STATE OF NEVADA

EXTERNAL QUALITY REVIEW ORGANIZATION (EQRO)

RFP: 3491

FEBRUARY 22, 2018

DEPARMENT OF HEALTH AND HUMAN SERVICES (DHHS), DIVISION OF HEALTH CARE FINANCING AND POLICY (DHCFP)

PART IA – TECHNICAL PROPOSAL

MAKE TOMORROW, TODAY MERCER

SECTION I – TITLE PAGE

Part IA – Technical Proposal	
RFP Title:	EQRO
RFP:	3491
Vendor Name:	***Mercer Health & Benefits LLC***
Address:	***2325 E. Camelback Road, Suite 600*** ***Phoenix, AZ 85016***
Opening Date:	2/22/18
Opening Time:	2:00 PM

II

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III

SECTION III – VENDOR INFORMATION SHEET

Vendor Shall:

A) Provide all requested information in the space provided next to each numbered question. The information provided in Sections V1 through V6 shall be used for development of the contract;

B) Type or print responses; and

C) Include this Vendor Information Sheet in Section III of the Technical Proposal.

Mercer Health & Benefits LLC (Mercer) provides the Vendor Information Sheet in this section of our proposal.

VENDOR INFORMATION SHEET FOR RFP 3491

Vendor Shall:

A) Provide all requested information in the space provided next to each numbered question. The information provided in Sections V1 through V6 shall be used for development of the contract;

B) Type or print responses; and

C) Include this Vendor Information Sheet in Section III of the Technical Proposal.

V1	Company Name	Mercer Health & Benefits LLC
V2	Street Address	2325 East Camelback Road, Suite 600
V3	City, State, ZIP	Phoenix, AZ 85016

V4	Telephone Number		
	Area Code: +1 602	Number: 522 6500	Extension: N/A

V5	Facsimile Number		
	Area Code: +1 602	Number: 522 6499	Extension: N/A

V6	Toll Free Number		
	Area Code:	Number: N/A	Extension:

V7	***Contact Person for Questions / Contract Negotiations, including address if different than above***
	Name: Frederick Gibison Jr, MBA
	Title: Partner
	Address:
	Email Address: fred.gibison@mercer.com

V8	Telephone Number for Contact Person		
	Area Code: +1 602	Number: 522 6526	Extension: N/A

V9	Facsimile Number for Contact Person		
	Area Code: +1 602	Number: 522 6499	Extension: N/A

V10	***Name of Individual Authorized to Bind the Organization***	
	Name: Frederick Gibison Jr, MBA	Title: Partner

V11	Signature ***(Individual shall be legally authorized to bind the vendor per NRS 333.337)***	
	Signature:	Date: Feb. 12, 2018

IV

SECTION IV – STATE DOCUMENTS

A. The signature page from all amendments signed by an individual authorized to bind the organization.

B. Attachment A – Confidentiality and Certification of Indemnification signed by an individual authorized to bind the organization.

C. Attachment B – Vendor Certifications signed by an individual authorized to bind the organization.

D. Attachment H – Certification Regarding Lobbying signed by an individual authorized to bind the organization.

E. Copies of any vendor licensing agreements and/or hardware and software maintenance agreements.

F. Copies of applicable certifications and/or licenses.

Mercer provides the required State documents in this section of our proposal.

A. AMENDMENTS

Mercer acknowledges being in receipt of the following Amendments:

- ***Amendment #1 – February 2, 2018***
- ***Amendment #2 – February 8, 2018***

See signed amendments starting on the following page.

State of Nevada
Department Administration
Purchasing Division
515 E. Musser Street, Suite 300
Carson City, NV 89701

Brian Sandoval
Governor

Jeffrey Haag
Administrator

SUBJECT:	Amendment 1to Request for Proposal 3491
RFP TITLE:	External Quality Review Organization (EQRO)
DATE OF AMENDMENT:	February 2, 2018
DATE OF RFP RELEASE:	January 10, 2018
OPENING DATE:	February 22, 2018
OPENING TIME:	2:00 PM
CONTACT:	Ronda Miller, Purchasing Officer II

The following shall be a part of RFP ***3491***. If a vendor has already returned a proposal and any of the information provided below changes that proposal, please submit the changes along with this amendment. You need not re-submit an entire proposal prior to the opening date and time.

RFP CHANGES:

1. ***Old language:***

   2.2.5 As described in (described in §438.310(c)(2)) an EQRO may not:

   New language:

   2.2.5 As described in (described in §438.**354**(c)(2)) an EQRO may not:

2 ***Old language:***

   2.1.5 Technical Assistance and Optional Activities

   The vendor may be required to provide technical assistance and/or optional activities described in 42 CFR 438.58(c) or comparable activities that assess the quality or utilization of services in the fee-for-service program to DHCFP and the participating MCOs, PAHP, and CMO during the contract period. The specific nature of the technical assistance will be defined on a case-by-case basis, but at a minimum, may include educational sessions to enhance the use of EQR results, identification of healthcare trends or "best practices" in performance measures or quality improvement activities; providing clinical consultation and/or expertise; and conducting evaluations of health care initiatives. Optional activities described in 42 CFR 438.358(c) may include:

New language:

2.1.5 Technical Assistance and Optional Activities

The vendor may be required to provide technical assistance and/or optional activities described in 42 CFR **438.358**(c) or comparable activities that assess the quality or utilization of services in the fee-for-service program to DHCFP and the participating MCOs, PAHP, and CMO during the contract period. The specific nature of the technical assistance will be defined on a case-by-case basis, but at a minimum, may include educational sessions to enhance the use of EQR results, identification of healthcare trends or "best practices" in performance measures or quality improvement activities; providing clinical consultation and/or expertise; and conducting evaluations of health care initiatives. Optional activities described in 42 CFR 438.358(c) may include:

3. *RFP section deletions:*

RFP Section 2.2.9 to be deleted in its entirety.

4. *RFP ATTACHMENT G – COST PROPOSAL REVISED:*

Vendors to submit cost on the following revised cost proposal:

EQRO Cost Sheet Revised 2.1.18.xlsx

QUESTIONS AND ANSWERS:

1. Vendor Duties and Responsibilities-1.5-7-The RFP requests that vendors be available for regular meetings, including teleconference and face-to-face meetings in Nevada; however, the Cost Schedule provided in Attachment G does not include a category for teleconference and face-to-face meetings to be priced by vendors. Will the DHCFP consider issuing a Cost Schedule that includes meetings, as it has in prior RFPs?

   Yes, the Cost Schedule will be amended to include web meetings, teleconferences, and face to face meetings.

2. 2.1 and Attachment G – Cost Schedule-2.1.5.4.A, B, C-12 and 41-There does not appear to be a designated column on the Optional Activities Cost Schedule for the new Nevada ABD managed care expansion program. Under which column(s) should the vendor price the optional activities for the ABD managed care expansion program?

   Refer to the beginning of this amendment. Attachment G has been revised.

3. Attachment G – Cost Schedule--41-The entries in the Cost Schedule column labeled "RFP Citation" do not align with the RFP citations for the activities listed in Section 2. Will the DHCFP consider issuing a revised Cost Schedule to help ensure vendors address the correct RFP requirements for each price proposed?

   Refer to beginning of this amendment for RFP submittal change.

4. Attachment G – Cost Schedule--41-Please confirm that not all cells on the Cost Schedule require that a price be entered. For example, on the Optional Activities schedule, the row for Technical Assistance – Onsite contract compliance audit of the contracted CMO vendor will only have a price under the CMO-FFS column.

   Refer to the beginning of this amendment. Attachment G has been revised.

5. 2.1.1.4; 2.1.3.4-Network Adequacy Validation; page 7; Validation of MCO and DBA/PAHP network adequacy during the preceding 12 months; page 9-Are there current contract requirements or other guidance for the MCOs and PAHP for Network Adequacy?

   There are current network adequacy standards outlined in the MCO RFP 3260 Section 3.7.5 Access and Availability, and DBA RFP 3425 Section 3.6.5 Access and Availability.

6. 2.1.1.4; 2.1.3.4-Network Adequacy Validation; page 7; Validation of MCO and DBA/PAHP network adequacy during the preceding 12 months; page 9-What are the current network adequacy standards for the MCOs and PAHP?

   Refer to MCO RFP 3260 Section 3.7.5 Access and Availability, and DBA RFP 3425 Section 3.6.5 Access and Availability.

7. 2.1.1.4; 2.1.3.4-Network Adequacy Validation; page 7; Validation of MCO and DBA/PAHP network adequacy during the preceding 12 months; page 9-Has the State of Nevada developed the new managed care requirements, related to time and distance standards, format for annually certifying adequacy of their networks?

   Refer to MCO RFP 3260 Section 3.6.3.2. Twenty-Five Mile Rule.

8. 2.1.1.4; 2.1.3.4-Network Adequacy Validation; page 7; Validation of MCO and DBA/PAHP network adequacy during the preceding 12 months; page 9-Does Nevada contract with MCOs or PAHPs for long term services and supports?

   Refer to MCO RFP 3260 Section 3.4.4.2 Excluded Populations, Services and Coverage Limitations for Individuals Enrolled in Managed Care. The DHCFP does not contract with the DBA for adult dental services.

9. 2.1.2.4-Conduct of PIPs in addition to those conducted by health plan; page 8-Please clarify who would be conducting these PIPs?

   The selected EQRO vendor may be asked to conduct PIP activities in addition to the validation of MCO PIP activities.

10. 2.1.2.4-Conduct of PIPs in addition to those conducted by health plan; page 8-What is the EQRO's role with PIPs in addition to those conducted by health plan?

The EQRO's role would be to validate additional PIPs conducted by the PCCM/CMO related to Pay for Performance Measures (P4P).

11. 7-2.1.3-Validation of MCO, DBA/PAHP and CMO Performance Indicators; page 8-Which measures are the HEDIS measures?

    The State does not understand this question. Is the vendor looking for a list or an amount of the HEDIS and non-HEDIS measures?

12. 2.1.3-Validation of MCO, DBA/PAHP and CMO Performance Indicators; page 8-Which measures are not HEDIS and will be validated using the CMS protocol?

    Refer to the response provided in question 11.

13. 2.1.3.3-Validation of Performance Improvement Projects (PIPs); page 8-Does DHCFP have a preference for whether the PIP topics are selected by DHCFP, the MCO or the EQRO?

    Historically, the DHCFP has collaborated with both MCO and EQRO vendors to determine PIP topics based from performance measure data for the MCO vendors.

14. 2.1.3.3-Validation of Performance Improvement Projects (PIPs); page 8-Does DHCFP have a preference for the selection of a single PIP topic across all MCOs or for allowing MCOs to select distinct and separate PIP topics?

    The DHCFP has had the same PIPs across plans as well as selected distinct and separate PIPs. PIP selection is determined by performance indicators, as well as determined with Nevada Department of Health and Human Services health goals and objectives in mind.

15. 2.1.3.3-Validation of Performance Improvement Projects (PIPs); page 8-If the MCO is allowed to select the PIP topic, is the topic vetted and approved by DHCFP or the EQRO before implementation?

    Yes.

16. 2.1.3.5-Validation of the Nevada DHCFP State QAPIS in SFY 2019 and each subsequent EQR contract renewal year; page 9-Can the state provide more detail about what data or documents the EQRO might review as part of the QAPI to measure objectively the progress and status of Value Based Purchasing?

    Validating performance measure data related to pay for performance programs outlined within CMO, MCO, or DBA contracts.

17. 2.1.4-Compliance Review; page 10-How many sections are in the compliance review?

IQAP Compliance Review Calendar		
Standard Number	Compliance Review Standard	Review Year
I	Internal Quality Assurance Program	**FY 2020**
II	Credentialing and Recredentialing	**FY 2018**
III	Member Rights and Responsibilities	**FY 2019**
IV	Member Information	**FY 2019**

V	Availability and Accessibility of Services	FY 2018
VI	Continuity and Coordination of Care	FY 2019
VII	Grievance and Appeals	FY 2019
VIII	Subcontracts and Delegation	FY 2018
IX	Cultural Competency Program	FY 2020
X	Coverage and Authorization of Services	FY 2019
XI	Provider Dispute and Complaint Resolution	FY 2018
XII	Confidentiality and Recordkeeping	FY 2020
XIII	Provider Information	FY 2018
XIV	Enrollment and Disenrollment	FY 2020
XV	Program Integrity	FY 2020

18. 2.1.5-Technical Assistance and Optional Activities; pages 10-11-Can you clarify whether cost information for the Technical Assistance and Optional activities described in Section 2.1.5 is requested for the Cost Proposal at this time; or whether it should be provided after a specific request and scope of work is provided by DHCFP (as indicated at the end of 2.1.5)?

