NAVIGANT

**Proposal for:**

# Analysis of Prop 206 Impact on Provider Network Adequacy

## Task Order No. YH18-0031

**Presented to:**

AHCCCS
Arizona Health Care Cost Containment System

**Arizona Health Care Cost Containment System**
**701 East Jefferson, MD 5700**
**Phoenix, Arizona 85034**

***September 28, 2017***


**Presented by:**

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September 28, 2017

Michael Kowren, Procurement Specialist
AHCCCS Procurement Office
701 East Jefferson, MD 5700
Phoenix, Arizona 85034

*Sent via e-mail:* *Michael.Kowren@azahcccs.gov*

**RE: Analysis of Prop 206 Impact on Provider Network Adequacy, Task Order No. YH18-0031**

Dear Mr. Kowren:

On behalf of Navigant Consulting, Inc. (Navigant), I thank you for the opportunity to present this proposal to the Arizona Health Care Cost Containment System (AHCCCS) for assistance with the Analysis of Prop 206 Impact on Provider Network Adequacy.

We look forward to continuing to partner with AHCCCS on Arizona's critical healthcare transformation initiatives. Our proposed team brings the skills and experience to work with AHCCCS to provide a comprehensive network adequacy study of the impact of Proposition 206. Our team members have worked with health plans, providers, and states to perform provider network analyses and evaluate overall access to various types of services.

As requested in the RFP, please see the other Required Elements below:

| | |
|---|---|
| 8.A.1 Company Name | Navigant Consulting, Inc. |
| 8.A.1 Contract Number | ADSPO13-058528 or YH14-0033-09 |
| 8.A.3 Contact Information | Catherine Sreckovich, csreckovich@navigant.com, 312.583.5747 |

We are confident our approach and experience will deliver the needed resources to support AHCCCS in this endeavor. Do not hesitate to contact me directly at 312.583.5747 with any questions or if we can otherwise be of assistance. We look forward to discussing the next steps with you both.

Sincerely,

Catherine Sreckovich

Catherine Sreckovich
Managing Director

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# Section I Experience and Capacity

## *a. Experience of the Firm*

Navigant is a specialized professional services firm focusing on markets and clients facing transformational change and significant regulatory or legal pressures. Our healthcare professionals include public policy experts; medical professionals; hospital, life sciences, health plan, government, and healthcare operations professionals; finance executives; analysts; and clinicians. Our project team has experience with the design and delivery of behavioral health services and programs, provider network analyses, and provider surveys.

We also have more than 20 years of experience working with Arizona state agencies, including Arizona Health Care Cost Containment System (AHCCCS). This unique combination of experience will allow us to effectively conduct a comprehensive study of the network adequacy of behavioral health services provided to children enrolled in the Comprehensive Medical and Dental Care Program (CMDP) statewide. We further describe our experience in each of these areas below.

### *Experience Assessing the Adequacy of Provider Networks*

In Medicaid programs throughout the country, provider access has been in the forefront of issues of concern to stakeholders. Navigant has been working with states for many years to better define and assess access, and to make recommendations to improve access. Over the years, our consultants have provided support related to the "equal access provision," found at *42 U.S.C. §1396a(a)(30)(A).* The equal access provision requires that state Medicaid provider payments 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."

Now that managed care regulations have provided guidance regarding access to services in managed care plans, states must update their managed care contracts as well as evaluate their methodologies for developing network adequacy requirements, processes for monitoring provider networks and exceptions, and enforcement tools. See Appendix B for a white paper written by the Navigant team describing the Final Rule and its impact on states.

Consistent with federal regulations, we have worked with our state clients to evaluate provider access issues, develop MCO network standards, evaluate MCO compliance with network standards, and develop plans for monitoring access going forward. On the following pages, we describe selected projects representative of our provider access experience.

Navigant assisted the Wyoming Department of Health with development of its Access Monitoring Review Plan (AMRP) in compliance with *42 CFR 447.203,* which requires states to analyze access to care among Medicaid beneficiaries. We reviewed available data to assess access for six service types: behavioral health, primary care, physician specialty, maternity,

home health, and dental. The AMRP provided information about the extent to which Medicaid beneficiaries' needs are met (based on self-reported survey data), availability of Medicaid-enrolled providers (based on enrollment data), providers' willingness to accept Medicaid patients (based on self-reported survey data), and changes in utilization of covered services over a three-year period (based on claims data). In addition, we compared Wyoming Medicaid fee-for-service reimbursement rates to payment available from Medicare, private payers, and Medicaid in other states to identify services where reimbursement could negatively affect access.

Navigant conducted a Federally-mandated independent assessment of North Carolina's managed care behavioral health program, Piedmont Behavioral Health, for the Division of Medical Assistance (DMA). The program operates under concurrent section 1915(b) and 1915(c) Federal waivers. Our consultants assessed access to care, quality of services, and cost-effectiveness of the 1915(b) waiver. We conducted interviews with DMA staff and Piedmont Behavioral Health in the areas of mental health, substance abuse, and mental retardation / developmental disabilities to gain an understanding of how the waiver program operates. We developed evaluation measures for access and quality, as well as a methodology for assessing the cost-effectiveness of the waiver. We conducted focus groups of Piedmont Behavioral Health providers and stakeholders and surveys of consumers to gain information about how implementation of the waiver program affected access to and quality of behavioral health services from consumers', providers', and other stakeholders' perspectives. We reviewed documentation related to access and quality provided by Piedmont Behavioral Health and determined the cost-effectiveness of the waiver. We summarized the results of these reviews and included them in the final assessment report, which the State submitted to the Centers for Medicare and Medicaid Services (CMS).

Our consultants provided technical assistance to the Texas Health and Human Services Commission (the Commission) to evaluate provider network composition compliance for all of its Medicaid and Children's Health Insurance Program (CHIP) managed care organization (MCO) contracts. The assessment included an evaluation of the accuracy of provider directory information, a geo-access assessment of the provider network files, and an evaluation of the MCOs' strategies for monitoring provider network compliance.

Navigant was engaged to assist the Commission in answering a number of key questions, such as: "Are there adequate providers in each of the STAR, STAR+, and CHIP networks? Do MCOs provide accurate information about their providers? Do members have reasonable access to providers?" We reviewed structured data found in MCO provider files as well as unstructured data (e.g., provider contracts and results of phone interviews and surveys). We also produced automated audit tools to standardize some of the less structured data to quantify results and again offer a full-spectrum solution to the inquiry. Our analytics involved the use of ArcGIS software for robust geo-mapping analyses, SAS programming to review and quantify audit results, and use of other relational database tools to guide the program team in completing these tasks. In the evaluation of the accuracy of provider directory data, we sampled each

MCO's network, stratifying by program and service delivery area. Our consultants compared the sampled records to the hard copy provider directories and submitted provider contracts and Department of Insurance applications (or other approved submissions). Results were logged in a customized database that automated comparative analysis for each evaluation. The telephone surveys evaluated primary care physician (PCP) open panel status and specialists' appointment scheduling times. The Commission used our reports to evaluate ongoing monitoring efforts and to report to the Texas Legislature and other stakeholders regarding the network composition of Medicaid and CHIP MCOs.

Navigant has assisted various state clients in broad range of services to build, monitor, and sustain suitable networks for a variety of Medicaid programs. Our services range from creating state network adequacy standards and developing the administrative service rules for network adequacy to developing reporting requirements and databases and assisting with audits resulting from consent decree suits regarding limits in the access of care. Our experience includes states such as Texas, Indiana, Pennsylvania, Alabama, and Mississippi.

In Alabama, Navigant is supporting the Alabama Medicaid Agency (AMA) to plan for and implement a new care delivery model that will improve beneficiary outcomes and address fragmentation in Alabama's Medicaid program. Under the new model, risk-bearing, provider-based Regional Care Organizations (RCOs) will be paid on a capitated basis to provide the full scope of Medicaid benefits, including primary, acute, behavioral, maternal, pharmacy, and post-acute services. We assisted the AMA to develop managed care contractual requirements related to enrollment and enrollee services, provider network and services, covered services, and care coordination. We developed contract language in accordance with State laws, administrative rules, and Federal regulations and presented contract language to RCO representatives and other stakeholders. We worked jointly with AMA and stakeholders to refine contract language based on stakeholder comments.

We similarly assisted Georgia in developing provider network access and availability standards for multiple Medicaid managed care programs, including enhanced ongoing network adequacy oversight requirements. We developed pre-implementation network adequacy standards and participated in workgroup meetings with the State, sister agencies, and MCOs to evaluate provider network adequacy prior to implementation.

To support many of our access studies, we have completed geo-mapping exercises in several states. For example, we have served as the prime contractor assisting with readiness reviews in several states, including Alabama, Georgia, Indiana, Kansas, Mississippi, Texas, Indiana, and Pennsylvania.

Our experience includes the following evaluations:

- Analyze detailed Geo-Access Reports mapping the number of providers available by zip code and member location, and member-to-provider ratios
- Monitor member and provider access complaints

- Analyze provider reluctance to contract with the MCO and prioritize resources to negotiate or maintain contracts
- Determine why PCPs are closing panels and if the MCO can encourage PCPs to keep their panels open
- Analyze member utilization of preventive services
- Analyze member utilization of inpatient or emergent services so that these encounters are appropriately managed
- Conducting telephonic surveys to evaluate appointment availability
- Audit of provider contracts and data files to validate information shared via provider directories, member services, and enrollment broker information regarding the composition of networks

As we conduct readiness reviews of managed care plans in states – assessing whether they are "ready" to accept enrollment of Medicaid beneficiaries into at-risk Medicaid programs – we require health plans to submit for review geo-access studies.

In the development of a Rural Health Care Model for the State of Wyoming on behalf of the Wyoming Health Care Commission, we used ArcGIS mapping software to create visual aids for analysis and presentation of Wyoming's healthcare resources for its core healthcare services.

***Provider Resource Analyses***

Our consultants assisted the State of Vermont in preparing a Health Resource Allocation Plan. We designed and developed a health resource inventory database, which is a comprehensive listing of health practitioners, practice locations, and health facilities available to Vermont residents. To design and develop this database, our consultants administered surveys, performed research, and collected data, which we then synthesized into a database designed specifically to handle complex information. Throughout the design process, we took steps to create a flexible, accurate database that could easily produce counts of the number of practitioners or facilities available to residents in a certain locality by type of healthcare service. In addition to including practitioners and facilities, we made efforts to include the services provided at each facility, as well as the major medical equipment available throughout the State.

Navigant is considered one of the industry leaders in designing, developing, and operationalizing partner networks inclusive of clinically integrated networks (CINs), accountable care organization (ACO), and risk-based contracting entities. Unlike other advisory firms, the multidisciplinary Navigant team includes strategy, operations, analytics, and physician experts. For example, we have:

- Conducted more than 30 ACO and CIN projects across the country giving our team the requisite experience to design and develop the full range of CIN strategies

- Assembled a deep bench of strategy, operations, analytics, physician, and financial experts who uniquely position our team to address the full spectrum of design and implementation issues inherent in building and capitalizing an ACO and/or CIN
- Selected partner of choice to a dozen leading organizations building and deploying new care models that focus on managing episodes and populations
- Developed a comprehensive methodology to identify quality and efficiency improvements to guide initial value based care programs
- Acquired a broad understanding of key healthcare reform drivers and steps required to build and implement a successful partner network strategy
- Developed an inclusive approach to engage physicians and health system leaders to align network and health system objectives and quantitative analysis to identify individual physician performance and drivers of performance variation
- Used a variety of vendor tools (Crimson, Milliman, Medventive, Verisk, Truven, Aetna, Optum, etc.) and understands both what works and what does NOT work for clients building capabilities to deliver value based care
- Conducted planning, financial feasibility and application assistance for 6 of the 32 Pioneer ACOs; assisted with daily project management for one of the nation's largest Pioneer ACOs

Navigant has a 20-year history of providing clients with medical staff planning and physician strategy consulting assistance. Clients regularly turn to us for services ranging from single-specialty provider needs assessments to more comprehensive system-wide provider needs assessments and resource development planning including network adequacy assistance. We provide our health system clients analyses of market supply and demand levels using Navigant's proprietary Physician Requirements Model, a state-of-the-art, highly customizable model. We help our clients understand the current and emerging needs in the community and to establish a foundation for physician recruitment / resource initiatives that support larger strategic planning efforts on the part of the organization.

