tribal partners to shape Alaska's Medicaid into a cost-effective and sustainable program for current and future generations. We believe our team's breadth of experience positions us to effectively support the State in this significant undertaking and accomplish these deliverables successfully within the timeframe specified in the RFP.

METHODOLOGY USED FOR THE PROJECT

Agnew::Beck has convened a team with the right mix of experience, expertise, knowledge of Alaska and its Medicaid enterprise, familiarity with national health reform efforts and models of Medicaid expansion, and a deep commitment to the project's goals. Our approach is driven by DHSS's requirements described in the RFP and informed by our experience with the Medicaid system, including reform and expansion efforts in other states. We will work with the DHSS client team to ensure that this effort builds on the foundational work of DHSS, The Trust, the Medicaid Reform Advisory Group and other parallel efforts, to identify strategies for Medicaid expansion and reform best suited for Alaska. These strategies must optimize enrollee health outcomes and access to care, increase value in health care delivery, and contain costs for Alaska's Medicaid program.

The project will have two phases:

- Phase 1 begins with project start-up and culminates in the final Report on Recommended Medicaid Expansion and Reform Strategies for Alaska, delivered to DHSS by January 15, 2016. Our analysis will include evaluation of the financial, operational, and client implications for all reform options.

- Phase 2 concludes with the final Report on Recommended Action and Evaluation Plans for Expansion and Reform due to DHSS May 16, 2016. This report will be based on the Recommended Medicaid Expansion and Reform Strategies included in the Phase 1 report, and will include a 3-year action plan and evaluation plan to implement and evaluate the recommended strategies.

PHASE 1: DRAFT AND FINAL REPORT ON RECOMMENDED MEDICAID EXPANSION AND REFORM STRATEGIES FOR ALASKA

TASK 1: PROJECT START-UP

The Project Team will begin the process to develop the draft and final report immediately upon contract award, which will result in a final report submitted to DHSS by January 15, 2016. The final report will clearly communicate a suite of recommended expansion and reform strategies including all regulatory requirements and actuarial analyses to support the recommendations. The report will explain the rationale and trade-offs between scenarios analyzed during the project, and will include a discussion of other states' experience with similar reforms. The report's intended audiences are DHSS leaders, legislators, health care providers, policy makers, and other key stakeholders who will be impacted by health reform and Medicaid expansion. Our team, led by Agnew::Beck, is experienced with producing documents and presentations on complex health-related public policy issues that are informed, understandable, and engaging to a broad audience.

The following sub-tasks will be completed during Project Start-Up:

Project Kick-off Meeting

We will work diligently during start-up to confirm with our client the project schedule, scope, deliverables, approach, communications protocol, and project management plan. This will begin with an initial project kick-off meeting. We will also identify dates for bringing national experts to Anchorage or Juneau for a two-day work session with the DHSS client team in August 2015.

Develop Project Plan

In the initial weeks of the project, we will work with the client team to tailor our methodology and plan to align with DHSS's needs and leverage existing analysis. We will develop a refined scope of work, project schedule, and list of deliverables for project plan. We will develop in MS Project a detailed project plan for Phase 1 to outline the sequence and timing of tasks to ensure completion of deliverables on time.

Develop Stakeholder Engagement Plan

Early in the project, it will be important to identify key individuals and groups to engage on a regular basis with project updates, and identify key dates for community outreach and stakeholder engagement to incorporate into the project schedule. Agnew::Beck will also develop a master contact list and develop a template for an e-newsletter to regularly inform all contacts about updates on the project (*see Task 6 for our proposed outreach strategy*). The stakeholder engagement process is defined as coordination of direct input from various stakeholder groups to review and narrow the options for Medicaid reform and expansion to be included in the final report. Key stakeholders include providers of medical, behavioral health and long-term services and supports, consumer organizations, and the Tribal health system. Because Medicaid reform and expansion will affect many sectors of health care and many stakeholders within those sectors, developing a clear plan for stakeholder engagement will be very important at the outset of this project.

Gather Background Documentation

In conjunction with the DHSS client team, the project team will develop a list of previous studies that form the analytical foundation for this project. We will develop a list of key datasets, contacts, and processes for securing this information in a timely manner.

Begin Process of Securing Necessary Data

From experience, we know that transfer of HIPAA-protected data sets can take time. Following contract award, Milliman will work with DHSS to secure access to necessary data sets. Likewise, the team will work with DHSS to ensure the necessary business associate agreements are in place.

TASK 2. RESEARCH AND DRAFT BACKGROUND: MEDICAID REFORM ENVIRONMENTAL ASSESSMENT.

During this task, we will draw upon our experience with and knowledge of Alaska's Medicaid program and reform efforts in Alaska and in other states to develop the Medicaid reform Environmental Assessment. We will begin by reviewing the existing relationships between divisions within DHSS, the councils and advisory boards, the Alaska Mental Health Trust Authority (The Trust), and other agencies to understand their interdependencies. Our team will research the availability of existing information that is relevant and

informative to our work. We realize Alaska has a wealth of valuable information and resources that were critical to the development of the Healthy Alaska Plan released in February, as well as the recommendations of the Alaska Health Care Commission and Medicaid Reform Advisory Group. We intend to supplement our own experience and knowledge with the work that has occurred both inside and outside the state related to Medicaid reform. We will then develop an assessment of the current program environment and current reforms already underway in Alaska.

We will also conduct an environmental scan of existing and planned state Medicaid expansions and other reforms in other states, as well as the CMS response and requirements to these efforts. We will use HMA's contacts across state Medicaid agencies and at CMS to explore options being considered but not yet documented. This initial unrestricted search will be paired with a literature review, based on an identified set of trusted primary and secondary sources. The team will use existing sources of information wherever possible, supplemented by additional research and analysis to fill in information gaps and answer supplemental questions. We will conduct this research and analysis within the framework of the Alaska environment, taking into consideration the State's needs and interests in light of its political, economic, cultural, and technological landscape. Reform and expansion options will be analyzed with a "best fit" approach in order to ensure that proposed options are relevant to and actionable by the State.

The team's fluency with state and federal Medicaid programs and requirements will promote a comprehensive assessment of relevant models and requirements. The work conducted in Task 2, along with actuarial analyses performed under Task 5, will allow the team to identify which proposed reforms best align with Alaska's reform goals and current expansion and reform efforts and would have the greatest impact on outcomes and quality of care without compromising Alaska Medicaid's long-term financial sustainability. We will conduct comparative analyses to understand the pros and cons of each proposed options, as well as its fit for Alaska. Models that are most relevant for Alaska and provide a high degree of value to the consumer and state will be prioritized for additional analysis and interpretation.

The team will identify opportunities for maximizing federal funding through the use of new and existing Medicaid financing methodologies through State Plan, Waiver and ACA authorities. We will take a holistic approach, seeking to ensure coordination in serving Alaskans' behavioral and physical health care needs. Medicaid expansion will create opportunities that will allow funding of behavioral and mental health programs to shift from current State sources to the enhanced federal funding available for the adult Medicaid expansion group.

The ACA has created new pathways for structuring the delivery, payment, and financing of services. In developing the plan for Alaska, we will assess all options available to enhance the redesign of Alaska's Medicaid program. For example, in addition to State Plan authorities, our approach will consider:

- ACA Section 2703 Health Homes Initiative for individuals with Chronic Conditions. The Health Homes Initiative through State plan can address the unique needs of the Mental Health Trust population that would transition into the Medicaid expansion group.
- ACA Section 1331, The Basic Health program, which could stabilize enrollment between the Medicaid and Exchange populations for individuals with income between 138 and 200% FPL.

- ACA Section 1332, State Innovation Waiver that will become available in January 2017 and provide Alaska with additional options for program design and modernization.
- Social Security Act Section 1115 Demonstration Waivers, which give states options to expand Medicaid eligibility to individuals who are not otherwise Medicaid or CHIP eligible that 1) provide services not typically covered by Medicaid; 2) use innovative service delivery systems that improve care, and 3) increase efficiency, and reduce costs.

The environmental assessment will include case studies from other states and will include at least one state that has implemented a private insurance option for the ACA Medicaid expansion population. This environmental assessment will be drafted and presented at the first work session with DHSS leadership.

The result of this task will be a report that includes, as specified by the RFP:

- Factors shaping Medicaid programs generally across the nation, and factors specifically impacting Alaska's Medicaid program today;
- Description of all federal Medicaid financing authorities, including those added under the Patient Protection & Affordable Care Act of 2010 (ACA), that may be useful in restructuring Medicaid health care delivery and payment and can be exercised through State Plan Amendments or waivers;
- Analysis and description of other states' experience with Medicaid health care delivery and payment restructuring. It will include a description of alternative models using private insurance options for serving the ACA Medicaid expansion population implemented under waivers by states choosing not to expand eligibility under the traditional Medicaid program design; and
- Medicaid reform initiatives currently underway in the department.

TASK 3: FIRST ROUND OF CONSULTATION WITH DHSS LEADERSHIP TO SELECT ALTERNATIVE MODELS AND REFORM OPTIONS.

Early in the project, in August 2015, we will convene a two-day, in-person work session with the project and DHSS client teams to review the results of the environmental assessment and use those results to select a menu of alternative models and reform options. Representatives from Agnew::Beck, HMA, and Milliman will attend this work session in person; this meeting will serve to inform work in all task areas.

Following a presentation of the findings from the environmental assessment, much of our discussion during this two-day work session will focus on identifying Alaska's reform goals and options to select a menu of options for further analysis. In order to identify the appropriate models, the Project Team will use the meeting to deepen our understanding of Alaska's needs and priorities, to include:

- Understanding current coverage gaps in the state, including the populations now uninsured and underinsured, as well as those accessing state-funded programs who could be covered through Medicaid;
- Identifying where alignment and coordination between state resources and programs can be improved;
- Discussion of state priorities and interest in pursuing reforms;

- Strategies and incentives to encourage healthy behaviors and personal responsibility;
- Policy decisions that encourage the development and use of medical homes, especially for people with chronic diseases or who are high utilizers of the health system;
- Initiatives to minimize unnecessary use of emergency rooms and hospitals by expanding access to primary and urgent care;
- Programs to support and reward care management teams that achieve better health outcomes and encourage effective access to care and utilization of services;
- A review of existing regulations or contract requirements that discourage or impede the use of effective care management or other innovative tools for managing costs;
- Evaluation of current telemedicine requirements and opportunities to use this and other telehealth services more effectively;
- Identification of regulatory or administrative barriers that prevent or discourage private insurers from using cost-efficient strategies to deliver care to Alaska Medicaid enrollees.

A critical part of this work will be to identify which Medicaid reforms and models for coverage expansion will create a sustainable model that ensures continued access to care in the context of improved health status of Alaskans and an efficient use of limited resources. HMA will incorporate best practices and lessons learned from models of reform with proven performance. We will focus on those models that most closely align to the needs of Alaska and its current and future Medicaid population. Where possible, we will identify potential cost savings that will help minimize the impact of expansion on the state and federal government.

TASK 4. DEVELOP DESCRIPTION OF FIRST ROUND OF ALTERNATIVE MEDICAID EXPANSION MODELS AND REFORM INITIATIVE OPTIONS FOR STAKEHOLDER REVIEW.

The result of the two-day work session and state and national environmental scans will be summarized in an internal memo for the DHSS client team. This summary will include a list of reform options that the team will explore in the following tasks. Once reviewed and approved, we will summarize key findings into a presentation and other materials to share with community stakeholders, including potentially the first issue of a project e-newsletter that would be generated quarterly to keep stakeholders informed.

Once the project and client teams have agreed on the list of potential reforms and expansion options to explore, we can begin to develop specific questions for further analysis. We will examine how various state Medicaid programs could meet the needs of Alaska in terms of improved enrollee health outcomes and access to care and increased value and cost containment, and seek to understand the trade-offs between various program designs. In this manner, we envision an iterative process to review, identify and confirm priorities, explore options through data analysis, and assess feasibility of prioritized options through additional analysis and stakeholder engagement.

TASK 5. PERFORM FIRST ROUND OF ACTUARIAL, FISCAL AND REGULATORY ANALYSIS ON MODELS AND REFORM OPTIONS.

Work under this task will be led by Milliman with support, oversight, and critical thinking by all members of the team and input from the DHSS client team. For each proposed reform option accepted by the DHSS client for further analysis, the team will prepare for and implement an actuarial analysis of the costs and savings associated with each option. This includes identification of data requirements and analysis. Team members will collaborate to determine the timing and steps of the modeling and analysis activities to ensure the data results complement and support all aspects of the team's work.

Our general approach to the actuarial analysis will be to:

- Identify sources of data (including existing data within Milliman);
- Collect any data that is not currently available to the State or Milliman;
- Populate and calibrate Milliman's models to the State's situation;
- Discuss initial estimates, projections and/or conclusions with the State; and
- Refine models, estimates, projections and/or conclusions based on feedback, through a repeating feedback loop with State.

Milliman's research and prior experience has yielded a number of powerful methods and resources that will be the backbone of the financial projections we provide to the State:

- Milliman's *Healthcare Reform Financing Model (HCRFM)* is an analytic engine that Milliman uses for modeling the impact of changes in health care financing. Milliman developed the HCRFM to assess, quantify, and understand the potential impact of specific health care reform proposals. The HCRFM projects the potential costs and movements of individuals and the interaction between competing medical cost payers and providers within and between the various insurance markets that comprise the health care system.
- Milliman's *Health Cost Guidelines™ (HCGs)* will be the primary tool for determining actuarial values of essential benefits, mandates and various health plan designs. The Health Cost Guidelines include utilization rates for specific services plus cost variations for different parts of the country and within the same state, which is critical for plan pricing and benchmarking. More than 100 insurers rely on the Guidelines, and we invest $5 million annually to incorporate the most up-to-date research.
- *Alaska and Industry experience*. Milliman has experience and data specific to the Alaska marketplace.

Milliman will blend existing resources and data with additional information that the State may have (e.g., survey, insurer filings, historical Medicaid enrollment and expenditures). The team will develop the financial projection estimates for each of the scenarios that DHSS has deemed most desirable. We will create a model that projects enrollment and healthcare expenditures for the current Medicaid population as well as the projected expansion population.

The process will begin with building a model, or reviewing current projections, of the baseline financial projections if no changes to the Medicaid program are implemented. This model will then be modified to reflect each scenario by developing assumptions unique to the desired scenario. These assumptions will be

based on a combination of results from other states, industry knowledge, and the Milliman Health Cost Guidelines. All assumptions will be reviewed and modified to account for the specific characteristics of the Alaska population and marketplace.

The following summarizes some of the assumption that will be used for each population:

- For the current Medicaid and individuals who are currently eligible for Medicaid but not enrolled (the "woodwork" effect population), we will likely rely upon State Fiscal Year 2014 Medicaid costs (Basic) as the baseline from which our projection is constructed. Costs will be trended at annual per member per month (PMPM) trend estimates. We will review U.S. Census Bureau data for Alaska to estimate the Medicaid expansion population and the currently-eligible but not enrolled population. The U.S. Census Bureau data also provides information regarding the number of children, parents, and adults with and without health insurance, below a stratified set of Federal Poverty Levels;
- Annual enrollment growth rate, including for any expansion population, using assumptions of Alaska's population in addition to experience in other states to proxy the managed care costs;
- Projected increased level of morbidity for any expansion population;
- Estimates of cost-sharing subsidies and actuarial plan values;
- Alaska Federal Medical Assistance Percentage (FMAP);
- Latent demand assumptions for new enrollees;
- Administrative expenditures projected, in addition to expenditures associated with medical services;
- Estimates of the health insurer fee, if applicable: the health insurer fee grows to $14.3 billion in CY 2018 and is indexed to the rate of premium growth thereafter. The health insurer fee is considered an excise tax and is nondeductible for income tax purposes. The fee will be allocated to qualifying health insurers based on their respective market share of premium revenue in the previous year (including Medicaid managed care premium). Taxes are generally considered to be an unavoidable cost of doing business. If Alaska moves to a Medicaid managed-care model, the managed-care capitation rates are required to be actuarially sound; capitation rates for Alaska would need to cover the cost of the tax. Because the ACA health insurer fee is a federal tax, all tax revenue collected as a result of the fee will accrue to the federal government. Since Medicaid is funded by the state and federal governments, both governments share in funding the premium component that funds the tax. This situation results in the federal government taxing itself and taxing state governments to fund higher Medicaid managed-care premiums required to fund ACA health insurer fees, with no net financial impact to Medicaid managed care organizations (MCOs); and,
- Offsets of any State programs that may produce savings to the Medicaid program.

Each change in benefit design, population, provider fee schedules, provider payment mechanisms, and other program characteristics will have an impact on the utilization of health care services as well as cost per service. The expected medical expenses of the population will be developed by projecting the expected change in utilization and average cost using broad services categories. These service categories include days per 1,000 and average cost per day by medical, surgical, maternity, psychiatric, and alcohol and drug abuse for hospital inpatient services. For hospital outpatient services, the broad categories include emergency room

visits, radiology, pathology, and surgery. For professional services, the broad categories include office visits, preventive care visits, radiology, and pathology. Other services include prescription drugs, ambulance, and prosthetics. There are approximately 70 broad service categories in total.

The detailed medical cost projection will produce an estimated PMPM cost for each population, to be aggregated for the financial projections. The final deliverable will be a financial projection that shows the revenue and expense over a five-year period for each scenario. The financial projection will consider both the State and Federal expenditures.

TASK 6. CONVENE FIRST ROUND OF STAKEHOLDER ENGAGEMENT TO REVIEW ALTERNATIVE MODELS AND REFORM OPTIONS.

Based on the results of the previous tasks, the project team will develop materials to share results with stakeholders to engage in a refinement of the options to be included in the final report. We recognize that stakeholder input is imperative to produce a realistic list of recommended options for the State's Medicaid reform and expansion efforts. This task will provide the opportunity for a shared exchange of information with the project's key stakeholder groups. The audience for this task is not the public but organizations and groups that are directly impacted by reform and expansion, including potential beneficiaries. The following table identifies an initial list of stakeholder groups that could be invited to stakeholder engagement opportunities. The project team will work with DHSS to identify the appropriate forums for engagement.

We also propose sending email updates, in the form of a project e-newsletter, approximately every quarter to the groups listed below. We will develop an email contact list to use for distribution of the e-newsletter. We have found e-newsletters can be an effective tool to communicate progress to a broad range of stakeholders.

Stakeholder Groups
Alaska Health Care Commission
Alaska Primary Care Association
Alaska State Hospital + Nursing Home Association
Alaska Academy of Family Physicians and other Medical Providers' Associations
Tribal Health Directors' Quarterly Meetings, which include Alaska Native Tribal Health Consortium
State of Alaska Behavioral Health System Leadership: Alaska Mental Health Trust Authority, Division of Behavioral Health, Alaska Behavioral Health Association, and Alaska Mental Health Board/Advisory Board on Alcoholism and Drug Abuse
Tribal Behavioral Health Directors Quarterly Meetings, which include Alaska Native Tribal Health Consortium
Community Mental Health Clinic Providers at the Division of Behavioral Health Change Agent Conference
Commonwealth North + Alaska Common Ground
Long Term Services + Supports Providers Meeting - inviting representatives from AgeNet, Alaska PCA Providers Association, Alzheimer's Resources of Alaska, Community Care Coalition SILC and IL Network Governor's Council on Disabilities and Special Education, Alaska Association for Developmental Disabilities
Legislative hearings + administrative briefings

The results of this round of stakeholder engagement will be summarized in an internal memo for review by DHSS in the following task.

TASK 7. SECOND ROUND OF CONSULTATION WITH DHSS LEADERSHIP TO REVIEW ANALYSIS AND STAKEHOLDER INPUT AND SELECT ALTERNATIVE MODELS AND REFORM OPTIONS TO INCLUDE IN SECOND ROUND OF ANALYSIS.

The second work session with DHSS leadership will take place with Agnew::Beck project staff in person and HMA and Milliman project staff joining via teleconference and screen sharing, including a video link, if possible. The purpose of this work session will be to refine the alternative models and reform options to include in the second round of analysis. The result of this task will be a reduced menu of options and guiding questions for the second round of analysis.

TASK 8. PERFORM SECOND ROUND OF ACTUARIAL, FISCAL AND REGULATORY ANALYSIS ON PREFERRED OPTIONS.

Using the same approach as described in Task 5, Milliman will lead this second round of analysis for the selected strategies. Milliman will modify the financial models developed in the first round to reflect the changes desired for the second round of analysis. Most of these changes will be modifications to the projected utilization and average charge based on changes in the program parameters between the first and second round of analysis. There may also be refinements in the original assumptions if stakeholder feedback produces credible sources for any modifications.

TASK 9. REVIEW ANALYSIS WITH DHSS LEADERSHIP AND SELECT FINAL MODEL AND REFORM OPTIONS TO INCLUDE IN FINAL REPORT.

The third work session with DHSS leadership will take place with Agnew::Beck project staff in person, with HMA and Milliman project staff joining via teleconference, screen sharing, and video link if possible. The purpose of this work session will be to review the results of the second round of analysis and select the preferred model and set of reform options for the final report.

TASK 10: DRAFT FINAL REPORT TO SUBMIT BY DECEMBER 1, 2015. INCORPORATE EDITS AND FINALIZE REPORT TO SUBMIT TO DHSS BY JANUARY 15, 2016.

The findings of the Environmental Assessment completed in Task 2, along with the results of activities and analyses undertaken for Tasks 3 through 9, and all findings to date will be documented in the draft report. The project team will prepare and deliver a draft of this report by December 1, 2015. The period between the submittal of the draft report and the final report on January 15, 2016 will allow for adequate review, comment, collaboration, and revisions. The draft report will include, as specified in the RFP:

- Executive Summary;
- Background: Medicaid Reform Environmental Assessment (developed in Task 2);
- Medicaid Expansion and Reform Recommendations;
- Alternative Medicaid Expansion Models: The proposed model will include a description of covered benefits, cost-sharing provisions, emphasis on healthy behaviors and personal engagement, and the expansion models will address the service needs of Alaska Mental Health Trust beneficiaries; and

- Medicaid Reform Initiative Options: A minimum of five (5) and a maximum of ten (10) Medicaid reform initiatives for Alaska.

Each alternative Medicaid expansion model and each of the reform initiative options will include:

- Definition and description of the expansion model or reform initiative;
- Description of how the expansion model or reform initiative can be used for improving quality, efficiency and effectiveness in service delivery;
- Description of how and why the expansion model or reform initiative can be expected to improve enrollee health outcomes and access;
- Analysis performed by a certified health care actuarial of the projected costs and savings associated with the expansion model or reform initiative;
- Description of the federal requirements for implementing the expansion model or reform initiative, including the recommended federal financing authority. Including a description of the associated flexibilities and limitations the state would have to operate within under the recommended financing authority and the associated waiver and State Plan Amendment requirements;
- Explanation of state statutory and/or regulatory changes that would be required to implement the expansion model or reform initiative;
- Description of the recommended rate structures and payment mechanisms for implementing the expansion model or reform initiative;
- Description of Centers for Medicare and Medicaid Services (CMS) monitoring and reporting requirements, and the associated Alaska Medicaid system needs, that would be required for implementation and management of the expansion model or reform initiative;
- Brief discussion of the experience of other states with the expansion model or reform initiative including lessons learned, especially by states with conditions similar to Alaska;
- Discussion of potential challenges and unintended consequences the Alaska Medicaid program might encounter with implementing the expansion model or reform initiative;
- Roles of the medical and behavioral health provider community in implementing the expansion model or reform initiative;
- Opportunity for collaboration with other state agency, federal and private health care purchasers in development and implementation of the expansion model or reform initiative; and
- Projected timeline and state resource requirements for planning and implementation of the expansion model or reform initiative.

The report will also include Recommended Reform Initiatives. From the options analyzed through this project, we will identify proposed reform initiatives most likely to meet the department's Medicaid reform goals and will explain the rationale for the recommendations. We will describe how the recommended reform initiatives align with: 1) the proposed alternative expansion model, and 2) current Medicaid reform initiatives already underway in the department. We will also explain how the recommended reform initiatives fit within

the framework of Alaska's current Medicaid program, and how the new initiatives will contribute to transformation of the state's Medicaid program and the health care delivery system so that they are sustainable and deliver high value care

Agnew::Beck will be responsible for compiling all of the results into a readable, visually compelling report that the department will use to educate legislators and stakeholders about the recommended strategy for Medicaid reform and expansion in Alaska. With the submittal of the final report on January 15, 2016, Phase 1 will conclude.

PHASE 2: DRAFT AND FINAL REPORT ON RECOMMENDED ACTION AND EVALUATION PLANS FOR EXPANSION AND REFORM

TASK 11: PARTICIPATE IN UP TO FOUR LEGISLATIVE HEARINGS.

As requested by DHSS, our team members will be available for select in-person activities, including up to four legislative hearings. We have a range of expertise and will work with the client team to identify the best team member(s) for each consultation. We will also work closely with the DHSS client team to develop our message and talking points, as well as any materials necessary to support these activities.

TASK 12: DEVELOP 3-YEAR ACTION PLAN AND EVALUATION PLANS TO SUBMIT TO DHSS BY APRIL 1, 2016.

Agnew::Beck will lead the action-planning portion of this task and HMA will lead the evaluation-planning portion. The project team will submit the draft action and evaluation plans for DHSS review by April 1, 2016, and will submit the final report by May 16, 2016.

To complete the action plan, Agnew::Beck will convene a work session with DHSS leadership to review the recommended reform strategies and identify action steps, responsible parties, timeframes, required resources and other key elements to develop a comprehensive three-year action plan for implementation of the proposed reforms, including those underway by the department. The action plan will also include action steps and implementation guidelines for meeting medical management, health analytics and actuarial needs.