    After a specific scope of work and request for costs is provided by the DHCFP.

19. 2.2.9-ICD-9 and EDI compliance; page 14-Section 2.2.9 indicates the vendor must maintain ICD-9 and EDI compliance as defined by CMS. Could the state cite the CMS regulations to which this compliance refers?

    Refer to beginning of this amendment for RFP submittal change.

20. 2.4.1-Implementation; page 15-Is a preliminary work plan required as part of the proposal?

    A preliminary work plan is not required as part of the RFP.

21. 9.2-Proposal Evaluation and Award Process, page 28-Is there a state statute, regulation or written rule that describes in more detail the specifics for the 5% discount for Nevada-based businesses? If not, can DHCFP elaborate on the criteria used to determine the 5% discount?

    Refer to Assembly Bill 280 dated March 13, 2017.

22. 7.-RFP Timeline; page 21-Is there a meeting of interested bidders prior to the submission of the bid?

    No.

23. 8.2.2.5-Part IA-Technical Response, Section V-Scope of work; page 24-Are there instructions on preferred response content for the Scope of Work sections?

    The State has no additional instructions. The State will accept a clarifying question.

24. 8.2.2.5-Part IA-Technical Response, Section V-Scope of work; page 24-The instructions indicate that the vendor shall place their responses to the technical sections immediately following the applicable RFP question, statement, and/or section. Does this mean that the

vendor must respond to every section/subsection individually or can sections/subsections be combined where it makes sense?

Vendors shall respond to the Scope in its entirety.

25. ATT. G-Cost Schedule Spreadsheet (attachment to the RFP); page 41 -The cost spreadsheet has citations that are supposed to be directed back to the RFP, but they are missing digits. For example, on the first line of the spreadsheet for the Activity of Performance Improvement Project Validation, one of the citations is 2.3.3. We cannot find a 2.3.3 in the RFP.

    Refer to beginning of this amendment for RFP submittal change.

26. ATT. G-Cost Schedule Spreadsheet (attachment to the RFP); page 41 -In the cost spreadsheet, under Optional Activities, there is an Activity for Consulting. The citation is 2.5.6, but there is no 2.5.6 in the RFP. We believe it references Section 2.1.5.6 regarding consulting, however there is no scope of work (SOW) for that. In fact, this page (12) implies that a SOW would be submitted in writing from the state after the contract is awarded to the EQRO so that the EQRO may submit a cost proposal at that time. Can the state provide details for the consulting work if it is intended to be part of the cost proposal for this RFP?

    The Cost Schedule has been revised. Please refer to the beginning of the amendment for this document.

27. ATT. G-Cost Schedule Spreadsheet (attachment to the RFP); page 41 -In the cost spreadsheet, can you clarify which Optional Activities that you expect proposed cost for at this time?
    The Cost Schedule has been revised. Please refer to the beginning of the amendment for this document.

28. ATT. G-Cost Schedule Spreadsheet (attachment to the RFP); page 41 -For Optional Activities that do not include a scope of work, are you requesting hourly rates?
    The Cost Schedule has been revised. Please refer to the beginning of the amendment for this document.

29. ATT. G-Cost Schedule Spreadsheet (attachment to the RFP); page 41 -For Optional Activities that do not include a scope of work, are these sections to be completed once a final vendor is selected and scope of work is provided?

    The Cost Schedule has been revised. Please refer to the beginning of the amendment for this document.

30. Section 2.1.3, Scope of Work, page 8. Can the State clarify the total number of plans that would undergo a Performance Measure Validation audit?

    3 MCOs, 1 DBA, and 1 CMO.

31. Section 2.1.3, Scope of Work, page 8. Can the State clarify the total number of HEDIS and non-HEDIS measures that it will require each of the entities to report or a maximum number of performance measures to be validated?

    MCOs- 26 HEDIS measures (9 hybrid measures).
    DBA- 1 HEDIS measure, and 3 non-HEDIS measures.

CMO-22 HEDIS like measures.

32. Section 2.1.3, Scope of Work, page 8. Can the State clarify the number of hybrid measures that is expects each entity to report on?

    Refer to the response provided to question 31.

33. Section 2.1.3, Scope of Work, page 8. Can the State clarify its expectations for the timing of performing the performance measure validation audits?

    The start of this activity usually begins in January and the final audit report is presented in July.

34. Section 2.1.4, Scope of Work, page 10. It states "Conduct a compliance review evaluating the effectiveness of the quality strategy within the previous 3 years. This review will be broken out in sections to be reviewed annually." Can the State clarify as to what is meant by "broken out into sections to be reviewed annually"? What sections must be reviewed in SFY19?

    Refer to the response provided to question 17.

35. Section 2.2.8 Qualifications of External Quality Review Organizations, page 14. Can the State clarify why an NCQA-Certified Health Employer Data Set (HEDIS) Compliance Auditor is a required position if the validation of performance measure activity can be conducted using the Centers for Medicare & Medicaid Services (CMS) Validating Performance Measure Protocol, which does not require the use of an NCQA-Certified HEDIS Compliance Auditor?

    State choice.

36. Section 9, Proposal Evaluation and Award Process, page 27. RFP indicates "Conformance with the terms of this RFP" carries a weight of 10%. Does the submission of modifications/exceptions to the contract terms and conditions have any impact on the scoring of the vendor's proposal?

    The evaluation committee may take into consideration any modifications/exceptions when scoring.

37. Section 9.8, part of Proposal Award and Evaluation, page 28. This section indicates "A Letter of Intent (LOI) shall be issued in accordance with NAC 333.170 notifying vendors of the State's intent to award a contract to a vendor, pending successful negotiations." Is the LOI sent directly to all vendors or posted on the website or provided in a different way?

    The LOI only goes to the proposing vendors.

38. Section 10, Terms and Conditions, page 29 and Attachment C, Contract Form, page 37. Is the State willing to negotiate the terms and conditions of the contract? If yes, where should vendors include contract modifications/exceptions, e.g., attachment to cover letter, appendix of RFP response, etc.?

    No.

39. General Question. Please provide the names of vendors who submitted questions. If the State is unable to provide the names, please provide the number of vendors who submitted questions.

Health Insight Assure, LLC; HSAG.

40. General Question. Health Services Advisory Group (HSAG) is the incumbent. What is the annual contract value and hours in their current contract? Is the scope of work requested in this RFP substantially similar to the current work being provided by HSAG?

The scope of work outlined within the RFP is similar to the current HSAG contract with the exception of some of the optional activities listed, as the DHCFP has potential to include the activities, but forward movement related to expanding coverage of the managed care populations and service areas has not yet been solidified.

41. General Question. What is the maximum budget for this project?

The State chooses not to disclose this information.

42. 2.1.3.2-8-Does the DHCFP anticipate requesting MCOs to become NCQA Accredited or Certified in the future?

More than one MCO is currently NCQA accredited. This is not a current State of Nevada requirement.

43. 2.1.3.2-8-Can the vendor subcontract with a Certified HEDIS Compliance Auditor to conduct the validation of performance indicators task or is a NCQA licensed organization required?

Refer to RFP 3491 Section 2.2.8.

44. 2.1.3.2.A-8-Does DHCFP currently require submission of HEDIS data using IDSS to NCQA? Will DHCFP require this in the future?

Yes, it is currently submitted via IDSS and we foresee no change in this process.

45. 2.1.3.2.A-8-Will DHCFP require or expect the MCOs and CMO to report their HEDIS performance measures to NCQA? If yes, are the MCOs and CMO required to publicly report their HEDIS results?

The current EQRO vendor reports the performance measures to NCQA. The DHCFP publicly reports the performance measures within our External Quality Review Annual Technical Report.

46. 2.1.3.2.A-8-Are all performance measures HEDIS or are other types of measures included as well?

MCO- Currently, all MCO performance measures are HEDIS, but the state has used non-HEDIS measures before, and may elect to use them in the future.
CMO- There are 22 performance measures that are validated by the EQRO vendor. They are non-HEDIS measures.
DBA- 1 HEDIS and 3 non-HEDIS measures are validated for this program.

47. 2.1.3.3-8-Confirm the CMO is not required to conduct PIPs (only the MCOs and PAHP will conduct PIPs). If the CMO is required to conduct PIPs, how many? And, clinical or non-clinical?

The CMO is not currently conducting PIPs.

48. 2.1.3.3-8-Can DHCP provide a list of PIP topics currently underway or expected to be implemented?

The SFY 2017 Technical Report can be located here:
http://dhcfp.nv.gov/Resources/AdminSupport/Reports/CaseloadData/

49. 2.1.3.6-9-Will the vendor develop the first annual technical report using the current EQRO's audit information/reports?

Yes. The information is owned by the DHCFP.

50. 2.1.3.6-9-What is the due date to submit the first annual technical report to DHCFP?

Technical Reports are due October 2018.

51. 2.1.3.6.H-10-Can you provide a copy of the latest QAPIS and Performance Tracking Tool?

Please refer to the DHCFP Managed Care Report link located here:
http://dhcfp.nv.gov/Resources/AdminSupport/Reports/CaseloadData/

52. 2.1.4-10-Confirm the Compliance Review standards are broken out and approximately 1/3 of the standards will be reviewed annually. So in a three year period, a comprehensive review is completed.

Refer to question 17 of this amendment.

53. 2.1.4-10-Are the Compliance Reviews to be conducted on-site or via desktop? 2.1.4-10-What programs are to be reviewed under the Compliance Reviews? MCO, DBA/PAHP, and CMO?

Compliance reviews are conducted for all MCOs and the DBA. MCO/DBA compliance reviews have both on-site and desktop components. The last CMO compliance review was conducted in FY 2015 and the report, which outlines the review standards can be located here: http://dhcfp.nv.gov/Pgms/BLU/HCGPOriginal/ Nevada DHCFP is proposing to phase out of the CMO program, and if phase out is completed, then the CMO contract will end June 30, 2018. Nevada may elect to implement a similar program in the future, which may require EQRO compliance efforts.

54. 2.1.5.1. C-11-Please define what DCHFP means by "omission studies"?

During an encounter data validation, an EQRO vendor will often speak to the encounter data completeness and accuracy. This would include information related to data omission rates for various services.

55. 2.1.5.2-11-Provide clarification regarding the differences between the CMO, the Care Coordination Vendor, and the CMO Vendor.

2.1.5.2A. and B. are both referencing the same vendor. Currently, DHCFP has a contract with our CMO vendor through June 2018. This contract may not be extended if the CMO program is phased out, however a similar vendor/service for care coordination may exist in the near future (2019).

56. 2.1.5.2-11-Are activities A and B mandatory activities for the Nevada Medicaid Care Coordination program?

Yes, they are part of the Special Terms and Conditions of the waiver.

57. 2.1.5.6-13-Should the vendor submit technical assistance costs as part of the cost proposal or will costs be submitted on a case-by-case basis when a request is received from DHCFP?

These can be submitted on a case-by-case basis with a SOW when request is received from the Division.

58. 2.2.9-14-"Contractor must maintain current International Classification of Diseases (ICD) and Electronic Data Interchange (EDI) compliance as defined by CMS regulation and policy and no funding will be provided for contractor's compliance."

This is not a question.

59. How does this statement apply to tasks under the EQRO scope of work? Can you provide a reference to the specific regulation this requirement refers to?

Refer to the beginning of this amendment. Section 2.2.9 has been removed.

60. Section 4- page 20-Can DHCFP revise the cost proposal template and shade or block the cells that do not require a cost (as not all tasks are being completed for each entity)? This will eliminate additional costs that are not necessary.

The Division has provided an updated cost proposal template. Cells for costs that are not necessary or that cannot be determined without an additional SOW have been removed.

61. Section 4- page 20-Clarify which tasks require a separate Title XIX (Medicaid) and XXI (CHIP) cost. For example, one Annual Technical Report will address Medicaid and CHIP. Would DHCFP like for the costs of one Annual Technical Report be broken down to the Medicaid and CHIP level?