Our well-defined methodology determines current and future physician requirements and offers a continuum of consulting services to clients relative to physician resource planning. Working in concert with a leading healthcare actuarial firm, Navigant has developed an actuarially driven model that allows us to project physician demand for more than 30 specialties based on market demographics, payer mix, and other factors. For this type of analysis, we typically produce a fully verified physician roster and a final report containing geo-access maps.

For example, Navigant recently assisted a large national health plan (Part C, Part D, Medicare-Medicaid) with the overhaul of its existing policy infrastructure and developed a comprehensive set of policies addressing Medicare and Medicare-Medicaid products. Tasks included policy life cycle management design, development of a policy template, policy research and development,

and procedure review. The policy research and development component incorporated a review of all relevant regulatory frameworks, including federal and state regulations, federal and state guidance, and contracts with government purchasers. At the conclusion of the project, led the review and update of over 400 policies.

### *(a)(30)(A) Litigation Experience*

Navigant has assisted states with (a)(30)(A) equal access claims and Olmstead plans and litigation by developing and analyzing access metrics and comparing utilization and macroeconomic indicators between publicly financed and general populations (including work with the States of California, Illinois, New York, Maine, Montana, Pennsylvania, Oregon, Washington, Ohio, and others). In earlier years, this included work on more than a dozen Boren Amendment litigations, which included defining and demonstrating efficiency, economy, quality of care, and access compliance. Through our work on (a)(30)(A) litigation and more recent technical assistance we have provided CMS with regard to evaluating HCBS rate sufficiency, we have developed an understanding of the issues that states face in addressing these statutory requirements.

We conduct performance reviews of long term supports and services programs for state clients and health plans, evaluating access to care, quality of services and cost-effectiveness, and identifying opportunities for improvements in operations and service delivery. Consistent with federal regulations, we have worked with our state clients to evaluate provider access issues and develop plans for monitoring access going forward.

Navigant has also assisted various state clients in a broad range of services to build, monitor, and sustain suitable networks for a variety of Medicaid programs. Our services range from creating state network adequacy standards and developing the administrative service rules for network adequacy to developing reporting requirements and databases and assisting with audits resulting from consent decree suits regarding limits in the access of care. To support many of our access studies, we have completed provider geo-mapping exercises in several states.

For example, the Washington State Department of Social and Health Services (DSHS) engaged Navigant to conduct studies of the Medicaid reimbursement rates for nursing facility, assisted living, adult family home, and supported living services. We completed these studies to evaluate DSHS' compliance relative to the efficiency, accessibility, and the quality of care standards established under federal requirements as described in U.S.C. § 1396a (a)(30)(A).

To determine if the Medicaid reimbursement rates were consistent with these federal requirements, Navigant reviewed current and historic data related to access and quality of the services in the state and also supplemented the analysis with independent research where data was available. In addition, Navigant calculated payment-to-cost ratios for each of these services to determine the current level of cost coverage for providers. Navigant has been engaged by DSHS to complete various reports since 2010. Our findings are described in reports submitted to DSHS for each of these services.

More recently, Navigant was engaged to develop additional rate comparison reports for the Washington DSHS for each of these services. The purpose of these rate comparison reports is to compare the Medicaid reimbursement rates for services in Washington to the Medicaid reimbursement rates paid in other states for similar services. To develop these reports, Navigant first evaluated services provided to Medicaid recipients in other states to identify the services that were most similar to the services provided in Washington. We then evaluated the rate methodology employed by each of the states and the most recently published Medicaid reimbursement rates in those states and compared the rates to Washington's reimbursement rates for these services.

***Readiness Assessment and On-going Monitoring***

As a leader in Medicaid consulting, Navigant is recognized for hands-on experience in Medicaid managed care program support, including the design, implementation, monitoring, and administration of Medicaid delivery systems. We believe this experience will further enhance the ability of our team to deliver on this engagement within the desired timeframe. Our consultants bring "real world" experience to every engagement. We bring extensive experience with risk-based managed care program planning and procurement, including drafting waiver applications and administrative code, cost projections, requests for proposals, and proposal evaluation criteria and conducting contract negotiations and readiness reviews to assess a health plan's readiness to accept enrollment and to perform all required functions such as transmitting encounter data, filing required reports, operating TPL/TPR units, and program integrity (PI) functions. We support states with ongoing monitoring of contractors for Medicaid delivery systems by providing staff training, establishing monitoring processes, procedures and reporting, developing reporting requirements, and conducting monitoring on behalf of the state.

We have extensive experience supporting states with conducting readiness reviews for risk-based managed care, enhanced primary care case management, disease management, and medical coordination programs, among others. We also supported Texas with a systems readiness review for their foster care program. We have conducted systems readiness reviews and assessments of information technology strategies for major health insurers as well. These reviews incorporate thorough technical reviews of the joint interface plans, disaster recovery plans, business continuity plans, risk management plans, and systems quality assurance plans, testing prior to implementation and compliance with HIPAA requirements.

We have served as the prime contractor assisting with readiness reviews in several states, including Alabama, Georgia, Indiana, Kansas, Mississippi, and Pennsylvania. Readiness review tasks we have conducted for our state clients include:

- Defining the review criteria and developing readiness review tools
- Developing readiness review protocols, schedules, and work plans
- Training state staff and vendor staff on the review process
- Establishing and maintaining data exchange options, such as SharePoint sites

- Conducting desk reviews and on-site reviews
- Developing final recommendations reports and corrective action plans

While a vast majority of the work of our team has been on behalf of states, many of our projects require us to work directly with Medicaid MCOs. We have conducted systems readiness reviews, assessments of information technology and reporting strategies, performance assessments of HEDIS reporting, and risk adjustment reviews for major health insurers. These reviews incorporate thorough technical reviews of the Joint Interface Plans, Disaster Recovery Plans, Business Continuity Plans, Fraud Waste and Abuse Plans, and Risk Management Plans and Systems Quality Assurance Plans, testing prior to implementation and compliance with HIPAA requirements.

The Navigant team brings a wealth of experience from our engagements with numerous states to design, implement, and support operations of their Medicaid managed care programs. We assist state Medicaid programs to become high-performing purchasers of efficient care. Over the last 15 years, our engagements have ranged from focused reviews of specific program areas, to serving as the sole independent monitor of MCOs for state Medicaid programs. Through the development and documentation of mission-critical protocols, policies, practices, and training agency staff, Navigant has empowered many states to more effectively manage their MCOs.

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

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

***Provider and Consumer Engagement – Focus Group Experience***

The Navigant team has extensive experience working with **internal and external stakeholders**, including healthcare providers and consumers. We have facilitated the work of State, Provider, and Health Plan Boards of Directors, steering committees, advisory groups, and other work groups convened to develop policies and implement programs. We have been trusted advisors to these groups, providing them with information necessary to resolve issues and address healthcare reform and transformation. Virtually every one of our rate methodology projects has included information gathering through the facilitation of advisory groups, work groups, or steering committees consisting of a variety of stakeholders.

We have facilitated public stakeholder meetings to gather information from consumers, families, and advocates regarding rate setting methodologies. We develop presentations for use in public meetings and provider meetings, technical analysis, and rate methodology documentation for use by the state agency, as well as for use in presentations with other state policy makers.

In addition to facilitating meetings, we help prepare our clients when they must serve as the facilitators. We proactively establish then execute tactics to gain participation in these studies and to address contention. We have expertise in tailoring discussions based on the audience – understanding how to engage individuals with limited to extensive knowledge of the topics at hand. Our team members are ideal facilitators due to our strong leadership and interpersonal skills and our ability to relate to a wide spectrum of individuals and groups such as legislators, state leaders, physicians, hospitals and other constituents involved with Medicaid and CHIP services. We also have conducted and gathered stakeholder feedback through various approaches, including focus groups, large and small stakeholder forums, listening sessions, structured interviews, online surveys, and project email addresses / websites for gathering input and questions.

We have organized and managed robust **stakeholder engagement** processes in Arizona. Through our work with DES and DDD, we organized and facilitated focus group meetings with stakeholders across the State through three phases of the project: assisted the Division to review and understand the benchmark rate recommendations, present the benchmark rates to the provider community, and estimate budget impact and implement the final rates.

***Surveys, Sampling, and Stakeholder Support***

Our team members have extensive experience developing, administering, and evaluating surveys to gather a variety of different types of feedback. For example, we have used surveys to measure the impact of services provided through waivers to analyze trends in the program. We also collect data from consumers through satisfaction surveys, which provide us with an understanding of the system or program being evaluated from the consumer's perspective. We often fold this into other state-provided stakeholder and focus group feedback and incorporate it into our final reports. Navigant's expertise includes the design and implementation of statistically valid methods for random sampling. Our consultants have experience with this type of research and analysis to support a range of state initiatives.

***Data Analytics***

Through the course of this project, we may need to review and analyze paid claims and encounter data. Navigant's current work with AHCCCS has allowed us to become experts in the analysis of AHCCCS claims and encounter data. Navigant has unsurpassed experience and qualifications related to healthcare data analysis. We conduct analyses that help inform policy-making decisions and define public health priorities in a quantitative, evidence-based manner and in the evaluations of the effectiveness of the programmatic activities. For example, we regularly work with a variety of clients including state agencies, Federal agencies, health plans, and most types of providers.

We often provide policy and planning support in connection with public and private healthcare delivery systems and payment mechanisms. For many projects, we develop and organize available datasets including claims data sets, cost report data, state hospital discharge database, and all-payer claims databases, among others. We then incorporate program data analyses, including utilization, cost, and quality indicators to develop recommendations for improving current systems including options to improve access to care and increase cost effectiveness. We develop and execute focus studies on healthcare delivery system purchasing, as well as delivery impact studies assessing probable outcomes in the design and implementation of new / revised policies, procedures, and programs. We bring the technology to support clients in automating and running advanced reports to inform strategic thinking, create "what-if" scenarios, and conduct predictive modeling. Through a combination of our seasoned staff and best-in-class analytic tools and approach we routinely offer clients:

- Experience using human services data from states – eligibility and demographic data, service utilization data, and provider data – to develop databases of claims, cost, demographic, financial, and other data and prepare reports for issue identification and solutions development. For example, we have identified for some clients unnecessary services and avoidable costs, then translated such analytics into new operational models designed to improve care efficiencies.
- Experience defining analytic reports to evaluate spend trends, identify cost savings, translate reports into operating models, and to model the consequences of policy initiatives that might influence health and healthcare spending. We also conduct retrospective outcomes evaluations of policy decisions based on historical claims data.
- A proven process to integrate input from key stakeholders so that reports solve key business problems and surface innovative, forward-thinking ideas.
- Expertise in integrating financial analysis and quality metrics from claims data to identify performance trends and benchmark comparisons.
- Payment Activation Measure (PAM) and Payment Error Rate Measure (PERM) studies.

Navigant has hundreds of analytic models, including a library of reports and performance metrics that we use in our consulting engagements. We have developed, for example, analytic

tools used by our clients, which are customized to meet their needs in evaluating cost and utilization trends against benchmarks, simulate future state scenarios, and allow for drill-down analysis to support day-to-day operations. In addition to Navigant's proprietary analytic products, we have access to resources and tools that support our analytics and data mining efforts. For example, we frequently use SAS Analytics Solutions (SAS), which provides an environment for predictive and descriptive modeling, data mining, text analytics, forecasting, optimization, simulation, and experimental design. SAS provides a range of techniques and processes for the collection, classification, analysis, and interpretation of data to reveal patterns, anomalies, key variables, and relationships.

***Experience with Arizona Programs***

Over the last 20 years, Navigant or its predecessor firms have worked with AHCCCS, the Arizona Attorney General, the Division of Behavioral Health (DBH), and the Division of Developmental Disabilities (DDD) on a variety of projects. These include:

- Navigant was recently awarded a task order to analyze and update existing AHCCCS managed care contracts, rules, and policies related to the implementation of the new CMS Medicaid Managed Care Regulations.
- Navigant assisted the Arizona Department of Corrections with its evaluation of proposals for outsourcing inmate correctional health services. We are assisting with data and benchmarking relative to a Market report for healthcare professionals, an inpatient / outpatient utilization study, an EHR system implementation study, and a report of other state prison pharmacy models, utilization (including HepC), and delivery methods.
- For AHCCCS and DBH, we recently served in a project management function to support the transition of DBH into the AHCCCS organization.
- For AHCCCS, we assisted developing and submitting its State Innovation Model design and testing application and with the development of a streamlined State Medicaid Health Information Technology Plan for the Medicaid Electronic Health Record Incentive program.
- For AHCCCS, we assisted in the design and implementation of a prospective payment reimbursement system, to transition the legacy per diem payment model to a per discharge using the APR-DRG patient classification system.
- For Regional Behavioral Health Authorities (RBHAs), we have developed integrated physical and behavioral health services programs.
- For DDD, we established payment methodologies for all providers of community-based services for people with developmental disabilities by conducting a cost survey, analysis of survey responses, numerous stakeholder meetings, and impact analyses of new payment rates to estimate budgetary implications. We developed rebased benchmark rates for developmental disabilities services that we used to estimate an impact of recommended benchmark rates compared to expenditures at current rates.