In this task, HMA will work with DHSS to identify the type of cost, quality, and access data needed to measure performance and assess progress towards the State's goals, including aligning with existing scorecards and metrics. The goal of performance measurement is to provide a clear view of the State's health system using available data sources that optimizes information available, while minimizing additional reporting and data collection requirements for stakeholders, and specifically payers and providers. Our extensive experience developing monitoring and evaluation frameworks and tools has highlighted the need to:

- Consider collection and reporting requirements, and availability of existing data, as key factors when developing a set of recommended indicators;
- Ensure full understanding of applicable state, federal and other monitoring and reporting requirements to align development of indicators with existing needs and requirements;

- Engage broad stakeholder groups that collect and/or house key data sets to build partnerships and reach agreements vis-à-vis data access, confidentiality and periodicity;
- Develop integrated or "nested" dashboards that capture financial, clinical, and other programmatic data that allow decision-makers instant access to a broad and detailed array of data;
- Engage IT work teams in the planning and development of dashboard to enhance functionality and ensure integration with other IT systems; and
- Develop business requirements for dashboards to optimize usability for decision-makers.

Initial conversations with the DHSS client team and information available from recent reports including the Healthy Alaska Plan and the recommendations of the Medicaid Reform Advisory Group and the Alaska Health Care Commission will inform the proposed framework for measurement of the reform efforts to be implemented. The State's desire to improve health outcomes, increased efficiency and reduced costs, will also inform the structure of metrics and measures utilized.

Based on discussions with the DHSS client team and our knowledge of analytic measurement and the likely requirements of CMS related to the implementation of a program expansion, we will propose a set of measures to track before, during and after implementation of an expansion and reforms. Measurement may include, but would not be limited to, the following areas:

- Health Care Cost and Utilization (e.g., Per Member Per Month costs; Emergency Room spending PMPM; Primary care expenditures PMPM);
- Health Insurance Coverage (e.g., enrollment in Medicaid's current population and expansion group);
- Quality of Care (e.g., preventable inpatient admissions over time and compared to national or state benchmarks);
- Medical Debt (e.g., percent of enrollees currently paying off medical costs); or
- Health Status (e.g., percent in poor or fair health by insurance status, poverty status and race/ethnicity).

Data used for this kind of reporting can include state enrollment and utilization data, member surveys as well as national data with Alaska-specific samples. While the initial focus is on Medicaid and the uninsured, the dashboard could eventually be expanded to include data from the commercially-insured and Medicare populations. To the extent that other populations are included in dashboard data, the state will gain additional information about the impacts of program and policy decisions, health status and utilization of various populations in the state, such as variance between Alaskans by income, race, ethnicity and region.

Performance indicators will be developed in alignment with existing federal and state reporting requirements. To accomplish this, we will utilize our project team's extensive CMS IT and policy backgrounds to identify and interpret existing federal requirements and translate those requirements into recommendations to inform the development of performance indicators.

The creation of a recommended list of performance indicators will be based not only on meeting state and federal requirements, but also on stakeholder outreach to assess the relevance and viability of including

various indicators in the list. We will also focus on aligning recommended indicators with existing data collection and monitoring requirements to minimize additional regulatory and reporting burdens for stakeholders, recognizing that while data collection is important, efficient data collection must remain a priority. We understand that data sharing is more than just a mandate, it is an iterative process with stakeholders to understand their perspective and design an operational and legal framework to ensure protection of personal health information, while also facilitating the free flow of data and development of a comprehensive set of measures to track performance.

Once performance indicators are identified, we will design user-friendly interfaces that optimize usability and accessibility. We will work with DHSS to provide draft templates for dashboards to present financial, clinical and programmatic information to allow users to flow freely through information sets. The development of nested dashboards provides the user a broader array of information and ultimately enhances the value of the information being provided.

TASK 13. PERIODIC CONSULTATION WITH DHSS, MONTHLY PROGRESS REPORTS AND OTHER PROJECT MANAGEMENT TASKS.

Agnew::Beck, as team lead, will provide overall project management for this effort and will be the main point of contact with DHSS. The experts on our team from all three firms will be available to DHSS for periodic consultation. During the Project Start-up task, we will identify a communications schedule that meets DHSS needs and allows for adequate consultation with our team members. Agnew::Beck will be responsible for submitting monthly progress reports and informal communication with DHSS to report on the progress of the work. The details of our management approach are described in the following section.

MANAGEMENT PLAN FOR THE PROJECT

PROJECT RESOURCES AND ACCOUNTABILITY

Our team brings unparalleled national and local expertise to bear on this important project. Local contractor, Agnew::Beck, will lead the engagement with the support of two national firms, HMA and Milliman. The organization of the project team below supports collaboration across firms and leverages the strengths and expertise of each partner to produce the best and most cost effective products possible while providing clear lines of authority and responsibility on each task.

As the Project Lead, Agnew::Beck brings a team with Alaskan expertise in health care, behavioral health, and long term services and supports and extensive experience working with Tribal and non-Tribal providers across the state. Agnew::Beck has managed and executed multiple complex projects of similar scope and scale to the one proposed here since 2002. Principal in Charge, Thea Agnew Bemben, is the managing principal and co-founder of Agnew::Beck. Thea has worked with Alaska DHSS, The Trust, and many Tribal and non-Tribal health organizations across Alaska on a wide range of health-related projects for nearly 20 years. Thea will oversee the team as a whole and be ultimately responsible for contract deliverables. Thea will help facilitate team meetings and stakeholder engagement, and assist with developing, drafting and finalizing the deliverables for this project.

Project Manager, Heidi Wailand, is a certified Project Management Professional and a managing associate at Agnew::Beck. Heidi has extensive systems and qualitative analysis experience and is currently overseeing the Alaska Behavioral Health Systems Assessment, which will be completed in June 2015. Heidi will supervise the work of all subcontractors. Heidi will help facilitate team meetings and stakeholder engagement, and assist with drafting and finalizing the deliverables for this project.

Shanna Zuspan, managing associate at Agnew::Beck, will also help facilitate some of the stakeholder engagement and assist with drafting and finalizing the deliverables for this project. Anna Brawley, senior associate, and Heidi Heimerl, associate at Agnew::Beck, will provide analytical, logistical and production support for the team in all tasks. Inger Deede, senior graphic designer at Agnew::Beck, will assist with layout and graphic development for reports and stakeholder engagement materials.

The Agnew::Beck team will be responsible for ensuring that materials developed throughout the project are visually compelling and that the draft and final reports use a consistent voice and style, weave findings from each chapter into the next, and include the team's collective recommendations.

HMA brings national expertise in Medicaid policy. HMA will lead the environmental assessment, and the selection, description and analysis of Medicaid expansion models and reform options. HMA will supervise Milliman's work to ensure close alignment of the two firms' work on this project. HMA's role will include proposing and describing options that have been used in other states, listening and responding to the challenges and opportunities faced in Alaska, identifying performance data, reviewing results, and assisting in the selection of recommended options and timeline/implementation approach.

HMA offers a team of individuals with extensive experience in Medicaid expansion and reform at the state and national levels. In his former capacity as director of Medicaid for the State of Washington, HMA principal Doug Porter led Medicaid expansion and will lead the HMA team's work in Alaska. Doug Porter will play a strategic advisory role on the project and will provide assistance to HMA Principals Nora Leibowitz and Lee Repasch, who will share responsibility and accountability for project deliverables. Nora Leibowitz brings Medicaid, ACA, and private insurance market subject matter expertise to the project, as well as evaluation experience. Lee Repasch has federal Medicaid and ACA expertise. Gina Lasky is a nationally recognized expert on behavioral health system design, integration of behavioral health and primary care, and team development. Joan Henneberry, will serve as a senior advisor on the project. Joan served as Executive Director of Colorado's Medicaid program and senior health policy advisor to then Governor Bill Ritter, where she was responsible for developing and implementing policies and programs that expanded the availability of public health insurance, increased financing for Medicaid through a hospital provider fee, and began tying quality measures to provider reimbursement.

Milliman brings national expertise in Medicaid offering states, health plans and providers a broad perspective on Medicaid services, providing innovative solutions to help them better evaluate risk and manage costs. Milliman will lead the financial and actuarial analysis of Medicaid expansion models and reform options, and work closely with the team to ensure close alignment of actuarial analysis and policy decisions on this project. Milliman's role will include financial projections for each option selected for analysis, based on actuarial cost models and reflect actuarially-sound assumptions.

Milliman offers a team of individuals with extensive experience in Medicaid expansion and reform at the state and national levels. Susan Pantely, Principal at Milliman, will lead her team's work in Alaska. She led the firm's work in Puerto Rico's Medicaid expansion feasibility and has worked on teams in other states for engagements related to Medicaid and Medicaid expansion. Ben Diederich and Justin Birrell will share responsibility for project deliverables. Ben and Justin bring Medicaid, ACA, and private insurance expertise to the engagement. Ben and Justin developed the financial projections for the state of Idaho's Medicaid expansion scenarios. Rob Damler will provider peer review oversight for this engagement. Rob has over 25 years of experience and has worked with numerous Medicaid agencies on projects from rate certifications to financial feasibility studies.

The Experience and Qualifications section includes an organizational chart that outlines the roles and responsibilities described above and the estimated hours that will be dedicated to the project by each firm and each team member.

PROJECT PHASING AND TEAM ALLOCATIONS

We have divided the project into two phases. Phase 1 begins with project start-up activities and culminates in the final Report on Recommended Medicaid Expansion and Reform Strategies for Alaska, delivered to DHSS by January 15, 2016. Phase 2 concludes with the final Report on Recommended Action and Evaluation Plans for Expansion and Reform due to DHSS by May 16, 2016. This report will be based on the Recommended

Medicaid Expansion and Reform Strategies included in the Phase 1 report and will include a 3-year action plan and an evaluation plan to implement and evaluate the recommended strategies.

During Phase 1, our team will work closely with the core team at DHSS, building from the previous studies completed by DHSS and the experience of other states, we will identify the potential options for reform to investigate, assess these options through fiscal and data analysis and stakeholder feedback, and identify the framework for Alaska's Medicaid Expansion and Reform initiative. Phase 1 demands a high level of national policy expertise paired with deep knowledge of Alaska's medical, behavioral health, and long-term services and supports systems and stakeholders. Skillful facilitation and meaningful engagement with the target stakeholder groups will go hand in hand with the qualitative, quantitative, and fiscal analyses necessary to produce a Final Report that is respected and accepted by Alaskans and the legislature. An on the ground, local presence will be key to success. HMA and Milliman team members plan to make two trips to Alaska during Phase 1, once at the onset and again at a time deemed to be strategic for the project. Our national policy experts will also be available to speak at legislative hearings or administrative briefings or provide testimony as requested by the client. This approach will bring immediate, national expertise to the project and allow for transfer of knowledge to the client team.

During Phase 2, the work will focus on implementation and evaluation. As described in the methodology, Agnew::Beck will work closely with DHSS to develop a clear, detailed three-year action plan for implementing Medicaid reform and HMA will work closely with DHSS to develop a meaningful evaluation plan. We recognize that the specific needs of the project may require a slightly different allocation of time across our firms and have agreed to review and reassess our preliminary budget assumptions once the specific options to be addressed through the project become clearer. This approach will ensure that we have the right team on the right tasks at all times and will foster an iterative process of discovery, analysis, and path setting.

LINES OF AUTHORITY AND PROJECT COMMUNICATIONS

A successful project requires strong coordination and frequent communication between the client team and the consultant team; and, for a project of this scale, the same is true of internal communications across our firms. Communication is a component of project management that comes very naturally to Agnew::Beck. We have a strong record of working on projects large and small to create a comfortable project atmosphere with strong client partnerships, clear scopes, regular communications, and alignment of tasks.

Thea Agnew Bemben will serve as Principal in Charge. Thea will provide overall project oversight for the consultant team, and will be ultimately responsible for ensuring that all contract obligations are met or exceeded. Thea will participate in team meetings and help facilitate discussions. She will also facilitate some of the stakeholder engagement and participate in developing, drafting and finalizing project deliverables.

Heidi Wailand will serve as Project Manager and provide leadership and support to the project as a whole in addition to coordinating the completion of project tasks and managing the overall scope, timeline, and project budget. Heidi will serve as the primary contact for this contract and will work closely with the DHSS project director and project team to achieve the project's goals. Heidi will maintain an updated master project plan in Microsoft Project throughout the course of the project. The project plan will highlight key dates associated

with benchmarks, intermediary goals and deliverables for completion based to ensure the team is on track with the project schedule. The project plan will serve as an internal tool to ensure that expectations are clear and timelines are regularly monitored regularly and will be available to the client lead and core team as appropriate or as desired. A monthly status report will be circulated to keep key project leaders abreast of progress and any issues or risks to the project. The project manager will work closely with the client project manager to troubleshoot unexpected delays or issues that arise. It is our belief that the project manager should ensure that the right conversations are happening and have a strong handle on the content so that she may step in as needed to troubleshoot or make connections across tasks and teams. The project manager must also be able to provide an accurate summary of the issues and considerations across the breadth of the project's scope at any given time.

Each firm will guide the day-to-day communications and analysis activities required to fulfill their responsibilities under the contract according to the required time schedule. This responsibility includes compiling preliminary results and incorporating results into the appropriate chapters of the Final Report. It is the responsibility of each firm and each team member to communicate any issues or challenges that arise to the project manager so that they can be addressed quickly and collectively as a team.

The Agnew::Beck project manager will work directly with the client project manager to identify and discuss potential scope changes as needed to achieve to the project's objectives. Any changes or risks to scope will be raised directly with the client project manager as soon as possible. Agreed-upon changes to the project scope, and the corresponding changes in budget and timeline, will be documented. As the contract lead, Agnew::Beck will address all contract management matters.

TEAMWORK AND PROBLEM IDENTIFICATION AND SOLVING

The team's roles leverage the specialties of each firm and maximize areas where collaboration and synergies among team members will be most beneficial. In this way, national experience will be merged with local expertise, local relationships and local results. The management plan laid out above strives to ensure that those elements are in place throughout the duration of the project. With a project of this scope, scale, and nature (in terms of politics, potential savings, and impacts), there are many potential problems that could arise and some that almost certainly will. Teamwork, collaboration and communication, within and across the contractor and State teams, will be key to identifying problems early and solving them jointly. Walking in lock step with a core team of DHSS and systems leaders and truly operating as a strong, coordinated team will be instrumental to our project's ability to mitigate potential problems and navigate the real problems that do arise, regardless of their nature.

Given the depth of our broader (including project staff at DHSS and its partners) team's national and state policy expertise, financial modeling, health care pricing and actuarial experience, Alaska program and community engagement experience, and Alaska Medicaid data analysis experience, we are confident that we have some of the best people available for the task at hand. We anticipate that given our collective team's far-reaching experience and qualifications and our commitment to each other and the goals of this project, the technical components of this project will be complex but achievable. The most difficult aspect of this effort

will be the art of shepherding change at this scale, and laying out an implementation plan that takes into account the intricacies of our systems, programs, and providers, as well as patients and their families, and that makes sense for Alaska. Meaningful stakeholder engagement will be essential to the project, and to the ultimate acceptance or rejection of the recommended reforms by the various stakeholder groups and associations. We will work steadfastly with DHSS and its partners to create an effective strategy for engagement and to establish a plan for building partnerships with a range of stakeholders groups. We have a strong record of successfully navigating multi-faceted improvement initiatives on sensitive topics and building common ground among stakeholders; we will bring those skills and experiences to bear on this project. Our local presence will mean regular in-person attendance at meetings and frequent, consistent communication with our client and other stakeholders and our national experience will help to ensure we share successes of and learn from efforts in other states.

LOGISTICS

Agnew::Beck occupies a fully functioning office, served by all necessary office equipment to complete tasks in a timely and professional manner. All work will be performed in Anchorage. Agnew::Beck's office is located at 441 West Fifth Avenue, Suite 202, Anchorage, Alaska 99501. Agnew::Beck staff are available to attend project meetings at the client site and other locations as required by project circumstances and as allowed for by the project budget.

National team members will travel to Alaska for select project meetings and otherwise be available by video or teleconference. We have all hardware, software, equipment, and licenses necessary to perform the contract. The firm uses a secure FTP site for transferring files and storing data, with a discrete security certificate specifically for data transfer. A range of software programs are then utilized in the data analysis, including SPSS, SQL and R, among others. Additionally, we use several proprietary tools such as the Health Cost Guidelines (HCG), HCG Grouper, Milliman Advanced Risk Adjusters (MARA), and Health Care Reform Model to create actuarial models.

PROJECT MANAGEMENT PROCEDURES

We employ the following practices to ensure that projects are carried out according to reasonable and agreed-upon scope, timeline and budget, with strong coordination and frequent communication between the client and consultant team.

REGULAR STATUS REPORTING

Good communications and regular status reporting are key to the success of any project. A project status update will be sent to the DHSS project director on a monthly basis. The update will include a high-level status update on the project scope, timeline, and budget, as well as a detailed overview of the work completed during the prior month, work slated during the upcoming month, and any issues or risks that need to be addressed to ensure the project progresses according to plan. The status update provides the DHSS project director with a comprehensive snapshot of the project each month. For the project to be as successful as

possible, the DHSS project director should also plan to partner with the project manager on a regular (at least weekly) basis to address project issues as they arise and provide leadership and direction to the project team.

SCOPE MANAGEMENT

We anticipate that the nature of this contract will require flexibility on our team's part as we embark on an iterative process to define the terms of Medicaid expansion and reform in Alaska. Early in this project, we will want to identify priority issues and establish boundaries for this wave of Medicaid expansion and reform based on what is needed and what is feasible (feasible to undertake and feasible to implement). It is not uncommon for the scope of a project to change as more is learned during the discovery and analysis process; however, changes in scope can have an impact on a project's budget and timeline and it is important to set up a clear process for handling such changes. The project manager will work directly with the DHSS project director to identify and discuss potential scope changes as needed to achieve to the project's objectives. Any changes or risks to scope will be raised directly with the DHSS project director as soon as they are identified and agreed upon changes to scope, and the corresponding change in budget and timeline, will be documented.

TIMELINE MANAGEMENT

A detailed project timeline will be created to highlight benchmarks, intermediary goals and deliverables for completion by the project team to keep the project on track. The project manager will work closely with the team and with the DHSS project director to troubleshoot any unexpected delays that occur. Changes to the timeline based on internal or external forces will be communicated as they occur and the project timeline will be adjusted accordingly. Given the high profile, high stakes nature of this project and the Department's desired schedule for Medicaid expansion, we recognize that on-time delivery of the project deliverables is exceedingly important. Two factors are the biggest candidates for delaying the project—transfer of Medicaid and any other data from the State and scheduling of stakeholder engagement activities (either ability to schedule or desire to leverage an existing conference or meeting that does not quite meet the project's desired timeframe). The data issue cannot be underscored enough: the Medicaid files necessary to complete the Alaska Behavioral Health Systems assessment took nine months to secure. The Business Associates Agreement also took time. We will work with DHSS to mitigate potential delays.

BUDGET MANAGEMENT

In creating the project budget, Agnew::Beck and partners estimated the level of effort this project is anticipated to require on a task by task and firm by firm basis. At the aggregate level, the project budget outlines the total funding available for the project based on the scope outlined in this document. It is important to note, however, that some project tasks can take longer than originally anticipated while others can take less time. Agnew::Beck reserves the right to modify the amount budgeted to an individual task while staying within the original total budgeted amount. In developing our budget for this project, we recognize that the specific needs of the project may require a slightly different allocation of time across our firms and

have agreed as a team to review and reassess our preliminary budget assumptions once the specific options to be addressed through the project become clearer.

All time at Agnew::Beck is captured through our timekeeping software and can be readily monitored weekly to ensure tasks remain on budget. Subcontractors will be asked to submit their invoices monthly and the project manager will monitor the budget and report on the budget monthly, modify the budget allocated to a given task as needed. If changes in scope or delays in the project timeline present a risk to the total project budget, the principal and DHSS project director will be notified as soon as anticipated issues arise. At minimum, budget and progress reports will be submitted to the client on a monthly basis.

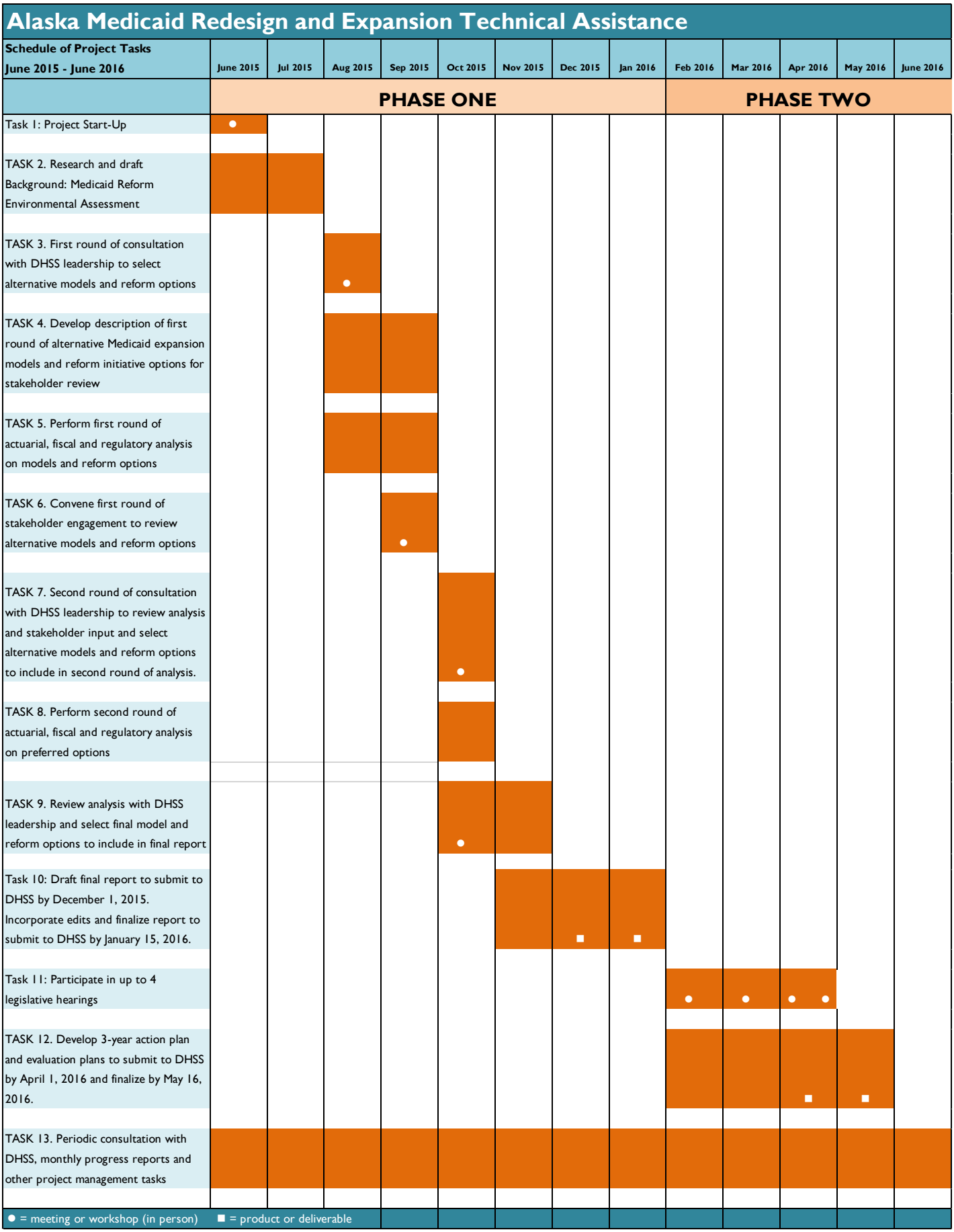
The management plan strives to ensure that sound project management practices are in place throughout the duration of the project to achieve results that are on time, on budget and on scope.

PROJECT TIMELINE

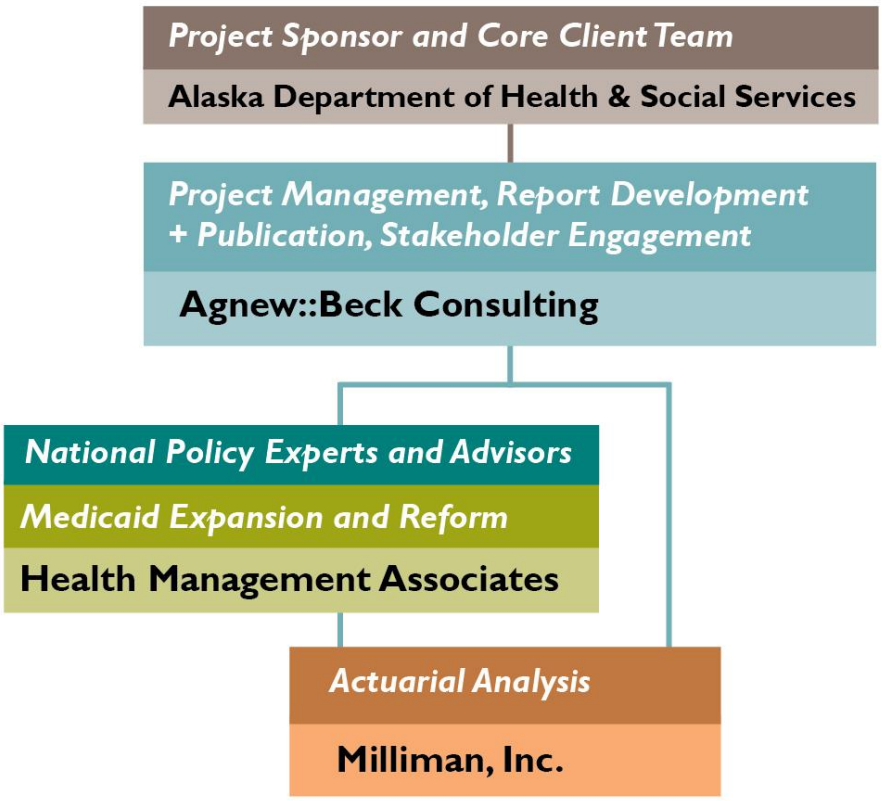
The following timeline provides a high-level overview of the anticipated project schedule; a graphic timeline is included on the following page. This timeframe is very aggressive, however it is also necessary to meet the needs of the Department and engage with the legislature during the upcoming 2016 session.