Yes.

62. Section 4- page 20-Confirm a total (all three MCOs) Medicaid and CHIP cost should be provided for each activity and not a per MCO cost.

Costs should be broken out as outlined within the cost proposal template. The template does not allow for costs to be broken out by each separate MCO.

63. Section 4- page20-Please revise the RFP citations on the cost proposal template. The citations are not consistently matching up with the RFP. For example, references in the cost proposal

template are based on three numbers X.X.X and references in the RFP are based on four numbers X.X.X.X.

Refer to beginning of this amendment for RFP submittal change.

64. Section 4- page 20-For Attachment G, detail is requested for the cost. Please give examples of what is expected.

Refer to the answer provided for question 60. Additional detail will not be provided at this time.

65. 1. PROJECT OVERVIEW-1.5-7-The RFP requests that vendors be available for regular meetings, including teleconference and face-to-face meetings in Nevada; however, the Cost Schedule provided in Attachment G does not include a category for teleconference and face-to-face meetings for pricing by vendors. Will the DHCFP consider issuing a Cost Schedule that includes meetings, as it has in previous RFPs?

See revised cost schedule at the beginning of this amendment.

67. 2. SCOPE OF WORK-2.1.2.1-7-Does the DHCFP anticipate conducting the encounter data validation study for the DBA in FY 2019 or FY 2020?

FY 2019

68. 2. SCOPE OF WORK-2.1.2.5, 2.1.5.1.A-8 & 11-Please confirm the anticipated number of entities to be considered in the studies (i.e., MCOs, FFS, PAHP).

Possibly 3 MCOs, 1 DBA, 1 CMO, and FFS.

69. 2. SCOPE OF WORK-2.1.2.5, 2.1.5.1.A-8 & 11-Will the data necessary to complete focused study analyses be obtained from the managed care entities (i.e., MCOs, PAHP, etc.), from the DHCFP, or through a direct connection to the DHCFP's data systems?

Depending on the study the data may come directly from managed care organizations, the DBA, or from the Division.

70. 2. SCOPE OF WORK-2.1.2.5, 2.1.5.1.A-8 & 11-Has the DHCFP identified clinical or non-clinical focused study topics for the first contract year? Are there clinical or non-clinical areas of interest to the DHCFP for purposes of studies on quality?

Topics have not yet been identified for the contract period.

71. 2. SCOPE OF WORK-2.1.2.5, 2.1.5.1.A-8 & 11-Please clarify the DHCFP's expectations regarding the frequency and timing of the focused studies (i.e., one study per year to be completed during the contract year).

The DHCFP has not determined the number of optional studies to be conducted during the contract period.

72. 2. SCOPE OF WORK-2.1.2.5, 2.1.5.1.A-8 & 11-As different study topics may require different data sources, does the DHCFP have a preference as to whether these studies are conducted

using a hybrid methodology (i.e., inclusion of medical record review), a survey, or administrative data?

The study topic will likely determine the data sources. Previous studies have included administrative data, hybrid, and surveys.

a. If a hybrid methodology is requested, will the selected study sample be based on a statewide sample, or should the sample be stratified by FFS/MCOs such that inter-plan comparisons can be made?

It is likely that the sample would be stratified by FFS/MCO so that inter-plan comparisons can be made.

73. 2. SCOPE OF WORK-2.1.2.5, 2.1.5.3-8 & 11-As different study topics may require different data sources, does the DHCFP have a preference as to whether these studies are conducted using a hybrid methodology (i.e., inclusion of medical record review), a survey, or administrative data?

a. If a hybrid methodology is requested, do the FFS/MCOs' provider contracts outline any requirements for the procurement and submission of medical records to the EQRO?

Reference RFP 3260 Section 3.10.18.1 Accessibility and Availability of Medical Records.

74. 2. SCOPE OF WORK-2.1.2.5, 2.1.5.1.A-8 & 11- As different study topics may require different data sources, does the DHCFP have a preference as to whether these studies are conducted using a hybrid methodology (i.e., inclusion of medical record review), a survey, or administrative data?

a. If a hybrid methodology is requested, do the FFS/MCOs have a minimum required timeframe to procure and submit medical records for a focused study?

Timeframes for data submission specific to special projects are usually presented to the MCOs and adjusted if needed after discussion. A calendar of project deliverables and deadlines are provided to the plans for adherence.

75. 2. SCOPE OF WORK-2.1.2.5, 2.1.5.1.A-8 & 11-As different study topics may require different data sources, does the DHCFP have a preference as to whether these studies are conducted using a hybrid methodology (i.e., inclusion of medical record review), a survey, or administrative data?

a. If a hybrid methodology is requested, will the FFS/MCOs be expected to procure and submit requested medical records to the EQRO for abstraction, or will the EQRO be required to abstract the medical records from either physician offices and/or the FFS/MCOs' offices?

The FFS/MCOs will be expected to procure and submit requested medical records to the EQRO.

76. 2. SCOPE OF WORK-2.1.3.4-9-Will the vendor be responsible for creating a crosswalk of MCO provider specialty types for all three MCOs and the FFS program to ensure consistency in categorizing providers?

Yes.

77. 2. SCOPE OF WORK-2.1.3.4-9-Will the vendor be responsible for working with the DHCFP to create network adequacy standards for specialty providers if such standards are not currently defined?

The DHCFP plans on adopting network adequacy standards as established by the Division of Insurance; however, for specialty providers that the DOI have not assigned network adequacy standards for the DHCFP will require the EQRO to assist in identifying/establishing standards for the remaining provider specialties identified within 42 CFR 438.68(b).

78. 2. SCOPE OF WORK-2.1.3.4-9-Is the DHCFP interested in validation results reported for a specific list of provider specialties or provider groups? How many provider specialties does the DHCFP anticipate including in the analysis for each managed care entity (i.e., MCOs, and DBA/PAHP)?

Refer to the last DHCFP network adequacy report located here:
http://dhcfp.nv.gov/Resources/AdminSupport/Reports/CaseloadData/
Future reporting requirements may not exactly mirror previous reports. The Division consults with the Department of Health and Human Services prior to proceeding with Network Adequacy studies to incorporate their recommendations.

79. 4. COST-4-20-The RFP states, "Vendors must provide detailed fixed prices for all costs associated with the responsibilities and related services. Clearly specify the nature of all expenses anticipated."

    a. In addition to completing Attachment G, Cost Schedule, does the DHCFP require detail on all direct costs associated with the tasks, as well as a budget narrative?

    The DHCFP does not require additional cost information outside of the documentation required within Attachment G.

80. 2. SCOPE OF WORK-2.1.5-10 - 11-The RFP states, "The vendor may be required to provide technical assistance and/or optional activities described in 42 CFR 438.58(c)...." Please confirm this citation should be 42 CFR 438.358(c), as stated later in the text.

The correct citation is 42 CFR 438.358 (C). Refer to the beginning of this document.

81. 2. SCOPE OF WORK-2.1.5-10, 11-The last sentence in the cited paragraph states, "Optional activities…may include." The list that follows, 2.1.5.2.a and b, includes compliance audit and performance measure validation for the CMO vendor, which are also listed in the requirement at 2.1.1 for the vendor to perform mandatory activities for the CMO, inclusive of a compliance review (2.1.1.3) and performance measure validation (2.1.1.2).

    a. For purposes of completing the cost schedule, please clarify whether these are optional or mandatory activities the vendor must perform.

    These are optional activities.

83. 2. SCOPE OF WORK-2.1.5.2 B-11-Will the vendor be required to provide a validation of source data (claims processing vendor) as part of the validation of performance measures for the DHCFP's CMO vendor?

Yes.

84. 2. SCOPE OF WORK-2.1.5.3-11-Does the DHCFP anticipate the vendor will be required to produce two Quality Rating Systems—one for Nevada Check Up and one for Medicaid?

Yes, one quality rating system inclusive of both Nevada Check Up and Medicaid beneficiaries.

85. 2. SCOPE OF WORK-2.1.5.4 C-12-Other than conducting performance measure calculation and/or validation, can the DHCFP clarify the activities associated with the evaluation of the implementation of performance measures for the ABD population?

The EQRO would calculate and validate the ABD performance measures.

86. 2. SCOPE OF WORK-2.1.5.4.B-12-The RFP references the need to conduct an information systems (IS) readiness review of a new ABD MCO vendor. Should this also include an operational readiness review that contains the elements described in 42 CFR 438.66(d)(4)?

Yes.

87. 2. SCOPE OF WORK-2.1.5.5.B-12-The RFP references the need to conduct an information systems (IS) readiness review of a new MCO vendor for rural county expansion. Should this also include an operational readiness review that contains the elements described in 42 CFR 438.66(d)(4)?

Yes.

88. 2. SCOPE OF WORK-2.1.5.4.A, B, C-12 & 41-There does not appear to be a designated column on the Optional Activities Cost Schedule for the new Nevada ABD managed care expansion program. Under which column(s) should the vendor price the optional activities for the ABD managed care expansion program?

Attachment G has been revised. Optional activities will be priced by project when a request and SOW is provided to the vendor. Refer to the beginning of this document.

89. 2. SCOPE OF WORK-2.2.5-13-The Code of Federal Regulations citation listed as the reference for the EQRO independence requirements (i.e., §438.310(c)(2) appears to be incorrect. Please confirm the DHCFP intended to refer instead to §438.354(c)(2).

§438.354(c)(2)is the correct citation. Refer to the beginning of this amendment.

90. 2. SCOPE OF WORK-2.2.9-14-Subsection 2.2.9 states, "Contractor must maintain current International Classification of Diseases (ICD) and Electronic Data Interchange (EDI) compliance, as defined by CMS regulation and policy."

a. Compliance with ICD and EDI are more applicable to the original data submitters, as opposed to secondary data users. Please clarify what constitutes compliance with ICD and EDI for secondary data users.

Refer to the beginning of this amendment. Section 2.2.9 has been removed.

91. 2. SCOPE OF WORK-2.4.3 -15-The RFP states, "Unless otherwise agreed to by the DHCFP, submit to the DHCFP, within a minimum of ten (10) working days of the service state date, all deliverables to permit any DHCFP identified modifications." Will the DHCFP please specify the deliverables it expects to receive within 10 working days of the service start date? Are these separate from the work plan, noted in Section 2.4.1 of the RFP, which is due no later than one month following notification that the vendor has been awarded the contract?

The work plan is to be delivered within one month from the notification of contract award. Within 10 days of the service start date the vendor will supply a list of all deliverables they are requesting modifications be made for. The DHCFP will have 20 working days from receipt to respond to the requested modifications/revisions. If the DHCFP does not respond by the 20th working day after receipt, then the DHCFP's approval of the submission will be assumed as granted.

92. 2. SCOPE OF WORK-2.1.1.2-7-Will the DBA performance measures be standardized measures or measures developed by the DHCFP?

DBA- 1 HEDIS and 3 non-HEDIS measures

93. 2. SCOPE OF WORK-2.1.1.2-7-If the DHCFP-developed performance measures are used, will the DHCFP update and maintain the methodologies, or will the vendor update and maintain the methodologies?

The vendor will update and maintain the methodologies.

94. 2. SCOPE OF WORK-2.1.1.2-7-Will the vendor be responsible for updating and maintaining the performance measure specifications for the CMO?

Yes.

95. 2. SCOPE OF WORK-2.1.1.2-7-Will the vendor provide technical assistance in determining or selecting performance measures for the CMO program?

The current vendor provided technical assistance with selecting performance measures for the CMO. CMO performance measures were identified at the beginning of the demonstration waiver. The demonstration waiver will expire 6/30/2018.

96. 2. SCOPE OF WORK-2.1.2.2 & 2.1.5.1-7 & 11-For the Nevada Medicaid FFS population, one of the optional activities listed is CAHPS. Will the vendor be required to administer a survey?

Yes.

97. 2. SCOPE OF WORK-2.1.2.2 & 2.1.5.1-7 & 11-For the Nevada Medicaid FFS population, one of the optional activities listed is CAHPS. Please confirm only one (1) reporting unit (i.e., the entire Nevada Medicaid FFS population) will be sampled.