We are experienced with the Arizona healthcare community and its stakeholders, many of whom are involved in the delivery of behavioral health services. We worked with Banner Health System and Aetna to develop a Phoenix-based commercial ACO. We have worked with Maricopa Integrated Health System (MIHS) on a number of projects, including an evaluation of the certified public expenditure program within the context of hospital services delivered to both Medicaid and uninsured individuals; an evaluation of potential strategic options related to the Maricopa Health Plan and Maricopa Care Advantage; and assistance to management and the Board with implementation planning for Proposition 480.

Because of our Arizona-specific experience, we have a multi-dimensional perspective of the market and Arizona's unique Medicaid delivery system and program objectives.

### *b. Experience of the Proposed Staff*

Our team has the experience and qualifications to fully meet your needs and provide you with exceptional deliverables. Below, we provide a skills matrix to show the depth and breadth of our team's experience in the subject areas of this RFP:

| | Personnel | | | | | |
|---|---|---|---|---|---|---|
| **Areas of Work** | **Porter** | **Abdouch** | **Hallum** | **Kim** | **Pederson** | **Bulot** |
| **Provider Access Assessment** | ✓ | ✓ | | ✓ | ✓ | |
| **Network Adequacy** | ✓ | ✓ | ✓ | ✓ | | ✓ |
| **Network Standards** | ✓ | ✓ | | ✓ | | ✓ |
| **Document and Policy Review** | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| **Survey Design** | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| **Geo-Mapping** | ✓ | | | | ✓ | |
| **Stakeholder Engagement / Focus Groups** | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| **Data Analytics** | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| **Arizona Experience** | | ✓ | | ✓ | ✓ | |

***We are pleased to propose the following team:***

**Team Composition:** Tamyra Porter will be the Engagement Director, working with Greg Abdouch as the Project Manager. Their bios are included below.

**Tamyra Porter | Director | Engagement Director**

Tamyra has nearly 16 years of experience working on the design, implementation, and oversight of Medicaid programs and initiatives in many states, including Alabama, Pennsylvania, North Carolina, Indiana, Mississippi, Texas, the District of Columbia, Maryland, Kansas, Ohio, Iowa, Illinois, and Georgia. Her experience provides clients with subject matter expertise to interpret legislation, develop administrative service codes, and conform to various other Federal requirements and opportunities. In addition, Tamyra has worked with Pennsylvania, Mississippi, and Alabama in the developing or refining their quality strategy. As part of these efforts, Tamyra assists Medicaid Agencies in evaluating MCO program policies, incentive programs, and quality work plans to determine best practices align pay-for-performance incentives and drive program outcomes. Tamyra has also worked closely assisting clients in administering and amending 1915 (c) waivers. In these engagements, Tamyra has worked to develop improved internal operations regarding oversight and quality improvement of these waivers, assisting with CMS-issued corrective actions, and discussing the needed changes to consolidate these waivers to integrate these services into more comprehensive managed care delivery systems.

As the Engagement Director, Tamyra will provide be responsible for the quality review of all deliverables and provide oversight and direction to the team. She will address contract and scope of work issues and other corporate matters, should these issues or matters arise.

**Greg Abdouch | Managing Consultant | Project Manager**

Greg focuses on managed care, behavioral health, and project management oversight for clients who are making large-scale transitions in their Medicaid programs. Greg has managed program transformation teams within both state agencies and Medicaid managed care plans. In addition, Greg has assisted state clients with development and review of managed care report submissions so that contractors are meeting requirements including network adequacy, case management, and member outreach. In addition, Greg has worked with MCOs to identify gaps in compliance and develop and implement policies, procedures, and operations that meet or exceed contract requirements.

In addition, Greg assisted in the implementation of a managed long term services and supports program. This included working with staff to develop a statewide provider network that met or exceeded the contractual requirements for network sufficiency. He has also worked directly with providers in an effort to expand the provider network in areas where there was increased member needs for a particular set of services.

Greg served as project manager to support the transition of Arizona's Division of Behavioral Health Services (DBHS) into the AHCCCS organization. He led and facilitated the operational and personnel integration of the two agencies to support a seamless Administrative Simplification transition. Most recently Greg is helping AHCCS to analyze and update existing managed care contracts, rules, and policies related to the implementation of the new CMS Medicaid Managed Care Regulations.

As project manager, Greg will use this experience to lead the analysis and deliver on this quick turnaround project. He will be involved in the coordination, development, and quality review of all deliverables. He will talk frequently with the AHCCCS Project Manager so that resources are deployed efficiently. Greg will be responsible for bringing in our Subject Matter Experts, as needed. He will manage the delivery of quality work products and provide status updates to AHCCCS on a monthly basis.

Together with Tamyra, he will oversee the completion of each task, review project deliverables, and participate in discussions with AHCCCS staff regarding progress of the project, draft, and final deliverables and other issues as they arise. Greg is located in Phoenix, so will serve as an on-site presence for the project. He will be available in-person to meet with AHCCCS, as well as to conduct focus groups and DDD and MCO interviews, as necessary.

**Annie Hallum | Associate Director | Data Team Lead**

Annie has seven years of experience and is a Fellow of the Society of Actuaries and a Member of the Academy of Actuaries. She is experienced in developing Medicaid rate methodologies, plan design, and implementing policy. Her actuarial experience includes advising Medicaid agencies, commercial health plans, and providers related to Medicaid rates, value-based purchasing, and cost-saving strategies.

Recently, Annie assisted with home- and community-based service review and rate analysis for a state's children's mental health waiver. She used actuarial training to apply expert data analytics and evaluation skills. She assisted our CMS project team to develop a detailed example of how to develop a statistically-sound fee-for-service tiered rate, using individual assessment scores as the basis for determining tiers.

Annie has several years of experience managing the rate-setting process for the States of Nevada and Washington. As the Project Manager for these and other tasks, Annie was responsible for developing work plans and timelines, identifying the appropriate sources of data, developing and tracking data requests, managing internal and external project resources, ensuring the timely completion of project tasks, reviewing and monitoring budgets, supervising data analyses, developing rate models, preparing final results and deliverables, and presenting results to appropriate stakeholders.

Annie will lead our data team and be responsible for the survey development, sample determination, and data collection. She will also support the team with data analytics of claims and encounter data, should that be necessary.

**Nancy Kim | Managing Consultant | Managed Care Team Lead**

Nancy has more than eight years of experience working in the healthcare industry, most specifically with government payers and programs. Nancy has led efforts to conduct readiness reviews of MCOs for several states, including Georgia, Mississippi, Iowa, and Alabama. As part of these engagements, she reviewed states' contracts against CMS guidelines for readiness,

developed readiness review tools, and reviewed MCOs' policies, procedures, and corresponding documents to determine alignment with the state's program. She has also conducted onsite reviews to verify preparedness for go-live. She has conducted desk reviews of contractors' policies and procedures for alignment with state contract requirements or new programmatic changes. Additionally, as part of readiness, she has assisted states in identifying federal network adequacy requirements, conducting a scan of other states' network adequacy standards, and assessing the state's current network standards for compliance with federal requirements. Nancy is currently assisting AHCCCS with a review of managed care contracts.

Nancy will support project tasks under the direction and supervision of the Engagement Director and Project Manager and perform activities such as leading the qualitative review of ALTCS network impact of Prop 206, development of the network standards summary, and analysis and report writing.

**Andrea Pederson | Director | Subject Matter Expert**

Andrea has more than 16 years of experience with policy analysis, program assessment and data analysis supporting Medicaid, Medicare and commercial insurers, with a focus on HCBS programs for individuals with developmental disabilities, behavioral health and long-term care. She has worked extensively in the development, implementation and impact analysis of rate setting methodologies. She has developed legislative reports, presented to legislative committees and has facilitated stakeholder meetings for DES/DDD in Arizona. Andrea led the Navigant team in 2013 to develop rebased HCBS rates for DES/DDD. Through that engagement, Andrea gained a thorough understanding of the Arizona landscape. She currently serves as a manager and subject matter expert for the 1915(c) HCBS waiver reviews Navigant conducts for CMS. Her role includes directing the development of trainings for CMS and presenting trainings on nationwide technical assistance webinars alongside CMS. The issue of provider network adequacy has been an area her team has provided guidance to CMS about with regards to 1915(c) waivers.

**James ("Jay") Bulot, PhD | Associate Director | Subject Matter Expert**

We are pleased to propose Dr. Jay Bulot as a Subject Matter Experts who will supplement our team as appropriate to address AHCCCS' analysis, planning, and implementation needs relative to this contract. Jay is nationally recognized expert on Aging and Disability Services, Assistive Technology, and LTSS. Prior to joining Navigant, Dr. Bulot served as the State Director for Aging and Adult Services for three governors, managing hundreds of millions of dollars in budget and hundreds of employees. He has provided expert testimony to federal agencies, Congress and the White House regarding aging and disability issues. In his roles as consultant, state government leader, professor, and President of the National Association of State Units on Aging and Disability, Jay has worked closely with clinical and performance benchmarking data, particularly in relation to long-term care supports and services. He's assisted state clients developing and enhancing traditional and managed LTSS programs. Dr. Bulot provides clients with valuable insight, policy consulting, grants management, budget

analysis, and technical assistance, while empowering them to realize success in areas such as organizational development, revenue enhancement, enhancing federal match, interagency collaborations, and state planning services.

**Support Staff** – Navigant will assign support staff as appropriate to support project tasks and activities.

### *c. Capacity / Availability of the Firm*

Our team is available to initiate services beginning in October 2017. In addition, our proposed Project Manager is located in the Phoenix area, which allows us to more easily meet with you in person when needed.

### *d. Resumes*

We have included resumes for the entirety of our proposed team in Appendix A, in the order found in Section I.b. Experience of the Proposed Staff, on the previous pages.

## Section II Methodology and Approach

We understand that Proposition 206, the Fair Wages and Healthy Families Act, requires Arizona's minimum wage to increase to $12 per hour by 2020 and require paid sick leave for employees working greater than 30 hours per week. AHCCCS has requested consulting services to analyze and review the impact of the implementation of Proposition 206. An increased minimum wage has led AHCCCS to increase fee-for-service (FFS) rates for Home- and Community-Based (HCBS) and Nursing Facility Services. In addition to FFS, many AHCCCS Arizona Long Term Care System (ALTCS) members receive their services from managed care organizations (MCOs) who contract with these same or similar HCBS and Nursing Facility providers. Navigant understands that setting sufficient HCBS rates is key to ensuring individuals receive quality care and have access to an adequate pool of providers.

While we know from our vast experience of waiver rate analyses that insufficient rates can contribute to access and availability concerns and changes such as those mandated by Proposition 206 seem a natural solution to network concerns, we appreciate there are other factors that states must consider in implementing such changes. As state and Medicaid budgets are fixed, these increases can have unforeseen impacts on quality and availability of services. Our comprehensive analysis will begin with a more quantitative assessment of changes to the network composition before and after the implementation of Proposition 206 and will further seek to understand rationale for these changes using document reviews, surveys and focus groups.

Given the quick turnaround of an analysis and report development, it will be important for AHCCCS to find a contractor with substantial understanding of the services and population of the ALTCS and familiarity with the State of Arizona, while also experienced in conducting provider network analysis. Navigant can provide all of this expertise and does not have any conflicts of interest that would impact our work on this project.