- Task 1: Project Start-up will develop a strong foundation for all project tasks. It will be completed within one month from the contract execution date. Target completion date is June 30, 2015.
- Task 2: Research and draft Background: Medicaid Environmental Assessment will begin in June and be completed by July 31, 2015 to present to DHSS leadership in August 2015.
- Task 3: First round of consultation with DHSS leadership to select alternative models and reform options will occur in August 2015.
- Task 4: Develop description of first round of alternative Medicaid expansion models and reform initiative options for stakeholder review will follow directly from Task 3 and will occur in August and September 2015, concurrent with Task 5.
- Task 5: Perform first round of actuarial, fiscal and regulatory analysis on models and reform options will occur concurrent with Task 4 and be completed by September 2015.
- Task 6: Convene first round of stakeholder engagement to review alternative models and reform options will occur in September 2015.
- Task 7: Second round of consultation with DHSS leadership to review analysis and stakeholder input and select alternative models and reform options to include in second round of analysis will follow directly from the stakeholder engagement and will occur concurrent with Task 8 in October 2015.
- Task 8: Perform second round of actuarial, fiscal and regulatory analysis on preferred options will occur in October 2015.
- Task 9: Review analysis with DHSS leadership and select final model and reform options to include in final report will occur concurrent with Tasks 7 and 8 and will extend into November 2015 while the project team is drafting the report.

- Task 10: Draft final report to submit to DHSS by December 1, 2015. Incorporate edits and finalize report to submit to DHSS by January 15, 2016. This will complete Phase 1 of the project.
- Phase 2 will begin with Task 11: Participate in up to four legislative hearings during the legislative session between January and April 2015.
- During the same period, we will complete Task 12: Develop 3-year action plan and evaluation plans to submit to DHSS by April 1, 2016 and finalize by May 16, 2016.
- Task 13: Periodic consultation with DHSS, monthly progress reports and other project management tasks spans the life of the project and has been described in detail above.


Alaska Medicaid Redesign and Expansion Technical Assistance
Schedule of Project Tasks
June 2015 - June 2016
June 2015
Jul 2015
Aug 2015
Sep 2015
Oct 2015
Nov 2015
Dec 2015
Jan 2016
Feb 2016
Mar 2016
Apr 2016
May 2016
June 2016
PHASE ONE
PHASE TWO
Task 1: Project Start-Up
TASK 2. Research and draft Background: Medicaid Reform Environmental Assessment
TASK 3. First round of consultation with DHSS leadership to select alternative models and reform options
TASK 4. Develop description of first round of alternative Medicaid expansion models and reform initiative options for stakeholder review
TASK 5. Perform first round of actuarial, fiscal and regulatory analysis on models and reform options
TASK 6. Convene first round of stakeholder engagement to review alternative models and reform options
TASK 7. Second round of consultation with DHSS leadership to review analysis and stakeholder input and select alternative models and reform options to include in second round of analysis.
TASK 8. Perform second round of actuarial, fiscal and regulatory analysis on preferred options
TASK 9. Review analysis with DHSS leadership and select final model and reform options to include in final report
Task 10: Draft final report to submit to DHSS by December 1, 2015. Incorporate edits and finalize report to submit to DHSS by January 15, 2016.
Task 11: Participate in up to 4 legislative hearings
TASK 12. Develop 3-year action plan and evaluation plans to submit to DHSS by April 1, 2016 and finalize by May 16, 2016.
TASK 13. Periodic consultation with DHSS, monthly progress reports and other project management tasks
● = meeting or workshop (in person)
■ = product or deliverable

ORGANIZATION OF THE PROJECT TEAM



EXPERIENCE AND QUALIFICATIONS

FIRM OVERVIEWS

AGNEW::BECK CONSULTING – MANAGING FIRM

Agnew::Beck Consulting is an award-winning, multidisciplinary consulting firm based in Anchorage, Alaska. We are skilled in analysis, policy development, planning, public engagement, and project implementation. Since 2002, we have helped clients strategically respond to challenges and opportunities to achieve their goals. Our team is committed to effective and efficient project management. We work to build healthy communities locally, regionally and statewide.

Our firm's areas of specialty include:

- Public Policy Analysis + Development
- Public, Behavioral and Community Health
- Program Evaluation + Assessment
- Strategic Planning + Facilitation
- Data Analysis + Market Research
- Housing and Affordable Housing
- Grant Writing + Project Financing

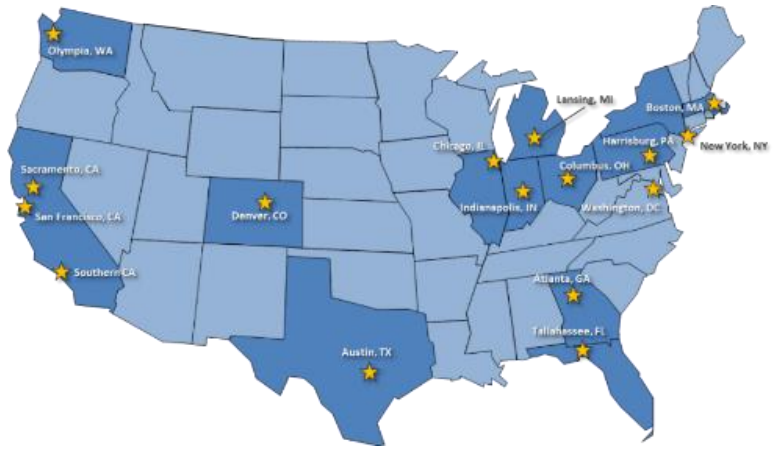
By combining creativity and vision with practical implementation, Agnew::Beck helps clients accomplish short-term objectives and set out a clear path for long-term success. We are committed, passionate, and practical partners, working together to identify and tackle a project's most important issues with smart, effective solutions, and with community stakeholders at the center of the process.

"Engage, Plan, Implement" is our approach to helping people, places and organizations get beyond ideas and issues, and get into making things happen.

References: Please refer to the attachments for letters of reference for Agnew::Beck Consulting.

HEALTH MANAGEMENT ASSOCIATES

Health Management Associates (HMA) is a consulting firm specializing in the fields of health system restructuring, health care program development, health economics and finance, program evaluation, and data analysis. HMA is widely regarded as a leader in providing technical and analytical services to health care purchasers, payers, and providers, with a special concentration on those who address the needs of the medically indigent and underserved. HMA is a private, for-profit "C" corporation, incorporated in the State of Michigan in good standing and legally doing business as Health Management Associates, Inc. Founded in 1985, Health Management Associates has offices in Atlanta, Georgia; Austin, Texas; Boston, Massachusetts; Chicago, Illinois; Columbus, Ohio; Denver, Colorado; Harrisburg, Pennsylvania; Indianapolis, Indiana; Lansing, Michigan; New York, New York; Olympia, Washington; Sacramento, San Francisco, and Southern California; Tallahassee, Florida; and Washington, DC.



HMA HAS 16 OFFICES ACROSS THE COUNTRY

HMA has clients across the country, including the major safety net health systems, private sector providers, and local, state, and federal governments. The firm has extensive experience and expertise in the design and implementation of health programs, particularly with respect to system development, managed care, long- term care, and behavioral health care.

The staff of HMA is composed of over 165 health care professionals with up to thirty years of experience in the health and human services fields, including senior staff with long experience in clinical and administrative leadership of Medicaid agencies and public hospitals. HMA brings a strong interdisciplinary expertise to clients. Staff backgrounds include health economics, public health policy and administration, health care finance and reimbursement, clinical services, managed care, pharmacy benefit design and management, social work, program development and evaluation, and information systems.

Of particular relevance to work outlined in the RFP, HMA has extensive and recent waiver experience, including in the states of Texas, Illinois, California, Vermont, and Maryland. Of particular interest is our work assisting the State of Maryland in securing a waiver from the Centers for Medicare and Medicaid Innovation that realigns the state's all payer hospital system to drive further innovation. HMA has also worked on State Innovation Model projects in several states, including Oregon, Michigan, and Illinois.

HMA has experience in designing, developing and implementing initiatives similar to those anticipated for Alaska. HMA possesses unique expertise in the design, implementation, and operation of Medicaid reforms. Our team consists of former Medicaid directors who understand program strengths and weaknesses and people who are experts in the CMS policy and waiver process in Medicaid and in its Center for Consumer Information and Insurance Oversight (CCIIO), the agency that will likely oversee the Section 1332 waiver process. In addition, we have a team of experts devoted to analyzing and implementing delivery system reforms that can lead to improved management of chronic diseases that are the drivers of Medicaid costs.

Over the last five years, HMA has provided services similar to the work included in this RFP, including the following projects:

- Assisted states in the preparation of and analysis of 1115 waivers
- Provided technical assistance to states implementing or reforming managed care in their Medicaid programs for all populations including those dually eligible for Medicaid and Medicare and those needing behavioral health services
- Assisted Medicaid programs and other state agencies throughout the country to coordinateinitiatives, assessing operations, analyzing costs, and recommending strategies to improve care and efficiency
- Worked with state Medicaid agencies and providers to model impacts of current and proposed payment methodologies and financing mechanisms on uncompensated care and access to services
- Worked with states to assess current and proposed payment methodologies and financing mechanisms on the bases of regulatory compliance, adequacy, equity and sustainability
- Drafted legislative/regulatory language and/or Medicaid state plan amendments (SPAs) to implement new or revised financing and payment methodologies and support states in CMS negotiations to finalize SPAs
- Served as the lead consultant to the National Governor's Association Center for Best Practices project: Developing State-level Capacity to Support Super-Utilizers Policy Academy, a forum for states to receive specialized technical assistance on how to stand up and sustain care management/coordination programs aimed at Medicaid super-utilizers
- Assisted multiple states and their provider systems in their efforts to undertake Medicaid-wide delivery system reforms to reduce costs and improve health care outcomes and shepherd those reforms through federal and state approval processes
- Assisted states in the upgrades of their MMIS systems and IT capabilities, including developing and enhancing capabilities to operate enrollment and eligibility systems and processes.
- Developed integrated care strategies for health care systems to improve chronic disease management
- Worked with state departments of health to achieve a higher level of population health management
- Provided analysis and strategic planning to states and counties on the interaction between Medicaid and prison health systems
- Assisted multiple states in designing and implementing Medicaid expansions

The HMA team understands that in order to be successful in meeting the needs of the Alaska Department of Health and Social Services, it is essential to have a successful record and deep experience with the type of transformation that the DHSS seeks to accomplish in the coming years. In order to demonstrate experience in this regard, we are providing background on selected projects from our extensive list of current and former clients. With HMA, all of our staff resources are available to be pulled onto the project as needed and were subject matter expertise warrants.

References: Please refer to the attachments for letters of reference for Health Management Associates.

MILLIMAN

Milliman is among the world's largest independent actuarial and consulting firms. Founded in Seattle in 1947, we have grown to 54 offices in principal cities worldwide. Milliman employs more than 2,400 people, including over 100 Fellows of the Society of Actuaries (FSAs) practicing full-time in health-related issues.

Milliman has been active in healthcare consulting since the late 1950's. One of the first actuarial studies of a group prepayment health plan (later to be called HMOs) was made by the Milliman San Francisco office in 1960. Throughout the late 1960s and 1970s, Milliman became known as a premier consultant to Blue Cross and Blue Shield organizations and HMOs. Milliman continues to be a leading healthcare consulting firm to employers, governments, health plans, providers, managed care organizations, and insurance companies. Milliman has made a major commitment to the public sector. Governmental actuarial services are our priority, as the firm's largest clients are in the public sector.

Milliman is not affiliated with a brokerage, insurance company, or accounting firm. Milliman is a partnership that is wholly owned by its approximately 350 Principals. We believe this independence is critical in bringing an unbiased perspective and allows us to focus solely on your needs and priorities. Our health consultants apply in-depth industry knowledge and superb technical skills to the issues you face, with analysis supported by the most current research and innovative proprietary tools. You can depend on us as industry experts, trusted advisors, and creative problem-solvers who bring intelligence and insight into everything we do.

Known for our technical and business acumen, we provide expert consultation on both the financing and delivery of healthcare. We provide our clients with groundbreaking analysis on health reform and business issues impacting the health industry. Our clients include most of the leading health insurers, BCBS plans and HMOs, as well as providers, employers, and sponsors, government policymakers, pharmaceutical companies, and foundations. As a firm, we provide actuarial consulting to over half of the state Medicaid agencies. Working as consultants to insurance regulators is an important part of Milliman's practice. Over the past few years, we have worked with regulators in nearly all states, often in an educational or advisory role with respect to new or complex topics.

Milliman consultants include actuaries, clinicians, health care consultants, and information technology specialists- offering a diversity of experience, intelligence, and perspective to help clients cost-effectively manage healthcare delivery and financing without compromising quality of care.

Combined with our unique expertise in advanced modeling, informatics, and analytics, we can offer a broad range of resources to our clients. This remarkable combination of skills and experiences enables us to examine health care trends, assess emerging needs, and develop programs that target health problems to deliver improved outcomes. Applicable experience includes:

- Strategic consulting that encompasses all facets of health care reform
- Market research, data collection, and analytics
- Insurance regulation and monitoring
- Medicaid expansion and integration with state Exchange
- Planning, development and implementation of IT support systems

- Federal research and compliance issues
- Developing and refining health care reform policies
- Estimating the cost and coverage impacts of health care reform plans
- Determining the cost of insurance coverage to various stakeholder groups
- Population and cost projection models
- Public and private plan design
- Health care contract management
- Trend analysis

Our consultants take great pride in our firm's commitment to professionalism through development of leading-edge tools and databases, direct and pragmatic client communications, client focus and responsiveness, and independent peer review of all client work. For our clients, this means objective, unbiased advice and a superior work product based on the best tools and data available.

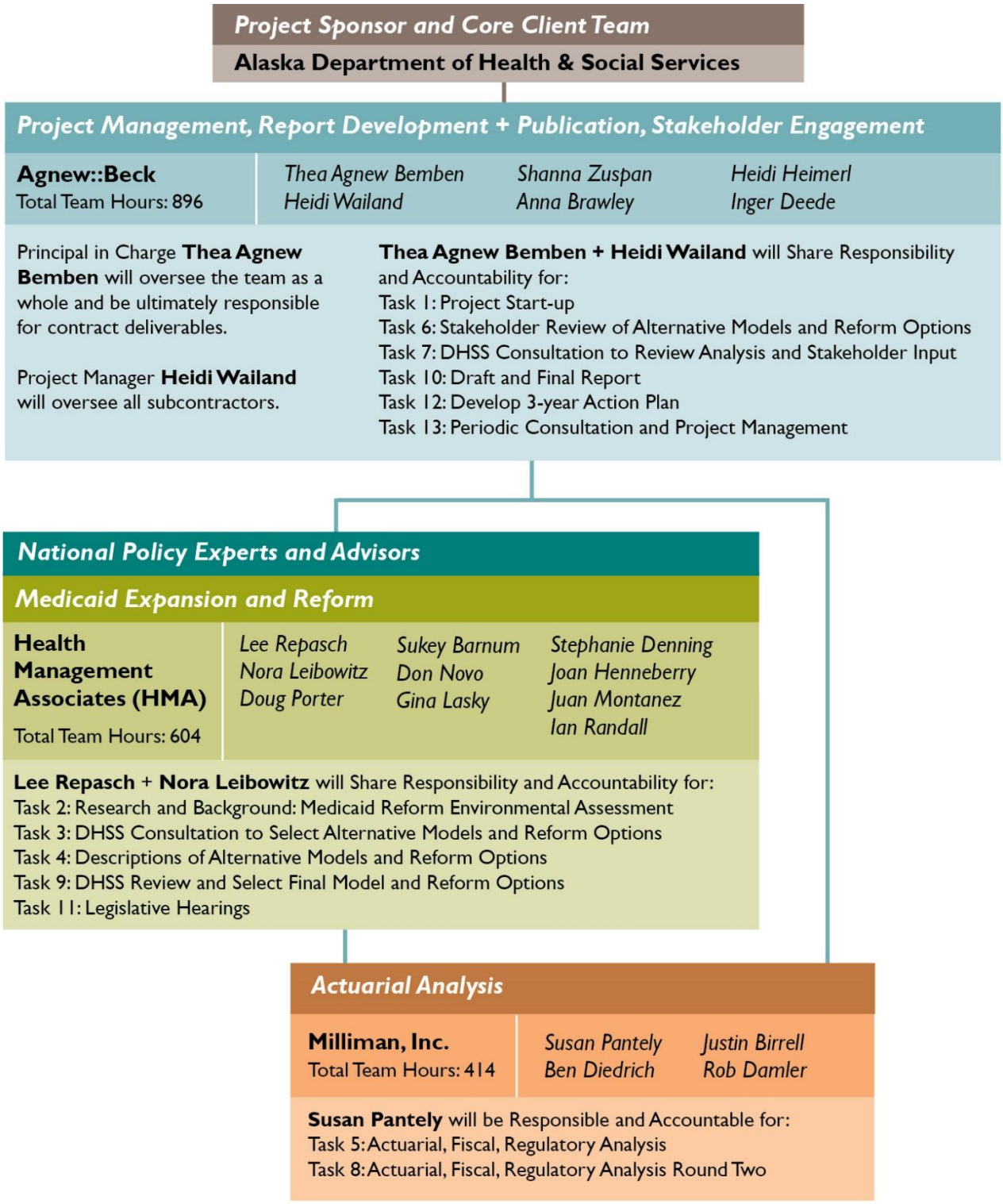
References:

Sandra V. Peña Pérez, PT, MHSA
Deputy Executive Director
Administración de Seguros de Salud de Puerto Rico (ASES)
Puerto Rico Health Insurance Administration (PRHIA)
Phone (787) 474-3300 ext. 3002
spena@asespr.org

David N. Taylor, CPA, CFE
Deputy Director over Support Services/Licensing and Certification
Idaho Department of Health and Welfare
Phone (208) 334-5500
TaylorD@dhw.idaho.gov

PERSONNEL ORGANIZATIONAL CHART AND ROSTER

Below is an organizational chart specific to the personnel who will work on this project. A personnel roster and biographies follow, and resumes are included as attachments. Please see the Management Plan for a narrative of the organization of the project team.



Below is a roster of all personnel assigned to this project, along with their years of experience in specified areas of expertise.

	Areas of Expertise										
	Technical Assistance: Medicaid Expansion	National Medicaid Policies + Reform	State Medicaid Policies + Reform	AK Experience: State Medical, BH + LTSS Program Areas	Tribal Health Systems	Fiscal + Financial Analysis	Large Data Set Quantitative Analysis	Actuarial Analysis	Public Outreach + Stakeholder Engagement	Dashboard Development + Administration	Community Health Material Development
Technical Assistance Team	**Years of Experience**										
Agnew::Beck											
Thea Agnew Bemben			5	19	19	13			19		13
Heidi Wailand			3	5	3	5			10		4
Shanna Zuspan			3	5	3	15			15		3
Inger Deede											10
Anna Brawley				2	2	2			4		4
Heidi Heimerl			1	3	2.5	1			4		2.5
Health Management Associates – Team to be supplemented by other staff as needed.											
Lee Repasch	4	4	14		2				18		10
Doug Porter	2	20	20		10				10		
Sukey Barnum	5	18	18						9		
Nora Leibowitz	4	8	10			1			8		2
Joan Henneberry	10	15	15	1		4		3	6		5
Stephanie Denning	2	3	10						20		20
Juan Montanez	5	13	13	2	1	21					
Don Novo	22	7	14	1	7	7			22		6
Gina Lasky					2		3		2		2
Ian Randall	2	3	3		5				3		
Milliman											
Susan Pantely	5	13	13								
Ben Dietrich	5										
Jason Birrell	5					5		25			
Rob Damler	5	15	15			10		28			

THEA AGNEW BEMBEN

Title: Principal in Charge | **Firm**: Agnew::Beck | **Location**: Anchorage, Alaska | **Estimated number of hours**: 264

Thea Agnew Bemben is the managing principal and co-founder of Agnew::Beck Consulting in 2002. Thea has 19 years of experience working with communities and organizations to increase their effectiveness and viability and recommend practical strategies to reach common goals. These efforts result in changing whole systems, integrating silos or re-tooling operations. Thea works with statewide and tribal agencies to improve the systems that promote individual and community wellness. Her expertise in health and human services planning and community development is coupled with strong experience working with Alaska Native communities and tribal organizations. Thea is an experienced facilitator of decision-making dialogue on a variety of public policy issues. She has helped organizations and communities raise millions of dollars to develop public facilities and programs to better meet the needs of the people they serve. Thea has led multiple projects related to long-term services and supports, behavioral health, prevention of chronic disease and behavioral health issues working with consumers, providers, regional service arrays and statewide health systems both tribal and non-tribal.

HEIDI WAILAND, MRP, PMP, LSSG

Title: Managing Associate | **Firm**: Agnew::Beck | **Location**: Anchorage, Alaska | **Estimated number of hours**: 296

Heidi, a Certified Project Management Professional, has extensive experience guiding stakeholder-driven systems change initiatives across a number of fields including health and behavioral health care, city and state government, workforce development and business management. Since moving to Alaska, Heidi has become a student of the Affordable Care Act and Alaskan health and behavioral health care systems. Heidi has successfully managed many initiatives to improve health and behavioral health care systems in Alaska, working extensively with Tribal and non-Tribal and rural and urban stakeholders in efforts to leverage data to identify priorities and pursue positive change at the organizational, community and state-wide levels. Prior to joining Agnew::Beck, Heidi served as the Executive Director of Strategic Operations for the City of New York's Department of Small Business Services and led multiple systems change initiatives that transformed the way the agency conducted business.

SHANNA ZUSPAN

Title: Managing Associate | **Firm**: Agnew::Beck | **Location**: Anchorage, Alaska | **Estimated number of hours**: 40

Shanna is a project manager with a background in data and economic analysis, as well as community planning and public health research. Whether working with local governments, tribal entities, state agencies, or the private sector, Shanna provides objective facts and analytical tools to help organizations find common solutions to critical issues. Since joining Agnew::Beck in 2010, she has served as the project manager and lead analyst on a

range of long term care initiatives including the development of recommendations for a strategic plan for long term services and supports at the state level and the strategic planning process to develop Alaska's Alzheimer's Disease and Related Dementia Roadmap. Shanna recently completed a demand forecast for assisted living in Juneau and is currently leading an effort to assess the financial feasibility for an expanded senior services program for Wasilla Area Seniors Incorporated (WASI). Shanna also completed the State budget analysis to develop a fiscal policy "meeting-in-a-box" tool kit for the House Finance Committee to help the general public understand Alaska's fiscal situation.+

INGER DEEDE

Title: Senior Associate | **Firm**: Agnew::Beck | **Location**: Anchorage, Alaska | **Estimated number of hours**: 32

Inger is passionate about articulating the objectives of organizations through graphic design. As marketing specialist and graphic designer at Agnew::Beck, she applies her strong background in art to explore visual possibilities and hones in on the most useful and aesthetically appealing design solutions. Inger has an interest in clean, clear design that incorporates modern constructs with a respectful nod to tradition. She garnered considerable experience working with a wide range of organizations in her capacity as a freelance designer. She applies that experience at Agnew::Beck helping to market the firm and showcase our successes.

ANNA BRAWLEY

Title: Senior Associate | **Firm**: Agnew::Beck | **Location**: Anchorage, Alaska | **Estimated number of hours**: 204

Anna uses her strong education in urban planning, policy and history to develop strategies and shape planning and implementation efforts in the fields of organizational development, public health and social policy for Agnew::Beck. Her experience ranges from planning, data analysis, GIS analysis, process improvement, policy research, qualitative research methods, web and graphic design, document production, organizational structure and leadership development. She effectively navigates between the details and the big picture and helps coordinate the actions of the contract team, client staff, partner organizations and other stakeholders to achieve the project's goals. Anna is also an active volunteer in her community, serving on the Turnagain Community Council and as a board member of NeighborWorks Anchorage.

HEIDI HEIMERL, LMSW

Title: Associate | **Firm**: Agnew::Beck | **Location**: Anchorage, Alaska | **Estimated number of hours**: 60

Heidi's clinical experience, communication skills, organizational abilities, and creative problem solving techniques accentuate her work at Agnew::Beck. As a licensed social worker, Heidi is interested in assessing, developing and implementing programs that meet the needs of Alaska's diverse communities, specifically the senior population. She has been instrumental in

helping to plan for and secure critical program funding and is committed to understanding how programs and organizations can work with, rather than simply within, the complex behavioral health and long term care systems.

LEE REPASCH

Title: Principal | **Firm**: Health Management Associates | **Location**: Denver, Colorado | **Estimated number of hours**: 55

Lee Repasch will manage the project for HMA. She is a flexible and creative leader with a proven record of achievement in project management and development. Technologically savvy and detail oriented, Lee brings more than 20 years of experience in health policy research and analysis to HMA.

Lee focuses on the intersection of policy and information technology, with specialized knowledge of Medicaid health IT policy and development and has an in-depth understanding of health care reform, including the Health Information Technology for Economic and Clinical Health Act (HITECH) and the Affordable Care Act (ACA).

Prior to joining HMA, Lee worked as a health IT/ health insurance specialist with the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, where she specialized in translating policy into application to industry, as well as communicating between industry and government. She worked closely with states – including Colorado, Utah, Wyoming and Arkansas on funding, developing and implementing enrollment and eligibility systems that met the requirements of the ACA. She also provided technical assistance and policy guidance to states implementing the both the ACA and HITECH. Before joining the HITECH team, Lee worked with the Division of Medicaid and Children's Health Operations in Region 8 as a health reform specialist. In this capacity, she provided technical assistance to states in implementing and interpreting ACA policies.

Lee previously worked as a research/policy analyst with the George Washington University Department of Health Policy for 14 years, where she worked with the department's growing research arm on a wide variety of sponsored projects centered around access to care for poor and vulnerable populations, with a focus on Medicaid and FQHCs, as well as served as project manager for the multiple health IT projects the department had undertaken. Lee also served as the department's public affairs liaison and as an adjunct professor.