This is true of the current project. Future projects may differ in scope. The DHCFP would provide a request outlining the SOW of future projects and request a cost proposal at that time.

98. 2. SCOPE OF WORK-2.1.2.2 & 2.1.5.1-7 & 11-For the Nevada Medicaid FFS population, one of the optional activities listed is CAHPS. Will both adult and children be surveyed?

The population and type of CAHPS survey(s) would be determined prior to implementing the optional activity. The vendor would be provided a SOW and a cost proposal would be requested by DHCFP prior to initiating the project.

99. 2. SCOPE OF WORK-2.1.2.2 & 2.1.5.1-7 & 11-For the Nevada Medicaid FFS population, one of the optional activities listed is CAHPS. If children are surveyed, which version of the CAHPS survey instrument will be required for administration:

(1) the Child Medicaid CAHPS Survey without the Children with Chronic Condition measurement set or;

(2) the Child Medicaid CAHPS Survey with the Children with Chronic Conditions measurement set?

See question 98 of this amendment.

100. 2. SCOPE OF WORK-2.1.2.2 & 2.1.5.1-7 & 11-For the Nevada Medicaid FFS population, one of the optional activities listed is CAHPS. How many supplemental items will be added to the standard CAHPS surveys?

The DHCFP would determine project details once it is decided to move forward with the optional activity.

101. 2. SCOPE OF WORK-2.1.2.2 & 2.1.5.1-7 & 11-For the Nevada Medicaid FFS population, one of the optional activities listed is CAHPS. Please confirm whether the DHCFP requires oversampling.

In the event DHCFP selects this optional activity the Division would require oversampling.

102. 2. SCOPE OF WORK-2.1.2.2 & 2.1.5.1-7 & 11-For the Nevada Medicaid FFS population, one of the optional activities listed is CAHPS. In which languages will the surveys be administered?

In the event DHCFP selects this optional activity the surveys would likely be administered in English and Spanish.

103. 2. SCOPE OF WORK-2.1.2.2 & 2.1.5.1-7 & 11-For the Nevada Medicaid FFS population, one of the optional activities listed is CAHPS. Please confirm a standard mixed-mode methodology will be employed for all survey administration activities (i.e., two mailings, two reminder postcards, and telephone follow-up).

The DHCFP would determine project details once it is decided to move forward with the optional activity.

104. 2. SCOPE OF WORK-2.1.2.2 & 2.1.5.1-7 & 11-For the Nevada Medicaid FFS population, one of the optional activities listed is CAHPS. Will survey results be submitted to the NCQA and/or AHRQ's CAHPS Health Plan Survey database?

Yes.

105. 2. SCOPE OF WORK-2.1.2.2 & 2.1.5.1-7 & 11-For the Nevada Medicaid FFS population, one of the optional activities listed is CAHPS. What deliverables will be required for this activity?

The DHCFP would determine project details once it is decided to move forward with the optional activity.

106. 2. SCOPE OF WORK-2.1.2.2 & 2.1.5.1-7 & 11-For the Nevada Medicaid FFS population, one of the optional activities listed is CAHPS. Will the vendor be required to validate?

In the event DHCFP selects this optional activity the vendor would be required to validate.

107. 2. SCOPE OF WORK-2.1.2.3-8-Regarding the calculation performance measures, in addition to those reported by health plans, does the DHCFP anticipate having the vendor calculate hybrid measures?

Measures for this optional activity have not yet been selected. It is possible that hybrid measures may be selected.

108. 2. SCOPE OF WORK-2.1.2.3-8-Please confirm the vendor will validate both clinical and non-clinical PIPs, for a total of five (5) PIPs per MCO to be validated.

RFP 3491 Section 2.1.3.3 states that mandatory activities would include the validation of 2 clinical PIPs and 3 non-clinical PIPs (5 PIPs) per MCO; and one clinical PIP and one non-clinical PIP for the DBA.

109. 2. SCOPE OF WORK-2.1.2.3-8-Please provide the approximate number of measures the vendor will be required to calculate for the FFS population.

Currently, there are 9 administrative measures that are calculated for the FFS population.

110. 2. SCOPE OF WORK-2.1.2.3-8-Please provide the number of sub-populations within the FFS population the vendor will be required to calculate measures.

The FFS performance measures are: Follow up after hospitalization after hospitalization for Mental Illness (FUH), Mental Health Utilization (MPT), Follow up after ED visit foe Mental Illness, Follow up after ED visit for ETOH and other Drugs, Use of opioids at high dosage (UOD), Use of opioids from multiple providers (UOP), Children and Adolescents access to primary care (CAP), Annual Dental Visit (ADV), and Adult Access to primary care (AAP).

111. 2. SCOPE OF WORK-2.1.2.6-8-Please clarify the type of assistance that will be required for the Quality Rating System for the FFS population. Will this assistance be limited to technical assistance or development and production of a Quality Rating System?

Development and production of the QRS.

112. 2. SCOPE OF WORK-2.1.3.2 C & D-8-Please confirm if the DHCFP anticipates including both Medicaid and CHIP HEDIS rates in the comparative analysis? If yes, does the DHCFP anticipate receiving separate reports for each population or a single report only?

The expectation is the Medicaid and CHIP rates will be included in a comparative analysis within in a single report. Please refer to our previous Technical Reports for more information.
http://dhcfp.nv.gov/Resources/AdminSupport/Reports/CaseloadData/

113. 2. SCOPE OF WORK-2.1.3.2 A-8-The RFP states that validation will be required for HEDIS and other performance measures. Will the DHCFP provide a list of the non-HEDIS measures that are required for reporting by the MCO, DBA/PAHP, and CMO? Are any of the non-HEDIS measures required to use hybrid methodology?

Currently there are 26 HEDIS measures for the MCOs, 1 HEDIS and 3 non-HEDIS measures for the DBA, and 22 HEDIS like measures for the CMO. The non-HEDIS measures for the DBA have not yet been determined, and it is uncertain the number that may use a hybrid methodology at this time.

114. 3. COMPANY BACKGROUND AND REFERENCES-3.4-20 & 40-Section 3.4 states that a resume is required "for each key personnel…;" however, Attachment F indicates a resume is to be completed "for all proposed prime contractor staff and proposed subcontractor staff." Due to a significant difference in the number of resumes potentially required, please confirm whether the DHCFP requires submission of all proposed vendor and subcontractor staff resumes or only resumes for those designated as key vendor and contractor personnel.

Submit forms for all proposed contractor and subcontractor staff.

115. 9. PROPOSAL EVALUATION AND AWARD PROCESS-9.1-27-The scoring for cost indicates that the total cost for the proposal will be included in the cost formula to determine the cost criteria score. There are several tasks listed in Section 2.1.5 Technical Assistance and Optional Activities, that may or may not be requested by the DHCFP, which are included in the cost schedule in Attachment G. Further, Section 2.1.5.6 does not specify the tasks related to technical assistance or consulting, but the activity seems to be referenced in the cost schedule in Attachment G. Would the DHCFP consider removing costs associated with undefined technical assistance and consulting from the cost formula to determine the cost criteria score?

No, cost must be evaluated per NRS 333. However, the cost has been revised. Refer to beginning of this amendment.

116. 9. PROPOSAL EVALUATION AND AWARD PROCESS-9.6-28-This requirements states, "Each vendor shall include in its proposal a complete disclosure of any alleged significant prior or ongoing contract failures, contract breaches, any civil or criminal litigation or investigations pending which involves the vendor or in which the vendor has been judged guilty or liable."

Please provide the proposal part and section in which the State would like the response, even if there is nothing to report.

Refer to Section 3.1.7 of RFP 3491.

117. ATTACHMENT E – REFERENCE QUESTIONNAIRE-Attachment E-39-There is an inconsistency between the Instructions to Proposing Vendor and the Reference Questionnaire regarding where the Reference should be returned. The Instructions to Proposing Vendor states it should be returned to: rlmiller@admin.nv.gov. However, the Reference Questionnaire states:

Business reference is requested to submit the completed Reference Questionnaire via email or facsimile to:

State of Nevada, Purchasing Division
Subject: RFP 3491
Attention: Purchasing Division
Email: rfpdocs@admin.nv.gov
Fax: 775-684-0188

Please confirm the correct e-mail address for the return of the Reference Questionnaire.

The correct e-mail is rlmiller@admin.nv.gov

118. ATTACHMENT F– PROPOSED STAFF RESUME-Attachment F-40-Please clarify what is expected in the field entitled, "# of Years in Classification". Is this the number of years the staff member has been in their current position?

This is the number of years doing this type of service.

119. ATTACHMENT G – COST SCHEDULE-Attachment G-41-The entries in the Cost Schedule column labeled "RFP Citation" do not align with the RFP citations for the activities listed in Section 2. Will the DHCFP consider issuing a revised Cost Schedule to help ensure vendors address the correct RFP requirements for each price proposed?

Refer to beginning of this amendment for RFP submittal change.

120. ATTACHMENT G – COST SCHEDULE-Attachment G-41-Please confirm that not all cells on the Cost Schedule require that a price be entered. For example, on the Optional Activities schedule, the row for Technical Assistance – Onsite contract compliance audit of the contracted CMO vendor will only have a price under the CMO-FFS column.

The Cost Schedule has been revised. Please review revised Attachment G at the beginning of this amendment.

ALL ELSE REMAINS THE SAME FOR RFP 3491

Vendor must sign and return this amendment with proposal submitted.

Vendor Name: Mercer Health & Benefits LLC

Authorized Signature:

Title: Partner Date: 2/6/2018

This document must be submitted in the "State Documents" section of vendors' technical proposal.

State of Nevada
Department Administration
Purchasing Division
515 E. Musser Street, Suite 300
Carson City, NV 89701

Brian Sandoval
Governor

Jeffrey Haag
Administrator

SUBJECT:	Amendment 2to Request for Proposal 3491
RFP TITLE:	External Quality Review Organization (EQRO)
DATE OF AMENDMENT:	February 8, 2018
DATE OF RFP RELEASE:	January 10, 2018
OPENING DATE:	February 22, 2018
OPENING TIME:	2:00 PM
CONTACT:	Ronda Miller, Purchasing Officer II

The following shall be a part of RFP ***3491***. If a vendor has already returned a proposal and any of the information provided below changes that proposal, please submit the changes along with this amendment. You need not re-submit an entire proposal prior to the opening date and time.

Clarification from Amendment 1:

Old Response:

42. 2.1.3.2-8-Does the DHCFP anticipate requesting MCOs to become NCQA Accredited or Certified in the future?

    More than one MCO is currently NCQA accredited. This is not a current State of Nevada requirement.

New Response:

42. 2.1.3.2-8-Does the DHCFP anticipate requesting MCOs to become NCQA Accredited or Certified in the future?

    The MCO's are required to be accredited by a nationally recognized organization that provides an independent assessment of the quality of care provided by the vendor.

QUESTIONS & ANSWERS:

1. Since the State re-issued a new version of Attachment G Cost Proposal form, will the State please answer the following clarification questions:

    a. New Attachment G - Cost Proposal Form: Is the State expecting a price for each cell in this new Attachment (whether or not the Activity may be applicable to the listed column/program/entity)?

No. Cells that are not applicable shall be marked N/A.

b. New Attachment G - Cost Proposal Form: If PIPs are not currently conducted by the CMO-FFS entity, is the Vendor allowed to list a $0 price in the validation of performance improvement project cost cells? If not allowed, in what year does the State expect this Activity to be applicable to the CMO-FFS entity/program?

The state has no expectation of PIP activities for the current CMO-FFS vendor, and the state does not have a projected date of activity for future CMO-FFS vendors/projects. Please indicate N/A in cells that a cost is not applicable.

c. New Attachment G - Cost Proposal Form: If an Activity can be conducted under one entity/program, but cover multiple entities/programs, does the State want one price in the appropriate column (e.g., MCO Title XIX) and other columns/entities/programs listed with $0 (e.g., MCO Title XXI) or does the State want costs to be allocated across all columns/entities/programs?

The state expects a cost per activity by population (MCO Title XIX, MCO Title XXI, CMO FFS, etc). If the population is not applicable to the activity, then N/A can be indicated within the cell. The state would interpret $0 as an indication the activity would be completed for no charge.

2. Can the State please reconcile responses to Questions 36 and 38 regarding whether suggested modifications/exceptions to the contract are permitted or not?