To complete this work, we propose the following tasks:

**Task 1: Initiate Project and Define Data Requirements**

**Task 2: Review and Analyze ALTCS Networks**

**Task 3: Review and Analyze Reports and Policies**

**Task 4: Collect and Analyze Provider Survey Data**

**Task 5: Facilitate Focus Groups Discussions**

**Task 6: Develop Comprehensive Network Report**

In the work approach that follows, we describe our plan for completing our analysis of the impact of Proposition 206 on provider network adequacy. Our work approach provides a number of advantages that we believe will contribute to the success of this quick-turnaround project:

- Experienced staff with subject matter expertise in network adequacy analysis, Managed Long Term Services and Support (MLTSS), and Developmental Disabilities (DD)
- Proactive approach to collect and gather information immediately from AHCCCS to hit the ground running
- Robust methodology to analyze data to determine network sufficiency and identify any gaps, based on data provided by AHCCCS

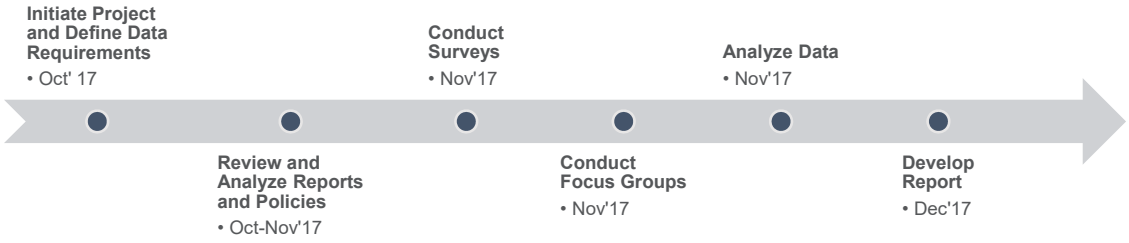
On the following pages we describe in detail our proposed approach to conduct the tasks described in Section 4.0 of the RFP. Our methodology and approach to the analysis requested by AHCCCS is outlined in tasks one through seven. Furthermore, each task will have subtasks and associated deliverables.

### Task 1: Initiate Project and Define Data Requirements

Navigant will schedule a project kick-off meeting with the AHCCCS-designated Project Manager and Navigant's Engagement Director and Project Manager upon contract execution. The kick-off meeting is an effective way to foster communication with the project team. Our experience is that discussions like these help the project team anticipate and even head-off possible project challenges or barriers before they arise. Prior to the meeting, we will request that AHCCCS' Project Manager provide any materials that would be relevant for our review and are not publicly available. During kick-off we will discuss:

- ***Project Schedule and Work Plan:*** We will review the proposed work plan with AHCCCS' Project Manager to answer questions about our work approach and make any changes necessary to finalize the work plan. Due to this compressed timeline, it will be important to agree to deadlines so as to complete the final report by January 2, 2018. We anticipate the following timing for the main components of the project. This timeline assumes a project start date of October 11, 2017, within one week of anticipated contract award; however, we will adjust this timeline based on contract start.

  **Figure 1. Proposed Project Timeline**




- ***Data Request Processes and Submissions:*** Based on our review of the RFP and supporting files, we have developed a preliminary list of anticipated data needs, including PAT files, Network Development Management Plans, and Minimum Network Requirement Verification deliverables, as well as current network provider lists for the ALTCS and DDD programs. We will be ready to provide this list to AHCCCS upon contract award, but also intend to review this list during the kick-off meeting to further refine its content. We anticipate that we will identify additional items to request from AHCCCS. *Given the accelerated timeframe, our aim will be to use as much existing information as possible, while supplementing with survey and focus group information. As such, we will look to use MCO reports rather than create our own primary analysis.* Immediately after the kick-off meeting, we will submit all remaining data requests to AHCCCS.

**Figure 2. Preliminary List of Data Needs**

| Item | Purpose | Source |
|---|---|---|
| 1. Provider Affiliation Transmission (PAT) file | Analyze statewide network of individual providers within AHCCCS Contractor's networks | AHCCCS |
| 2. Network Management and Development Plans | Review previous network analysis, use as basis for comparison and validation of assessment results | AHCCCS |
| 3. Minimum Network Requirement Verification | Review previous network analysis, use as basis for comparison and validation of assessment results | AHCCCS |

| Item | Purpose | Source |
|---|---|---|
| 4. ACOM 415 Provider Network Development Attachments D and E | Analyze providers that have made a reduction in service provision | AHCCCS |
| 5. ACOM 413 Non Provision of Service Report | Analysis of timely delivery of services | AHCCCS |
| 6. Claims data*, optional | Report impact of provider rates | AHCCCS |
| 7. Encounter data*, optional | Report impact of provider rates | AHCCCS |
| 8. Provider contracting policies and practices | Conduct analysis | AHCCCS |
| 9. Network Standard Policy | Conduct analysis | AHCCCS |
| 10. Annual Title XIX Rate Reimbursement Studies (2010-2017)** | Review previous network analysis, use as basis for comparison and validation of assessment results | DDD |

**Navigant has a long history working with AHCCCS (including DDD) claims and encounter data. We have used claims data to examine provider networks by counting providers by type, location, and specialty. Such analyses allow us to do heat maps to show not only volume of providers but the specific providers and subset providing most of the services. We have used this data to create maps for clients that provide the visualizations needed to show stakeholders the issue at hand. We note this data analysis is optional; however, Navigant will work with AHCCCS to determine the appropriate use of paid claims and encounter data, and will be prepared to deploy our experts to quickly perform the necessary analyses within the timeframe of this engagement; however, we will look to streamline analyses and take advantage of existing MCO reports whenever possible.*

*** Navigant is very familiar with the rates and rate methodology used by DDD, as we assisted DES with its rate rebase in 2013. The issues identified in the Annual Title XIX Rate Reimbursement Study foreshadow larger potential issues for the provider network since provider rates have not historically been funded to 100 percent of the benchmark rates. Navigant will use the historical information from the Annual Title XIX Rate Reimbursement Study as a resource for understanding the issues, e.g., the specific services or providers that are most at risk for provider network inadequacy, and to inform all areas of the study.*

- ***Monthly Status Reports:*** We will recommend to AHCCCS a format for delivering monthly status reports and suggest that the status report be reviewed with the AHCCCS Project Manager. We will deliver the monthly status reports by the 5th of each month.
- ***Deliverable Submissions:*** We will work with the AHCCCS Project Manager to confirm the expectations for the content, format and timing of deliverables for this contract, and use that format for our deliverables due to AHCCCS by January 2, 2018.

The subtasks associated with this task are:

| Subtask | Description |
|---|---|
| 1.1 | Schedule and conduct project kick-off meeting; provide meeting agenda to AHCCCS prior to kick-off meeting |
| 1.2 | Address any questions about the work plan |
| 1.3 | Review data request processes |
| 1.4 | Submit data requests, including requests for aggregate member and provider data |

The deliverables associated with this task are:

| Deliverable | Description |
|---|---|
| 1.1 | Data requests |

**Task 2: Review and Analyze ALTCS Networks**

Network adequacy is an important component of the successful delivery of healthcare. It is common for states to compare networks before and after a major change in the program or delivery system such as the rate changes for the ALTCS providers. We propose gathering the provider network data that represent timeframes before and after the rate changes., Then we will examine the network data to complete a snapshot analysis of the ALTCS network one month prior to the implementation of the rate changes, and six months following the rate change. Understanding that the MCO rate changes may have different effective dates compared to the HCBS and nursing facility rates, we will adjust the timeframes for the comparison analyses as needed.

We will organize the data so we can isolate changes based on geography, provider types and service provision level. Through these analyses we will identify changes and deficiencies in the ALTCS network that appear to be resulting from the changes to the rates. Our analysis will identify:

- Number of providers and members
- Geographic dispersion of providers and members
- Appropriateness of provider types
- Given that for HCBS the providers come to the consumer, travel times and standards on provider timeliness are very important

We will summarize our analyses identifying the Percent of Adequacy, which represents how often services were delivered within the “Adequacy Standard” timeframe.

The following table provides sample data of this type of analysis. We will provide stoplight illustrations to demonstrate when the percent of adequacy meets current adequacy benchmark requirements (green), is close to meeting adequacy benchmark requirements (yellow), and fails to meet adequacy benchmarks (red).

| County | Service | Adequacy timeliness Standard | Adequacy Benchmark | Percent of Adequacy |
|---|---|---|---|---|
| Maricopa | Visit to PCP | 15 minutes/10 miles | 90% | 95% |
| Maricopa | Visit to Dentist | 15 minutes/10 miles | 90% | 80% |
| Maricopa | Visit to Pharmacy | 15 minutes/10 miles | 90% | 89% |

As part of this current analysis, we will also create member-to-provider ratios. This ratio will also reflect the utilization patterns and clinical needs of the ALTCS population. We will likely want to group providers into larger categories to streamline the analysis. These groups may include: Nursing Facilities, HCB Services, Assisted Living, and DD Group Homes. These groupings will allow us to evaluate network adequacy for each of the types of service. The current provider ratio will be important in determining how many members are being diagnosed by providers.

The following table provides sample data of this type of analysis. Again, we will be using stop-light illustrations to identify adequacy.

| County | Provider | Minimum Provider Ratio | Current Provider Ratio |
|---|---|---|---|
| Maricopa | PCP | 1.75/1,000 | 1.88/1,000 |
| Maricopa | Crisis Provider | 1.5/1,000 | 1.48/1,000 |
| Maricopa | Behavioral Health Residential Facility | .75/1,000 | .6/1,000 |

The member-to-provider ratio, as well as the assessment of adequacy, will provide a general understanding of whether the current network supports the delivery of needed services. As we determine the member-to-provider ratios that exist, we can evaluate whether these ratios are sufficient considering the mix of providers by comparing them to the overall population-to-provider ratio in the area.

Navigant will create a brief summary of its findings from this analysis to share with AHCCCS that will also be included as an appendix to the report.

The subtasks associated with this task are:

| Subtask | Description |
|---|---|
| 2.1 | Gather and review provider network data |
| 2.2 | Summarize observations from provider network data |

The deliverables associated with this task are:

| Deliverable | Description |
|---|---|
| 2.1 | Summary of provider network observations |

**Task 3: Review and Analyze Reports and Policies**

For Task 3, we will review and analyze various reports, policies, and other information to determine the impact of rate reimbursements on ALTCS provider retention or termination reasons. Our review of these sources will contribute to understanding reasons for provider terminations that may have resulted from the rate changes and to identify solutions that are meaningful and relevant to the current service delivery landscape.

| ***Review of AHCCCS Non Provision of Service Report trending for HCBS provided in the home of the member and any other available metrics related to whether services are being delivered timely*** |
|---|
| Navigant will review this report and evaluate non provisions of services. During the kick-off meeting we will seek to determine if there are other standardized reports or metrics to evaluate timely delivery of services. For example, we will discuss EVV data that might be available or other complaints that point to untimely services, provider no-shows, or other variations in care plans vs. actual services provided. Should this data not be available, we will include more detailed questions related to this in our focus group discussions. We will review reports on non-provision both before and after the proposition 206 rate changes to assess changes that might be associated with the change. |
| **Strategies / methodologies for establishment of new and/or additional network standards** |
| During the data review phase, we will summarize current network standards across the country, including AHCCCS current policies related to provider network standards. We will summarize these findings and meet to discuss additional considerations for AHCCCS. Our research and related summaries will serve as a basis for proposed strategies and methodologies for AZ to consider adopting as network standards. |
| **Review and analysis of ALTCS MCOs' policies and practices related to provider contracting and of MCOs' Network Management and Development Plan** |
| • ***Policies and Practices related to Provider Contracting and Network Standards***: We understand that MCOs are required to develop and maintain a provider network that is sufficient to provide all covered services to AHCCCS members [42 CFR 438.206(b)(1)]. The network standards policy establishes network standards. MCOs are required to assess their network against their entire membership for the purposes of complying with these standards. If established network standards cannot be met, it must be explained in the Network Development and Management Plan. Therefore prior to reviewing the Network Management and Development Plan Navigant will analyze these |

policies to conduct gap analysis of MCOs current network standards. We will then review the Network Management and Development plan to understand MCOs approach to close the gaps.

- ***Network Management and Development Plan***: This requires MCOs to provide a plan to close the network gaps. Additionally, Navigant will scrutinize the MCO practices concerning ALTCS covered services such as their activities to ensure: 1. Services are accessible to AHCCCS members in terms of timeliness, amount, duration, and scope as those are to non-AHCCCS persons within the same service area; 2. Prompt and reasonably accessible services in terms of location and hours of operation; 3. Sufficient personnel for the provision of all covered services; and 4. Provisions for the availability of services on a 7-day a week basis, and for extended hours, as dictated by member needs.