She has a master's degree in International Politics and Social Development/Political Economy from the Korbel School of International Studies at the University of Denver, and a bachelor's degree in international studies from Lock Haven University of Pennsylvania.

NORA LEIBOWITZ

Title: Principal | **Firm**: Health Management Associates | **Location**: Portland, Oregon | **Estimated number of hours**: 104

Nora Leibowitz is an experienced health policy and operations professional who has dedicated the past 18 years to improving Americans' access to quality, affordable health care. Working for public and private organizations at the federal and state level, Nora has sought challenges that have allowed her to increase access to care and improve consumer health outcomes.

She has subject matter expertise in Medicaid/CHIP, the private health insurance industry, market reforms and health care quality. Before joining HMA, Nora was the Chief Policy Officer at Cover Oregon, directing policy development and implementation for the state's health insurance exchange. At Cover Oregon, Nora developed the state exchange's individual market eligibility and enrollment policy and operations and managed corporate policies and procedures, compliance, and evaluation activities. She planned and implemented resolutions to high priority, public challenges facing the organization. As a key leader, Nora actively engaged in strategic and project planning, risk management and resource allocation.

Prior to the creation of Cover Oregon, Nora successfully worked to pass Oregon's state exchange authorizing legislation. In her role as Exchange Development Director, Nora led the initial planning and implementation of Oregon's exchange, including bringing in over $50 million in grant funding, directing the exchange planning team and partnering closely with legislators, Medicaid and technology staff.

Nora also has served Oregon as manager of its Medicaid Actuarial Services Unit, Interim Director of Policy for the Office for Oregon Health Policy and Research, and a Senior Policy Analyst for Health Reform. Previously Nora spent several years in Rhode Island as a consultant to Rhode Island Medicaid, where she helped build Medicaid managed care programs for special needs populations. She was also Lead Program Analyst for the federal Department of Health and Human Services Office of Inspector General.

Nora earned her Master's in Public Policy from the University of Chicago's Irving B. Harris Graduate School of Public Policy and a Bachelor of Arts degree in History from Reed College.

JOAN HENNEBERRY

Title: Vice President | **Firm**: Health Management Associates | **Location**: Denver, Colorado | **Estimated number of hours**: 20

Joan Henneberry, Advisor to the Project, joined HMA in January 2012 after serving as the Planning Director for the Health Insurance Exchange in Colorado, where she developed the strategic plan for the establishment of an exchange, staffed the first board of directors, monitored and responded to proposed rules and regulations, and developed four work groups of stakeholders and experts to advise the planning process. From 2007-2011, Joan served on the cabinet of Governor Bill Ritter, Jr. as the executive director of the Department of Health Care Policy and Financing, the state agency responsible for public health insurance programs including Medicaid and CHP+. She was the senior health policy advisor to the Governor, developing and implementing policies and programs that expanded the availability of public health insurance programs for the State of Colorado. Between 1997 and

2004 Joan held several positions at the National Governors Association in Washington, D.C., including Director of Health Policy. Joan serves on several state and national boards and advisory committees and serves on the board of Senior Support Services in Denver. She has a master's degree in management from Regis University, and completed the Senior Executives in State and Local Government program at the Harvard University, Kennedy School of Government in 2008. Joan was the 2011 recipient of the John Iglehart Award for Leadership in Health Policy from The Colorado Health Foundation.

STEPHANIE DENNING

Title: Senior Consultant | **Firm**: Health Management Associates | **Location**: Denver, Colorado | **Estimated number of hours**: 120

Stephanie Denning has worked in healthcare and health-related fields for more than 25 years. Her experience ranges across the public, non-profit and private sectors and includes expertise in health administration and operations, public policy, marketing and communications, public and private health insurance, and public health systems. Prior to joining HMA, Stephanie oversaw management of the Medicaid, Child Health Plan and Charitable Health Coverage lines of business for Kaiser Permanente Colorado. There, her responsibilities included managing business operations such as membership, marketing and outreach, and contract administration, product development, as well as support for care delivery operations and innovations. Stephanie also worked in the private sector where she managed state client relationships, developed proposals, created policies and procedures, and consulted on operations and policy issues with operations site managers. Her expertise includes helping to effectively translate policy into operations. Before her work in the private sector, she was the Director of Marketing and Public Relations for Denver Health, Colorado's largest public hospital and health system. Stephanie has a Master's Degree in Public Administration, Health Policy, from the University of Colorado Denver and a Bachelor's of Science Degree in Journalism from the University of Colorado Boulder.

GINA LASKY, PHD

Title: Project Manager | **Firm**: Health Management Associates/HMA Community Strategies | **Location**: Denver, Colorado | **Estimated number of hours:** 40

Gina Lasky is a licensed psychologist with 16 years of hands-on experience in the behavioral health public sector. Clinically, she worked in numerous non-profit community based organizations, a public hospital, and one of the State of Colorado's state hospitals. In her five years at the state hospital she specialized in treatment of dangerousness, treatment of serious mental illness, and traumatic brain injury. Working on numerous multi-disciplinary (medical and behavioral health) teams sparked her interest in team development and leadership in the public sector. Gina went on to a fellowship in Public Sector Psychology Administration and Evaluation at the University of Colorado, School of Medicine and had the opportunity as part of this training to work at the Colorado Department of Human Services-Office of Behavioral Health.

In 2011, Gina served as the Director of Behavioral Health for Axis Health System, a community behavioral health agency transforming into an integrated healthcare organization serving five rural counties in Colorado.

In that position she and the Director of Psychiatry led the opening and development of an integrated care clinic. In addition, as the director of an acute treatment unit, crisis services in five counties, and outpatient behavioral health, she oversaw clinical program development, quality improvements, and directly supervised clinical managers and providers. Part of her focus was moving integrated care into all aspects of clinical programming including crisis services, inpatient and outpatient behavioral health. In this role, Gina learned first-hand about the challenges of implementation of integrated care which furthered her interest in the unique leadership required and the importance of team development as essential elements of this innovative model.

In the last year and half, Gina has been consulting with organizations nationally on behavioral health system design, integration of behavioral health and primary care, and team development. Projects have included working with a state hospital on an improved risk assessment protocol; providing research for Colorado's Office of Behavioral Health on evidence based crisis interventions and lessons learned from states that had transitioned crisis systems and incorporated interventions into the continuum of care; partnering with the SAMHSA/HRSA Center for Integrated Health Solutions on projects related to workforce and team development within integrated care; and conducting assessment of readiness for integrated care for organizations wanting to transition from traditional care to team based integrated care.

Gina joined HMA in the new division Community Strategies in February 2014. Her project work continues to include behavioral health system design and integrated care. Through Community Strategies, she is working on community partnerships between and among community based organizations addressing the social determinants of health and traditional healthcare in addition to other projects designed to create healthy, equitable, and sustainable communities. Gina is also currently pursuing a master's in Public Leadership with a Specialization in Multi-Sector Management at George Washington University.

DOUG PORTER

Title: Principal | **Firm**: Health Management Associates | **Location**: Olympia, Washington | **Estimated number of hours**: 40

Doug Porter directed Washington's Medicaid program for more than ten years, and completed a successful merger with the state's Health Care Authority – responsible for Public Employee Benefits – that had been in process for two years. When Medicaid was still part of the Department of Social and Health Services umbrella agency, Doug was responsible for the Division of Mental Health and the Division of Alcohol and Substance Abuse. He directed the merger of these two divisions and put into place new management of the state psychiatric hospitals.

Under Doug's leadership, the state adopted the Medicaid expansion made possible by the Affordable Care Act, reduced the percentage of uninsured children in the state to record levels, redoubled program integrity efforts and was the executive sponsor of the procurement of a state of the art Medicaid Management Information System. Over the years, Doug directed a series of cost containment efforts that ultimately held medical cost inflation to less than four percent for the last five years, in large part by eliminating waste and inefficiencies.

Doug has also been responsible for the Medicaid program in the states of California (where it is known as Medi-Cal) and Maine. His work in California included the expansion of managed care into the twelve most populous counties in the state and the establishment of California's SCHIP program, Healthy Families.

During his tenure as a board member with the National Association of Medicaid Directors, he served on the Tribal Technical Advisory Group, co-chaired the Behavioral Health Technical Advisory Group and was the Executive Committee liaison to the Fraud Abuse and Detection Technical Advisory Group.

As a principal with HMA, Doug brings his policy expertise to clients around the country interested in payment reform, the expansion of Medicaid eligibility and program integrity strategies to combat fraud waste and abuse. He also opened HMA's fifteenth office in Olympia, where he is based. Doug's experience in the private sector includes serving as Chief Operating Officer for a 106-bed psychiatric hospital in South Portland, Maine and interim administrator for a 40 bed hospital in rural Arkansas.

SUKEY BARNUM

Title: Principal | **Firm**: Health Management Associates | **Location**: Columbus, Ohio | **Estimated number of hours**: 40

Sukey Barnum is an experienced professional in healthcare policy and program development, and healthcare information technology management. Over the last 18 years she has held a range of positions in state agencies, healthcare consulting organizations, and healthcare IT services and solutions organizations. She has developed a passion for helping her clients and her teams to hone problem and issue identification leading to more efficient assessment, solutioning and resolution. Her broad-based background gives her the ability to tackle questions, challenges and problems—even the most ambiguous—and to identify a path forward.

Before joining HMA, Ms. Barnum was helping Kunz, Leigh and Associates to establish a practice in Columbus, Ohio. KL&A is a healthcare IT firm providing both product/solution development services, and Project Management Office and IV&V services primarily to state health and human service customers. KL&A opened offices in Columbus in April of 2014. Ms. Barnum was responsible for the delivery side of establishing and managing KL&A's Ohio practice.

Prior to joining KL&A, Ms. Barnum was the Executive Account Manager for CNSI's Washington State account. CNSI built and operates Washington's MMIS and also its system for administering the Electronic Health Record Medicaid Incentive Payment Program. In the Account Manager role, and in her prior roles with CNSI including Project Manager and Functional Manager, Ms. Barnum enhanced her Medicaid knowledge and experience to encompass not just a policy perspective but also an enhanced operational perspective; and also gained invaluable experience and insight into Healthcare IT Project Management and operations. Ms. Barnum's particular areas of interest with respect to Healthcare IT management is governance and the establishment of effective systems and processes within State Medicaid Agencies and their IT contractors, and between the two.

Before joining CNSI, Ms. Barnum worked for Washington's State Health Care Authority as Senior Policy Analyst. Among other efforts, she managed the development of the state's policy, budgeting and plan for implementation of Medicare Part D relative to the state's retiree health benefits.

Prior to her move to Washington State, Ms. Barnum held a position with Health Management Associates in its Columbus, Ohio office as a Senior Consultant. In that capacity, she worked on a variety of projects for a variety of clients.

Ms. Barnum got her Medicaid "chops" in multiple roles with Ohio's State Medicaid Agency. There she was responsible for: budget development; strategic planning; constituent and stakeholder management; supporting major expansions of the use of Managed Care and transition for clients and counties from FFS to Managed Care enrollment; SCHIP implementation; eligibility and EPSDT policy development and oversight of county administration of eligibility application processing and EPSDT; and coordination between Medicaid and other human service programs such as TANF, Food Stamps, Child Care, Child Support and Child Welfare.

JUAN MONTANEZ

Title: Principal | **Firm**: Health Management Associates | **Location**: Washington, DC | **Estimated number of hours**: 20

Juan Montanez has more than twenty years of experience and an extensive knowledge base that encompasses information technology, financial planning, business process optimization, strategic planning, cost-benefit analysis, government procurement and project management.

Recently Juan led the multi-disciplinary team that worked with the Puerto Rico Department of Health on the feasibility assessment and planning of a Health Insurance Marketplace for the Territory. Juan has also worked on several Medicaid Management Information System (MMIS) and eligibility and enrollment system projects with government and private sector clients. Additionally, during his time at HMA Juan has led an eligibility system reengineering initiative in the state of California and several health plan IT readiness assessment projects. Finally, Juan has served as HIT/HIE solution architect to several states and provider organizations seeking to establish health home and accountable care organization (ACO) programs.

Before joining HMA was a senior consultant at a firm subsequently acquired by Mercer. While at that firm Juan led MMIS, encounter data management system and health information technology initiatives in Florida, Georgia, Hawaii, New Mexico, Tennessee and the U.S. Virgin Islands. Juan also provided project management and readiness assessment leadership to numerous managed care system implementations including implementations in the aforementioned states. Juan was also a key player in the design and implementation of Puerto Rico's Government Health Insurance Plan; Juan's role included project plan development, procurement strategy and facilitation of proposal evaluation teams. Juan is also a highly recognized expert in cost-benefit analysis and return-on-investment analysis in the public sector; while at the firm subsequently acquired by Mercer Juan led the cost-benefit/return-on-investment analysis phase of the Minnesota Health Care Connect project which led to reengineered eligibility and enrollment processes for Minnesota's health care programs.

Prior to his work as a consultant Juan served as senior advisor to Georgia's Chief Information Officer, Director of Strategic Research and Analysis for Georgia's Department of Community Health, and Budget Director and IT Manager with a thirteen-hospital system in the Atlanta metropolitan area.

Juan holds a Bachelor of Science in Engineering from the Massachusetts Institute of Technology and a Master of Business Administration from the Georgia Institute of Technology.

DON NOVO

Title: Principal | **Firm**: Health Management Associates | **Location**: San Francisco, California | **Estimated number of hours**: 40

Don Novo comes to HMA from the Centers for Medicare and Medicaid Services (CMS) where he most recently worked on Health Reform Implementation projects related to the establishment of both the Federal and State based Marketplaces. Prior to his marketplace work he was the Medicaid Program Branch Manager for CMS in Region IX. His areas of responsibility included program management oversight of the Region IX Medicaid programs for the states of Arizona, California, Hawaii, Nevada and the Pacific Territories which include American Samoa, Northern Mariana Islands and Guam. Don's Federal experience spans seven years in both the Boston and San Francisco Regional Offices and most recently working with the CMS Central Office on Health Reform implementation. Prior to his Federal involvement he served as the Director of Member Policy Implementation and Evaluation Services with MassHealth, the Massachusetts Medicaid Agency.

Don is a seasoned Health Policy Administrator with over 20 years' experience in working with analysis, evaluation and implementation of Waivers and Medicaid State plan requirements. Prior to his Federal involvement he was the Director of Policy Implementation and Evaluation Services with MassHealth. In this role he worked to develop new and innovative benefit plans necessary to allow the State to expand eligibility to their pre-Affordable Care Act Childless Adult expansion under 1115 demonstration authority. He also led efforts to streamlined the State's Medicaid eligibility determination process, implemented their online Virtual Gateway application process for the Medicaid program and developed the eligibility and systems processes and enhancements necessary to implement both the electronic web-based application and the State's Universal Healthcare expansion in Massachusetts.

In his early days with Mass Health he worked on the implementation of the State's groundbreaking 1115 Demonstration waiver. In this role he promoted the waiver to both the provider community and the public at-large. He worked with the Massachusetts Hospital Association, the Mass League of Community Health Centers and advocacy and stakeholder groups in promoting all aspects of the waiver. As a Senior Staff member within the Medicaid agency, he was responsible for the day to day Eligibility, Policy and Evaluation Services components of the State's Medicaid program. He was the key implementer responsible for ensuring operational compliance with both Federal and State Medicaid Regulations. He led several consolidations of State Public Health programs that eventually were incorporated into the MassHealth 1115 (Designated State Health Program (DSHP)) demonstration. He presided over the 2006 implementation of the State's Health Care Reform known as Romney Care, the program that shared several aspects of the Affordable Care Act.

In September 2007, Don accepted a position with the Centers for Medicare and Medicaid Services (CMS) Boston Regional Office. In this role he worked with the six-New England States to ensure programmatic compliance of their Medicaid State plans and ongoing waivers. Don was directly responsible for oversight of the State of Connecticut's Medicaid program. In this role he provided the Commissioner, State Medicaid Director and their staff with guidance and direction on both Waiver and State plan issues. Don was the a lead negotiator on Connecticut's 2008 1915(b) waiver that allowed the state to change their delivery system from prepaid inpatient health plans (PIHPs) to capitated at risk managed care (MCOs) plans. He worked with the State to dispel advocate concerns regarding network adequacy by reviewing state analysis of plan contacted providers and conducting a review based on data directly received from the state's managed care plans.

In 2010 Don became the Medicaid Program Branch Manager at the CMS San Francisco Regional Office. During his tenure he participated on the CMS negotiating team for California's 2010 1115 "Bridge to Reform" demonstration waiver. Through his efforts he ensured that the State maintained necessary beneficiary protections and safeguards for the state's new childless adult expansion through the inclusion of county operated indigent programs. He also required the state to implement strict safeguards for moving the Seniors and Persons with disabilities population into the managed care delivery system which was authorized through the new demonstration. Post waiver approval he continued to work on CA's 1115 waiver ensuring oversight to the Special Terms and Conditions along with requested waiver and state plan amendments including an amendment to create a new M-CHIP program to incorporate the previous population covered under the state's prior S-CHIP program.

IAN RANDALL, PH.D. *CAND.*

Title: Senior Consultant | **Firm**: Health Management Associates | **Location**: Olympia, Washington| **Estimated number of hours**: 125

Ian Randall, PhDc, is a results-oriented consultant with experience in strategy, operations, policy and research in the health care provider, payer and life sciences sectors. Recent consulting roles include estimating the cost of care for the uninsured in a southern metropolitan region; collaborating with PH-SKC and UW colleagues to construct a comprehensive operational and research framework to assess the impact of the ACA in King County; and, working with the WA OIC to convene a diverse stakeholder coalition to drive the development of premium stabilization programs for the Washington HBE.

Ian's past consulting experience includes the aforementioned roles as an independent consultant, more than two years with Deloitte Consulting's Strategy and Operations division working with Deloitte's healthcare group, and previous roles at an academic medical center and a strategic communications firm. Ian's past roles include provider-side performance improvement and clinical productivity, supply chain, comparative effectiveness and strategy projects; payer-side ICD-10 business and technical impact projects; federal and state policy and health reform analyses; and, health delivery system innovation research projects. Ian has managed key work streams, project personnel and dual client/consulting work teams, and collaborated with and presented to senior client partners. In addition to his consulting, policy and research work, he is a PhD Candidate in Health Services Research with a specialization in health finance at the University of Washington.

Trained as a researcher, Ian applies multidisciplinary training and methods from the fields of evaluation sciences, health economics, biostatistics and social determinants of health, among others, to research, operations, strategy and policy projects. His dissertation research applies novel statistical methods to isolate the effect of the medical home on utilization and cost at the Veterans Health Administration. Ian received a B.A. with Honors in International Relations from James Madison College at Michigan State University and a Master of Health Services Administration from the University of Michigan School of Public Health.

SUSAN E. PANTELY, FSA, MAAA

Title: Principal, Consulting Actuary| **Firm**: Milliman | **Location**: San Francisco, CA| **Estimated number of hours**: 120

Susan Pantely is a Principal and Consulting Actuary in Milliman's San Francisco office. She has been with the firm since 1989 and has over 20 years of healthcare actuarial experience with Milliman.

Susan works extensively with commercial, Medicare, and Medicaid plans, as well as with provider group clients in numerous states. In addition to providing traditional actuarial consulting services (e.g., financial projections, valuation of benefit plan design changes, experience analysis, provider reimbursement analysis, claim liability estimates, and feasibility studies), Susan consults with clients regarding innovative risk-sharing arrangements. Specific recent engagements have focused on feasibility analyses regarding various CMS demonstration projects including the Pioneer ACO program, Medicare Shared Savings program, Physician Group Practice demonstration, and CMMI Bundled Payments for Care Improvement Initiative.

Susan is currently the Vice-President of the Society of Actuaries, Board of Directors. She earned her BS in Mathematics from the University of Pittsburgh.

ROBERT M. DAMLER, FSA, MAAA

Title: Consulting Actuary| **Firm**: Milliman | **Location**: Seattle, WA| **Estimated number of hours**: 64

Robert has developed an expertise in the analysis of the financial risks associated with the financing and delivery of healthcare services. His experience includes both public and private pay healthcare. He has consulted on a wide array of topics, including managed care resource allocation models, financial projections, mergers and acquisitions, disease management, and risk adjuster development for specialized populations. Robert consults with state Medicaid programs, managed care organizations, insurance companies, self-funded insurance programs, and employers.

Robert's primary consulting areas include Medicaid programs and disease management. For Medicaid programs, Robert provides consulting services to several state Medicaid agencies and Medicaid HMOs regarding budget and population forecasts, long-term financial analysis, waiver cost effectiveness, new program initiatives, and actuarial certification for managed care capitation rates. Robert also provides consulting services to the pharmaceutical, clinical laboratory, and durable medical equipment industries. Robert consults with these industries regarding population specific healthcare costs and prevalence rates, as well as other disease management issues.

BENJAMIN J. DIEDERICH, FSA, MAAA

Title: Consulting Actuary| **Firm**: Milliman | **Location**: Seattle, WA| **Estimated number of hours**: 115

Ben's actuarial experience includes health policy analysis, Medicaid rate setting and actuarial certification, Medicare Advantage bid development, statements of actuarial opinion, reserving, pricing, procurement support, state budget projections, legislative impact analysis, and audit support.

With his main focus on public sector clients, Ben has completed a variety of projects relating to the analysis and projection of health plan costs. Recent projects include the following:

- A risk-adjusted experience review at the request of a legislative audit committee for a state Medicaid agency.
- Actuarial support for development of a small employer premium subsidy program.
- Update and redesign of a financial budget projection model for a state employee benefits program.
- Legislative impact analysis support for benefit mandates and plan design provision changes.
- Actuarial certification for conversion to a full-risk Medicaid capitation rate.
- Issuance of a statement of actuarial opinion for a multi-state health insurance company.
- Supported the development of Medicare Advantage bid for both special needs plans and standard plans.

Prior to joining Milliman, Ben worked for Aetna Global Benefits as the head of Actuarial and Underwriting. He managed a growing book of business covering health insurance as well as life, LTD, and stop-loss risk. This broad base of experience has provided a solid foundation for his work as an actuarial consultant.

JUSTIN C. BIRRELL, FSA, MAAA

Title: Consulting Actuary| **Firm**: Milliman | **Location**: Seattle, WA| **Estimated number of hours**: 115

Justin has more than 18 years of actuarial experience with a variety of health related issues. His primary focus over the last 10 years has been Medicaid. This has involved work for states, including Hawaii, Idaho, Nevada, Utah, Washington, and Vermont, as well as non-state clients working with Medicaid populations.

He has worked on a variety of projects, including medical, long-term care, behavioral health, transportation, disease management, procurement, health care reform, and other state- specific analyses. In addition to the development of capitation rates, Justin has worked with states to negotiate final rates and produce required CMS documentation. His work includes a focus on how PPACA will affect these populations, integration of long-term care services into managed programs, and integration of Medicare and Medicaid costs.

His experience includes:

- Current work in multiple states to develop rates and an appropriate structure integrating both the Medicare and Medicaid component of costs into a rate for members eligible for both programs
- Experience in developing rate structures for integrated (medical, mental health, chemical dependency, and long-term care) healthcare models for Medicaid recipients that improve healthcare and reduce expenditures, including CMS documentation of rates and rate structures
- Expertise in the development and documentation of Medicaid capitation rates in multiple states for managed care services for TANF, Aged, Blind, disabled, and other unique Medicaid populations, including those eligible for Medicare as well as those only eligible for Medicaid benefits
- Experience in documentation of cost effectiveness for Medicaid programs
- Experience risk-adjusting Medicaid capitation rates
- Experience in developing non-emergency transportation rates for Medicaid populations
- Expertise in analyzing large claims databases and healthcare modeling
- Experience in developing prescription drug formularies
- Expertise in Medicaid disease management financial savings analyses and analysis of soundness of disease management rates
- Work with state agencies to project impact of benefit and enrollment changes including the impact of PPACA legislation on state expenditures
- Design and evaluation of pay-for-performance incentives in Medicaid managed care programs

MINIMUM QUALIFICATIONS

1) Performance of at least two technical assistance projects within the past five years to states on the development of Medicaid expansion and/or reform plans or proposals.

For documentation of technical assistance projects with states implementing Medicaid Expansion within the past five years, please refer to the last section of the attachments. Documentation is provided for three projects performed by Health Management Associates: the Iowa Medicaid Expansion State Healthcare Innovation Plan, Cook County Medicaid 1115 Waiver, and MetroHealth Medicaid 1115 Waiver. A letter of reference from the State of South Dakota is also included in the Letters of Reference section in the attachments and serves as comparable evidence of HMA's work on South Dakota Affordable Care Act / Health Reform project. Due to the confidential nature of the report, it was not included.

2) At least five years of federal and/or state level experience within the past eight years with Medicaid policy and program development and analysis. Experience must include all or some combination of the following:

- Design and/or evaluation of Centers for Medicare and Medicaid Services (CMS) approved Demonstration Projects;
- Design and/or evaluation of Medicaid payment rate structures and mechanisms;
- Development of federal CMS waiver applications and/or Medicaid State Plan Amendments;
- Development of state Medicaid regulations and/or legislative proposals.

Health Management Associates has been providing national and state level assistance with Medicaid policies since December 2004 to March 2015, for a total of eleven years of experience. HMA has developed or is developing health homes for Missouri, Michigan, Ohio, Rhode Island and Washington, D.C. HMA has worked with these states to design their programs, drafted and submitted State Plan Amendments (SPA) for CMS approval, and successfully attained expedited SPA approval from CMS. Please refer to the table below for specific projects and dates that demonstrate this experience.

3) At least three years of experience in the past six years with some combination of: health program evaluation, health data analytics, behavioral health service development and evaluation, and/or health systems research and consulting that included the role and functions of tribal, community health center, military, and Veterans' Affairs health sectors.

Agnew::Beck has twelve years of health systems consulting experience in behavioral health programs and systems, tribal health systems, military and Veterans' Affairs health sectors, and community health center operations and funding with projects starting in August 2002 through March 2015. See representative projects below and staff resumes for specific engagements.