No.

ALL ELSE REMAINS THE SAME FOR RFP 3491

Vendor must sign and return this amendment with proposal submitted.

Vendor Name: Mercer Health & Benefits LLC

Authorized Signature:

Title: Partner Date: 2/8/2018

This document must be submitted in the "State Documents" section of vendors' technical proposal.

Amendment 2 *RFP 3491* *Page 2 of 2*

B. ATTACHMENT A – CONFIDENTIALITY AND CERTIFICATION OF INDEMNIFICATION

ATTACHMENT A – CONFIDENTIALITY AND CERTIFICATION OF INDEMNIFICATION

Submitted proposals, which are marked "confidential" in their entirety, or those in which a significant portion of the submitted proposal is marked "confidential" **shall not** be accepted by the State of Nevada. Pursuant to NRS 333.333, only specific parts of the proposal may be labeled a "trade secret" as defined in NRS 600A.030(5). All proposals are confidential until the contract is awarded; at which time, both successful and unsuccessful vendors' technical and cost proposals become public information.

In accordance with the submittal instructions of this RFP, vendors are requested to submit confidential information in separate files marked "**Part IB Confidential Technical**" and "**Part III Confidential Financial**".

The State shall not be responsible for any information contained within the proposal. If vendors do not comply with the labeling and packing requirements, proposals shall be released as submitted. In the event a governing board acts as the final authority, there may be public discussion regarding the submitted proposals that shall be in an open meeting format, the proposals shall remain confidential.

By signing below, I understand it is my responsibility as the vendor to act in protection of the labeled information and agree to defend and indemnify the State of Nevada for honoring such designation. I duly realize failure to so act shall constitute a complete waiver and all submitted information shall become public information; additionally, failure to label any information that is released by the State shall constitute a complete waiver of any and all claims for damages caused by the release of the information.

This proposal contains Confidential Information, Trade Secrets and/or Proprietary information.

Please initial the appropriate response in the boxes below and provide the justification for confidential status.

Part IB – Confidential Technical Information			
YES		NO	***X***
Justification for Confidential Status			

Part III – Confidential Financial Information			
YES	***X (Subcontractor)***	NO	***X (Mercer)***
Justification for Confidential Status			
Mercer is not submitting any confidential financial information. Per the statement below, our subcontractor NORC submits Part III - Confidential Financial Information as required in the RFP.			
NORC's financial information constitutes as trade secret and is not subject to disclosure under any federal or state freedom of information law or regulation. We have submitted a separate Part III – Confidential Financial Information form for NORC only.			

Mercer Health & Benefits LLC
Company Name

Signature

Frederick Gibison Jr, MBA, Partner — 2/6/2018
Print Name — Date

This document shall be submitted in Section IV of vendor's technical proposal

C. ATTACHMENT B – VENDOR CERTIFICATIONS

ATTACHMENT B – VENDOR CERTIFICATIONS

Vendor agrees and shall comply with the following:

(1) Any and all prices that may be charged under the terms of the contract do not and shall not violate any existing federal, State or municipal laws or regulations concerning discrimination and/or price fixing. The vendor agrees to indemnify, exonerate and hold the State harmless from liability for any such violation now and throughout the term of the contract.

(2) All proposed capabilities can be demonstrated by the vendor.

(3) The price(s) and amount of this proposal have been arrived at independently and without consultation, communication, agreement or disclosure with or to any other contractor, vendor or potential vendor.

(4) All proposal terms, including prices, shall remain in effect for a minimum of 180 days after the proposal due date. In the case of the awarded vendor, all proposal terms, including prices, shall remain in effect throughout the contract negotiation process.

(5) No attempt has been made at any time to induce any firm or person to refrain from proposing or to submit a proposal higher than this proposal, or to submit any intentionally high or noncompetitive proposal. All proposals shall be made in good faith and without collusion.

(6) All conditions and provisions of this RFP are deemed to be accepted by the vendor and incorporated by reference in the proposal, except such conditions and provisions that the vendor expressly excludes in the proposal. Any exclusion shall be in writing and included in the proposal at the time of submission.

(7) Each vendor shall disclose any existing or potential conflict of interest relative to the performance of the contractual services resulting from this RFP. Any such relationship that might be perceived or represented as a conflict shall be disclosed. By submitting a proposal in response to this RFP, vendors affirm that they have not given, nor intend to give at any time hereafter, any economic opportunity, future employment, gift, loan, gratuity, special discount, trip, favor, or service to a public servant or any employee or representative of same, in connection with this procurement. Any attempt to intentionally or unintentionally conceal or obfuscate a conflict of interest shall automatically result in the disqualification of a vendor's proposal. An award shall not be made where a conflict of interest exists. The State shall determine whether a conflict of interest exists and whether it may reflect negatively on the State's selection of a vendor. The State reserves the right to disqualify any vendor on the grounds of actual or apparent conflict of interest.

(8) All employees assigned to the project are authorized to work in this country.

(9) The company has a written equal opportunity policy that does not discriminate in employment practices with regard to race, color, national origin, physical condition, creed, religion, age, sex, marital status, sexual orientation, developmental disability or handicap.

(10) The company has a written policy regarding compliance for maintaining a drug-free workplace.

(11) Vendor understands and acknowledges that the representations within their proposal are material and important, and shall be relied on by the State in evaluation of the proposal. Any vendor misrepresentations shall be treated as fraudulent concealment from the State of the true facts relating to the proposal.

(12) Vendor shall certify that any and all subcontractors comply with Sections 7, 8, 9, and 10, above.

(13) The proposal shall be signed by the individual(s) legally authorized to bind the vendor per NRS 333.337.

Mercer Health & Benefits LLC
Vendor Company Name

Vendor Signature

Frederick Gibison Jr, MBA, Partner — 2/6/2018
Print Name — Date

This document shall be submitted in Section IV of vendor's technical proposal

EQRO *RFP 3491* *Page 36 of 44*

D. ATTACHMENT H – CERTIFICATION REGARDING LOBBYING

ATTACHMENT H – CERTIFICATION REGARDING LOBBYING

Certification for Contracts, Grants, Loans, and Cooperative Agreements

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

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

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

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

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

By: _____ 2/6/2018
Signature of Official Authorized to Sign Application — Date

For: Mercer Health & Benefits LLC
Vendor Name

This document shall be submitted in Section IV of vendor's technical proposal

E. VENDOR LICENSING & MAINTENANCE AGREEMENTS

Copies of any vendor licensing agreements and/or hardware and software maintenance agreements.

Mercer provides a Quality Compass License Agreement within this section of our proposal.

QUALITY COMPASS®
LICENSE AGREEMENT

This License Agreement along with all materials referenced herein ("Agreement") is a legal agreement between the Licensee and The National Committee for Quality Assurance ("NCQA") to permit Licensee through its Licensed Users to access and use, subject to the terms of this Agreement, NCQA's product identified in this Agreement and accompanying documentation provided electronically. "Licensee" means only the legal entity or organization whose authorized acceptance appears below as evidence of agreement to these terms. "Licensed Users" means the individuals who shall be eligible to access and use the Product on behalf of the Licensee pursuant to Section 4 below.

YOU MUST READ THIS AGREEMENT CAREFULLY BEFORE INDICATING ACCEPTANCE AT THE END BY CLICKING THE "ACCEPT AGREEMENT" BUTTON. THE INDIVIDUAL ACCEPTING THIS AGREEMENT ON BEHALF OF LICENSEE REPRESENTS THAT BY ELECTRONICALLY SIGNING THIS AGREEMENT THE INDIVIDUUAL HEREBY BINDS THE LICENSEE TO THE TERMS OF THIS AGREEMENT, AND THAT SUCH INDIVIDUAL IS AN EMPLOYEE OF LICENSEE AND DULY AUTHORIZED TO ENTER INTO AND BIND LICENSEE TO THE TERMS OF THIS AGREEMENT. IF YOU DO NOT AGREE TO ANY OF THE TERMS OF THIS AGREEMENT, CLICK ON THE "DECLINE" BUTTON AT THE END OF THIS AGREEMENT AND YOU WILL NOT BE PERMITTED TO ACCESS AND USE THE PRODUCT.

1. Product.
The Product is the versions (Commercial, Medicaid or Medicare) of Quality Compass® 2017 and any updates to a given version licensed by NCQA, whether in electronic or hard copy under this Agreement. Quality Compass is updated annually, and previous licensed versions remain available to Licensee for three additional years beyond the Product release year. Licensee may only access the version for years which they have licensed. To the extent the Licensee has access to multiple versions of Quality Compass, this Agreement applies respectively to the following Product versions: Quality Compass 2014, Quality Compass 2015, Quality Compass 2016 and Quality Compass 2017. Licensee may need additional software to use the Product and NCQA is not responsible for such additional software.

The Product contains individual Healthcare Effectiveness Data and Information Set (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) measures as well as Plan Specific, Regional, State, Census and National HEDIS and CAHPS rates (the "HEDIS Measures").

Each HEDIS measure may be comprised of a number of individual HEDIS indicators (the "HEDIS Measure Indicators"). For example, the Comprehensive Diabetes Care HEDIS measure includes seven (7) individual HEDIS Measure Indicators. Each question in a CAHPS composite HEDIS measure is considered an individual HEDIS Measure Indicator.

For 2014-2016 Quality Compass: Each RRU + Quality Index measure (Asthma, Cardiovascular Conditions, COPD, Diabetes and Hypertension) is comprised of multiple indices, all of which are also considered as individual HEDIS Measure Indicators.

2. License Grant and Restrictions.
Subject to the terms of this Agreement, NCQA hereby grants Licensee a personal, non-exclusive, non-transferable license to access and use the Product or any portion thereof in accordance with this Agreement ("License") as follows: competitor analysis; benchmark analysis; trended data analysis; quality improvement initiatives; data analysis; cost analysis; analysis of performance from year to year; profiling performance goals and surveillance; custom reporting; market research; and/or marketing/advertising plan performance. The License grants Licensee the right to access and use the Product, subject to the terms of this Agreement, to a limited number of Licensed Users as defined below. The License is not transferable from Licensee to any other person, entity, organization or association, including without limitation any affiliate, shareholder, partner, or member of Licensee. Nothing in this Agreement grants to Licensee any rights to transfer the License to or use of the Product by or on behalf of any parent, subsidiary or affiliate of Licensee. Except for authorized Licensed Users, each person, entity, organization or association, parent, subsidiary, or affiliate is required to separately contract and register with NCQA in order to obtain and access the Product. Licensee shall abide by the following limitations and restrictions on the License:

(A) The maximum number of individual HEDIS Measure Indicators contained in the Product which may ever be shared (internally or externally) by Licensee (whether in a single or multiple reports), is fifteen (15) HEDIS Measure Indicators, no more than two (2) averages or percentiles contained in the Product. Inclusion of additional HEDIS Measure Indicators, averages or percentiles require written approval of NCQA, which may be subject to fee assessment and require a separate license agreement.

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(B) **For 2014-2016 Quality Compass**: As these Licenses provide access to the Quality Compass RRU + Quality Index license, Licensees must jointly share the maximum number of individual HEDIS Measure Indicators as outlined in 2. (A). For example, a Licensee with access to a Commercial License and RRU + Quality Index License, would be permitted to publish a report with twelve HEDIS Measure Indicators and three RRU + Quality Index Measure Indicators. Collectively, these fifteen rates equal what is permitted in Section 2. (A).

(C) **For 2014-2016 Quality Compass**: As these Licenses provide access to a Commercial, Medicaid, or Medicare license **and** a separate standalone RRU + Quality Index license, Licensee would be permitted to publish a report with up to fifteen HEDIS Measure Indicators and all five RRU + Quality Index Measure Indicators, respectively. For Licenses that **only** have access to a standalone RRU + Quality Index License, Licensee would be permitted to publish a report with all five RRU + Quality Index Measure Indicators.

(D) Licensee may publish (whether in a single or multiple publications) the information contained in 2(A) above, for a maximum of twenty (20) health plan products contained in the Product. Publication of information on additional health plan products requires the written approval of NCQA.

(E) Licensee may compare an individual health plan's HEDIS Measures or HEDIS Measure Indicators to another health plan's HEDIS Measures or HEDIS Measure Indicators in the same geographic market, or to several health plans' HEDIS statistics in the same geographic market, provided that an average or percentile appears in the comparison (i.e. national, regional, or state) for that particular measure(s).