**Review of other reports related to provider terminations**

Navigant proposes to use the data provided in **ACOM 415 Attachment D (*Provider Termination due to Rates*) and Attachment E (*Providers that diminished their scope of service and/or closed their panel due to rates*)**. We will review and analyze the data by:

- ***Provider Type****:* We will analyze the data using the code utilized in the Prepaid Medical Management Information System (PMMIS). The data will be further delineated by Geographical Service Areas (GSA) 1, 2, and 3.
- ***Provider Capacity***: As available, we will review the number of members assigned to, residing in, or regularly receiving services from the terminated provider. For nursing facilities and alternative residential HCBS we will include the number of members residing in the facility at the time of termination notice by the provider. We will assess if there are utilization changes in these services or if that member continues to receive services from a new provider. Furthermore, we can assess member satisfaction or other changes that impact this.
- ***Reason for Termination***: We will analyze the reasons for provider termination and overall impact in these terminations on network composition. We will analyze terminations that are due to reimbursement rates, capacity, and other sustainability factors.
- ***Scope of Service diminished***: We will conduct analysis to determine if specific at-risk services have experiences a disproportionate share of provider terminations that may escalate that risk.
- ***Reason for diminishing service or closing panel****:* We will determine if reduction of services are more commonly affiliated with providers who are terminating or closing their panels due to any of the following reasons: Increased rate requested (provider initiated), AHCCCS FFS rate reduction (pass-through), MCO rate reduction (not associated with an AHCCCS reduction), and other significant patterns.

**Review of Gap in Critical Services (ACOM 413)**

We understand the critical services include Attendant Care, Personal Care, and Homemaking and Respite care. Using the definitions for critical services, we will summarize our assessment comparing critical services to other services. The summary reports will include: 1. Percent of critical providers terminating as compared to non-critical providers and 2. Trends by GSA, County, and provider-specific issues.

The review of these reports and documents, and perhaps others discussed during our kick off meeting, will provide greater insights to our gap analyses lending further understanding to factors contributing to these identified gaps in Task 2. Navigant will use our findings from Tasks 2 and 3 analyses to assist us with survey develop and focus group strategies, all leading up to our final report.

The subtasks associated with this task are:

| Subtask | Description |
|---|---|
| 3.1 | Conduct review and analysis of non-provision of services report for MCOs and DDD |
| 3.2 | Conduct MCO and DDD provider report data analysis (415 Attachments D and E) |
| 3.3 | Conduct review of policies and procedures on provider contracting |

| Subtask | Description |
|---|---|
| 3.4 | Conduct review of Network Management and Development Plan |
| 3.5 | Conduct review of any other reports or documents supporting the analysis |

### Task 4: Collect and Analyze Provider Survey Data

Navigant will develop and conduct a provider survey of a statically significant sample of providers to gather information about workforce capacity to support our analysis of the impact of Prop 206. Given the need to collect the survey data quickly, we will design a survey using a web-based tool, such as SurveyMonkey, to administer the survey to the sample and collect responses in an electronic format that will be simple to analyze.

Workforce planning and analysis is critical to structure the provider workforce to ensure there is sufficient capacity to meet future needs. In the white paper, "*The Need for Monitoring the Long-Term Care Direct Service Workforce and Recommendations for Data Collection"*, the National Direct Service Workforce Resource Center (DSW-RC)[1] recommends the following key pieces of workforce data:

| | |
|---|---|
| Workforce Volume | Number of full-time and part-time direct-care workers |
| Workforce Stability | Turnover rate and job vacancies |
| Workforce Compensation | Average hourly wages and availability of benefits |

Having completed a workforce survey for DES, we know firsthand the challenges with addressing all of these objectives through survey tools. For example, in our prior survey for DES, we considered the issues around health insurance costs, as the ACA was just being implemented. Further surveyors must consider response rates in relation to costs and value to overall findings. Based on our experience with DES and with others, we propose our sample be for the entire ALTCS provider population. We estimate we will achieve a 10-20 percent response rate that will offer meaningful insights regarding changes in provide rates.

Additionally, we recommend including the categories of survey questions outlined in Figure 3 to analyze the workforce data and to allow for summary conclusions of responses:

**Figure 3 – Sample Data to Collect through Surveys**

| Workforce Volume | Workforce Stability | Workforce Compensation | Workforce recruitment and retention strategies |
|---|---|---|---|
| • Number of Nursing Facility and HCBS employed or contracted<br>• Average number of workers per provider | • Average annual turnover Rate<br>• Average number of employees leaving in last 12 months<br>• Average number of employees dismissed due to challenges with quality of services, complaints, etc. | • Percentage of providers offering overtime<br>• Impacts of Proposition 206 on compensation structures (none, little, significant) | • Percent of providers offering paid sick Leave to full-time employees<br>• Percent of providers offering health insurance to workforce<br>• Member satisfaction rates<br>• Quality bonuses |

[1] The National Direct Service Workforce Resource Center (DSW-RC) supports efforts to improve recruitment and retention of direct service workers who help people with disabilities and older adults to live independently and with dignity. This Resource Center provides state Medicaid agencies, researchers, policymakers, employers, consumers, direct service professionals, and other state-level government agencies and organizations easy access to information and resources they may need about the direct service workforce. The Center brings together the nation's premier resources on the topic of the direct support workforce. The DSW Resource Center is funded and supported by the Centers for Medicare & Medicaid Services (CMS) under the U.S. Department of Health and Human Services.

We will develop a draft survey and review and finalize with AHCCCS. We will create the web-based survey and test its functionality. Likewise, we will pilot the survey with a test group of providers to determine any needed changes prior to launch. If necessary, we can create skip logic in the survey to allow providers to skip questions based on responses. The overall goal will be to develop a survey that is manageable for providers but at the same time collects the needed information and required for our analysis. We understand that AHCCCS will provide email addresses to facilitate the distribution of the survey to the providers. We will work with AHCCCS to create an email or other provider notice asking providers to complete the survey within an agreed upon timeframe, most likely no longer than two weeks given the accelerated project timeline. Further we will work with AHCCCS to promote the survey on various provider association websites to promote participation.

On a regular basis, we will track response rates to assess the representation of responses over various domains, such as geography, provider type, etc. As we identify under representation we will work with AHCCS to push additional reminders and to encourage participation. Navigant will provide support to providers throughout the survey completion, providing an email address for questions and hosting one webinar to provide a brief overview of the survey and to answer questions. Once the survey information has been disseminated, we will host the webinar and be available for questions until the survey period closes.

After the survey period closes, we will begin our analysis of the survey results. We will examine responses to identify any providers that might have helpful strategies or lessons learned that would benefit our analysis to learn more, in such cases, we would attempt to schedule interviews with these providers to learn more. Finally, we will analyze the results and summarize findings to be included in the final comprehensive report requested by AHCCCS. The quantitative findings will include summaries of: 1. Provider recruitment and retention rates, 2. Turnover rate 3. Vacancy rate, 4. Financial implication (overtime), 5. Member satisfaction rates, 6. Percent change in workforce capacity due to Prop 206, and 7. other trends due to Prop 206. Some qualitative data will include: 1. provider recruitment and retention strategies, 2. challenges with recruitment and hiring, 3. other trends due to Prop 206.

The subtasks associated with this task are:

| Subtask | Description |
|---|---|
| 4.1 | Develop Provider survey and Instructions (Initial Draft, Final Draft) |
| 4.2 | Administer Provider Survey |
| 4.3 | Review provider survey responses and follow-up as needed |
| 4.4 | Analyze provider survey results |

The deliverables associated with this task are:

| Deliverable | Description |
|---|---|
| 4.1 / 4.2 | Draft survey / Final survey |

**Task 5: Facilitate Focus Group Discussions**

Focus groups provide an informal method for identifying issues, obtaining initial spontaneous responses to an idea or concept, and/or assessing needs. The goal of conducting focus group will be to seek input from MCOs and DDD on specific issues such as access and availability of providers that may have resulted due to enactment of Prop 206. We propose using two key components suggested by the Center for Disease Control (CDC) on "*Data Collection Methods for Program Evaluation: Focus Groups*"[2] to plan the focus groups for ALTCS MCOs and DDD:

[2] https://www.cdc.gov/healthyyouth/evaluation/pdf/brief13.pdf

1. ***Develop the focus group guide****:* The focus group guide will have a series of questions and prompts for the facilitator to use. Navigant will have a facilitator who will direct questions to the group and allow time for participants to respond to each other's comments. The focus group guide will also serve as a "road map" and memory aid for the facilitator. When developing the focus group guide, we will identify the following:
   - Type of information that should be obtained: This will include collecting information to identify issues and challenges of the MCOs and DDD and determining the impact of Prop 206.
   - What will be the information gathered: Examples of information that will be collected includes access and availability, member choice, member satisfaction, and other.

   The same focus group guide will be used for each focus group. The questions in the guide will be geared such that they will assist Navigant in proposing strategies to identify and evaluate projected workforce capacities and strategies to establish a new network standard.
2. ***Number and type of participants****:* Navigant will then identify what types of participants are needed for each focus group. Each individual focus group will be made up of similar individuals, so the number of focus groups will depend on how many different types of groups from whom we want to gather information. We propose representatives from the following functional areas as participants of focus groups:
   - Network / Provider Development – to identify issues with access and availability of services
   - Member Services / Provider Assignment – to identify issues pertaining to member choice
   - Quality Assurance – to identify issues related to member satisfaction
   - Care Management – to identify issues pertaining to identification of member needs and receiving the services thereafter

   Furthermore, we propose to bring together six to nine people to discuss issues and concerns or respond to semi-structured questions.
3. ***Conducting a focus group:*** *Navigant proposes the following individuals conduct the focus group.*
   - ***Facilitator****:* will guide the group through discussion and keep the group focused and on-topic.
   - ***Note taker***: will be an observer. The notes should include a sense of what each person said; identify how comments were said.
   - ***Recorder****:* will record the focus group and create a transcript of the event.

   We recommend the focus groups to last for 60-90 minutes. Furthermore, we understand it is ideal to conduct a focus group in person; however, to ensure that everyone participates in the discussion it is possible to conduct a focus group by phone.

   Given the timeframe, we propose the following set of focus groups: (1) DES/DDD, as MCO*; however, we may cover questions about DES/DDD as administrative agency* (Phoenix); (2) MCO (Phoenix); (3) MCO (Tucson), and (4) MCO (Webinar).
4. ***Results of the focus group:*** *Focus group results will be considered qualitative rather than quantitative. We will provide focus group results in the comprehensive report requested by AHCCCS.*

The subtasks associated with this task are:

| Subtask | Description |
|---|---|
| 5.1 | Develop focus group guide |
| 5.2 | Identify focus group participants for MCOs and DDD |
| 5.3 | Conduct the focus group |
| 5.4 | Analyze the results of the focus group |

### Task 6: Develop Comprehensive Network Report

The final task will be to document our findings from the ALTCS network assessment in a final report. After analyzing the survey data and research, Navigant will develop a report that highlights the following:

- Discussion of goals and objectives of the Network Adequacy study
- Description of methodology used to gather information on the impact of Prop 602
- Identification of network gaps or access to care deficiencies, identified by provider type
- Identify potential opportunities, strategies, or methodologies to build capacity or enhance network structure and workforce needs

We will create a report outline for AHCCCS' review to agree upon the structure and components of the report. The report will describe the methodology and will provide the results in an easily digestible manner, including maps, tables, and charts.

Using our experience conducting similar work in other states, we will conclude the report with an identification of potential opportunities to build capacity or enhance the network structure. Depending on our findings, we may want to provide AHCCCS with recommendations for how the MCOs can expand their provider networks to improve access. These recommendations might include requiring MCOs to conduct outreach to try to enroll more providers, examining whether there are additional provider types who can provide behavioral health services, and potential changes to RBHA and CRS contracts with AHCCCS to support and align with the network standard requirements.

In other access studies we have conducted, we have made recommendations for establishing new or revised standards that are consistent with the goals of the program. We also examine other state standards to provide context to states. For example, for our Alabama client, we researched access standards in six states, including California, Oregon, and Texas, to provide information about mental health services and more. As part of our report development, we will provide information to AHCCCS in instances where we recommend enhancements. Where applicable, we will provide our recommendations for any necessary improvements in network standards, taking account standards that exist across similar programs in the State.