Health Management Associates has over thirty years of experience in Behavioral Health, including health program evaluation, health data analytics, behavioral health service development and evaluation, health systems research and consulting that included the role and functions of tribal and community health centers.

Milliman has over fifty years of experience in health data analytics and health program evaluation.

Please refer to the table and project descriptions below for demonstrated experience in these minimum qualifications for all subcontractors.

4) Project staff or subcontractor who can demonstrate experience with Alaskan health systems research or administration, or a proposed plan for gaining this essential knowledge.

The Agnew::Beck team has Alaska expertise in state health care and behavioral health program areas with projects starting in August 2002 through March 2015.

Please refer to the table and project descriptions below for demonstrated Alaska expertise in state health care and behavioral health program areas.

5) Project staff or subcontractor who is a certified health care actuarial with at least two years of experience within the past five years in the performance of health care pricing, reimbursement and utilization analyses.

Susan Pantely, Rob Damler, Ben Dietrich, and Justin Birrell are the actuarial team. Susan, Rob, Ben, and Justin meet the Qualification Standards of the American Academy of Actuaries for issuing a Statement of Actuarial Opinion regarding the work product contained in the RFP. All are both Fellows of the Society of Actuaries (FSA) and Members of the American Academy of Actuaries (MAAA). The status of their credentials can be verified at: https://www.actuarialdirectory.org/SearchDirectory/tabid/242/Default.aspx

All have many years of experience and the majority of their work involves health care pricing, reimbursement, and utilization analyses. Specific examples for each Milliman staff member:

Susan E. Pantely: ASES (Puerto Rico Medicaid): Susan has been the actuary for ASES since 2001 and her work includes health care pricing, reimbursement, and utilization analyses.

Capital District Physician's Health Plan (CDPHP): Susan has been the actuary for CDPHP's commercial and Medicaid business for 5 years and provides services related to health care pricing, reimbursement, and utilization analyses.

Ben Dietrich and Justin Birrell: Idaho Department of Health and Welfare: Ben and Justin have provided services related to Idaho Medicaid since 2011. Their work is predominantly services related to health care pricing, reimbursement, and utilization analyses.

Rob Damler: State of Ohio Department of Job and Family Services: Rob has been the actuary for the Ohio Medicaid program since 2007. His work is predominantly services related to health care pricing, reimbursement, and utilization analyses.

The table below lists the projects from Agnew::Beck, Health Management Associates, and Milliman that meet the minimum qualifications for this request for proposals. Following the table, full descriptions of each project are listed. Our firms have a strong record of delivering projects on time and on budget and meeting or exceeding client expectations. Please see our references for further information.

	Minimum Qualifications				Additional Relevant Qualifications		
	Technical Assistance: Medicaid Expansion	National + State Medicaid Policy + Reform	Medicaid Expansion + Reform in BH + Tribal Health Systems	Alaska Expertise: State Health + BH Program Areas	Medicaid Quantitative Analysis	Dashboard Development and Administration	Working Knowledge of ACA
Agnew::Beck Project Experience							
Project: Alaska Behavioral Health Systems Assessment **Date:** March 2014 – present	X		X	X			X
Project: Regulations Review and Drafting, Division of Public Assistance **Date:** May 2014 – present			X				
Project: Maniilaq Association Behavioral Health Program Assessment + Business Plan for Expansion **Date:** November 2014 – present			X	X			X
Project: Arctic Slope Native Association + North Slope Borough Preliminary Plan to Address Gaps in Behavioral Health Services **Date:** March 2015 – present			X	X			X
Project: Conflict-free Case Management **Date:** December 2014 – February 2015		X	X	X			X
Project: Alaska Title 4 Statute Revision and Stakeholder Engagement **Date:** May 2012; August 2013 – present				X			
Project: Wasilla Area Seniors Inc. Continuing Care Feasibility Study **Date:** September 2014 – present				X			
Project: SPF SIG Community Prevention Support Team Technical Assistance **Date:** September 2011 – June 2015				X			
Project: Alaska e-Health Network Transforming Clinical Practice CMS Grant Development Assistance **Date:** November 2014 – February 2015		X	X	X			X
Project: Village of Unalakleet Assisted Living Feasibility Study **Date:** February –December 2014			X	X			
Project: Alaska Pacific University Department of Psychology Student-Led Clinic Business Plan **Date:** November 2014 – present				X			X
Project: Alaska Patient Centered Medical Home Initiative Grant Development Assistance **Date:** March – April 2014			X	X			X
Project: CMS Health Care Innovation Grant Development Assistance for Project to Develop a Statewide Comprehensive Virtual Medical Home for Children with Complex Medical Conditions **Date:** June - August 2013			X	X			X
Project: Alaska Alzheimer's Disease or Related Dementia (ADRD) State Plan **Date:** December 2013 – December 2014				X			

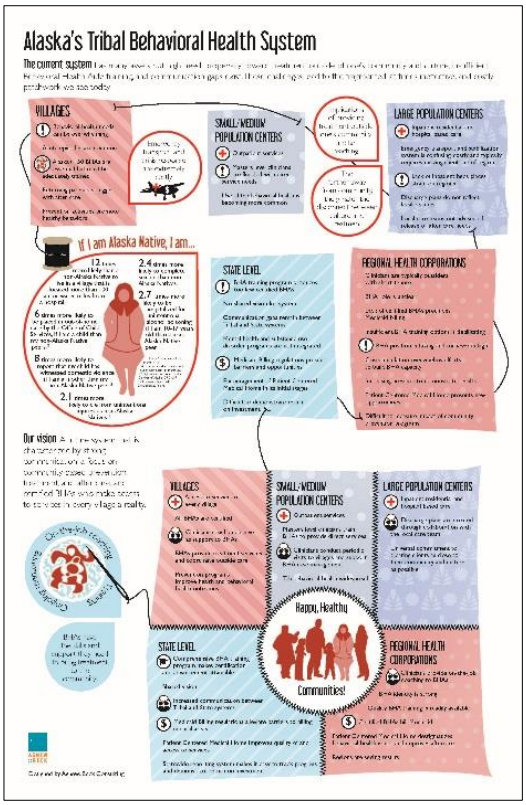
	Minimum Qualifications				Additional Relevant Qualifications		
	Technical Assistance: Medicaid Expansion	National + State Medicaid Policy + Reform	Medicaid Expansion + Reform in BH + Tribal Health Systems	Alaska Expertise: State Health + BH Program Areas	Medicaid Quantitative Analysis	Dashboard Development and Administration	Working Knowledge of ACA
Project: Survey of Behavioral Health Clients in General Relief Assisted Living **Date:** January 2013 – January 2014				X			
Project: Recommendations for an Alaska Long-term Care Strategic Plan **Date:** January 2013 – November 2013				X			
Project: Division of Senior and Disabilities Services Strategic Plan **Date:** May 2011 – March 2012				X			
Project: Family-centered Substance Abuse Treatment + Supportive Housing **Date:** January 2012 – June 2013				X			
Project: Statewide Independent Living Council Current State Assessment, Resource Allocation Plan, Statewide Vision for Service Delivery, + Performance Dashboard and Outreach **Date:** May 2010 – November 2010; May 2011 – June 2011; September 2014- present				X			
Project: Mat-Su Health Services Patient Centered Medical Home Pilot Evaluation and Technical Assistance **Date:** September 2010 – May 2011				X			X
Project: Elder Long-term Care Needs Assessment + Long-term Care Guidebook **Date:** May 2009 - May 2011			X	X			
Project: Bristol Bay Needs Assessment + Service Delivery Plan **Date:** January – August 2009			X	X			
Project: Prince of Wales Health Behavioral Health System Planning Project: Needs Assessment, Strategic Planning and Capacity Building **Date:** March 2009 – June 2011			X	X			
Project: Marrulut Eniit "Grandma's House" Operations Plan **Date:** January– November 2010			X	X			
Project: Oregon Veterans Long-term Care Needs Assessment **Date:** 2013-2014			X				
Project: Unalaska Community Health Needs Assessment + Clinic Expansion Study **Date:** September 2009 – June 2010				X			
Project: Mission 100 Outreach + Coordination, **Dates:** September 2011 – June 2013; October 2013 – present				X			
Health Management Associates Project Experience							
Project: IA SIM ACCO Development **Date:** April 2013 – September 2014	X	X	X				X

	Minimum Qualifications				Additional Relevant Qualifications		
	Technical Assistance: Medicaid Expansion	National + State Medicaid Policy + Reform	Medicaid Expansion + Reform in BH + Tribal Health Systems	Alaska Expertise: State Health + BH Program Areas	Medicaid Quantitative Analysis	Dashboard Development and Administration	Working Knowledge of ACA
Project: SD Project Manager – Medicaid Eligibility and Enrollment (E&E) System and Compliance with ACA for Health Insurance Marketplace **Date:** February 2013 – Present	X	X	X				X
Project: NGA Center for Best Practices **Date:** August 2013 – December 2014	X	X					X
Project: Illinois SIM **Date:** March 2013 – November 2013	X	X					X
Project: Montgomery County PA 1115 Waiver **Date:** May-December 2012	X	X					X
Project: Blue Shield of CA **Date:** February 2007 – April 2009	X	X					X
Project: Health Indiana Plan **Date:** August 2007- February 2009	X	X					X
Project: Los Angeles County Restructuring Health Care Delivery **Date:** 2005 to present		X	X				X
Project: Cook County Health and Hospital System **Date:** 2011 - present	X	X					X
Project: Metro Health System 1115 Waiver **Date:** June 2011-April 2012		X					X
Project: Oregon Coordinated Care Models **Date:** 2011		X					X
Project: San Francisco Continuum between Acute and LTC **Date:** 2005-2006		X					
Project: Parkland Health and Hospital System Restructuring **Date**: December 2004-2005		X					
Project: Maricopa Integrated Health System: Restructuring **Date:** 2005-2011		X					
Project: CA Prison Healthcare Receivership Chronic Disease Management Transformation **Date:** 2008-2009		X					
Project: San Mateo County Restructuring Health Care Delivery **Date:** 2008-2009		X					
Project: Louisiana Integrated Delivery System Model **Date**: 2006-2007		X					
Project: Comer Science Foundation, Medicaid Health Home **Date**: 2008-2011		X					
Project: Development of Baton Rouge Health Care Network **Date:** 2010 - present		X					X
Project: Health Funders Orange County – Managed Care **Date:** 2009 - 2012		X					
Project: Daughters of Charity Safety Net ACO **Date:** 2009-present		X					X

	Minimum Qualifications				Additional Relevant Qualifications		
	Technical Assistance: Medicaid Expansion	National + State Medicaid Policy + Reform	Medicaid Expansion + Reform in BH + Tribal Health Systems	Alaska Expertise: State Health + BH Program Areas	Medicaid Quantitative Analysis	Dashboard Development and Administration	Working Knowledge of ACA
Project: Alabama Health Services for the Uninsured **Date:** 2007		X					
Project: Lincoln, NE Sustainable Health Care Service **Date:** 2011-2012		X	X				X
Project: CMS TEFT Demonstration Grant **Date:** April 2014-present		X	X				X
Project: Medicaid utilization and performance measurement dashboards for WA Medicaid Foundation **Date: 2012**						X	
Project: Medi-Cal Interactive Performance Measurement Dashboards **Date:** 2013-2014						X	
Project: Restructuring Kentucky Department of Behavioral Health, Developmental and Intellectual Disabilities Medicaid behavioral health service, financing and benefits structure **Date:** 2011			X				
Project: Santa Barbara Inpatient Mental Health Delivery Service Analysis, Options and Recommendations for service delivery models and enhancements **Date:** 2012			X				
Project: Missouri State Plan Amendments for Mental Health, Primary Care Health Homes **Date:** 2012 – present		X	X				
Milliman Project Experience							
Project: State of Ohio Department of Job and Family Services Actuarial Services **Date:** July 2007– present	X	X	X				X
Project: Washington State Health Care Authority Exchange Planning **Date:** September 2010 – January 2011			X				X
Project: State of Indiana Family and Social Services Administration Actuarial Services **Date:** March 2010 – present	X	X	X				X
Project: State of South Carolina Actuarial Services **Date:** January 2008 – present	X	X	X				X
Project: State of Nebraska Medicaid and Long Term Care **Date:** April 2010 – November 2010	X	X	X				X
Project: New Hampshire Department of Health and Human Services Actuarial Services **Date:** July 2010 – present	X	X	X				X

	Minimum Qualifications				Additional Relevant Qualifications		
	Technical Assistance: Medicaid Expansion	National + State Medicaid Policy + Reform	Medicaid Expansion + Reform in BH + Tribal Health Systems	Alaska Expertise: State Health + BH Program Areas	Medicaid Quantitative Analysis	Dashboard Development and Administration	Working Knowledge of ACA
Project: Administration de Seguros de Salud (Puerto Rico Medicaid) Actuarial Services **Date:** August 2001 – present	X	X	X				X
Project: Florida Agency for Health Care Administration Actuarial Services **Date:** July 1999 – present	X	X	X				X
Project: Idaho Department of Health and Welfare Medicaid Redesign Projections **Date:** July 2012 – December 2012	X	X	X				X
Project: State of Nebraska Medicaid and Long Term Care Medicaid Redesign **Date:** October 2014 – February 2015	X	X	X				X
Project: State of California State Innovation Model Grant Submission **Date:** June 2014 – July 2014	X	X	X				X
Project: Medicaid Health Plans of America Health Insurer Fee Impact **Date:** September 2011 – January 2012			X				X
Project: Wyoming Department of Health Medicaid Expansion Analysis **Date:** June 2012 – September 2012	X	X	X				X
Project: Texas Associate of Health Plans Managed Medicaid Cost Impact **Date:** September 2014 – February 2015			X				X
Project: Iowa Department of Human Services Waiver Application **Date:** June 2013 – August 2013	X	X	X				X
Project: Mississippi Division of Medicaid Financial Impact of PPACA **Date:** June 2012 – December 2012	X	X	X				X
Project: Alaska Health Care Commission Drivers of Health Care Costs in Alaska and Comparison States **Date:** July 2011 – November 2011			X	X			X
Project: Minnesota Department of Human Services **Date:** June 2013 – present	X	X	X				X
Project: Arizona Health Care Cost Containment System Medicaid Access to Hospital Care **Date:** November 2010– June 2011		X	X				X
Project: North Dakota Department of Human Services **Date:** November 2010– June 2011			X				X
Project: State of Connecticut Office of Policy and Management Basic Health Plan Actuarial Analysis **Date:** November 2012– December 2012	X		X				
Project: Arkansas Comprehensive Health Insurance Program (CHIP) Actuarial Assistance **Date:** November 1996– present	X	X	X				X

ALASKA BEHAVIORAL HEALTH SYSTEMS ASSESSMENT



Alaska Mental Health Trust Authority | March 2014 to present | Agnew::Beck is currently project managing an ambitious effort to assess Alaska's behavioral health (BH) system. The goal of the project is to assess the need of Alaskans for publicly funded BH service and to assess the current capacity of the State of Alaska's BH system to meet that need. This project also includes an in-depth look at the implications of the Affordable Care Act and Medicaid Expansion for the behavioral health system, including estimations of the prevalence of behavioral health disorders among the newly eligible population and credentialing and other barriers to expanding services. Agnew::Beck and subcontractor Hornby Zeller Associates have teamed up to conduct the quantitative and qualitative components of the assessment. The quantitative analysis includes analyzing client level Medicaid, AKAIMS, and Tribal data to understand utilization trends while the qualitative analysis includes key informant surveys with Tribal and non-Tribal providers throughout Alaska to assess unused capacity and identify policy and regulatory barriers. Together, this body of work will result in an improved understanding of the behavioral health system, a methodology and framework for regular monitoring of the BH system, and recommendations for system improvements.

A Letter of Reference for this project is provided in the attachments.

REGULATIONS REVIEW AND DRAFTING, ALASKA DHSS, DIVISION OF PUBLIC ASSISTANCE

State of Alaska Department of Health and Social Services | May 2014 to present | Agnew::Beck and attorney partners, Sedor, Wendlandt, Evans & Filippi, LLC are providing expert consultation to the Division of Public Assistance to review existing regulations and craft new or improved regulations to meet the needs of the agency and populations it serves. To date, the Agnew::Beck team has primarily worked with the Child Care Program Office to update the regulations that govern their program to conform to changes at the Federal level. More recently, Agnew::Beck has been engaged to review and update Medicaid eligibility regulations to allow for Medicaid expansion under the Affordable Care Act. This important project was initiated in February 2015 with a kick-off meeting of key staff within the Division of Public Assistance and the Department's Medicaid Expansion team. Agnew::Beck will work with DPA staff over the next several months to ensure that State regulations conform to provisions of the Affordable Care Act, follow the proper public noticing process, and ultimately are adopted as the code that implements Medicaid expansion.

MANIILAQ ASSOCIATION BEHAVIORAL HEALTH PROGRAM ASSESSMENT + BUSINESS PLAN FOR EXPANSION

Maniilaq Association | November 2014 to present | The Maniilaq Association's Behavioral Health Department is hired Agnew::Beck to assist with an assessment of their behavioral health continuum of care and develop a feasibility assessment for a new facility to include supportive housing and an intensive outpatient service offering. As part of this effort, Agnew::Beck is undertaking an assessment of the Northwest Region's population needs and a thorough review Maniilaq Association's current service offerings and Medicaid billing practices. The team is examining services and billing practices within the community mental health clinic, in the villages, and at the Maniilaq Health Center, where efforts are underway to implement the patient centered medical home model. The end result will be a business plan that clearly outlines the strategy and implementation plan for expanding services in Kotzebue and throughout the region and dramatically increasing Medicaid revenues. The team is also examining the potential impact of Medicaid expansion to the region and modeling impact to Maniilaq's bottom line.

ARCTIC SLOPE NATIVE ASSOCIATION + NORTH SLOPE BOROUGH PRELIMINARY PLAN TO ADDRESS GAPS IN BEHAVIORAL HEALTH AND LONG TERM SERVICES + SUPPORTS

Arctic Slope Native Association + North Slope Borough | March 2015 to present | At the invitation of the Arctic Slope Native Association in October 2014, Agnew::Beck presented to a joint meeting of their board of directors and the North Slope Borough Health Board information about long term services and supports and ways to expand services in their region. We then facilitated a panel of experts in hospital and nursing care and tribal long-term care programs around Alaska. In 2015, Agnew::Beck is facilitating a series of stakeholder workshops to review the behavioral health continuum of care in the Northern Region and, along with representatives from The Trust and the Division of Behavioral Health, to assist with the development of a plan to address the behavioral health service gaps that currently exist.

CONFLICT-FREE CASE MANAGEMENT SYSTEM DESIGN

Alaska Association on Developmental Disabilities | December 2014 to February 2015 | Under contract to the Alaska Association on Developmental Disabilities (AADD) with funding and collaboration from the Alaska Mental Health Trust Authority, the Community Care Coalition and Alaska's DHSS, Senior and Disabilities Services (SDS), Agnew::Beck developed a system redesign to comply with new Centers for Medicare & Medicaid Services (CMS) regulations for conflict free case management. Alaska currently funds its Medicaid-funded Home and Community Based Services (HCBS) Waivers under the 1915(c) waiver authority. CMS published final rules that were effective on March 17, 2014 that affect these waivers. These rules have major implications for how case management, called 'care coordination' in Alaska, is provided under Alaska's waivers because they require that providers of HCBS direct services cannot also provide case management, except in very limited circumstances.

In order to make recommendations for implementation during 2015, this project was on an accelerated two-month timeframe. Over ten stakeholder interviews were conducted in preparation for a two-day workshop with over 40 provider and state organizations attending. Our team presented factual information on the new

CMS regulations and insight into how other states are meeting the requirements for conflict free case management. We facilitated small and large group discussions to identify the most effective way to redesign case management to meet the new requirements. The new CMS regulations fundamentally change the way providers serve recipients resulting in many stakeholders having strong and emotional opinions about the outcome of the process. Through the two day work session and a follow up half day meeting, we developed consensus where possible and documented areas of continued disagreement. Realistic options for meeting the CMS requirements, that make sense for Alaska, were developed into a clear and concise Final Report that contained background information, options for compliance and short and long-term activities with estimated time lines.

A Letter of Reference for this project is provided in the attachments.

ALASKA TITLE 4 STATUTE REVISION AND STAKEHOLDER ENGAGEMENT

Rasmuson Foundation + Alcoholic Beverage Control (ABC) Board | May 2012; August 2013 to present | Agnew::Beck provided process facilitation and support for a complex, multi-agency, consensus-driven effort that required aligning diverse, and at times opposing, stakeholder interests to produce a set of recommendations that the entire stakeholder body will support through to adoption by the Alaska State Legislature.

The Alcoholic Beverage Control (ABC) Board is the state-appointed regulatory body tasked with executing and enforcing Title 4, Alaska's statutes regulating the manufacture, possession, and sale of alcoholic beverages. In spring 2012, in response to ongoing and emerging public safety and health issues related to alcohol consumption, the ABC Board engaged Agnew::Beck to facilitate a face-to-face conversation with a large group of stakeholders to identify current problems with Title 4 and the need to better address issues such as overconsumption, underage drinking and consistent enforcement of Title 4. Agnew::Beck guided the conversation toward possible future actions to address these issues and provided detailed documentation of the discussion.

Following the initial stakeholder meeting, the stakeholder group formed five topic-based subcommittees to identify ways to better address through policy the effects of alcohol consumption on Alaska communities. Agnew::Beck was re-engaged to assist these subcommittees to review the entire body of statutes in detail, identify recommendations for improvement to better align with the ABC Board's overall mission, and to present these recommendations to the full stakeholder group in spring 2014. A::B assisted each subcommittee by taking detailed meeting notes, fulfilling research requests for background information or analysis of current policies in place, and synthesizing the discussion into a matrix of preliminary recommendations and level of consensus (if any) achieved by the group. The committees' recommendations and stakeholder input were used by the steering committee to develop a final set of recommendations for improvements to Title 4, to be introduced to the legislature for adoption in 2015.

WASILLA AREA SENIORS INC. CONTINUING CARE FEASIBILITY STUDY

Wasilla Area Seniors Inc. | September 2014 to present | The Wasilla Area Seniors Inc. (WASI) provides senior housing, meals, and senior center services in the Wasilla area. WASI is evaluating whether to expand

their service programs both on campus and throughout the Matanuska Susitna Borough. Agnew::Beck is preparing a study that assesses the overall need for a range of senior services and examines the regulatory, organizational, and financial feasibility of expanded programs for WASI. Services under evaluation include assisted living, personal care attendants, hospice, care management, and skilled nursing. The study began in October 2014 and is expected to complete in April 2015.

SPF SIG COMMUNITY PREVENTION SUPPORT TEAM TECHNICAL ASSISTANCE

State of Alaska Department of Health + Social Services | September 2011 to June 2015 | Agnew::Beck is the lead contractor to provide training and technical assistance to six grantees to implement the Strategic Prevention Framework in their communities. The Strategic Prevention Framework (SPF) is a five step process; 1) Assessment, 2) Capacity, 3) Planning, 4) Implementation, 5) Evaluation. The method uses data gathered in the community assessment phase to inform all subsequent phases and develop action-oriented strategies to improve health outcomes. As part of this project, Agnew::Beck is developing and providing a variety of training tools coupled with on- and off-site technical assistance to assist communities in deploying the SPF in their communities. The desired outcome of this statewide project is a reduction in youth alcohol use and adult binge drinking. A key component of the technical assistance includes small core/project team and coalition facilitation. Agnew::Beck has also played a key role in helping grantees facilitate and document small stakeholder group conversations. The six grantees include: Fairbanks Prevention Coalition, Homer Prevention Project (a subset of which includes the Homer Mobilizing for Action through Planning and Partnerships of the Southern Kenai Peninsula) Nome Community Alcohol Safety Team, 1-is2-Many Southeast Regional Wellness Coalition, a joint coalition representing the communities of Petersburg and Wrangell, and the Yakutat Healthy Community Coalition.

ALASKA E-HEALTH NETWORK TRANSFORMING CLINICAL PRACTICE CMS GRANT DEVELOPMENT ASSISTANCE

Alaska E-Health Network | November 2014 to February 2015 | This winter, the Alaska E-Health Network convened a mutli-disciplinary team, including representatives from the Southcentral Foundation's Nuka Institute, Alaska Primary Care Association, and the Alaska State Hospital and Nursing Association, to develop a grant application for a $10Million CMS grant to transform Alaska's health care system. The project aims to improve patient outcomes and patient care planning by supporting health and behavioral health care providers in their efforts to connect to the health information exchange and use patient data to drive care. If awarded, participating providers will be asked to improve clinical outcomes for diabetes, asthma, heart failure; increase screening for childhood obesity and adult depression; reduce unnecessary testing; and reduce unnecessary emergency department admissions. The project team estimated cost savings of $7,000 per Medicaid recipient over the four year grant period. Agnew::Beck facilitated the stakeholder working sessions, including development of a clear vision and identification of the systems changes necessary to support the vision, and provided key grant-writing support throughout the process. If successful, this grant will have a major impact on the way health and behavioral health providers care for their patients and will ready Alaskan providers, and hopefully private insurers, for value-based payment reform.

VILLAGE OF UNALAKLEET ASSISTED LIVING FEASIBILITY STUDY

Native Village of Unalakleet | February to December 2014 | The Native Village of Unalakleet has proposed to build an assisted living facility for elders in the region. Currently there is no assisted living in the Norton Sound Region; Unalakleet is looking to fill this gap. The feasibility study examined a number of different models of assisted living care, including different sizes of facility, and a combined model with both assisted and independent living units. For each model, the study analyzed a range of scenarios that examined the cash flow resulting from a payer mix that would provide the minimal amount of fee-based income to the maximum fee-based income that the proposed facility might realistically see. The results confirm a systemic gap in Alaska's long term care system: assisted living in Alaska is costly to operate (a 2013 Genworth study found that assisted living had a median cost of $6,000 per person per month), and only a limited number of Alaskans have high enough incomes to be willing and able to pay the private pay cost for assisted living for any length of time. For the remaining seniors and people with disabilities, the income and level of care need requirements for public assistance programs that can support their stay in assisted living homes place many Alaskans out of the ability to access assisted living services. As a result, although there is a significant need for assisted living homes, the facilities often require a subsidy to operate, making them unfeasible for many would-be operators. The proposed Unalakleet facility is likely to be no different. However, through the scenario analysis, the study estimates the amount of funds that would be needed to fill the operating gap. The Native Village of Unalakleet is now working with regional partners to fill that gap through donations, contributions, and other arrangements, such as possibly designing the facility with rental housing to subsidize the assisted living home's operations.