(F) Licensee agrees to comply with any guidelines for publication, advertising, marketing or use of the Product that may be issued by NCQA from time to time and posted on www.NCQA.org.

(G) Licensee agrees to abide by all applicable local, state, national and international laws and regulations.

(H) Except as otherwise expressly permitted under this Agreement, Licensee may not itself or permit others to:

(1) distribute, sublicense, or copy the Product in any format, including, but not limited to, other print or electronic publication service or product;

(2) decompile, disassemble, analyze or otherwise examine the Product for the purpose of reverse engineering (except to the extent this restriction is expressly prohibited by applicable law);

(3) delete or in any manner alter any notices, disclaimers or other legends contained in the Product or appearing on any screens, documents, or other materials obtained by Licensee through use of the Product;

(4) provide service bureau facilities or commercial time-sharing services to any third party or supporting operations for any third party through the access and/or use of the Product;

(5) copy, reproduce, republish, upload, post, transmit, or distribute the Product, or any portion thereof, or facilitate or permit a third party to do so;

(6) modify or prepare derivative works from the Product;

(7) use any device or software to interfere or attempt to interfere with the proper operation of the Product;

(8) ship, transmit, transfer, or export the Product into any country or use the Product in any manner prohibited by United States export laws, restrictions or regulations;

(9) transmit the Product electronically or allow access to the Product over a network or a public computer-based information system which permits access to a greater number of users than licensed by Licensee;

(10) use the Product in multiple computer or multiple user arrangements unless that use is covered by a separate license for each computer or user; or

(11) rent, lease, or distribute or otherwise transfer possession of any copy of the Product to any third party.

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3. Product Updates.
Any updates, modifications, enhancements or new versions of the Product provided or made available to Licensee by NCQA, in accordance with Section 11, Support, of this Agreement, shall be considered part of Product updates and subject to this Agreement. NCQA may at any time and for any reason elect to modify, discontinue, delete or restrict any aspect or feature of the Product without notice to Licensee or any liability to NCQA or any NCQA Party (as defined in Section 6); however, NCQA agrees to make commercially reasonable efforts to provide Licensee with prior notice of any such changes.

4. Registered and Licensed Users.
In order for Licensee to access and use the Product, Licensee shall register with NCQA, provide NCQA with an email address, pay the license fee ("Fee") and obtain a unique password for accessing the Product ("Password"). The Fee shall be determined at the time of registration based on the number of authorized users. An authorized user is an employee of Licensee that is accessing and using the Product under the License solely on behalf of Licensee (each individual is a "User" and collectively referred to as the "Licensed Users"). The Fee is non-refundable upon use of the Password. Upon receiving a Password, Licensee may issue unique passwords solely to its Licensed Users, up to the number of Users paid for by Licensee. Licensed Users may only use and access the Product for Licensee's business purposes pursuant to Section 2 above and may not access or use the Product for any other purpose or for any other person or entity that is not the Licensee. NCQA and Licensee acknowledge and agree that NCQA may obtain email addresses from Licensed Users upon their accessing and using the Product. Licensee is responsible and wholly liable for all acts or omissions committed under Licensee's Password and any and all passwords issued by Licensee to Licensed Users. The sharing, transferring or dissemination of passwords with unauthorized persons is a material breach of this Agreement and a violation of the License. For avoidance of doubt, employees and agents of Licensee's parent, subsidiaries, affiliates, shareholders, partners, or members, or any other person or entity are unauthorized users.

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Licensee must include the following statement when using the Product under the terms of this Agreement in any publication:

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6. Disclaimers.
EXCEPT AS OTHERWISE EXPRESSLY PROVIDED IN THIS AGREEMENT, (A) THE PRODUCT IS PROVIDED "AS-IS" AND, TO THE MAXIMUM EXTENT PERMITTED BY APPLICABLE LAW, NCQA AND ITS DIRECTORS, OFFICERS, LICENSORS, SUBCONTRACTORS AND AGENTS ("NCQA PARTIES") DISCLAIM ALL WARRANTIES OF ANY KIND, EXPRESS OR IMPLIED, REGARDING THE PRODUCT OR OTHERWISE RELATING TO THIS AGREEMENT, INCLUDING WARRANTIES OF FITNESS FOR A PARTICULAR PURPOSE, MERCHANTABILITY, NON-INFRINGEMENT AND ACCURACY; (B) NEITHER NCQA NOR ANY NCQA PARTY WARRANTS THAT THE PRODUCT IS OR WILL BE ACCURATE, COMPLETE, UNINTERRUPTED, WITHOUT ERROR, OR FREE OF VIRUSES, WORMS, OTHER HARMFUL COMPONENTS, OR OTHER PROGRAM LIMITATIONS; (C) LICENSEE ASSUMES THE ENTIRE COST OF ALL NECESSARY SERVICING, REPAIR, OR CORRECTION OF PROBLEMS CAUSED BY VIRUSES OR OTHER HARMFUL COMPONENTS, UNLESS SUCH ERRORS OR VIRUSES ARE THE DIRECT RESULT OF NCQA'S GROSS NEGLIGENCE OR WILLFUL MISCONDUCT; (D) EACH OF NCQA AND THE NCQA PARTIES DISCLAIM AND MAKE NO WARRANTIES OR REPRESENTATIONS AS TO THE ACCURACY, QUALITY, RELIABILITY, SUITABILITY, COMPLETENESS, TRUTHFULNESS, USEFULNESS, OR EFFECTIVENESS OF THE REPORTS, DATA, SCORES, RESULTS OR OTHER INFORMATION OBTAINED,

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GENERATED OR OTHERWISE RECEIVED BY LICENSEE FROM ACCESSING AND/OR USING THE PRODUCT OR OTHERWISE RESULTING FROM THIS AGREEMENT, AND (E) USE OF THE PRODUCT IS ENTIRELY AT LICENSEE'S OWN RISK AND NCQA AND EACH OF NCQA PARTIES SHALL HAVE NO LIABILITY OR RESPONSIBILITY THEREFOR.

7. Proprietary Rights.
The Product is protected by applicable United States and foreign laws and treaties, including copyright laws and treaty provisions. NCQA or its licensors own all rights, title and interests in the Product, including trade secrets, patents, copyrights and database rights, and the Product shall remain the sole and exclusive property of NCQA. Except as provided in Section 2 of this Agreement, Licensee has no, and is not granted, any right, title, interest or license in the Product.

8. Trade names and Trademarks.
This Agreement does not grant to any party a license to use any trademark, trade name, or logo of the other party, and each party recognizes that the trademarks, trade names, and logos of the other party represent valuable assets of that party and that substantial recognition and goodwill are associated with such trademarks, trade names, and logos. Each party hereby agrees that it shall not use or permit any third party to use, at any time, the other party's trademarks, trade names, or logos, except as expressly permitted by this Agreement.

9. Injunctive Relief.
Each party acknowledges that a violation of Sections 2, 5, or 8 of this Agreement would cause irreparable harm to the other party for which no adequate remedy at law exists and each party therefore agrees that, in addition to any other remedies available, the aggrieved party shall be entitled to seek injunctive relief to enforce the terms of Sections 2, 5, or 8. The prevailing party shall be entitled to recover all costs and expenses, including reasonable attorney's fees incurred because of any such legal action.

10. Service Requirements.
Licensee agrees to access and use the Product in accordance with any and all operating instructions or procedures that may be issued by NCQA and amended by NCQA from time to time. NCQA does not make any commitments with respect to use or performance of the Product with browsers other than those browsers currently supported by Microsoft.

11. Support.
NCQA will provide Licensee with (a) commercially reasonable telephone and email support for the Product during normal business hours; and (b) updates and enhancements for the Product, to the extent that NCQA generally makes such updates and enhancements available to Licensees without a separate charge.

12. Limitation of Liability.
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13. Indemnity.

Licensee agrees to defend, indemnify and hold NCQA and each NCQA Party, harmless from any losses, liabilities, damages, actions, claims or expenses (including reasonable attorneys' fees and court costs) arising or resulting from Licensee's breach of any term of this Agreement or caused by acts or omissions performed by Licensee or under Licensee's Password or any password issued by Licensee to Licensed Users.

14. Severability.
If any portion of this Agreement is determined by a court of competent jurisdiction or any appropriate legislature to be wholly or partially unenforceable, for any reason, such unenforceability shall not affect the balance hereof.

15. Termination.
Licensee's right to use the Product shall be effective from the date Licensee accepts this Agreement by clicking "Accept Agreement" below, and shall terminate when Licensee ceases all access and use of the Product and provides NCQA with notice of such termination or as otherwise provided in this Agreement. NCQA may terminate this Agreement immediately if Licensee breaches a material term of this Agreement and fails to remedy that breach within five (5) business days after notice from NCQA. Upon termination of this Agreement, all rights, including the License granted to Licensee, under this Agreement will cease and Licensee's access to the Product may be disabled. Upon termination of this Agreement, Sections 2, 5, 6, 7, 9, 12, 13, 15, 17(A), 17(C), 17(D) of the Agreement, along with all payment obligations under this Agreement, shall survive such termination.

16. Electronic Agreement/Notices.

(A) Notices. All questions, comments or notices concerning this Agreement shall be submitted to NCQA by Licensee via https://my.NCQA.org or via mail at: NCQA, Attention: Information Products, 1100 13th Street, NW, Third Floor, Washington, DC 20005. All notices to be given under this Agreement to Licensee shall be submitted by NCQA via email at the account Licensee provided to NCQA pursuant to Section 4 or to Licensee upon accessing the Product.

(B) Acceptance. By clicking "Accept Agreement" below and providing NCQA with Licensee's email address under Section 4, Licensee agrees and consents to (i) contract electronically with NCQA for the Product in accordance with this Agreement; (ii) receipt of electronic legal notices regarding this Agreement to the email account Licensee provided under Section 4 or upon accessing the Product; and (iii) that by clicking "Accept Agreement", Licensee intends to be bound by this Agreement.

(C) Agreement. In order to access, download, and print this Agreement, Licensee should click on the link for the .PDF file version of this Agreement. Changes to these hardware and software requirements, if any, will be e-mailed to Licensee. Licensee may also request to receive a copy of this Agreement by U.S. mail free of charge by giving notice to NCQA of such request within forty five (45) days after entering into this Agreement.

(D) Changes. If Licensee consented to receive ongoing legal notices from NCQA via email Licensee may (i) update its email information by providing notice to NCQA and/or (ii) withdraw such consent by providing notice to NCQA. Please be aware that if Licensee withdraws its consent, such withdrawal of consent will not be effective until the date of receipt. The legal effect of this intervening time period is that Licensee is still bound by the terms of this Agreement during such period. The legal consequence of withdrawing Licensee's consent shall not act to void or invalidate Licensee's actions prior to the effective date that shall remain subject to the terms of this Agreement. Upon withdrawing Licensee's consent Licensee will be responsible for all incurred fees and charges payable under this Agreement.

17. Miscellaneous.

(A) Modifications. This Agreement is the complete and exclusive statement of the agreement between Licensee and NCQA, and supersedes any proposal or prior agreement, oral or written, and any other communications between the parties relating to the subject matter of this Agreement. This Agreement may not be modified by Licensee except upon mutual agreement by the parties in writing signed by an authorized officer of NCQA. NCQA reserves the right, at any time, to change the terms of this Agreement by providing Licensee with notice of such changes. Any use of the Product by Licensee after NCQA's publication or email of any such changes shall constitute Licensee's acceptance of the Agreement as modified.

(B) Force Majeure. NCQA will not be responsible for any failure to perform due to causes beyond its reasonable control, including but not limited to, acts of God, acts of terrorism, war, riot, embargoes, acts of civil or military authorities, national disasters, strikes and the like.

(C) Governing Law and General Provisions. This Agreement will be governed by the laws of the District of Columbia, excluding the application of its conflicts of law rules. This Agreement will not be governed by the United Nations

Convention on Contracts for the International Sale of Goods, the application of which is expressly excluded. If any part of this Agreement is found void and unenforceable, it will not affect the validity of the remainder of the Agreement, which shall remain valid and enforceable according to its terms. The words "and" as well as "or" shall be interchangeable to provide the broadest interpretation, and the word "including" shall mean "including without limitation" and "including but not limited to" to provide the broadest interpretation. The headings contained in this Agreement are for reference only and shall not affect the meaning or interpretation of this Agreement. NCQA's failure to exercise or enforce any right or power under this Agreement shall not constitute a waiver of such right or power.