Navigant will ask AHCCCS for comments on the report and ask that the comments be gathered into a single document for our consideration. We will develop the draft report based on the agreed upon outline, update the draft based on the comment received from AHCCCS, and create one last version of the report in its final format.

The subtasks associated with this task are:

| Subtask | Description |
|---|---|
| 6.1 | Develop draft report outline |
| 6.2 | Develop draft report |
| 6.3 | Review report with AHCCCS |
| 6.4 | Finalize report based on comments from AHCCCS |

The deliverables associated with this task are:

| Deliverable | Description |
|---|---|
| 6.1 | Draft report outline |
| 6.2 | First draft report |
| 6.3 | Final report |

## Section III Pricing Proposal

We believe the pricing proposal outlined below conveys our willingness and organizational commitment to continue our successful relationship with AHCCCS. Our proposed fees reflect reduced hourly rates in recognition of this ongoing partnership and our interest in investing in your AHCCCS. We are happy to discuss the pricing proposal with AHCCCS to adjust the level of effort upwards or downwards based on the level of support needed across the tasks.

| Staffing Resource | Level per Contract | Hours | Reduced Hourly Rate | Total Cost |
|---|---|---|---|---|
| *None proposed* | Managing Director | 0 | $257 | $0 |
| Tamyra Porter | Director | 104 | $231 | $24,024 |
| Annie Hallum | Associate Director | 156 | $231 | $36,036 |
| Greg Abdouch | Managing Consultant | 260 | $212 | $55,120 |
| Nancy Kim | Managing Consultant | 182 | $212 | $38,584 |
| *To be determined* | Senior Consultant | 312 | $189 | $58,968 |
| *To be determined* | Consultant | 390 | $167 | $65,130 |
| Jay Bulot | Subject Matter Expert | 24 | $250 | $6,000 |
| Andrea Pederson | Subject Matter Expert | 24 | $250 | $6,000 |
| ***Total Hours*** | ***1,452*** | | | |
| ***Total Fees*** | | | | **$289,862** |

# Appendix A Biographies of Proposed Navigant Team

We have provided resumes of our proposed Navigant team on the following pages.

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NAVIGANT

# Tamyra Porter

**Director**

tporter@navigant.com
Washington, DC
Direct: 202.973.3138

## Professional Summary

Tamyra Porter is a Director within Navigant's Government Healthcare Solutions practice. She has nearly 17 years of experience working on the design, procurement, implementation, readiness, and oversight of Medicaid programs and initiatives in many states including Alabama, Pennsylvania, North Carolina, Indiana, Mississippi, Texas, the District of Columbia, Maryland, Kansas, Ohio, Iowa, Illinois, and Georgia. Tamyra has worked on designing various managed care systems such as provider-sponsored, medical homes, full-risk MCOs, and integrated service models, including long-term care. One of Tamyra's key areas of expertise is in assisting clients in oversight and monitoring of the performance of their managed care programs. She provides operational strategy guidance to our state clients as they oversee their managed care programs while also providing similar oversight as the project manager for many of our practice's most complex engagements.

## Areas of Expertise

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

NAVIGANT

# Tamyra Porter

**Director**

## Professional Experience

### Medicaid Managed Care

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

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

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

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

NAVIGANT

# Tamyra Porter

**Director**

state agencies in all aspects of program operations. Provides support through entire software development process including development of UAT, user guides, and training, whether directing the development for clients or working as the business analyst for the client and interfacing with state-staffed developers.

- Directed an engagement for Texas Health and Human Services Commission to support compliance with Corrective Action Orders specific to the Consent Decree in *Frew v. Hawkins* and mandate to provide adequate supply of healthcare providers..

- Assisted states in the development or renewal of their state quality strategy. Worked with Pennsylvania, Mississippi, and Alabama in crafting the quality strategy as a foundational component of their overarching approach to value-based monitoring and oversight and as a means of aligning state program goals and objectives with the national quality strategy.

## Medicaid Performance Management

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

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

## Long Term Care

- Assisting states in their design and development of program reforms for their long-term care programs. Working with state clients to develop concept papers, stakeholder engagement efforts, waivers and state plan modifications. Coordinating efforts with legislative mandates and affiliated workgroups. Assistances also includes payment transformation and leveraging managed care designs to transition to alternative payment models. Recent efforts have focused on provider-led initiatives where provider groups would gradually assume risk for the long-term care population.

NAVIGANT

# Tamyra Porter

**Director**

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

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

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

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

## Government Payment Transformation

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

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

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

NAVIGANT

# Tamyra Porter

**Director**

## Medicaid Reform

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

## Health Information Technology

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

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

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

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

## Healthcare Compliance

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

## Work History

| | |
|---|---|
| Director, Navigant | 2016 – Present |
| Associate Director, Navigant | 2006 – 2016 |

NAVIGANT

# Tamyra Porter

**Director**

| | |
|---|---|
| Manager, Navigant | 2004 – 2006 |
| Manager, Tucker Alan Inc. | 1999 – 2004 |
| Web Developer, University of North Carolina Hospitals<br>Assistant to the Chair of Obstetrics and Gynecology | 1998 – 1999 |

## Education

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

## Selected Recent Presentations and Publications

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

NAVIGANT

# Greg Abdouch, MBA

**Managing Consultant**

gregory.abdouch@navigant.com
Phoenix, Arizona
Direct: 602.528.8101

## Professional Summary

Greg Abdouch is a Managing Consultant with Navigant's Government Healthcare Solutions practice. He focuses on managed care, long-term supports and services, behavioral health, and providing project management oversight of engagements for clients who are making large-scale transitions in their Medicaid programs. Greg has more than eight years of experience in Medicaid managed care and the supervision and management of program transformation teams within both state agencies and Medicaid managed care plans.

## Areas of Expertise

- Project Management experience including large scale implementation and merger integration.
- Extensive Medicaid Managed Care health plan operations experience including claims payment, medical management, and provider network management.
- Medicaid Managed Care Oversight and Monitoring.
- Managing and implementing Long-Term Supports and Services programs.

## Professional Experience

### Medicaid Managed Care

- Assisting the Arizona Health Care Cost Containment System (AHCCCS) organization (Arizona Medicaid) with contract and policy compliance related to the Medicaid Managed Care Final Rule changes around Network Adequacy, External Quality Review Organizations and Member Information.
- Facilitating workgroup meetings for the Arizona Health Care Cost Containment System (AHCCCS) organization (Arizona Medicaid) related to program design and procurement support for the Acute / CRS Request for Proposal. Developing work plan, agenda, and objectives to achieve predetermined goals for procurement.
- Served as an Executive Immersion Program Manager/Associate for a managed care organization (MCO) in the areas of health plan operations, internal audit, and product management and innovation. Assisted with the development of proposals for new managed care markets including technical writing and analysis. Provided procurement assistance in securing provider contracts and conducted stakeholder engagement for the communication of new health plan business lines and

changes to processes. Managed Health Benefits Ratio initiatives such as emergency room diversion and network improvement resulting in $1,500,000 savings. Conducted operational audits of health plans for compliance and identification of risks. Managed implementation and operations of Medicaid member incentive program across 12 health plans.

- Assisted Georgia's Department of Community Health as it planned for and implemented redesign options for its Medicaid and Children's Health Insurance Programs. Evaluated and prepared summaries of stakeholder feedback for consideration in development of state programs.

- Supported the Mississippi Division of Medicaid with review and analysis of operational managed care plan report submissions for a voluntary coordinated care program, MississippiCAN, for high-risk beneficiaries. Drafted requirements for the Division's managed care contract for the Children's Health Insurance Program (CHIP).

## Medicaid Performance Management

- Supported the Illinois Bureau of Managed Care with monitoring of the Institutional Care Program's managed care plans. Developed tools for the State to use in assessing health plan performance. Reviewed reports submitted by plans and providing actionable feedback to State for plan improvement.

- Developed Fraud, Waste, and Abuse Plan for large health plan's Texas STAR+PLUS business unit. Ensured all Federal and State requirements were met and aligned with internal C-HS policies and procedures.

## Behavioral Health

- Served as project manager to support the transition of Arizona's Division of Behavioral Health Services (DBHS) into the Arizona Health Care Cost Containment System (AHCCCS) organization (Arizona Medicaid). Led and facilitated the operational and personnel integration of the two agencies to support a seamless Administrative Simplification transition. Managed and facilitated several departmental work groups that include representatives from divisions managing policy, contracts, communications and legal. Fostered inter-agency collaboration and managed the overall structure and timeline of the integration. Reviewed and updated integrated Behavioral Health and Medicaid policies and procedures to maintain compliance with a previous settlement agreement.

- Supported the Louisiana Office of Behavioral Health (OBH) by developing a risk assessment that reviewed the adequacy and structure of monitoring and oversight of the State's managed care entity responsible for the administration of behavioral health services. Made procedural and operational recommendations based on findings of interviews with OBH staff and desk review of policies, procedures, and monitoring documentation.

NAVIGANT

# Greg Abdouch, MBA

**Managing Consultant**

## Long-Term Care

- Assisting the State of Alabama Medicaid in the development of the Integrated Care Networks program focused on delivering acute and long-term care services to individuals who meet nursing facility level of care. Leading contract development process to ensure compliance with Federal and State regulations. Supporting Stakeholder Engagement initiatives to ensure feedback is thoroughly considered and documented.
- Supported the implementation of the long-term care program operations at a managed care organization contracted with the Florida Agency for Health Care Administration to serve Medicaid, long-term care, and other government program members. Led and participated in work groups tasked with development of key operational processes, such as claims and medical management. Acted as primary liaison between the health plan and a subcontractor responsible for electronic visit verification of home care visits throughout the implementation.
- Served as Director of Long-Term Supports and Services and oversaw a regional team of more than 130 supervisors, case managers and support staff. Responsible for managing health plan finances and budget in excess of $300 million and 10,000 members. Represented health plan in meetings with stakeholders representing providers, consumers, advocates, and state agencies for the development and implementation of managed care coverage for long-term care and support services across Florida. Oversaw configuration, claims, contracting, and provider data management to develop and accurately and promptly compensate the provider network for delivery of care to members.

## Work History

| | |
|---|---|
| Managing Consultant, Navigant | 2014 – Present |
| Director of Long-Term Care and Supports Services, Centene Corporation | 2013 – 2014 |
| Executive Immersion Program Associate/Manager, Centene Corporation | 2010 – 2013 |
| MBA Intern, Centene Corporation | 2009 – 2010 |
| Finance Intern, Citi Smith Barney | 2008 |
| Personal Banker, JPMorgan Chase | 2006 – 2008 |

## Education

| | |
|---|---|
| Master of Business Administration, Finance and Healthcare Management | Washington University in St. Louis, Olin School of Business |
| Bachelor of Science, Business Administration | University of Arizona |

NAVIGANT

# Annie Hallum, FSA, MAAA

**Associate Director**

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

## Professional Summary

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

## Areas of Expertise

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

NAVIGANT

# Annie Hallum, FSA, MAAA

**Associate Director**

## Professional Experience

### Federal Initiatives

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

### Medicaid Reform

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

### Government Payment Transformation

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

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

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

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

### Litigation Services

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

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# Annie Hallum, FSA, MAAA

**Associate Director**

## Behavioral Health

- Assisting the State of Wyoming in maintenance and evaluation of their 1915(b)/(c) waiver High Fidelity Wraparound program for children with behavioral healthcare needs. Evaluating rate sufficiency and monitoring the contractor performance with regards to quality of service, provider supply, and other program quality metrics.

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

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

## Health Insurance Studies

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

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

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

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

## Long-term Care

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

## Actuarial Skills Experience

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

NAVIGANT

# Annie Hallum, FSA, MAAA

**Associate Director**

- Assisted a Professional Employers Organization with refining its unemployment insurance and workers' compensation insurance lines. Created an unemployment insurance algorithm and underwriting model using Monte Carlo simulation to maximize profit via client placement into different unemployment risk entities. Refined the workers' compensation underwriting model for enhanced risk selection.
- Assisted several health insurers and a Professional Employer Organization with estimating and monitoring reserves. Involved analysis of healthcare claims and premiums data to set Incurred but Not Reported Reserves and premium reserves and an analysis of workers' compensation claims data to develop claims reserves.
- Assisted a large health insurer in provider rate negotiations by comparing their fee schedules to other commercial data and to Medicare and Medicaid payment rates. Evaluated results to develop priorities for the negotiation team.
- Assisted a health plan and their opining actuary with preparing and reviewing Statements of Actuarial Opinion.