ALASKA PACIFIC UNIVERSITY DEPARTMENT OF PSYCHOLOGY STUDENT-LED CLINIC BUSINESS PLAN

Alaska Mental Health Trust Authority | November 2014 to present | In 2011, the Psychology Department at Alaska Pacific University (APU) opened its doors to Alaska's only Counseling Psychology Ph.D. program and, in 2014, graduated its first cohort of students. In an effort to augment the curriculum with robust on-the-job learning opportunities and to meet the requirements of accreditation, the APU's Psychology Department is planning a campus-based clinic to be staffed by practicum and intern students. Agnew::Beck is working with the Department on a business plan to define target populations, core services to be offered, the collaborative partners who will act as client referral sources, and the revenue sources that will support the clinic in becoming self-sustaining. Agnew::Beck has worked closely with APU staff and conducted surveys of Anchorage's leading non-profit and for-profit behavioral health and primary care providers to gauge service demand and develop a financial plan that will allow the clinic to meet its dual goals of educating students in a real-world environment while meeting outstanding behavioral health service gaps in the Anchorage area community.

ALASKA PATIENT CENTERED MEDICAL HOME INITIATIVE GRANT DEVELOPMENT ASSISTANCE

Alaska Center for Pediatrics | March 2014 to April 2014 | Agnew::Beck was hired to assist the Alaska Center for Pediatrics, a private medical practice in Anchorage, in developing and reviewing their successful

grant application for the Alaska Patient Centered Medical Home Initiative. Agnew::Beck facilitated a working session with Center staff to review progress already made toward the patient centered medical home, to identify current challenges and potential areas of focus, and to develop the concept for their proposed project.

CMS HEALTH CARE INNOVATION GRANT DEVELOPMENT ASSISTANCE FOR A PROJECT TO DEVELOP A STATEWIDE COMPREHENSIVE VIRTUAL MEDICAL HOME FOR CHILDREN WITH COMPLEX MEDICAL CONDITIONS

Alaska Native Tribal Health Consortium | June to August 2013 | Agnew::Beck was hired by the Alaska Native Tribal Health Consortium to assist with a grant application for round two of CMS' health innovation awards. As part of this engagement, Agnew::Beck facilitated stakeholder working sessions, reviewed Medicaid data analysis on high cost areas, and assisted with the development of a project concept to create a Statewide Comprehensive Virtual Medical Home for Children with Complex Medical Conditions. The project aimed to dramatically reduce the overall cost of care for these individuals, by reducing emergency department visits, reducing inpatient hospital admissions, decreasing emergent and non-emergent travel.

ALASKA ALZHEIMER'S DISEASE OR RELATED DEMENTIA (ADRD) STATE PLAN

Alaska Mental Health Trust Authority | December 2013 to December 2014 | Agnew::Beck worked with a core team including leaders from the Alaska Department of Health and Social Services, Alzheimer's Resource of Alaska, AARP and The Trust to draft a state plan to provide a comprehensive and coordinated approach to address the multiple and complex challenges that Alzheimer's disease and related dementia (ADRD) poses to individuals, families, caregivers and our State's budget. As part of this work, Agnew::Beck conducted a data review, background research, existing planning and needs assessments by the Alaska Commission on Aging. Agnew::Beck drafted the initial plan and prepared for and facilitated stakeholder work sessions to review the draft plan and determine action items. The State of Alaska released the Plan at the end of 2014 which highlighted seven priority strategies along with the convening organization.

SURVEY OF BEHAVIORAL HEALTH CLIENTS IN GENERAL RELIEF ASSISTED LIVING

State of Alaska Department of Health and Social Services, Division of Behavioral Health (DBH) | January 2013 to January 2014 | Agnew::Beck assisted the State of Alaska Department of Health and Social Services (DHSS), Division of Behavioral Health (DBH) with ensuring that clients with serious mental illness, residing in general relief assisted living homes, were receiving appropriate behavioral health services and assessed whether or not these clients could move to more independent living settings. Telephonic and electronic surveys were conducted with over 150 clients or their guardians (if one was identified). A narrative summary and analysis of the data were submitted, along with a database containing the information obtained from the surveys.

RECOMMENDATIONS FOR AN ALASKA LONG-TERM CARE STRATEGIC PLAN

State of Alaska Department of Health and Social Services | January ro November 2013 | The State of Alaska spent over $476 million on home and community based services and skilled nursing care for 44,711

long term care recipients in Fiscal Year 2012. As the baby boom generation ages, a bubble of increased demand for long-term care services will occur over the next three decades. This will increase costs, particularly as health care and related costs continue to rise. Looking to the future, there is a need to contain costs, ensure safe, quality care, while maintaining the right balance between home- and community-based services and skilled nursing facilities.

To address these issues, the State of Alaska Department of Health and Social Services (DHSS) hired Agnew::Beck to convene stakeholders and develop recommendations on ways to improve Alaska's long-term care system. Agnew::Beck provided technical assistance to the stakeholders by conducting best practice research, reviewing previous plans and evaluations of Alaska's long-term care systems, facilitating advisory board meetings, and drafting a plan that includes recommendations for a statewide plan for long-term services and supports. The draft recommendations help address rising costs, the lack of public accessibility to the system, and the need to effectively move people up and down the continuum of care based on their functional abilities. The results of this effort provide the basis for a future statewide strategic planning effort that will provide sustainable long-term care into the future.

DIVISION OF SENIOR AND DISABILITIES SERVICES STRATEGIC PLAN

Alaska Mental Health Trust Authority | **May 2011 to March 2012** | Agnew::Beck worked closely with SDS leadership and management team to advise on strategic planning process, provide additional data analysis, content development and document publication.

FAMILY-CENTERED SUBSTANCE ABUSE TREATMENT + SUPPORTIVE HOUSING

State of Alaska, Department of Health and Social Services, Division of Behavioral Health | **January 2012 to June 2013** | Agnew::Beck assisted the State of Alaska Department of Health & Social Services (DHSS), Division of Behavioral Health (DBH) with the Anchorage-based replication and implementation of the SHIELDS for Families model, an innovative program from Southern California that jointly provides substance abuse treatment and housing services for families involved in the child protection system. The goal of the project is to increase reunification and stabilization for Alaskan families affected by substance abuse, homelessness and poverty. Using the foundation of the Alaska SHIELDS business plan drafted by DHSS in 2011, Agnew::Beck's work included convening key stakeholders to create a strategic plan outlining policy decisions, timelines for decision making, and issues and analysis required for all decisions made. Agnew::Beck developed a program design, and financial and governance models that will guide the planning process and help the State bring aboard the appropriate housing and treatment service providers and other key partners.

CURRENT STATE ASSESSMENT, RESOURCE ALLOCATION PLAN + STATEWIDE VISION FOR SERVICE DELIVERY

Statewide Independent Living Council of Alaska (SILC) | **May to November 2010; May to June 2011; September 2014** to **present** | The Statewide Independent Living Council of Alaska (SILC) helps Alaskans with disabilities gain full inclusion and integration into mainstream society. The council promotes independent living and works to maximize opportunities for individuals with disabilities. This happens with

the aid of a philosophical framework that includes the following core components: consumer control, peer support, self-help, self-determination, equal access, and individual and system advocacy. The Alaska State Independent Living Council contracted with Agnew::Beck to provide analytical and project management support for the development of a new and equitable Resource Plan for allocating programmatic funds across the State to support independent living services for people living with disabilities. Over the course of this project, Agnew::Beck worked with Alaska SILC leadership to establish a vision for the future and make informed decisions about the structure, catchment areas, and resource allocation formulas. Steps included:

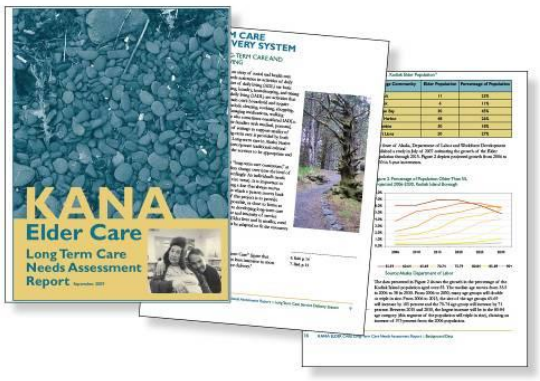
- Document the current structures, services, service levels, and costs for Alaska's Centers for Independent Living.
- Facilitate discussions regarding organizational goals and desired end state. Developing organizational and economic prototypes for weighing alternative approaches to achieving the desired end state.
- Research alternative service delivery and resource allocation models that may be applicable to Alaska.
- Present resource allocation formula options for allocating Federal and State funds across service delivery regions that are equitable, logical, and defensible and analyze cost differentials.
- Facilitate a final project meeting to review project findings, facilitate key organizational decisions, and outline next steps for creating a long-range service delivery plan based on these decisions.

With Agnew::Beck's support, the SILC is currently pursuing a targeted effort to expand the reach of its existing system into underserved areas of the state.

MAT-SU HEALTH SERVICES PATIENT CENTERED MEDICAL HOME PILOT EVALUATION AND TECHNICAL ASSISTANCE

Mat-Su Health Services | September 2010 to May 2011 | Mat-Su Health Services is a non-profit community health care organization providing high quality, low cost services to people living and working in the Borough. In an effort to integrate its behavioral health and primary care service delivery, the agency launched an Integrated Services pilot in 2011. Subsequently, MSHS enlisted the support of Institute for Social and Economic Research (ISER) and Agnew::Beck to develop and implement an evaluation plan for the Integrated Services pilot. A::B and ISER have assisted the organization in defining the core components of their agency-wide organization efforts, conducting an operational assessment with all staff to gauge current operations, and developed an evaluation plan for the pilot and for agency integration efforts as a whole. The team continues to work alongside MSHS staff to evaluate progress and engage staff in reviewing results and identifying priority strategies for achieving the organization's integration goals. Our work has helped to focus and clarify the organization's integration model and engage staff in assessment, prioritization, and implementation.

ELDER LONG-TERM CARE NEEDS ASSESSMENT + LONG-TERM CARE GUIDEBOOK



Kodiak Area Native Association | May 2009 to May 2011 | The goal of this two-year project was to understand and document the needs of Kodiak's Elders and their caregivers and to use this information to inform the development of future programs and services as part of a broader vision for Elder Long-term Care. In year one, Agnew::Beck completed a regional needs assessment of existing services, facilities and Long-term Care options available to Elders in the region and an implementation matrix. Year two resulted in a Long-term Care Guidebook that identified the processes and tools that KANA could use to implement the recommendations of the plan. This two-year project documented the needs of Kodiak's Elders and their caregivers and used this information as the basis for developing future programs and services to fit with the broader vision for Elder long-term care.

Agnew::Beck completed a regional needs assessment of existing services, facilities and long-term care options available to Elders in the region. Our firm also created an implementation matrix to guide the development of new services. The second year of the project focused on planning for implementation and building a coalition. The long-term planning process hinged on the meaningful involvement of Elders, their families and caregivers. It also rested on care providers offering the direction needed to gain a better understanding of what assistance, approaches and strategies best meet the needs. Our team efficiently facilitated focus groups and conducted individual interviews with families and elders to ensure their voices were heard. Agnew::Beck also designed user-friendly outreach materials and original graphics illustrating new findings in a way that clearly communicated the need and the vision in an appealing way to Elders, families and caregivers.

BRISTOL BAY NEEDS ASSESSMENT + SERVICE DELIVERY PLAN

Statewide Independent Living Council of Alaska (SILC) | January to August 2009 | The Statewide Independent Living Council of Alaska (SILC) helps Alaskans with disabilities gain full inclusion and integration into mainstream society. SILC promotes independent living and works to maximize opportunities for individuals with disabilities. Agnew::Beck worked with SILC, their rural outreach committee, and stakeholders in Bristol Bay to assess existing independent living services and identify needed services in Bristol Bay communities. The needs assessment process engaged many service providers, care givers, families, and people with disabilities in Bristol Bay and provided the foundation for working with the SILC Board during an intensive, facilitated work session to determine how to improve and enhance independent living services in Bristol Bay. Agnew::Beck also developed an Implementation Toolkit to aid in developing the model of service delivery determined by the SILC Board. The Toolkit contains initial planning documents and tools to use as guides for implementation. The project resulted in a Toolkit widely supported by the Council; a recommended approach for delivering Independent Living services in Bristol Bay and; the council was equipped with a variety of long term funding alternatives for sustainability.

PRINCE OF WALES HEALTH BEHAVIORAL HEALTH SYSTEM PLANNING PROJECT: NEEDS ASSESSMENT, STRATEGIC PLANNING AND CAPACITY BUILDING

Prince of Wales Health Network | March 2009 to June 2011 | In 2009, the Prince of Wales Health Network hired Agnew::Beck to help convene a group of committed behavioral health providers, stakeholders and community members from the communities of Prince of Wales Island to participate in a needs assessment and strategic planning process for behavioral health services. Agnew::Beck conducted a thorough needs assessment, based on input from stakeholders throughout the island and secondary data collection and analysis. Agnew::Beck also facilitated community coalition building and strategic planning, which lead to recommended actions at the local and state levels to identify steps to enhance behavioral health services on Prince of Wales Island and reduce the negative consequences from behavioral health.

MARRULUT ENIIT "GRANDMA'S HOUSE" OPERATIONS PLAN

Marrulut Eniit Assisted Living (MEAL) | January to November 2010 | Marrulut Eniit Assisted Living (MEAL), also known as "Grandma's House," was facing significant challenges to continuing its operation. In November 2010, MEAL engaged Agnew::Beck to develop a clear plan to achieve long-term sustainability. Working closely with the State of Alaska's Senior and Disabilities Services, Rural Long Term Care Coordinator, Agnew::Beck analyzed the current business model, provided recommendations for establishing sustainable operations and assisted with the development of an operations plan to implement those recommendations. Agnew::Beck also helped the program director to secure an operating grant from Senior and Disabilities Services to subsidize operations.

UNALASKA COMMUNITY HEALTH NEEDS ASSESSMENT + CLINIC EXPANSION STUDY

Iliuliuk Family Health Services | September 2009 to June 2010 | Agnew::Beck, working with researchers from the Institute of Social and Economic Research (ISER), was contracted by Iliuliuk Family Health Services to assess community health needs and existing health services, determine the financial feasibility of expanding the existing clinic, and to recommend a strategy for aligning services to best meet current and future patient needs. The project resulted in an improved understanding of community health needs, as well as customer concerns and organizational challenges. This understanding led to the adoption of a phased strategy for improving center services.

OREGON VETERANS LONG-TERM CARE NEEDS ASSESSMENT

Oregon Department of Veterans Affairs | 2013-2014 | Agnew::Beck and Rede Group, a Portland-based health planning firm, teamed up to help the Oregon Department of Veterans Affairs assess the supply and demand of long-term and nursing care facilities within the state. The project analyzed quantitative population health and patient data. We also reviewed projections for existing and planned nursing facility utilization and combined these data with qualitative input from veterans, family members and other key stakeholders. Patient data from the State of Oregon and Department of Veteran Affairs was analyzed to understand service utilization, delivery, and cost trends and compared to population need data to identify potential service gaps. The results of this needs assessment assisted the Oregon Department of Veterans Affairs in building a long-term plan for its facilities, internal structures and client services.

MISSION 100 OUTREACH AND COORDINATION, TOBACCO PREVENTION AND CONTROL PROGRAM

September 2011 – June 2013; October 2013 – present | Mission 100 (M100) is a strategic and ambitious public health initiative funded by the Alaska Tobacco Prevention and Control Program. The goal of M100 is to trigger statewide systems change through health organizations, community-based coalitions and public policies. Working closely with TPC leadership and staff, the project team created a multi-year framework for raising awareness about the benefits of tobacco free policies, prevention efforts and cessation interventions. Since its inception, the team launched a comprehensive outreach campaign and developed a program to offer technical assistance free of charge to all organizations interested in achieving tobacco-related systems change. In 2012, M100 began with primary care, then expanded its target audience to include substance abuse and behavioral health treatment providers, with the intention of further expanding the program's reach to all interested organizations in the state including military healthcare providers. In FY12-13, Agnew::Beck managed the work of team members from five organizations and coordinated outreach efforts and technical assistance delivery. A::B also produced a variety of materials for internal and external use to better understand the current policy landscape related to tobacco control and cessation services, such as a series of illustrative policy maps of primary care organizations and Alaska communities that have passed smokefree policies or tobacco taxes, and a second series of maps highlighting the tobacco use prevalence at the regional level. A::B also conducted in-depth research into opportunities for promoting tobacco screening and cessation services in the current Medicaid system and the new regulations outlined in the Affordable Care Act, including understanding billing systems and incentives for providers. In FY14, Agnew::Beck and its partners ANTHC and the Rede Group continue to provide technical assistance to the program and its funded partners. Other activities include: conducting outreach and providing technical assistance to healthcare and other organizations to implement best practices in tobacco control; developing a series of case studies to highlight successes and challenges for tobacco policy implementation; and working with community-based coalitions at the regional and state level to develop strong public support for a tobacco-free Alaska.

HEALTH MANAGEMENT ASSOCIATES

IOWA MEDICAID EXPANSION

Iowa Medicaid Enterprise | April 2013 to September 2014 | From April 2013 through September 2014, HMA provided consultation, research, stakeholder engagement, strategic support, and policy development support to the Iowa Medicaid Enterprise (IME) as Iowa worked to expand its Medicaid program and develop its Statewide Healthcare Innovation Plan. HMA staff provided critical support and strategic assistance to the IME and stakeholders throughout the state.

HMA worked with IME to identify the operations, policy, procedure, resources, roles and responsibilities that would be impacted by system change, including expansion and the move to an Accountable Care system, and worked with IME to develop plans and implement processes to ensure that transitions would be smooth and that the new system would be effective.

HMA also assisted with the development and implementation of a statewide communications plan that included communications to community stakeholders, partner agency staff, health care providers, hospital and health plan administrators and other interested parties to ensure that stakeholders were aware of the process and goals, as well as progress made on Medicaid expansion and other health care reform and innovation efforts. HMA managed an intensive stakeholder engagement process, including formation and management of four workgroups that met intensively for several months to contribute ideas to the state's innovation and expansion processes.

HMA staff assisted the IME in planning for the development of an Accountable Care Organization (ACO) model across the state and provided guidance and recommendations for the most effective policies and implementation strategies. HMA assisted the IME with development of contracts for ACOs and assisted the IME and the governor's office in writing and submitting both the Statewide Innovation Plan and the Model Test Grant Proposal. In 2014, Iowa was awarded a $43 million Model Test Award from CMS.

SOUTH DAKOTA: AFFORDABLE CARE ACT / HEALTH REFORM

State of South Dakota, Department of Social Services, Division of Economic Assistance | February 2013 to present | Since 2013, Health Management (HMA) has been working in the State of South Dakota, assisting the Department of Social Services (DSS), Division of Economic Assistance, with two major scopes of work: 1) Initial Compliance - to prepare the Medicaid business processes and systems to meet the new requirements in the Patient Protection and Affordable Care Act (ACA): and 2) Phased Modernization - to assist the State in acquiring a new eligibility system that meets all federal/state program and infrastructure requirements. The first scope was completed successfully by January 2014 as the majority of the ACA was implemented. HMA currently is continuing work on the second scope, exploring with South Dakota options for acquiring a modern eligibility system that meets all ACA requirements and supports the State's vision for integration of its core health and human services programs – Medicaid, Children's Health Insurance Program (CHIP), Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), Low Income Energy Assistance Program (LIEAP) and Child Care Assistance.

In addition to overall project management oversight, HMA helped the State develop operations and systems contingency plans for implementation of the ACA requirements. We supported State staff in meetings with the Centers for Medicare and Medicaid Services (CMS) and assisted in development and submission of all CMS documentation requirements throughout the life of the Initial Compliance phase.

HMA also helps to coordinate work between the Division of Economic Assistance and the State's Bureau of Information and Telecommunications (BIT) for all current eligibility system work, as well as strategy and planning for a new system. As part of the CMS requirements to prepare for an Implementation Advanced Planning Document (IAPD) to secure funding for a new eligibility system, HMA conducted a MITA assessment of the State's current system. Currently, the HMA team is working with Economic Assistance and BIT staff to develop requirements, identify all current system interfaces and document other desired system functionality in preparation for development of a Request for Proposal if/when the State determines to move forward with a formal procurement.

HMA's presence in South Dakota over the past two years has provided DSS leadership with comprehensive project management to execute complex work across programs within the required timeframes and State/federal budgets. We have served as strategic thought partners in building the vision and framework for acquisition of a modern eligibility system that can support the State's needs well into the future, not only for Medicaid and CHIP, but for all the core health and human services programs. As needed per project requirements or State request, HMA can draw from a deep bench of skilled colleagues across the country who have a wide variety of expertise in policy, programs, operations, IT, and customer engagement. HMA further ensures that work conducted for this project by any other contractors meets the State's quality and cost expectations.

A Letter of Reference for this project is provided in the attachments.

NATIONAL GOVERNOR'S ASSOCIATION: SUPER UTILIZERS

National Governors Association Center for Best Practices | August 2013 to December 2014 | HMA was engaged by the National Governors Association's Center for Best Practices to provide technical assistance (TA) to seven state/territory participants in a policy academy designed to help these jurisdictions implement programs aimed at addressing the needs of Medicaid 'super utilizers". As part of this engagement HMA developed instructional and guidance materials, conducted TA webinars, attended site visits with all academy participants, and facilitated targeted TA sessions. The subjects for which HMA subject matter experts offered technical assistance included:

- Models of care management and delivery;
- Information management and data analytics;
- Provider compensation and incentive strategies;
- Stakeholder engagement; and
- Ensuring the confidentiality of sensitive patient information.

HMA also reviewed and provided feedback on the super utilizer program action plans developed by all academy participants.

STATE INNOVATION MODEL DESIGN PROPOSAL

State of Illinois, Office of the Governor | March to November 2013 | HMA was engaged by the State of Illinois to, over the course of a year, 1) develop a State Healthcare Innovation Plan (SHIP) as prescribed by the Center for Medicaid and Medicare Innovation (CMMI), and 2) draft a proposal to CMMI for testing the elements of the SHIP. HMA worked with the Governor's Office and the leadership of the State's Medicaid, Mental Health, Information Technology, Aging and Public Health Departments to establish an executive team that oversaw the development of the SHIP and constructed a new Governor's Office level integrated entity to oversee SHIP implementation. Work groups—including State and public and private sector stakeholders, were appointed in the areas of Delivery System and Payment Reform, Population Health, Workforce and IT and worked over the course of six months to put together the elements of the SHIP. A broad-based Steering Committee provided input and, ultimately, endorsement of the SHIP. Subsequent to the approval of the SHIP, HMA assisted the State with the development of the CMMI proposal for "Model Testing" of the elements of the plan.

MONTGOMERY COUNTY, PA 1115 WAIVER

Montgomery County, PA | May to December 2012 | HMA assisted Montgomery County in preparing a Section 115 waiver proposal that would leverage federal funds to expand coverage to uninsured adults in Montgomery County. HMA completed: a Benefit package comparison working with the County indigent care program to determine whether and in what ways the benefits would differ from the benefit package in the base waiver proposal developed by the Ohio Department of Medicaid; a Source of funds review working with the County to perform a comprehensive analysis of the potential sources of funds available to be used as non-federal share, with an eye toward risk assessment (i.e., how easy or difficult will it be to gain CMS approval and set up allowance transaction procedures for each source of funds); a Data gap analysis which resulted in development of a comprehensive list of data elements that would be needed to quickly populate an approvable waiver application, identify gaps, if any, in the available data, and develop work-arounds or proxies where necessary; a Service delivery network review working with the indigent care program to determine what the ideal service delivery network would be, taking into consideration service gaps, current structure, availability of funds, and CMS policies; a Cost Analysis working in partnership with an actuarial firm engaged by the County in building a financial model that will drive the budget neutrality agreement that must be negotiated with CMS (This included discussion around an enrollment cap, taking into consideration that it is likely some funds will need to be reserved for individuals who do not meet with criteria for the waiver); and an Eligibility/enrollment review in which we formulated a strategy for enrolling eligible individuals that would minimize new administrative burdens while meeting CMS requirements.

CA WORKING COMMITTEE ON WAIVER DEVELOPMENT

Blue Shield of California | February 2007 to April 2009 | As a subcontractor to Harbage Consulting HMA, assisted the California Working Committee on Waiver Development and Medi-Cal Expansion with identifying sources of budget neutrality savings for a section 1115 waiver to cover low-income uninsured childless adults. HMA also assist with the preparation of a draft childless adult waiver proposal for presentation to the State for their consideration.

HEALTHY INDIANA PLAN

Indiana Family and Social Services Administration | August 2007 to February 2009 | HMA assisted the state with implementation duties related to the 1115 Healthy Indiana Plan, a Medicaid expansion for adults. HMA wrote administrative rules, policies and procedures; conducted statewide training for enrollment centers and the general public; conducted policy and financial analysis; conducted readiness reviews for HIP insurers and enrollment broker; wrote one plan's provider manual; and identified FFP sources. HMA also wrote a report on Nursing Home Moratorium activities in the states.