(D) Third Party Beneficiaries. Nothing contained in this Agreement is intended to confer upon any person other than the parties hereto and their respective successors and permitted assigns, any benefit, right or remedy under or by reason of this Agreement, except with respect to NCQA Parties who shall be deemed third party beneficiaries under this Agreement but solely with respect to those terms that specifically reference an NCQA Party or the NCQA Parties.

To **ACCEPT** this Agreement for the Product, **click Accept Agreement,** which will create a legal contract that will bind LICENSEE and NCQA as soon as you press "Accept Agreement".

To **DECLINE** this Agreement for the Product, **click Decline**, which will deny you access and use of the Product.

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F. CERTIFICATIONS & LICENSES

Mercer provides the following applicable certifications & licenses within this section starting on the following page.

- ***Mercer's Nevada Business License***
- ***National Committee for Quality Assurance (NCQA) Certified as Healthcare Effectiveness Data and Information Set (HEDIS) Compliance Auditor (CHCA) Confirmation Letter — Jennifer Lenz (subcontractor)***
- ***CHCA Seal — Jennifer Lenz (subcontractor)***
- ***CHCA Certificate 2015 — Jennifer Lenz (subcontractor)***
- ***HEDIS Survey Vendor Certificate — National Opinion Research Center (NORC) (subcontractor)***

MERCER HEALTH & BENEFITS LLC

Business Entity Information

Status:	Active	File Date:	10/21/2004
Type:	Foreign Limited-Liability Company	Entity Number:	LLC24798-2004
Qualifying State:	DE	List of Officers Due:	10/31/2018
Managed By:	Managers	Expiration Date:	10/21/2504
NV Business ID:	NV20041250294	Business License Exp:	10/31/2018

Registered Agent Information

Name:	THE CORPORATION TRUST COMPANY OF NEVADA	Address 1:	701 S CARSON ST STE 200
Address 2:		City:	CARSON CITY
State:	NV	Zip Code:	89701
Phone:		Fax:	
Mailing Address 1:		Mailing Address 2:	
Mailing City:		Mailing State:	NV
Mailing Zip Code:			
Agent Type:	Commercial Registered Agent - Corporation		
Jurisdiction:	NEVADA	Status:	Active

Financial Information

No Par Share Count:	0	Capital Amount:	$ 0

No stock records found for this company

Officers

☐ Include Inactive Officers

Managing Member - MERCER (US) INC

Address 1:	1166 AVENUE OF THE AMERICAS	Address 2:	
City:	NEW YORK	State:	NY
Zip Code:	10036	Country:	
Status:	Active	Email:	

Actions\Amendments

Action Type:	Application for Foreign Registration		
Document Number:	LLC24798-2004-001	# of Pages:	1
File Date:	10/21/2004	Effective Date:	

(No notes for this action)

Action Type:	Initial List		
Document Number:	20050057768-80	# of Pages:	1

File Date:	2/22/2005	Effective Date:	
(No notes for this action)			
Action Type:	Annual List		
Document Number:	20050500170-70	# of Pages:	5
File Date:	10/24/2005	Effective Date:	
(No notes for this action)			
Action Type:	Annual List		
Document Number:	20060548085-58	# of Pages:	3
File Date:	8/25/2006	Effective Date:	
(No notes for this action)			
Action Type:	Annual List		
Document Number:	20070676054-17	# of Pages:	3
File Date:	10/1/2007	Effective Date:	
(No notes for this action)			
Action Type:	Annual List		
Document Number:	20080648774-56	# of Pages:	3
File Date:	9/29/2008	Effective Date:	
(No notes for this action)			
Action Type:	Annual List		
Document Number:	20090737104-63	# of Pages:	3
File Date:	10/8/2009	Effective Date:	
09-2010			
Action Type:	Annual List		
Document Number:	20100633472-48	# of Pages:	3
File Date:	8/23/2010	Effective Date:	
2010/2011			
Action Type:	Annual List		
Document Number:	20110701755-39	# of Pages:	3
File Date:	9/28/2011	Effective Date:	
11/12			
Action Type:	Annual List		
Document Number:	20120674266-46	# of Pages:	1
File Date:	10/1/2012	Effective Date:	
12/13			
Action Type:	Annual List		
Document Number:	20130642331-95	# of Pages:	2
File Date:	9/30/2013	Effective Date:	
2013/2014			
Action Type:	Annual List		
Document Number:	20140690310-76	# of Pages:	2
File Date:	9/29/2014	Effective Date:	

(No notes for this action)			
Action Type:	Annual List		
Document Number:	20150444399-31	# of Pages:	1
File Date:	10/5/2015	Effective Date:	
15-16			
Action Type:	Annual List		
Document Number:	20160497389-49	# of Pages:	1
File Date:	11/14/2016	Effective Date:	
(No notes for this action)			
Action Type:	Annual List		
Document Number:	20170431695-98	# of Pages:	1
File Date:	10/10/2017	Effective Date:	
17-18			

NCQA
Measuring quality. Improving health care.

November 3, 2017

Jennifer Lenz, CHCA
Independent Consultant
4527 E. Villa Maria Drive
Phoenix, AZ 85032

Dear Jennifer:

Thank you for your continued participation in NCQA's HEDIS® Compliance Audit™ program.

Attached to this e-mail is your NCQA Certified HEDIS Compliance Auditor seal and executed Certification Agreement from NCQA's general counsel. The seal confirms that you met NCQA's requirements to maintain your status as a Certified HEDIS Compliance Auditor. Certification is valid for two years (expires October 31, 2019), contingent upon your compliance with the terms of the Certification Agreement.

Again, thank you for your continued support of the Audit program. If you have questions or comments, contact Ashley at 202-955-5159 or Buchanan@ncqa.org.

Sincerely,

Wendy Talbot
Director, Measure Validation
National Committee for Quality Assurance
1100 13 Street, NW, Third Floor
Washington, DC 20005
Telephone: 202.955.1708

Better health care. Better choices. Better health.

CERTIFIED
NCQA
HEDIS® COMPLIANCE AUDITOR
2017-2019

National Committee for Quality Assurance

is pleased to announce

Jennifer Lenz

passed the HEDIS® Auditor Examination, fulfilled all the necessary requirements
to conduct NCQA HEDIS Compliance Audits™
and attained the designation of

NCQA-CERTIFIED HEDIS COMPLIANCE AUDITOR

CELEBRATING 25 YEARS OF QUALITY NCQA

MARGARET E. O' KANE
PRESIDENT

DATE LICENSED: 11/1/2015 **EXPIRATION DATE:** 10/31/17

NCQA
Measuring quality. Improving health care.

National Committee for Quality Assurance

recognizes

National Opinion Research Center (NORC)

for fulfilling all necessary requirements to conduct NCQA HEDIS® Surveys

CERTIFIED NCQA HEDIS® SURVEY VENDOR 2018

MARGARET E. O'KANE
PRESIDENT
NATIONAL COMMITTEE FOR QUALITY ASSURANCE

November 1, 2017
DATE GRANTED

October 31, 2018
EXPIRATION DATE

V

SECTION V – SCOPE OF WORK

Vendors shall place their written response(s) to ***Section 2, Scope of Work*** in ***bold/italics*** immediately following the applicable RFP question, statement and/or section.

2.1.1 The selected vendor will be required under the contract to perform tasks and functions identified in the contract and to perform them according to specified levels of quality and comprehensiveness as determined by DHCFP. These mandatory activities are as follows:

2.1.1.1 Performance Improvement Project Validation;

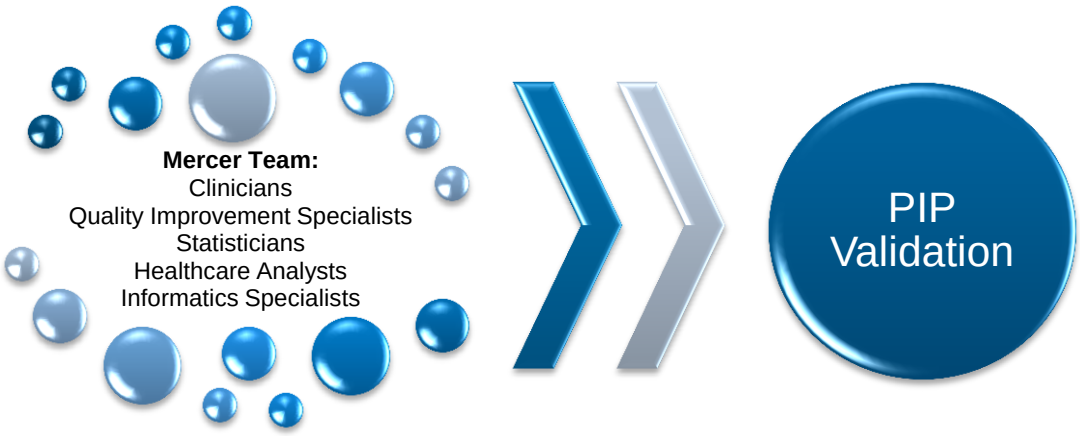
For over 14 years on comparable state Medicaid engagements, Mercer has been conducting performance improvement project (PIP) validations using the Centers for Medicare & Medicaid Services (CMS) protocol and providing technical assistance around PIP development and evaluation. Our approach to PIP evaluation includes the CMS external quality review (EQR) PIP Validation protocol elements, but in addition, Mercer includes evaluating the use of rapid-cycle quality improvement methodologies to ensure Managed Care Organizations (MCOs) are continuously evaluating and adjusting their activities throughout the performance year to ensure the highest probability of achieving improvement benchmarks. The use of rapid-cycle improvement techniques are CMS supported best practices that produce more measurable outcomes than methods that rely on less frequent evaluation of PIP performance and outcomes.

At the start of each new EQR engagement, we ask our clients a basic question "Are you getting the level of performance and results from your MCOs/vendors today that the State wants and expects?" How would Nevada answer this question about your program? We want to help you answer that question positively and more importantly get the results and outcomes the State desires.

Through our EQR work, we encourage our state clients to consider the provision of technical assistance as an important component of a comprehensive PIP validation process, as it can address the issues of PIPs that languish and produce limited outcomes and results which is counter-intuitive to the purpose of PIP in the first place. Our approach produces value for the Division of Health Care

Finance and Policy (DHCFP) and positively impacts the lives of those covered under the Nevada Medicaid and Nevada Check Up programs. Additionally, it ensures that MCOs build competencies with PIP design and analysis that support achieving DHCFP's quality strategy goals. We have learned through real-life experience that providing consistent, ongoing feedback with MCOs creates an atmosphere of collaboration and partnership with shared vision and ownership of outcomes.

Mercer's talented team includes healthcare quality improvement professionals with extensive experience designing, validating, and providing technical assistance training on PIPs within Medicaid programs. In addition to the core team supporting your important EQR program, Mercer offers you a diverse array of additional technical experts including clinicians (e.g., licensed social workers, registered nurses, physicians, dentists, psychologists, and pharmacists), bio-statisticians, IS consultants, healthcare analysts, and quality improvement professionals to provide consultation on PIPs that tackle clinical and non-clinical areas of interest such as: improving pharmacy management in high cost populations, improving claims payment and encounter submission timeliness and improving Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) activities within primary care. For example, our experience in assisting states in identifying proven strategies to address hospital readmission rates, not just in an acute care population, but also within Behavioral Health populations could be leveraged to support your PIP activity aimed at Reducing Behavioral Health-Related Hospital Readmissions within 30-days of Discharge. Our comprehensive knowledge and demonstrated expertise with managed care operations as a whole (e.g., quality, finance, and policy) can be a value-added benefit by choosing Mercer to be your EQR partner.