## Work History

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

## Certifications, Memberships, and Awards

Fellow of the Society of Actuaries

Member of the Academy of Actuaries

## Education

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

NAVIGANT

# Nancy Kim, MPH

**Managing Consultant**

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

## Professional Summary

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

## Areas of Expertise

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

## Professional Experience

### Medicaid Managed Care

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

NAVIGANT

# Nancy Kim

**Managing Consultant**

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

- As part of readiness, she has assisted states in identifying federal network adequacy requirements, conducting a scan of other states' network adequacy standards, and assessing the state's current network standards for compliance with federal requirements.

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

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

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

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

## Health Information Technology

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

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

NAVIGANT

# Nancy Kim

**Managing Consultant**

- Assisted several states, including Kansas and Pennsylvania, with their Medicaid EHR Incentive Programs such as drafting SMHPs and Advanced Planning Documents and developing communications strategies and program implementation plans. Developed landscape assessments, which required the review of statewide EHR adoption and factors influencing adoption such as average office size, office location (rural versus urban), connections to hospitals, presence of an EHR adoption network, and funding.

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

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

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

## Long-term Care

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

- Assisted the Illinois Department of Healthcare and Family Services with its design plan for the Balancing Incentive Program, a federal grant to help states rebalance their long-term services and supports (LTSS) delivery systems. Provided project planning, guidance, and technical assistance related to federally mandated structural changes that affect multiple State agencies, including the

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# Nancy Kim

**Managing Consultant**

design of a "no-wrong door" system of LTSS entry points and mitigation of conflict from LTSS case management processes. Assisted the State with the development of a uniform assessment instrument to be used for multiple LTSS populations.

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

## Other Relevant Experience

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

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

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

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

## Work History

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

## Education

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

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# Nancy Kim

**Managing Consultant**

## Selected Recent Presentations and Publications

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

NAVIGANT

# Andrea Pederson

**Director**

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

## Professional Summary

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

## Areas of Expertise

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

## Professional Experience

### Long-Term Services and Supports (LTSS)

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

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**Director**

- Assisted the Arizona Department of Economic Security, Division of Developmental Disabilities with its rebase of fee-for-service rates. Organized and facilitated focus group meetings with stakeholders across the State through three phases of the project. Conducted statewide provider survey collection to gather cost, wage, and staffing data on 10 major service areas to inform rate model development. Developed benchmark rates for home- and community-based services that include homemaker, respite, in-home nursing, day treatment and employment services. Assisted the Division to review and understand the benchmark rate recommendations, present the benchmark rates to the provider community, estimate budget impact and implement the final rates.
- Directed a case management engagement for the State of Colorado, Department of Health Care Policy and Financing to research best practices among states regarding HCBS case management service delivery and payment methods, and to recommend changes to streamline and standardize case management across waivers in Colorado. Oversaw research and in-depth data collection of case management service delivery in other states. Used the information, best practices and lessons learned from state research and interviews to inform recommendations regarding Colorado's case management delivery and payment system. Identified eight recommendations to improve Colorado's HCBS case management system delivery that included payment methodology standardized case manager qualifications and a clearly defined case management definition.
- Assisted the State of Colorado, Office of Community Living, with the development of a conflict-free case management implementation plan for submission to the Colorado Legislature, Joint Budget Committee in response to House Bill 15-1318. Examined the impact of conflict-free case management on its Community Care Boards related to the State's developmental disabilities waivers. Developed a financial survey and detailed documentation request to gather information from the Community Care Boards about their operations and costs. Oversaw the review of submitted data and documentation and conducted on-site visits to five Community Care Boards. Presented a proposed CFCM implementation plan at five community stakeholder meetings (four in-person meetings and one webinar) to collect input on the options for implementation and potential impact of each option and summarized the comments in a report.
- Assisted the Wyoming Department of Health with a cost and rate study for its long-term care and assisted living facility 1915(c) waiver services, including case management services. Directing the collection of cost and wage information from service providers through a customized survey tool. Evaluated available data for the development of transparent models to be used for rate determination, including Bureau of Labor Statistics wage data. Facilitated provider technical advisory groups to discuss cost and wage data, model assumptions and rate setting issues. Developed independent rate models for both waivers and assisted with waiver application submission and request for additional information from CMS. Both waivers were approved by CMS.
- In addition to Arizona, managed rate development for home- and community-based waivers in Nebraska, Minnesota, Wyoming, and Illinois. These projects require expertise and advisement on rate setting methodology for 1915 (c) waivers to develop rates that would be accepted by CMS. Project work involves:

# Andrea Pederson

**Director**

- Lead rate development for redesign of home- and community-based waivers.
- Review of proposed service definitions based on unbundling of current services or creation of new services
- Design, distribute and review cost and wage survey of providers; conduct provider trainings for cost and wage surveys.
- Research and identify other publicly available sources of cost and wage data.
- Facilitate in-person and webinar discussions and meetings with state decision-makers, technical advisory groups, focus groups, providers and various stakeholders.
- Develop rate model and fiscal impact analyses.
- Review waiver application submissions and correspondence from CMS, and assist with responses to CMS requests for additional information.

- Assisted the North Dakota Department of Human Services, Division of Developmental Disabilities, with the final phase of implementing the new cost-based rate methodology for select developmental disabilities services. Directed the development of detailed service descriptions and recommendations for the necessary changes to North Dakota's Administrative Code to reflect the new rate methodology and services. Developed recommendations for changes to the provider contract to comply with changes to the Administrative Code. Directed the development of a detailed Provider Manual and updated Medicaid waiver documentation and State Plan documents for the new rate system implementation.
- Assisted the Washington Department of Social and Health Services to perform an independent review and analysis of the Developmental Disability Administration's Supported Living Program; specifically, this work included a critique of their reimbursement methodology and a report that included suggestions for improvement. Led a review of data, reports, and documentation regarding the Supported Living Program's function and reimbursement methodology. Interviewed State staff and mapped key processes to better understand the existing infrastructure. Conducted interviews and research of other state's programs similar to Washington's Supported Living Program. Drafted a report assessing the Supported Living Program, drawing comparisons to similar programs in other states and provided recommendations to the State.
- Assisted the Illinois Department of Human Services Division of Developmental Disabilities to comply with a legislative mandate to develop a work group and final report on the scope of nursing services for the Division's community integrated living arrangement program. Assisted the Division with facilitating work group meetings; collected data regarding providers' use of nurses at community integrated living arrangement using a survey; researched nursing wage rates in Illinois and nationally and interviewed providers about the services that nurses provide. Developed the final report with recommendations regarding nursing ratios and wage rates that the work group presented to the Department of Human Services and the Illinois legislature and Governor's office. The work group leaders, consisting of providers and advocates, used the report to lobby the legislature for the

additional funding to raise nurses wages at community integrated living arrangement settings.

- Assisted the Illinois Department of Human Services Division of Developmental Disabilities to develop its strategic plan for state fiscal years 2007 through 2011 and the related work plan for state fiscal year 2007. Attended meetings to discuss the goals and outcomes the Division wanted to achieve with the strategic plan and work plan. Assisted the Division with designing and finalizing the format of the plans that are now posted on the Division's website. The Division used the strategic plan and work plan to develop tasks that respond to strategic plan goals.
- Assisted the Illinois Bureau of Long-Term Care in the determination of which nursing facility residents have a mental illness, and of those residents, which have medical diagnoses or conditions requiring long-term nursing home care. Analyzed two sets of information submitted by nursing homes: resident-level Minimum Data Set assessment data and facility-level On-line Survey Certification and Reporting data. Summarized results of analysis on a facility basis, provided profiles of selected residents, and created a facility roster and sample lists of residents for use by the Bureau of Long-Term Care. Transitioned SAS programming to the State for use in conducting the same analyses in the future.

## Government Payment Transformation

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

continue to assist with payment calculations on an annual basis.

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

## Behavioral Health

- Directed a behavioral health rate study for the Wyoming Department of Health to examine costs and payments for mental health and substance abuse services provided through community mental health centers, substance abuse treatment centers and independent behavioral health providers. Provided recommendations for improvements to billing practices, rate development and stakeholder outreach.
- Continue to assist the Wyoming Department of Health with the collection and analysis of cost report data and development of reimbursement rates for psychiatric residential treatment facilities that participate in the Medicaid program and residential treatment centers and group homes that

participate with the Departments of Family Services and Education. Conducted seven years of cost report collections and developed recommendations for provider peer group rates. Continue to update project website to communicate project status and to facilitate the distribution of cost report collection materials. Develop cost-based rate recommendations for the biennium budget.

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

discuss the community mental health needs of children. Interviewed states currently operating HCBS waivers for children to identify best practices for California to consider. Developed final recommendations for options to reduce costs for mental health services for children.

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

NAVIGANT

# Andrea Pederson

**Director**

## Work History

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

## Education

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|---|---|
| Bachelor of Science | University of Wisconsin, Madison |

## Selected Recent Presentations and Publications

- "Monitoring Fraud, Waste & Abuse in HCBS Personal Care Services" Division of Long Term Services and Supports, Disabled and Elderly Health Programs Group – Centers for Medicare and Medicaid Services (February 2016)
- "Rate Methodology in a FFS HCBS Structure" Division of Long Term Services and Supports, Disabled and Elderly Health Programs Group – Centers for Medicare and Medicaid Services (March 2016)
- "Fee Schedule HCBS Rate Setting: Developing a Rate for Direct Service Workers" Division of Long Term Services and Supports, Disabled and Elderly Health Programs Group – Centers for Medicare and Medicaid Services (July 2016)
- "Ensuring Rate Sufficiency: Rate Review and Revision Approaches" Division of Long Term Services and Supports, Disabled and Elderly Health Programs Group – Centers for Medicare and Medicaid Services (November 2016)
- Navigant Healthcare Policy Briefing: *Physical and Behavioral Health Integration – Considerations for Health Care Payers and Policy Makers, Part 1: Making the Case for Behavioral Health Integration* (December 2016)
- "Tiered Rates: Trends in Acuity-based and Geography-based Rate Variation" Division of Long Term Services and Supports, Disabled and Elderly Health Programs Group – Centers for Medicare and Medicaid Services (July 2017)
- "Trends in Rate Methodologies for High-Cost, High-Volume Taxonomies Division of Long Term Services and Supports, Disabled and Elderly Health Programs Group – Centers for Medicare and Medicaid Services (August 2017)
- "Cost Factors and Rate Assumptions Template" Division of Long Term Services and Supports, Disabled and Elderly Health Programs Group – Centers for Medicare and Medicaid Services (September 2017)

NAVIGANT

# James John Bulot, PhD

**Associate Director**

james.bulot@navigant.com
Suwanee, Georgia
Direct: 678-845-5656

## Professional Summary

Jay Bulot, Ph.D. an Associate Director with Navigant Healthcare. Jay is considered a national expert on Aging and Disability Services, Assistive Technology and LTSS. Prior to joining Navigant, Dr. Bulot served as the State Director for Aging and Adult Services for three governors, managing hundreds of millions of dollars in budget and hundreds of employees. He has provided expert testimony to federal agencies, Congress and the White House regarding aging and disability issues. In his roles as consultant, state government leader, professor, and President of the National Association of State Units on Aging and Disability, Jay has worked closely with clinical and performance benchmarking data, particularly in relation to long-term care supports and services.

Dr. Bulot develops, promotes, and maintains relationships with leaders at health systems, government agencies, universities and associations to drive better understanding of the need to integrate health, social and behavioral supports. He has taught graduate level courses in healthcare administration, long term care, and government programming (Medicaid, Medicare, Social Security and more). Further, Jay has experience leading the development and implementation of state programs such as waivers, Single Entry Point for LTSS, Balancing Incentive Program, Money Follows the Person, IAPDs and State Plans, Program Integrity initiatives, Home- and Community-Based Services, and more.

Dr. Bulot provides clients with valuable insight, policy consulting, budget analysis and technical assistance, while empowering them to realize success in areas such as organizational development, revenue enhancement, enhancing federal match, interagency collaborations, and state planning services.