LOS ANGELES COUNTY RESTRUCTURING HEALTH CARE DELIVERY

Los Angeles County | 2005 to present | HMA has been engaged by Los Angeles County, through both its Office of the CEO and its Department of Health Services (DHS), since 2005 to assess and assist in the restructuring/transformation of a variety of its organizational structures and clinical operations. Los Angeles County DHS is the second largest public hospital system in the United States. It contains three acute care hospital medical centers, a rehabilitation hospital, a large ambulatory care system, as well as contracted relationships with many community based ambulatory care facilities and hospitals. HMA has assisted DHS initially in responding to crises, through the implementation of strategic plans that are transforming DHS into a true integrated delivery system, capable of success in a time of change and reform in health care. These efforts have included: 1) successfully reducing length of stay at DHS's flagship hospital to meet court ordered maintenance of admission volume when moving to a new hospital with 20% fewer beds; 2) providing additional options for community based Long Term Care for patients discharged from DHS hospitals; 3) reviewing health services provided to detainees at the LA County operated jail and juvenile corrections system and recommending reorganization and redesign; 4) facilitating the transformation of DHS' Martin Luther King Hospital into a multi-specialty ambulatory and diagnostic center; 5) addressing the strategic role of the County's managed care organization and its ability to meet the challenge of future health reform requirements and facilitating the negotiation of a new partnership with LA Care, the large managed care plan, to take on health plan functions; 6) organizing a new Ambulatory Health Network within DHS, designing its structure and leadership positions, writing job roles and scopes, educating and training staff, serving in interim medical and financial leadership positions, supporting and mentoring newly recruited leaders; 7) working to transform 144 primary care practices into Patient Centered Medical Homes including empanelment of 240,000 patients, selection of a patient care registry, provision of training and implementation, reorganization of staff into patient care teams, design, training and implementation of a Care Management program; 8) negotiating a new agreement between DHS and contracted Community Partners (FQHCs) that aligned their roles and activities in line with DHS strategic effort and goals; 9) overseeing an assessment and recommended redesign of DHS

subspecialty services, including efforts to decompress specialty clinics in partnership with FQHCs; and 10) assisting with efforts to integrate DHS primary care services with mental health services of the LA Department of Mental Health and application for a new California State Plan Amendment to gain enhance Federal matching funds.

COOK COUNTY HEALTH AND HOSPITAL SYSTEM: RESTRUCTURING HEALTH CARE DELIVERY

Cook County Health and Hospital System (Chicago) | 2011 to present | HMA has been engaged by the Cook County Health and Hospital System Cook County (CCHHS) since 2011 to facilitate the development of a Cook County Medicaid 1115 Waiver, to oversee its negotiation with CMS and coordination with the State of Illinois, and to lead and staff the transformational work at the delivery system level to meet the requirements of the Waiver. The elements of the delivery system scope of work include: 1) the creation of an Office of Managed Care and the negotiation of a third party administration (TPA) agreement; 2) the development of a network of both FQHCs, and hospitals to supplement the CCHHS services to meet the needs of the more than 100,000 patients covered under the Waiver; 3) to facilitate the training of CCHHS primary care providers to convert the clinics to Primary Care Medical Homes; 4) to assist with the decompression of CCHHS specialty clinics to assure appropriate utilization; 5) to work with CCHHS inpatient clinical and administrative leaders to assure appropriate transitions of care. In addition, HMA is providing the CCHHS leadership with strategic assistance in setting priorities, monitoring progress, and anticipating opportunities for partnerships and collaboration. HMA was notified on February 10th, 2015, that the firm will be engaged at Cook County for another 3 years, for about $1.5 million per year.

METRO HEALTH SYSTEM: 1115 WAIVER

MetroHealth Hospital System | 2011 to June 2012 | HMA and Optumas were engaged by MetroHealth Hospital System (MHS) in Cleveland Ohio to develop and gain federal approval for a county-based Medicaid 1115 waiver demonstration for their bridge insurance program, slated to begin enrollment on July 1, 2012. The waiver program was intended to expand health care coverage to low-income adults in Cuyahoga County and rely exclusively on the MetroHealth System to deliver and coordinate all services. The MetroHealth 1115 Waiver was also designed to bring increased federal matching funds to MHS to cover its indigent population that would be eligible for this waiver. HMA assisted MetroHealth with designing the waiver, presenting the waiver to stakeholders including the State Medicaid Agency, and with

"[I] wanted you to know that in April the State of Ohio administratively transferred the remaining 26,000+ waiver patients onto the State Medicaid program effectively bringing an end to our waiver demonstration. Because of this transfer, Cuyahoga County has the highest percentage of newly eligible enrolled in Medicaid. The demonstration was an unqualified success on many levels. It brought better care to thousands of previously uninsured adults, it helped financially stabilize us, it prepared us for the ACA, it gave us new credibility with policy makers, and it provided evidence on why Ohio needed to expand Medicaid. We've done a little bit of evaluation, but plan to do more in the months ahead. But in the meantime I thought you might like to see this piece that the RWJ Cleveland Aligning Forces for Quality Project produced. So thanks for helping us get it off the ground at the very beginning. It was quite the journey."

John R. Corlett
Vice President, Government Relations and Community Affairs, The MetroHealth System

gaining State approval to submit the waiver proposal forward CMS. MetroHealth's 1115 Waiver Concept Paper, completed in collaboration with HMA, was submitted to CMS and following negotiations was approved. Our partner, Optumas developed the budget neutrality calculations and provided a fully-customized, completely transparent toggle-drive population/cost model to MHS for use during the negotiations and as a program management tool following program implementation. The waiver served as a testing ground for Medicaid expansion in Ohio prior to the ultimate decision in Ohio to expand Medicaid statewide under the ACA. Following approval of the waiver, 28,294 previously uninsured individuals were enrolled in this county based Medicaid waiver, called Care Plus. In April of 2014, the Care Plus waiver enrollees transferred into the State Plan State Medicaid program, effectively ending the demonstration. Because of the demonstration, Cuyahoga County had the highest percentage of newly eligible enrolled into Medicaid. The demonstration is viewed as an unqualified success. It brought better care to thousands of previously uninsured adults, it helped financially stabilize MeroHealth, it prepared MetroHealth and Cuyahoga County for the ACA, it, and it provided evidence demonstrating the need in Ohio for Medicaid.

DEVELOPMENT OF AN INTEGRATED DELIVERY SYSTEM SERVING THE MEDICAID AND UNINSURED RESIDENTS OF THE GREATER PORTLAND, OREGON AREA

Oregon Health Leadership Council | 2011 | Health Management Associates (HMA) was engaged in the summer of 2011 by the Oregon Health Leadership Council (OHLC) to develop an integrated delivery model and a creative financing strategy to respond to the State of Oregon's mandate for the establishment of "Coordinated Care organizations" (CCOs) to assume responsibility for the Medicaid population. HMA worked with the leadership of OLOL—which consists of the CEOs of the State's health systems and health plans--over a period of four months to: 1) complete a thorough assessment of the health status and utilization patterns of the target population; 2) individually assess the various roles of critical providers—including three County health departments delivering mental health services, a diverse group of Federally Qualified Health Centers (FQHCs), all five of the major health systems and several free-standing physician groups—serving the Medicaid and uninsured populations in the area and develop a model of care utilizing all providers in an integrated system; 3) develop a creative financial model that both identified new revenues to offset imminent State budget cuts and could demonstrate long term sustainability building upon delivery system changes; 4) identified several options for relationships between the new integrated delivery system and managed care plans; and 5) determined a set of priorities for infrastructure development, care management and information technology. The report was developed through regular interaction with the steering group of system CEOs, augmented by key stakeholders from the Counties, the State, private physicians and FQHCs. The plan was unanimously endorsed by the OHLC Board of Directors in December, 2011 and work groups are now in place working on implementation.

As a result of this work, HMA was engaged to assist the State in the development of financial assumptions and projections related to the potential for savings as a result of the establishment of real delivery system reform through the CCOs. This report was completed and presented to the State legislature in January, 2012.

SAN FRANCISCO CONTINUUM BETWEEN ACUTE AND LONG-TERM CARE

Evaluation of the San Francisco Department of Public Health

City/County of San Francisco, California | 2005 to 2006 | HMA was engaged in the spring of 2005 by the Office of the Controller of the City/County of San Francisco to evaluate the effectiveness of the continuum between acute and long-term care services provided by the San Francisco Department of Public Health (DPH). In order to accomplish this assessment, HMA assembled a team of senior staff that included three former public health and hospital system leaders (including a physician), a national long-term care expert and two former state Medicaid Directors. The work was divided between two major components of the overall charge: 1) assessing the mission, structure, leadership and operation of the Department as a "seamless" continuum of care and making specific recommendations to assure greatest possible integration; and 2) examining the current state and the appropriateness of long-term care services that are and should be available for the population that the Department has determined that it serves and proposing actions to make those services more effective. The development of the report was the product of myriad interviews of key stakeholders (both within and external to the Department), site visits to Department facilities and observation of clinical and administrative activities, review of data and previous reports, and group meetings with clinicians, business leaders, union representatives, political leaders, advocates, and others with clear impressions about the current state and future challenges for DPH. HMA's recommendations resulted in: a new plan for the replacement of the system's long term care facility; an organizational strategy to assure greater integration between DPH's clinics and hospitals and programs, and; an initiative with the State of California for a home and community-based services Medicaid waiver.

Facilitate the Preparation of the San Francisco Department of Public Health for National Health Reform

City/County of San Francisco, California | 2013 | HMA was engaged in the spring of 2013 to help facilitate the transformation of the various programs and services of the SFDPH into an integrated delivery system. HMA's focus included: 1) change management (overseeing the process of integrating the elements of the Department, assuring participation and buy-in, drafting and vetting the vision and new organizational structure, drafting job descriptions for new leaders, setting a communications plan and an evaluation strategy to assure that the restructuring is maintained; 2) overseeing technical assistance and training for the transformation of Department primary care and behavioral health into medical and health homes; 3) establishing a strategy and building the infrastructure for managed care within the department, and 4) developing a financial forecast and overseeing the redesign and implementation of new financial tools within the Department to assure accountability and transparency. This effort took place over the course on nine months (with the primary care efforts lasting a full year) and resulted in the establishment of the San Francisco Health Network, an integrated delivery system for 100,000 people.

PARKLAND HEALTH AND HOSPITAL SYSTEM RESTRUCTURING

Dallas County Health System | 2004 to 2005 | Health Management Associates (HMA) was engaged in 2004 by the Dallas County Commissioners Court (the local governing body) to provide an assessment of the clinical, structural, operational and financial priorities that it needed to address to assure that the public hospital and primary and specialty clinic system was operating efficiently and effectively as it attempted to

serve the medically vulnerable communities and populations throughout the county. Over the course of the six month effort, HMA: interviewed several hundred people (providers, community and business leaders, public officials in neighboring counties, social service providers, physician leaders and medical school hierarchy, County and Hospital District board members); reviewed extensive utilization, health status and cost data; observed clinical practice within the hospital and its clinics; met with patient focus groups; discussed key issues with Parkland leadership, and; and held community meetings to determine approaches to key priorities. The resulting strategic work plan was presented and approved by the Dallas County Parkland leadership.

Subsequently, HMA was engaged by Parkland and the County to take on the following specific projects related to the implementation of the strategic recommendations approved in 2004: 1) renegotiation of the Parkland academic/clinical contract with the University of Texas-Southwestern Medical School; 2) assessment of the Parkland clinics for potential conversion to Federally Qualified Health Center (FQHC) status; 3) evaluation of the Parkland Emergency Department and the provision of recommendations for restructuring; 5) facilitation of a community-wide "Blue Ribbon" panel to oversee the capital planning for a replacement hospital; 6) assessment of the jail health services operated by the County and recommendations for operational changes, and 7) potential partnerships with other Dallas area hospitals. Finally, HMA has continued to provide consulting services to Parkland and other Texas public hospitals in the development of a Medicaid Waiver to expand available resources for Medicaid beneficiaries.

RESTRUCTURING THE PUBLIC HEALTH AND HOSPITAL SYSTEM FOR MARICOPA COUNTY, ARIZONA (PHOENIX)

Maricopa Integrated Health System | 2005 to 2011 | Health Management Associates (HMA) was engaged in 2005 to assist a newly-constituted Board of the Maricopa Specialty Health Care District and the newly engaged leadership of the Maricopa Integrated Health System (MIHS) to identify the clinical, structural, operational and financial priorities that it needed to address to assure that the public system of a hospital (including level one trauma and a major burn center), mental health services, primary and specialty clinics and extensive home health care was operating efficiently and effectively as it attempted to serve the medically vulnerable communities and populations throughout the county. In addition to the internal operational assessment, HMA was asked to evaluate the potential partnerships and linkages possible for MIHS, including: the University of Arizona/Arizona State collaboration that was bringing a medical school to Phoenix; the State of Arizona Medicaid program; the MIHS-affiliated physicians group; non-MIHS FQHCs, and; other community hospitals. Over the course of the six month effort, HMA interviewed several hundred people, reviewed extensive utilization and cost data, observed clinical practice areas and held community meetings to determine approaches to key priorities. The resulting strategic work plan was presented and approved by MIHS and the District.

Subsequently, HMA has assisted MIHS with the renegotiation of its contractual relationship with the affiliated medical group, has provided support in preparation of CMS surveys, has acted as interim finance leadership and has continued to represent MIHS in negotiations with the State of Arizona.

CHRONIC DISEASE MANAGEMENT TRANSFORMATION

California Prison Healthcare Receivership | 2008 to 2009 | Health Management Associates (HMA) worked with the California Prison Healthcare System, under the auspices of its federally-mandated Receiver, to develop and implement a chronic disease quality improvement initiative throughout the 33 facility system. Interdisciplinary teams from each prison clinic were brought together to form a learning collaborative where they were immersed in the concepts of a primary care medical home, clinical content of priority chronic diseases, the Chronic Care Model (a framework for improving chronic disease care), the Model for Improvement (approach to rapid cycle change) and benefited from peer support. Correctional leadership and patient-inmate representatives were engaged in the development of the program. Teams were charged with making priority changes in processes of care and they were provided resources, tools, and technical support between learning sessions as they engaged in this work. HMA trained quality improvement advisors to build capacity in the system to continue quality improvement work. HMA promoted an interdisciplinary team-based approach to chronic care management, led by a nurse care manager embedded in the primary care practice. An electronic patient registry allows for risk stratification of patients enabling interventions to be targeted to the highest risk patients. The registry also provides alerts to support systematic preventive screening, monitoring of chronic disease control, and timely transition care. These elements were infused into the initiative. Further, HMA has significant expertise in correctional health care and tailored the approach and implementation of the chronic disease initiative to the unique housing, logistical and procedural environment of the California prison system.

RESTRUCTURING HEALTH CARE DELIVERY FOR THE UNINSURED AND MEDICAID POPULATIONS

San Mateo County, California | 2008 to 2009 | Health Management Associates (HMA) was engaged in early 2008 by the San Mateo County government and its County Manager to facilitate a thorough assessment of the health services that they were delivering to the uninsured and Medicaid populations of the County. The HMA assessment had three distinct phases: 1) an evaluation of the County's health care situation as it related to a sustainable financing strategy (exploring both cost-efficiencies and revenue-generation priorities); 2) an assessment of the approach that the County should take in its continued delivery of services (there was, at the time, a very real bias to closing the public hospital), and; 3) the potential for collaboration with other providers serving the population within the County. Over the course of a year, HMA: developed a financial strategy that addressed the widening budget shortfall; developed an organizational plan that restructured the County's acute care hospital, long term care facility, primary and specialty clinics, behavioral health services and public health programs into one integrated system and assisted in the recruitment of a new system leader, and; 3) developed a collaboration of all of the community's hospitals (public and private), FQHCs, employed physician groups and the County Medicaid managed care plan to create the "Community Health Network for the Underserved" that rationalized and coordinated all health care services for the uninsured and Medicaid population. HMA continued to assist the San Mateo health system with specific regulatory and staffing issues related to behavioral health, long term care and acute inpatient services.

DEVELOPMENT OF INTEGRATED DELIVERY SYSTEM MODEL FOR POST-KATRINA NEW ORLEANS

State of Louisiana Department of Health and Hospitals | 2006 to 2007 | Health Management Associates (HMA) was engaged in early 2006 by the State of Louisiana's Department of Health and Hospitals (DHH) to assist in the redevelopment work in post-Katrina New Orleans. This effort included: 1) providing support to all of the financial activity between the State, City and federal government related to bringing in the resources necessary to support the rebuilding—and restructuring—the delivery system serving the uninsured and Medicaid populations of New Orleans and the surrounding communities; 2) facilitating the organizational processes that formed the planning venues for bringing forth plans to key stakeholders; and 3) developing an intensive on-the-ground assessment of the current delivery system left after the storm, the services needed for the population that remained and those projected to return, the available public and private resources (acute inpatient, primary and specialty, behavioral health) and willingness of those resources to participate in a redesigned system of care, and the framework for a new delivery system. This work was performed by HMA as adjunct to DHH leadership and was integrated into the overall plan for recovery.

DEVELOPMENT OF THE MEDICAL HOME NETWORK FOR MEDICAID PATIENTS ON THE SOUTH SIDE OF CHICAGO

Comer Science and Education Foundation | 2008 to 2011 | Health Management Associates (HMA) was engaged in early 2008 by the Comer Science and Education Foundation to develop a rational approach to assure access to a comprehensive set of health services for children livening on the south side of Chicago covered by the Medicaid program. This request was spurred by the Foundation's concern that, despite significant investment in a children's hospital in the community, there was anecdotal evidence that children were still having great difficulty accessing both primary and specialty services. Over the course of the past four years, HMA has facilitated the development of the Medical Home Network (MHN) which included the following steps: 1) thoroughly assessing the utilization of services for Medicaid enrollees, identifying specific geographic and services gaps and duplications; 2) mapping out regional networks of providers (public and private) to cover the large area; 3) working with the providers to identify the model of care to be delivered, including expanding access to County-delivered specialty services; 4) working with the State Medicaid agency to both match the Foundation ongoing contribution and develop a plan for sharing savings that would result from the management of patients (now expanded to all Medicaid enrollee categories); 5) assisting the Foundation to build an organizational structure and recruit a full-time staff to manage the MHN.

MHN is now composed of six private hospitals (including a large academic medical center), the County's public hospital and clinic system, hospital-employed physician groups and all of the FQHCs serving the target population. MHN has established innovative technology to connect all providers and deliver real time utilization data on the 170,000 Medicaid lives enrolled in the integrated delivery system. There is now discussion about expanding the geography to include a greater portion of the city and county. A principal from HMA now serves as the MHN interim Medical Director.

DEVELOPMENT OF THE BATON ROUGE AREA HEALTH CARE NETWORK, A SAFETY NET ACO

Our Lady of the Lake Medical Center/LSU | 2010 to Present | Health Management Associates (HMA) was engaged in early 2011 by Our Lady of the Lake (OLOL), the largest private health care system serving the Baton Rouge, Louisiana area, and Louisiana State University (LSU), which operates the State's expansive public hospital system, to develop the model for an integrated delivery system serving the Medicaid and uninsured populations of the eight parish region. These two systems had come together, spurred by the six storms which hit the area over the past five years and significantly impacted the delivery of health care services, and agreed to merge resources. The LSU system is slated to close its inpatient and emergency services in 2013—to be picked up by OLOL—and will significantly expand outpatient resources. Both systems will integrate their training programs and will, together, reach out to the major provider of mental health services to assure a collaborative model between medical and behavioral health services. HMA developed an implementation plan addressing the organization of care, the clinical model of care between the two systems (including affiliated physician groups), the mental health provider, the local PACE program and senior services and school based programs. HMA is also working with the systems to develop an innovative Graduate Medical Education curriculum focused on the training of new providers within an integrated delivery system environment.

HMA is assisting with the implementation of the financial model that will support this effort in Baton Rouge and perhaps in other parts of the State.

A MANAGED SYSTEM OF CARE FOR THE UNINSURED OF ORANGE COUNTY, CALIFORNIA

Health Funders of Orange County | 2009 to 2012 | Health Management Associates (HMA) was engaged by the Health Funders of Orange County—with the financial support emanating from all of the hospital systems located within the County, the Orange County Health Services Agency and CalOptima, the community's large Medicaid managed care plan—to develop the clinical, financial, organizational and infrastructure elements of an integrated, rational and equitable delivery system to serve the half million uninsured residents of Orange County, California. Over the course of a year, HMA developed a plan for a new delivery system—the Managed System of Care (MSC)—and a second plan for the creative financing of the MSC. As the community has no public hospital system and few Federally Qualified Health Centers (FQHCs), the plan built heavily upon the private physician and hospital network that composed the providers for the Medicaid system, recommended expansion of existing FQHCs and initiating new starts, rationalized the specialty network between the various member health systems, suggested approaches to the integration of behavioral and primary care services and built on existing IT strategies that had been piloted to assure greater linkage between the County's hospitals and primary care sites.

As part of the finance plan, HMA reviewed the county public health budget as well as other partner organizations for money that could be redirected and more efficiently used in the integrated delivery model. Strategies included matching mental health monies and other uninsured costs as well as raising money from

other sources. HMA also created three year cash flow models showing the financing of various infrastructure investments as well as an expanded coverage mechanism and the impact on all parties.

DAUGHTERS OF CHARITY: DEVELOPMENT OF A SAFETY NET ACO

Daughters of Charity Health System/HealthCare First South LA (HFSLA) | 2009 to present | Health Management Associates (HMA) was engaged by the Daughters of Charity in 2009 to assess the future of its community hospital serving the neighborhoods that make up South Los Angeles, the only hospital left in a geographic area of 1.2 million people, 2/3 of whom are either uninsured or covered by Medicaid. Over a period of nearly two years, HMA facilitated a process that: 1) completed a thorough assessment of the health status and utilization patterns of the population; 2) brought together all key providers--including the community hospital, private physician groups, ten Federally Qualified Health Centers (FQHCs) and the Los Angeles County Health System—serving the Medicaid and uninsured populations in the area; 3) developed a creative financial model that rewards best practice and saves money; 4) developed, working with the providers, a model of care delivery focused on Medical Homes and intensive care management; 5) negotiated an innovative relationship between the new delivery system and LA Care, the County's large Medicaid managed care plan; 6) determined quality and process benchmarks that will serve as the evaluation of success for the integrated delivery system serving a population with among the worst health status in the nation; 7) involved a major national health care union in the development of workforce restructuring strategies to meet the demands of the new delivery model; 8) established a governing body and organizational structure to assure accountability while recognizing the unique institutional boards of individual providers; and 9) determined a set of priorities for infrastructure development, including workforce and information technology.

HMA was recently engaged by the Molina Health Plan to take this model to full implementation.

AN ANALYSIS OF HEALTH SERVICES FOR THE UNINSURED AND UNDERINSURED IN THE RIVER REGION OF ALABAMA: AUTAUGA, ELMORE, LOWNDES, MACON, AND MONTGOMERY COUNTIES

Envision 2020 | 2007 | Envision 2020 contracted with HMA in October 2007 to provide an in-depth analysis of how the indigent and uninsured population in the River Region access care, how that care is financed, barriers to access, the current supply of primary care physicians and specialty physicians and current clinic facilities to determine the scope of services available in the River Region. HMA's multi-disciplinary team represented finance, health systems operations and management, clinical care, health care architecture, and public and community health. This team worked closely with the staff of Envision 2020 to determine the issues facing the River Region. The health care system in the River Region faced a host of challenges including: lack of transportation; difficulty accessing routine medical care, dental care and mental health services; the key Federally Qualified Health Center (FQHC) was in need of replacement; trauma services in the region required additional resources to reach optimal levels and to meet the state's goal of establishing a statewide trauma system; and an aging local physician community with difficulty recruiting physicians. There were also positive aspects within the delivery system to be built upon. There were a number of clinics dedicated to caring for the most vulnerable, some of which were staffed by volunteers and others which had

relatively steady sources of operating funds; and other organizations, including strong churches that stepped in to fill critical needs and help individuals navigate a complex system. HMA made a number of recommendations, including extending hours, adding new sites for existing providers, replacing aging FQHCs, improving recruitment of health professionals, and better coordination of services for those in need. The development of new financial resources and new funding was critical so HMA specifically recommended working with Medicaid to expand coverage to parents up to 100 percent of the federal poverty level, and higher as more match becomes available. For childless adults, HMA proposed a locally-funded program with proceeds from a Medicaid supplementary payment program to private hospitals serving as the backbone of funding. Finally, HMA recommended increased physician rates from Medicaid for physicians providing the greatest access to these patients and expressing a willingness to be part of the trauma program. To ensure that local resources were found and to help coordinate future investments, we recommended the establishment of a coordinating council.

Since 2008, when HMA finished the study, the River Region community of stakeholders led by Envision 2020 has "used the study as the guiding wisdom that provides the necessary 'authority' for our daily work to implement the recommendations." They successfully applied for and received an $11.3M federal stimulus grant that was used to replace the largest of the aging FQHCs. That award was one of only 85 such awards in the U.S. in December 2009 and was the only one in Alabama. In July 2011 the group held ribbon-cuttings for replacement FQHCs in Lowndes County in the town of Hayneville and in Eclectic in Elmore County. In December 2011, the new 55,000 sq. ft. FQHC that is the Lister Hill replacement facility – The River Region Healthcare Center – officially opened.

COMMUNITY HEALTH ENDOWMENT: A COMPREHENSIVE PLAN TO ADDRESS EFFECTIVE AND SUSTAINABLE HEALTH CARE SERVICES FOR UNINSURED AND MEDICAID POPULATIONS IN LINCOLN, NEBRASKA

2011 to 2012 | Health Management Associates (HMA) was engaged to produce a work plan to address the clinical, organizational, financial, patient management and policy components related to the establishment of a more integrated health care delivery system for the underserved populations in Lincoln. Key points of focus in this work were an assessment of Lincoln's Federally Qualified Health Center (FQHC), the potential integration of behavioral and physical health and creative funding strategies. It became immediately apparent to HMA that the Lincoln community has a number of relatively unique characteristics. There is a tremendous volunteer spirit among health professionals, owing at least in part to a very engaged and active medical society that plays a central role in health care efforts for low income individuals. While Lincoln is a relatively small city, it provides health care for a large geographic area well outside the County borders. There is a robust family practice residency that both local hospitals actively support. There is a relatively low unemployment rate in the area, and there is a significant local resource in the form of a governmental endowment established primarily through the sale of the City Hospital. On the other hand, the community is subject to the same economic and political factors impacting the entire country. The state and county are reducing funding to health care and divesting themselves of certain activities, there is no central body with the responsibility to coordinate efforts for safety net activity, and there is a growing uninsured population. In HMA's estimation, the safety net is currently undersized for the need.

HMA used interdisciplinary teams experienced in and focused on 1) community assessments (including who is the population, where do they get their care now, where are the gaps and duplications, what is the projected impact of health reform); 2) FQHC assessment; 3) options for mental health services delivery and coordination; 4) medical care delivery systems (from primary to specialty to inpatient services); 5) short and long-term financing strategies to assure sustainability; and 6) governance options. HMA recommended both a set of short and long term strategies to build a more coordinated local system, and a governance structure for taking charge of implementation. Strategies included establishing and funding an organization willing to apply for the Centers for Medicare and Medicaid Innovation (CMMI) grant and to be responsible for overseeing efforts in the safety net; FQHC should partner with the Lincoln Medical Education Partnership (LMEP) to operate a satellite clinic at LMEP's current site; integration of mental and physical health in partnership with the Community Mental Health Center and other mental health providers; and CHE and hospitals should work with leadership in Omaha to influence the state to create an upper payment limit program for certain hospitals.

TEFT DEMONSTRATION GRANT TECHNICAL ASSISTANCE

Centers for Medicare and Medicaid Services | April 2014 to present | HMA was engaged by the CMS to assist on the Testing Experience and Functional Tools (TEFT) in Community-Based Long Term Services and Supports (CB-LTSS) planning and demonstration technical assistance (TA) project. The TEFT initiative furthers adult quality measurement activities under Section 2701 of the Patient Protection and Affordable Care Act. HMA is working on the following components of the TEFT Demonstration TA contract to assist in meeting the goals of the TEFT Demonstration program:

- The provision of TA to State Grantees (AZ, CO, CT, GA, KY, MD, MN) and CMS related to areas of health information technology (HIT) including health information exchanges, electronic health records, personal health records, interoperability and standards.
- The provision of TA to Grantees to demonstrate use of PHR systems with beneficiaries of CB-LTSS. The PHR is intended to provide CB-LTSS grantees with a range of personal LTSS and health information to facilitate decision making about care. The PHR can encourage a more active role for beneficiary/caregivers in managing care and result in better outcomes through more efficient management of services.
- The provision of TA to Grantees participating in the Office of National Coordinator's (ONC) Standards and Interoperability (S&I) Framework for the development, testing and piloting of a new electronic standard for an eLTSS record.

MEDI-CAL INTERACTIVE PERFORMANCE MEASUREMENT DASHBOARDS

California Department of Health Care Services | January 2013 to December 2014 | Created Medi-Cal utilization and performance measurement dashboards using California Medicaid claims and eligibility data provided by that state. Published on secure HMA server for State staff to access. Dashboards were received well and subsequently worked with the State to move IT infrastructure in-house and create dashboards internally.

This is just a fantastic tool! I congratulate you on developing what is surely the most useful and user-friendly managerial and stakeholder tool ever devised for figuring out what's going on with the program".

- Robert Isman, DDS, Medi-Cal Dental Services

UTILIZATION AND PERFORMANCE MEASUREMENT DASHBOARDS

Washington Dental Service Foundation | April to November 2012 | Created Medicaid utilization and performance measurement dashboards for The Washington State Medicaid Foundation using Washington Medicaid claims and eligibility data. Published on secure HMA server for Foundation staff to access. Created publication in pdf format documenting Washington state utilization and expenditures and cost drivers over time for public dissemination.

KENTUCKY BEHAVIORAL HEALTH SERVICE, FINANCING AND BENEFITS IMPROVEMENT

Kentucky Division of Behavioral Health | 2011 | The Kentucky Department of Behavioral Health, Developmental and Intellectual Disabilities (KDBHDID) contracted with Health Management Associates (HMA) to assess and recommend changes to the state's Medicaid behavioral health service, financing and benefits structure in order to help position the state to leverage the opportunities and understand the challenges posed by federal health care reform.

HMA conducted a comprehensive review of information and data about behavioral health services administered and funded by the state, including Medicaid-funded behavioral health services in order to better understand delivery systems (e.g., Medicaid benefit structure, general fund use, responsibility for governance and oversight, covered services, priority populations, service costs and utilization trends, performance measurements and outcomes monitoring, etc.). This analysis was structured to inform future policy decisions concerning coverage and financing of behavioral health services.

Phase II of the work with Kentucky included HMA providing recommendations for expanding service and provider capacity that could be achieved by making system changes. These recommendations included engaging CMS to develop sustainable policy and reimbursement strategies, ways to establish a more cohesive and structured partnership between Medicaid and the state mental health authority in order to redesign and strengthen the behavioral health system, promoting collaboration between CMHCs and FQHCs, and leveraging opportunities provided by the Affordable Care Act, such as applying for a 1915i waiver.

ANALYSIS AND RECOMMENDATIONS FOR SERVICE DELIVERY IMPROVEMENTS

Santa Barbara County Public Health Department | 2012 | In August 2012, the County of Santa Barbara County Executive Office was authorized by the Board of Supervisors to engage Health Management Associates (HMA) to conduct an analysis of the inpatient mental health delivery service (including acute psychiatric inpatient services, crisis residential and Institutions for Mental Disease (IMD)) and to provide options and recommendations on both new service delivery models and enhancements to the current psychiatric hospital facility (PHF) model in Santa Barbara. The overall goal of the analysis has been to develop options for the County of Santa Barbara and its Board of Supervisors with the following considerations:

- Alternative opportunities for inpatient bed service delivery within the County as a means to provide high quality services in an efficient and cost-effective manner;
- Comparing and contrasting licensing and accreditation standards of the various models;
- If the current inpatient system service delivery system is the optimal structure and sustainable given the level of service and overall needs of the County;
- Any legal and compliance issues related to the intake process and recommendations and opportunities for improvement to effectively manage inpatient psychiatric facility function and enhance service delivery; and
- Recommendations regarding patient mix within the PHF.

MISSOURI HEALTH HOMES

Missouri Department of Mental Health | 2012 to present | HMA is serving as the primary content developer for two state plan amendments for the Missouri Department of Mental Health (i.e., mental health and primary care Health Homes). As part of this effort, HMA engaged Missouri in the planning stages of their SPA, including financial modeling, identification of target populations, identification of services potentially convertible to Medicaid Health Home services, and making changes to their current health homes services in their proposed SPAs (i.e. rates, measures, service, descriptions, etc.). HMA is presently working with Missouri on final modification before submission to CMS.

In addition to its work in Missouri, HMA has developed or is developing health homes for Michigan, Ohio, Rhode Island and Washington, D.C. HMA has worked with these states to design their programs, drafted and submitted State Plan Amendments (SPA) for CMS approval, and successfully attained expedited SPA approval from CMS.

MILLIMAN

ACTUARIAL SERVICES

State of Ohio Department of Job and Family Services | July 2007 to present | Milliman was engaged by the Ohio Medicaid Administrative Study Council to assist in the development of recommendations regarding the formation of a new Ohio Department of Medicaid (ODOM). Milliman efforts were focused on evaluation of the existing organizational structure, development of recommendations regarding the design for the new department, development of a high-level transition plan to support implementation of the new department, and development of recommendations regarding the information technology structure for the new department

Milliman also been performing the annual review of Ohio's Medicaid managed care plans for regulatory compliance with prompt pay and other operational initiatives for ODJFS.

Milliman provides actuarial consulting services related to the Medicaid program. Milliman's primary responsibilities include development of capitation rates for the Medicaid population enrolled with managed care plans, budget development and forecasting, actuarial support of program changes and initiatives, and review of HCR impacts to the state program and budget.

Milliman assisted the ODJFS with its responsibilities regarding the design, development, assessment, research and analysis of an exchange in Ohio. This is to include an analysis of available data to determine the impact of an exchange and related reforms on public and private programs in Ohio in accordance with Section 1311 of the Patient Protection and Affordable Care Act (ACA). The primary deliverables of this assignment included estimates of the impact of the ACA on the Medicaid program enrollment and expenditures over the period 2014 to 2019.

EXCHANGE PLANNING

Washington State Health Care Authority | September 2010 to January 2011 | Milliman provided assistance to the Washington State Health Care Authority to help legislators and other stakeholders understand the issues related to establishing a Health Benefits Exchange. As part of this assistance Milliman has developed a transparent, easily understandable model and accompanying report to analyze and communicate the potential impact on the State's healthcare market of the following key decisions:

- Whether or not to merge the individual and small group markets
- Whether or not to establish a Federal Basic Health program
- How to define the maximum size for small groups in 2014 and 2015

Milliman also developed several issue briefs related to the establishment of an Exchange, covering topics such as administration, risk management, and healthcare cost containment. In addition, Milliman developed communication material and facilitated at stakeholder meetings.

MANAGED CARE RATE SETTING AND PROJECTIONS

State of Indiana Family and Social Services Administration | March 2010 to present | Since 2000, Milliman has been contracted by the State of Indiana, Family and Social Services Administration (FSSA), to provide full actuarial services to the Medicaid healthcare program, including the TANF, Aged, Disabled, SCHIP, and Healthy Indiana Plan populations. Milliman actively participates in budget and forecasting discussions with legislative fiscal analysts and the State Budget Agency.

Milliman provided technical assistance to the Indiana Health Exchange Planning Committee. Milliman prepared different scenarios regarding a proposed design of the Health Care Exchange required under ACA. Milliman consultants participated in the technical planning meetings, as well as provide supporting material for review. The material includes white papers regarding various aspects of the Exchange, technical assistance regarding various Exchange design requirements, and population projections. The population projections review the modeling of the small group, individual, and uninsured populations and insurance markets.

MANAGED CARE RATE SETTING AND PROJECTIONS

State of South Carolina | January 2008 to present | Milliman provides comprehensive Medicaid actuarial consulting services for the South Carolina Medicaid program, including Medicaid managed care rate setting, risk adjustment, budget projections, health care reform analysis, and other financial analysis.

ACA MEDICAID FISCAL IMPACT ANALYSIS

State of Nebraska Division of Medicaid and Long Term Care | April to November 2010 | Milliman was retained to develop the state's fiscal impact for the Medicaid budget due to the passage of ACA. Milliman prepared a report that outlined the population projection with and without the Medicaid expansion scheduled for 2014 under ACA. Milliman analyzed all aspects of the ACA related to the Medicaid program, including: (1) develop fiscal impact for state fiscal years 2011 through 2020, (2) estimate the population that will be eligible for Medicaid under the expansion to 138% FPL, (3) population projection due to the woodwork effect, (4) increase in medical and administrative expenditures, (5) impact to pharmacy rebate program, (6) impact to the need for increased physician reimbursement, (7) impact of expansion due for the foster children to age 26, (8) impact of the DSH program reductions, and (9) reduced costs to state only funded medical programs. Milliman provided a written report that was distributed in a public forum, including a briefing with Governor Heineman.

MANAGED CARE RATE SETTING AND PROJECTIONS

New Hampshire Department of Health and Human Services | January 2010 to present | Milliman supports New Hampshire's Medicaid and CHIP programs with a variety of rate setting and financial analyses. Milliman is working with DHHS to design a potential Medicaid managed care program and evaluate the impact of PPACA on the New Hampshire Medicaid program.

MEDICAID RATE SETTING, BUDGETING, PROJECTIONS

Administration de Seguros de Salud (Puerto Rico Medicaid) | August 2001 to present | Milliman supports Puerto Rico's Medicaid and CHIP programs with a variety of rate setting and financial analyses.

Milliman worked with ASES to set premium rates as managed care was implemented. Milliman assisted ASES with the Medicaid expansion projections.

MEDICAID RATE SETTING, BUDGETING, PROJECTIONS

Florida Agency for Health Care Administration | July 1999 to present | Milliman has worked with the Florida Medicaid program for over 10 years to support its Medicaid managed care programs. Milliman provides rate setting, risk adjustment, and related analysis for acute care, behavioral health, and long term care programs

FINANCIAL IMPACT OF ACA TO MEDICAID

Idaho Department of Health and Welfare | July to December 2012 | Milliman has provided support to the Idaho Department of Health and Welfare Medicaid programs through a subcontracting agreement with Boise State University for the last six years. Our reference work in this instance is a project which involved estimating the Medicaid Expansion population and costs to the Department. Our project was on a very tight timeline and culminated in the delivery of a presentation to a State of Idaho Work Group on the topic. The cost estimates were for 10 years and based on the current specifications of the health reform law. The services provide included budget analysis and cost projections. The economic impact of new federal funds into the state was beyond the scope of work.

MEDICAID EXPANSION

State of Nebraska Division of Medicaid and Long Term Care | October 2014 to February 2015 | Legislative bill 472 (LB472), the Medicaid Redesign Act, provides for immediate state plan amendment to expand Medicaid. Milliman assisted by estimating the fiscal impact of the expansion.

STATE OF CALIFORNIA STATE INNOVATION MODEL GRANT SUBMISSION

State of California | June to July 2014 | Milliman developed the financial projections for the State of California submission for the CMMI State Innovation Model. Projections included estimating costs for the impact of several changes to the health care system including neonatal care changes, bundled payments, and end of life care initiatives.

ACA HEALTH INSURANCE FEE ANALYSIS

Medicaid Health Plans of America | September 2011 to January 2012 | Milliman was retained by MHPA to provide an independent analysis of the impact of the PPACA health insurer fee on state Medicaid programs and Medicaid health plans. The report summarized the annual fee on health insurance providers under the PPACA, examined how the health insurer fee impacts the manner in which state Medicaid agencies set Medicaid managed care rates, and quantified the financial impact of the health insurer fee on Medicaid programs under various Medicaid enrollment growth scenarios.

MEDICAID EXPANSION ANALYSIS

Wyoming Department of Health | June to September 2012 | Milliman was engaged by the Wyoming Department of Health (WDH) to conduct a study to summarize historical enrollment and cost trends for

Wyoming Medicaid, and to develop projections of enrollment and costs for the current program and the expansion of the program under the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, together commonly referred to as the Affordable Care Act (ACA), starting in 2014.

MEDICAID MANAGED CARE COST IMPACT

Texas Associate of Health Plans | September 2014 to February 2015 | Milliman was engaged by TAHP to evaluate the cost impact that managed care has had on costs to the state for Texas Medicaid. The study was done using a methodology typically used in retrospective evaluations of disease management and/or case management programs.

WAIVER APPLICATION

Iowa Department of Human Services | June to August 2013 | Milliman was retained by the State of Iowa, Department of Human Services (DHS) to assist in the development of the 1115 waiver filing associated with the Iowa Marketplace Choice Plan. The Iowa Marketplace Choice Plan 1115 waiver request in concert with the Iowa Wellness Plan 1115 waiver request replace the Iowa Care 1115 waiver demonstration which expires December 31, 2013. DHS submitted a five-year waiver request effective January 1, 2014. The initial waiver request aims to fill the coverage gap in the post 2014 healthcare environment by extending coverage to non-pregnant, non-medically frail individuals between 19 and 64 years of age who are between 101% and 133%1 of the federal poverty level (FPL) based on Modified Adjusted Gross Income (MAGI) and not currently eligible for comprehensive Medicaid or Medicare coverage. Milliman prepared the budget neutrality filing materials associated with the waiver renewal filing.

FISCAL IMPACT OF PPACA

Mississippi Division of Medicaid | June to December 2012 | Milliman was retained by the State of Mississippi to develop financial projections under various scenarios of the fiscal impact the PPACA.

DRIVERS OF HEALTH CARE COSTS IN ALASKA AND COMPARISON STATES

Alaska Health Care Commission | July to November 2011 | The Alaska Health Care Commission ("AHCC") engaged Milliman to compare Alaska's health care payment rates and underlying drivers to those in certain other states. The comparison states are Washington, Oregon, Idaho, Wyoming, and North Dakota. Hawaii was also included in the comparison states where practical. The comparison states were selected by the AHCC. Three reports were delivered. The first report analyzed physician payment rates in Alaska. The second report analyzed facility payment rates in Alaska. The final report is focused on how Alaska's health care costs and underlying drivers compare to other states.

MEDICAID RATE SETTING, BUDGETING, PROJECTIONS

Minnesota Department of Human Services | June 2013 to present | Milliman support the Minnesota Medicaid managed care programs. Milliman provides rate setting, risk adjustment, and related analysis for acute care, behavioral health, and long term care programs

MEDICAID HOSPITAL ACCESS ASSESSMENT

Arizona Health Care Cost Containment System | November 2010 to June 2011 | In response to budgetary pressures, the Arizona Health Care Cost Containment System (AHCCCS) was considering or in the process of implementing several measures that will result in changes to hospital payment levels. Most of the changes will reduce payment. In preparation for such reductions, AHCCCS wanted to ensure that the resulting hospital payments would be consistent with efficiency, economy, and quality of care, and sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area. In November 2010, Milliman produced a study for AHCCCS that compared Arizona hospital financial and other measures to hospitals in other states and nationwide. That study was conducted to evaluate the expected impact on access to quality hospital care of a 5% decrease in hospital payment rates on 4/1/2011. An additional report updated that study, considering the many payment changes currently in process or under consideration.

BASIC HEALTH PLAN ACTUARIAL ANALYSIS

State of Connecticut Office of Policy and Management | November to December 2012 | Milliman was retained by the State of Connecticut, Office of Policy and Management (OPM) to assist the Basic Health Program Work Group (Work Group) in modeling the various actuarial aspects of the Basic Health Program (BHP) option defined in Section 1331 of the Affordable Care Act (ACA).

RATE SETTING AND FINANCIAL PROJECTIONS

Arkansas Comprehensive Health Insurance Program (CHIP) | November 1996 to present | Milliman has assisted the Arkansas CHIP program with actuarial consulting services since 1996, including surveying health insurance rates in the state and proposing plan rates for the Board's considerations. We perform periodic rate reviews, estimate claims reserves, and perform other actuarial work on an as-needed basis. We have provided assistance with the new federal risk pool set up including actuarial value calculation, development of premium rates, and enrollment and financial projections.

EXCEPTIONS TO THE STATE OF ALASKA'S APPENDIX A: GENERAL PROVISIONS

The Proposer has reviewed the State's preferred form of contract and is proposing revisions to the same to ensure that any contract resulting from this proposal is in a form acceptable to the State and meets the needs of the Proposer. These revisions have been accepted by the State in previous Millliman engagements. The submission of this proposal in response to the RFP may constitute Proposer's acceptance of the State's contract terms should the changes to the provisions below, or the addition of the new provisions below, be accepted. The Proposer shall not be bound by any contract terms or obligated to perform the services described in this proposal until a mutually-acceptable written agreement is signed by the parties.

Section	Exception	Purpose
Article 2.1	The department may inspect, upon prior written notice and in the manner and at reasonable times ~~it considers appropriate~~mutually agreed by the parties, all the contractor's facilities and activities under this contract.	Proposer is amenable to audits and inspections, but simply wants to be able to avoid major workflow disruptions in connection with the same.
Article 3.1	~~If the contractor has a claim in connection with the contract that it cannot resolve with the State by mutual agreement, it shall pursue the claim, if at all, in accordance with the provisions of AS 36.30.620-632.~~ In the event of any dispute concerning a question of fact or other dispute arising out of or relating to the engagement of Contractor by the State that is not disposed of by mutual agreement will be resolved under the Alaska "Revised Uniform Arbitration Act," AS 09.43.300-09.43.585, as modified hereunder. The arbitration shall take place before a panel of three arbitrators. Within 30 days of the commencement of the arbitration, each party shall designate in writing a single neutral and independent arbitrator. The two arbitrators designated by the parties shall then select a third arbitrator. The arbitrators shall have a background in either insurance, actuarial science or law. The arbitrators shall have the authority to permit limited discovery, including depositions, prior to the arbitration hearing, and such discovery shall be conducted consistent with the Alaska Rules of Civil Procedure. The arbitrators shall have no power or authority to award punitive or exemplary damages. The arbitrators may, in their discretion, award the cost of the arbitration, including reasonable attorney fees, to the prevailing party. Any award made may be confirmed in any court having jurisdiction. Subject to applicable law, any arbitration shall be confidential, and except as required by law, neither party may disclose the content or results of any arbitration hereunder without the prior written consent of the other parties, except that disclosure is permitted to a party's auditors and legal advisors.	Proposer would strongly prefer that all disputes be addressed via final and binding arbitration, and is amenable to using the State's statutory arbitration process with a few minor exceptions as noted herein.
Article 10.	~~Except as otherwise provided herein~~Subject to the terms of this Article 10, ~~A~~all designs, drawings, specifications, notes, artwork, and other work developed and delivered to the State of Alaska in the performance of this agreement ("Deliverables") are produced for hire and remain the sole property of the State of Alaska and may be used by the State ~~for any other purpose~~as described in the RFP and as permitted herein without additional compensation to the	Proposed edits are intended to ensure interpretational consistency with the new language proposed below in this Article 10. Proposer's intent is to (a) ensure that Proposer and Proposer's subcontractors retain rights in and

Section	Exception	Purpose
	~~contractor~~Contractor. The contractor agrees not to assert any rights and not to establish any claim under the design patent or copyright laws. ~~Nevertheless, if the contractor does mark such documents with a statement suggesting they are trademarked, copyrighted, or otherwise protected against the State's unencumbered use or distribution, the contractor agrees that this paragraph supersedes any such statement and renders it void.~~ The contractor, for a period of three years after final payment under this contract, agrees to furnish and provide access to all retained materials at the request of the Project Director. Unless otherwise directed by the Project Director, the contractor may retain copies of all the materials. Contractor and its subcontractors shall retain all rights, title and interest (including, without limitation, all copyrights, patents, service marks, trademarks, trade secret and other intellectual property rights) in and to all technical or internal designs, methods, ideas, concepts, know-how, techniques, generic documents and templates ("Tools") that have been previously developed by them or developed during the course of the provision of the Services provided such Tools do not contain and/or are not based upon or derived from any State confidential information or proprietary data. Rights and ownership by Contractor, or its subcontractors, of its Tools shall not extend to or include all or any part of State's proprietary data or confidential information. To the extent that Contractor may include in the Deliverables any Tools, Contractor and its subcontractors agree that State shall be deemed to have a fully paid up perpetual license to make copies of the Tools as part of this engagement for its internal business purposes and provided that such Tools cannot be modified or distributed outside the State without the written permission of Contractor or except as otherwise permitted herein. The Deliverables are prepared solely for the use and benefit of the State Contracting Agency in accordance with its statutory and regulatory requirements. Contractor recognizes that materials it delivers to State Contracting Agency may be public records subject to disclosure to third parties, however, Contractor does not intend to benefit and assumes no duty or liability to any third parties who receive Contractor's work and may include disclaimer language on its work product so stating. The State Contracting Agency agrees not to remove any such disclaimer language from Contractor's work. To the	to their own knowledge capital and intellectual property employed in the rendering of services to the State. Proposer and Proposer's subcontractors will use their own knowledge capital, proprietary software, spreadsheet tools and models in the performance of its services, and thus need to protect their rights in and to the same. Proposer and proposer's subcontractors may develop new tools, or modifications or improvements to our existing tools during the course of a client engagement, and similarly must protect their rights in such tools and modifications that are developed during the course of the performance of services – but which are not specifically requested as deliverables by the State. The rights retained herein do not extend to client specific information or custom client deliverables. As per the terms of the RFP, Proposer has retained the services of a certified actuary to assist in the performance of services to the State. This term is required by the certified actuary and is intended to

Section	Exception	Purpose
	extent that Contractor's work is not subject to disclosure under applicable public records laws, State Contracting Agency agrees that it shall not disclose Contractor's work product to third parties without Contractor's prior written consent; provided, however, that State Contracting Agency may distribute Contractor's work to (i) its professional service providers who are subject to a duty of confidentiality and who agree to not use Contractor's work product for any purpose other than to provide services to State Contracting Agency, or (ii) any applicable regulatory or governmental agency, as required. No third party recipient of Contractor's Deliverables should rely upon the Deliverables. Such recipients should engage qualified professionals for advice appropriate to their own specific needs.	prohibit the distribution of Proposer's work product to third parties unless (a) the State has a legal or statutory obligation to share the work product, or (b) the State receives a public records request for the work product.
Article 11.	This contract is governed by the laws of the State of Alaska. ~~To the extent not otherwise governed by Article 3 of this Appendix, any claim concerning this contract shall be brought only in the Superior Court of the State of Alaska and not elsewhere.~~	Edits to this section are required to fully implement the changes that Proposer has suggested to Article 3.
Article 12. *New Article Limitation of Liability	Contractor will perform all services in accordance with applicable professional standards. In the event of any claim arising from services provided by Contractor or its Subcontractors at any time, the total liability of Contractor, its officers, directors, agents, subcontractors and employees to State shall not exceed five million dollars ($5,000,000). This limit applies regardless of the theory of law under which a claim is brought, including negligence, tort, contract or otherwise. In no event shall Contractor or its Subcontractors be liable for lost profits of State or any other type of incidental or consequential damages. The foregoing limitations shall not apply in the event of the (i) intentional fraud or willful misconduct of Contractor or its Subcontractors; (ii) any personal injury, death or property damage claims to the extent arising from Contractor's or its subcontractor's performance of the services; or (iii) any employer related obligations of Contractor or its subcontractors to their respective employees. The parties recognize and agree that it is their collective intent, as sophisticated parties represented by counsel, that the Limitation of Liability contained in this Article 12 should be enforced in its entirety.	Proposer's risks must be somewhat proportional to the size of the project. Agreeing to unlimited liability is not a sustainable business model going forward. In order to provide meaningful, quality services to clients Proposer needs to take steps to demonstrate to its insurers that it is mitigating its risks.

ATTACHMENTS

OFFEROR'S CHECKLIST

CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION LOWER TIER COVERED TRANSACTIONS

ALASKA BUSINESS LICENSE

RESUMES

LETTERS OF REFERENCE

DOCUMENTATION OF TECHNICAL ASSISTANCE WITH MEDICAID EXPANSION