## Areas of Expertise

- Recognized National Expert in Aging and Disability Services; including Gerontology, Alzheimer's disease and Related Disorders, Elder Abuse, Adult Protective Services, Public Guardianship, Access to Services and LTSS.
- Interpreting and evaluating complex rules and regulations as it relates to community based services for Older Americans Act, Medicaid Home and Community Based Services and the impact of the Affordable Care Act on systems change and systems innovations and enhancements.
- Implementation of statewide performance based funding initiatives in Medicaid and State funded LTSS.

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# James John Bulot, PhD

**Associate Director**

## Professional Experience

### LTSS Performance Management

- Worked with state agencies to provide professional leadership and direction within the Medicaid and Non-Medicaid Long-Term Services and Supports for Georgia to coordinate and enhance service delivery for adults aging with disability. Ensured agency is compliant with all Local and State Laws, Federal Medicaid Laws / Rules. Recognized by CMS, ACL and VA with the Excellence in Action Award for Outstanding Achievement in Changing Systems by a State.

- Manages 300+ employees, 28 regional offices and 30+ contract agencies; Directs the development of strategy and execution of policy for Department's Long-Term Services and Supports portfolio including State Plan on Aging, Medicaid Waivers Service and the State Plan for Alzheimer's and Related Dementia's.

- Developed coordinated, multi-agency collaborations and programs resulting in statewide Aging and Disability Resource Centers, Single Entry Point for LTSS, Balancing Incentive Program, Money Follows the Person, integration of BH for people aging with serious and persistent mental illness and CMS funded Hospital Transitions statewide.

- Modernized statewide claims and administrative management system, instituted sustainability initiatives among throughout contracts and redesigned the structure and effectiveness of case management services

- Developed and instituted first ever LTSS Quality Measures for adults aging with disability in a home and community based setting - National Core Indicators – Aging and Disability. Utilized comparative data to institute program improvement initiatives across settings. Coordinated compliance and regulatory activities for agency and 64+ contract agencies.

### LTSS Leadership

- As President of NASUAD, represented 56 State Directors in policy discussions with CMS, ACL, AoA, and VA; participates in CMS Meetings, provides CMS with policy recommendations, and assists with development of regulatory guidance; provided testimony to federal agencies, congress, and the White House regarding aging and disability issues; and coordinated with other national associations (ASTHO, NADDDS, NAMD) on public statements, rule commentary, and other issues of national interest to state directors.

- Worked with state agencies to provide professional leadership and direction within the Medicaid and Non-Medicaid Long-Term Services and Supports for Georgia to coordinate and enhance service delivery for adults aging with disability. Ensured agency is compliant with all Local and State Laws,

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**Associate Director**

Federal Medicaid Laws / Rules. Recognized by CMS, ACL and VA with the Excellence in Action Award for Outstanding Achievement in Changing Systems by a State.

- Consulted with states, national organizations and federal agencies including Congress, White House, CMS, ACL, AoA, CDC, FEMA, AARP and NASUAD on disaster preparedness and emergency response; impact of managed LTSS on quality of care; contract development, monitoring and oversight; innovation in LTSS; impact of community based services on the health of the population.

- Provided professional leadership and direction through the Governor's Office in areas related to Emergency Preparedness, Health, Employment, Disability Services, Medicaid, and Home and Community Based Services.

## Health Information Technology

- Subject matter expert and thought leader on development and implementation of LTSS data system for states and national technology corporations; integrated multiple disparate data systems resulting in better coordination of services, regulatory compliance and performance measures. Provided guidance, direction and implementation of TEFT related initiatives including Experience of Care, eLTSS and electronic Personal Health Record.

- Worked with data analysis team to establish a large database for benchmarking clinical and performance outcomes, GIS Mapping of service delivery and gap analysis;

- Invited speaker to the Mediware Users Conference the changing environment of aging and disability services and the role of technology.

## Vulnerable Adult Protections

- Developed first State entity for Forensic Special Investigations provide leadership and guidance on crimes against vulnerable adults. Provided training to over 1,800 Law Enforcement Officers, first responders prosecutors and judges. Resulted in required training for all Georgia Bureau of Investigation agents.

- Developed policy and legislations strengthening agencies ability to protect and prosecute crimes against vulnerable adults; recognized regionally and nationally as model approaches; assisted with development of white paper outlining best practices for investigating and prosecuting vulnerable adult crimes.

- Created Georgia's first Public Guardianship Office revise policy and procedures to reflect community living as first choice and decision making follows best interest/substitute judgment ideasl.

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# James John Bulot, PhD

**Associate Director**

- Restructured Adult Protective Services; coordinated both the law enforcement and home and community based services agencies to provide services for older adults and people with disabilities. Institute performance management and improvement initiatives, migrated to modern hosted data system for management and improvement initiatives.

## Other Relevant Experience

- Responsible for setting the strategic direction and development of the Department of Gerontology, Sociology, and Political Science; developed and tracked performance metrics for faculty, academic programs, and the department.
- Managed departmental and research budgets of $25+ million, ensuring value and cost-effectiveness in the use of staff and resources; Wrote and received more than $10 Million in competitive grant funding.
- More than 60 peer reviewed presentations, articles, citations, references and reports; wrote Quality Improvement Plan (QIP) for College and contributed to QIP for University.
- Conducted research, taught graduate level courses in healthcare administration, long-term care and government programing (Medicaid, Medicare, Social Security, etc.).

## Work History

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|---|---|
| Associate Director, Navigant | 2016 – Present |
| Director, Georgia Department of Human Services (Division of Aging Services) | 2010 – 2016 |
| President, National Association of State Units on Aging and Disability | 2009 – Present |
| Executive Director, Louisiana Governor's Office of Elderly Affairs | 2008 – 2010 |
| Department Head, University of Louisiana, Monroe | 2002 – 2008 |

## Certifications, Memberships and Awards

American Society on Aging, Member

Gerontology Society of America, Member

National Association of Long Term Care Administrator Boards

National Committee for the Prevention of Elder Abuse, Member

National Council on Aging, Leadership Council Member

National Association of States United for Aging and Disability (Treasurer, Secretary, Vice President, President)

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# James John Bulot, PhD

**Associate Director**

## Education

| | |
|---|---|
| Doctorate of Philosophy, Gerontology | University of Massachusetts, Boston |
| Master of Science, Gerontology | University of Massachusetts, Boston |
| Bachelor of Science, Psychology | University of Louisiana, Lafayette |

## Selected Recent Presentations and Publications

### APP Development

- Cardell, D. & Bulot, J. (2014). Georgia Telephone Support for Seniors. EyeOn APP, LLC (Available on Apple – Android in Development).
- Cardell, D., Bulot, J., Burt, C. & Rhines, S. (2015). Georgia Abuse, Neglect and Exploitation. EyeOn APP, LLC (Available for Apple, Windows and Android).

### Publications

- Mitchell, C., Brown, A. & Bulot, J. (2015). Georgia State Plan on Aging. Department of Human Services.
- Bulot, J. & Haley-Dunn, C (2014). Georgia Alzheimer's and Related Dementias State Plan. Department of Human Services.
- Bershadsky, J., Bulot, J. & Walters, K. (2014). Initial Findings from the National Core Indicators Adult and Disability Pilot Study. The Gerontologist, Vol 53.
- Price, T., King, P., Dillard, R. and Bulot, J. (2011). Elder Financial Exploitation: Implications for Future Policy and Research in Elder Mistreatment. Western Journal of Emergency Medicine, Vol 22, No 3.

### Presentations

- Bershadsky, J., Bulot, J. & Walters, K (2015). Update on NCI-AD: National Core Indicators for Aging and Disability Services. Gerontological Society of America, Orlando, FL.
- Bulot, J. (2015). Change Underfoot: LTSS in Georgia and Beyond. Harmony Users Conference. Atlanta, Ga.

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# James John Bulot, PhD

**Associate Director**

- Bulot, J. (2015). Invited Address – Development and Change in the Aging Services Network. Southeastern Association of Area Agencies on Aging. Savannah, GA.
- Bulot, J. & Helms, G. (2015). Get Started…Implementing the Georgia Alzheimer's and Related Dementia's State Plan. Southeastern Association of Area Agencies on Aging. Savannah, GA.
- Bershadsky, J., Walters, K. & Bulot, J (2015). Rollout of the National Core Indicators- Adults and Disability Survey. National Home and Community Based Services Conference. Washington, DC.
- Bulot, J., Fike, K. & Cardell, D. (2014). Technology, Innovation and Aging: How New Technology Companies are Making a Big Impact for Elders and Care Providers; and Policy Revisions to Make it Happen. 2014 National Home and Community Based Services Conference. Washington, DC.
- Bulot, J. (2014). Meals on Wheels Association of Georgia; Keynote Address, Welcoming Remarks. Marietta, GA, April 29-30, 2014.
- Bulot, J. (2013). Avoiding a Fiscal Cliff: Using the ACS to Mitigate Major Population Shifts Over Time. Southern Demographic Association Annual Meeting. Montgomery, Al.
- Bulot, J. (2013). Bridging the Gap between the Researcher and Public Policy Maker. Presentation given to the John W. McCormack Graduate School of Policy and Global Studies. University of Massachusetts Boston. Boston, MA.
- Bulot, J. (2012). Georgia: Trends in Aging and Service Delivery. Presentation given to the Georgia Senate Aging Study Committee. Atlanta, GA.
- Bulot, J., Carl, D. & Tax, A., (2012). A Statewide Approach to LGBT Inclusion for Aging Networks. Paper Presentation at the 2012 National Home and Community Based Services Conference. Washington, DC.
- Bulot, J. (2012). Aging with Disability: Demographic, Social and Policy Considerations. Invited presentation to the National Institute of Health, National Institute on Aging, U.S. Department of Health and Human Services; and the Interagency Committee on Disability Research. Washington, DC.
- Bulot, J. (2011). Capacity to Care: Building Competency in Geriatric Mental Health. Presentation at Emory University. Atlanta, GA.
- Bulot, J. (2010). The Future of Aging Services. Presentation at Georgia Tech, Design and Technology for Healthy Aging Initiative. Atlanta, GA.

# Appendix B White Paper: "Provider Network Adequacy Changes in Medicaid Managed Care Final Rule Leave States with Much to Address"

We have included the white paper on the following pages.

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HEALTHCARE

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


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**About Navigant**

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

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

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

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

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

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

We reviewed contracts to determine:

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

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

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

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

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

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

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

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

## TIME AND DISTANCE STANDARDS

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

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

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

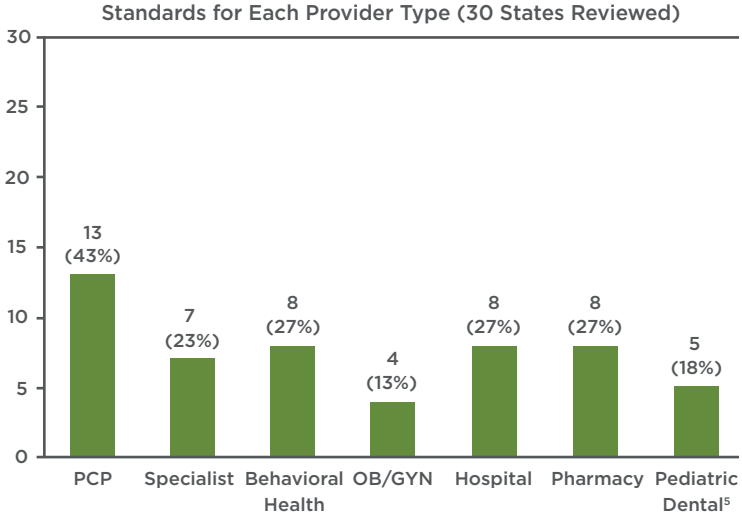
4. Managed Care, 42 C.F.R. § 438.68 (b).

**NAVIGANT RESEARCH INDICATES:**

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

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

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




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

## EXCEPTIONS TO PROVIDER NETWORK STANDARDS

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

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

**73%** of states grant exceptions to provider network standards.

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

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

## REQUIRED ELEMENTS FOR ESTABLISHING PROVIDER NETWORK STANDARDS

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

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

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

**Additional State Considerations**

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

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

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

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

## PROVIDER NETWORK DOCUMENTATION

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

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

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

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

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

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

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

**NETWORK ADEQUACY REPORTING**

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

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

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


**Ready for 2018?**

To prepare for the new regulations, states should consider:

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

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

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

**About Navigant Government Healthcare Solutions**

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