As depicted in the previous graphic, our deep bench of experienced professionals and team approach to our EQR work has allowed Mercer to not only provide robust PIP validation findings and recommendations, but to provide intensive technical assistance in the design, implementation, and on-going measurement phases of PIP activities to support successful validation outcomes on both clinical and non-clinical topics on comparable engagements such as:

- ***"How to complete a quality improvement activity form" to more technical discussions and workshops on how to employ lead versus lag measures to create PIPs using rapid cycle process improvement techniques.***
- ***In New York we provided targeted assistance in performance measure (PM) selection, benchmark development and incremental targets for improvement for one of the State's Medicaid HIV-SNPs.***
- ***In Pennsylvania and New Jersey we have researched and provided best practice information to the States' MCOs on topics such as reducing low-acuity, non-emergent (LANE) emergency room utilization and potentially preventable admissions and readmissions. This information was provided to assist MCOs in barrier analysis and in identification of interventions that have proved successful in other states.***

With a team of experienced EQR professionals supporting not just your quality initiatives, but your overall program goals, Mercer provides a partner who can meaningfully support your staff and your managed care partners and other vendors to help achieve your quality strategy goals.

Mercer In Action:

In our role as the EQRO for Delaware, we encouraged targeted technical assistance on PIP protocols, standards, and rapid cycle improvement at a time where the State had re-procured their MCOs and a new MCO entered the market. This MCO did not have prior Medicaid experience and faced a steep learning curve to achieve both PIP and State quality strategy goals. To expedite that learning, Mercer provided a series of technical assistance sessions on PIP protocols and required PIPs topics throughout the first year of operations. As a result, the MCO successfully met the first-year validation requirements and developed a strong foundation on which to build their interventions and remeasurement efforts. The training aids developed as part of these sessions have been leveraged by the MCO to develop its own internal training on PIPs for their staff involved with these activities.

2.1.1.2 Performance Measurement Validation;

There is an old adage that says, "If you cannot measure it, you cannot improve it." This statement has never been truer than in today's healthcare environment where the focus on improved clinical quality outcomes, enhanced member experience and decreased cost, along with enhanced provider participation and satisfaction place performance measurement at the forefront of all discussions. It also underscores the importance of assuring that PMs are calculated in a standardized format with a consistent application of technical specifications in order to provide meaningful information for comparative purposes between individual MCOs, within and across regions and to benchmark the progress of Nevada's program to established standards.

As an external quality review organization (EQRO), Mercer has been validating PMs for over 14 years and has a standardized, robust process to evaluate, validate, and report information regarding MCO PMs. Mercer has applied the most up to date CMS "Protocol 2: Validation of Measures Reported by the MCO" (currently reflected as, Version 2.0, last updated September 2012), to validate a variety of PMs for our state clients. PMs have ranged from state-developed measures, to standardized national measures including HEDIS, Consumer Assessment of Healthcare Providers and Systems (CAHPS), Adult Core Measures, and Pediatric Core Measure sets. We use our national knowledge and exposure to managed care IS to quickly identify areas of concern in system architecture, data exchange and processes to capture, control and integrate various data sources from delegated vendors and alternative data resources (e.g., registries and electronic health records, etc.) to efficiently and effectively identify issues that can impact downstream PM production.

Our comprehensive Medicaid policy, financing and program knowledge and fresh perspectives provide added value to DHCFP beyond what other firms that are limited to just EQR activities can offer. For example, we can help ensure that DHCFP continues to select and monitor PMs that align with the State's Quality Assessment and Performance Improvement Strategy (QAPIS) and we can ensure that our presentation of information and depth of analysis can aid DHCFP in responding to advocate, legislative and other stakeholder questions as described in the Nevada Medicaid Delivery Model Recommendation Report produced by Navigant, January 3, 2017, DRAFT regarding the efficiency and effectiveness of the MCOs, dental benefits administrator prepaid ambulatory health plan (DBA/PAHP), and care management organization (CMO).

Mercer's team is comprised of individuals with extensive experience across the PM spectrum including: measure selection, technical specification documentation, calculation, validation and reporting both clinical and non-clinical PMs. When it comes to PM validation we believe our experience designing innovative Medicaid programs and selecting performance metrics to target key areas within those complex program designs (i.e., ACOs, health homes, etc.) set us apart from other EQROs.

Mercer has over 30 years of extensive experience using national standards to evaluate, validate and report on PMs.

Our clinicians have expertise to validate that appropriate medical record abstraction processes and inter-rater reliability standards are used for data collection as appropriate for hybrid measures. Our research and analysis team has expertise in researching national, regional and state-specific benchmarks and goal setting. Our Informatics data management team has expertise in SAS, SPSS, Visual Basic and Microsoft Office Products (e.g., Excel and Access), and has programmed many of the national standard measures (e.g., HEDIS, AHRQ, National Quality Forum, etc.) for reporting purposes on comparable engagements for clients such as Arizona, New Jersey, New Mexico, and Ohio. This informatics expertise and experience is especially important when analyzing the code used to produce non-HEDIS based PMs.

To complement our in-house resources, we are excited to add to our team Jennifer Lenz of Quality Review Solutions, LLC (QRS). Ms. Lenz is an NCQA Certified HEDIS® Compliance Auditor (CHCA) and has over 10 years of recent senior level experience managing high visibility projects with state agencies, extensive knowledge of PM validation, and managing a HEDIS and PM validation audit team. Additional information about Jennifer and QRS can be found in our response at 2.2.8. As the following graphic illustrates, our team represents a variety of skill sets and competencies to undertake effective PM validation.

Mercer's ability to validate a broad range of PMs is based on the deep bench of staff available to participate in the validation process. We have validated a wide array of PMs on comparable engagements including:

- ***State-specific measures in Delaware, Idaho, and North Carolina such as provider complaints, member grievances, brand versus generic prescribing, and number of primary care practices converting to a patient-centered medical home.***
- ***Nationally Recognized Measure Stewards in Delaware, New Jersey, Ohio, and Pennsylvania including the Agency for Healthcare Research and Quality's Adult and Pediatric Core Indicators and NCQA's HEDIS data sets.***
- ***Pay-for-performance measures in the District of Columbia and North Carolina, including potentially preventable admissions and LANE emergency room utilization.***

Mercer In Action:

Mercer was asked to validate a state defined low birth weight PM. As part of the measure validation the MCO indicated it used a low birth weight database, populated by maternity case managers and concurrent review staff to identify low-birth weight infants. This manual process resulted in incomplete and inaccurate data, which raised concerns with the validity of the measure calculation. As part of the Information System Capabilities Assessments (ISCA) we learned that the MCO was not routinely capturing birth weight on newborn claims, although the field is available on the UB-04 billing form. We made recommendations to the State and the MCO to provide education to hospital billing providers on coding newborn birth weights on the claim and a recommendation to modify MCO claim system edits for deliveries to ensure newborn weight was submitted. This improved the State's ability to capture and report on birth weight trends as well as, improved efficiency and accuracy of MCO collection of birth weight data resulting in improved validity of the PM.

2.1.1.3 A review, conducted within the previous 3-year period, to determine plans 'compliance with the standards set forth in subpart D of 42 CFR 438 relating to access; care coordination; amount, duration, and scope of covered services and other plan standards; and

In our 30-plus year history as a dedicated government healthcare consulting firm, we have performed hundreds of managed care plan reviews. The purpose of these reviews has varied and includes:

- ***Assessing compliance with federal Medicaid managed care regulations.***
- ***Evaluating clinical and operational efficiencies.***
- ***Assessing readiness for new program and/or population implementations.***
- ***Addressing post-implementation progress towards meeting corrective action plan (CAP) compliance.***

Our vision for providing EQR services is to become your trusted advisor

Years of experience have allowed us to develop best practices and state-of-the-art tools to aid in the efficiency and effectiveness of our approach. However, at the end of the day, there is no process or tool that can replace the value of the subject matter expertise that our consultants bring to the table. Our extensive experience, tools, and comprehensive perspectives of the role an effective EQRO can offer to improve managed care performance and outcomes truly distinguishes us from our competitors. As your EQRO, Mercer will provide the required CMS activities to meet federal requirements and can also provide

broader technical assistance that will allow DHCFP to gain the greatest benefit from EQR activities. Our vision for EQR is to be a trusted advisor to DHCFP, your MCOs and other program providers, and we believe that our EQRO consultants coupled with our tools and processes can deliver on that vision with fresh ideas and a renewed energy.

Contained within 438 subpart D are the Health Information System requirements found at 438.242. While the requirements are brief, the depth of their importance and breadth of information covered are vital to program operations and long term fiscal sustainability of a Medicaid program. We have extensive expertise in conducting information systems capabilities assessments using the approach outlined in CMS' Appendix V.

For over 30 years we have been using managed care claims and encounter data to develop actuarially-sound managed care capitation rates, develop risk adjustment models, and implement state monitoring and oversight tools. Therefore, we understand the critical nature of valid and reliable data, particularly as Medicaid programs adopt and integrate more value-based purchasing (VBP) arrangements. We bring this same level of systems critique to our EQR work, creating significant added value for our EQRO clients. If you to want see more action and improved outcomes from your MCOs, we can bring new perspectives and ideas.

Mercer's EQR team has experience performing MCO compliance reviews in accordance with the standards set forth in subpart D of 42 CFR 438 relating to access; care coordination; amount, duration, and scope of covered services and other plan standards, including conducting MCO ISCAs. These reviews have encompassed different managed care models including those specific to managed behavioral health or physical health (PH) MCOs, integrated physical and behavioral health models and managed long-term services and supports (MLTSS) programs. Populations included under these reviews have encompassed standard Temporary Assistance for Needy Families (TANF) populations to more complex aged, disabled, dual eligible, and other special needs groups.

Many of the program design elements in these reviews have included complex systems of care like New York's Health and Recovery Plans (HARPs) that provide specialty behavioral health services for individuals with serious and persistent mental illness through the State's managed care delivery system, under 1915(i) waiver authority using the State's health home program. For more discussion of our work with New York, please see the "Mercer In Action" box on the following page.

As shown in the following illustration, our team consists of more than just basic compliance-based experience. You will have the ability to take advantage of Mercer's comprehensive knowledge of managed care operations to maximize the value and long-term effect of effective care coordination and data systems.

The Mercer team has recent relevant experience, which includes conducting compliance and ISCA reviews in comparable engagements such as:

- ***New Jersey, Delaware, and Kansas on assessing MCO readiness for the implementation of MLTSS programs.***
- ***New York, Pennsylvania, and the District of Columbia, we conducted targeted operational efficiency reviews that provided a detailed focus on specific areas of MCO program operations. Operational efficiency reviews dive deeper than standard compliance reviews to assess how the highly matrixed environments of managed care vendors integrate and coordinate across very specific MCO business units. For example, targeted efficiency reviews can examine topics, such as how MCO finance departments utilize encounter submission reports to validate expenditures or how aggregated claims data is harnessed to identify clinical drivers to support improvements in care coordination, utilization management and clinical outcomes.***
- ***Massachusetts and North Carolina, we targeted our compliance reviews to assess specific programs such as Massachusetts Senior Care Options, which combines healthcare with social services to the State's qualifying geriatric population, and North Carolina's Local Management Entities who are responsible for managing, coordinating, facilitating and monitoring the***

provision of mental health, developmental disabilities, and substance abuse services in the area they serve.

Mercer In Action:

The New York HARP Reviews were highly complex and dynamic and were developed to assess the readiness of managed care plans, their delegated behavioral health vendors and the State's community based health home entities to provide a new service array to one of the most vulnerable populations in the State and to ensure that each entity's information systems were able to support the vital exchange of healthcare data under New York's strict patient confidentiality statutes.

These reviews utilized the standard process that included a request for information, desk review, on-site interviews, analysis and individualized reports and were conducted by staff with expertise in behavioral health, physical health, and home and community based service delivery. We noted that there were three behavioral health vendors being utilized by the MCOs. To maximize value to the State and improve efficiency we performed compliance reviews directly with the delegated behavioral health vendors versus engaging the behavioral health vendors during each MCO review; this streamlining was vital to the timeline and represented the greatest efficiency for all participating in the review. We also engaged innovations such as use of tracer scenarios, which were developed to determine front-line staff knowledge and understanding of the HARP model across the three separate entities. Tracer methodology allowed the State and Mercer to assess the member's experience of care in a highly matrixed environment.

ISCA's were completed to ensure that information could easily flow between the three entities (MCO, behavioral health vendor, and Health Home provider). New York has rigorous rules, beyond standard HIPAA requirements, regarding the safeguarding of behavioral health data, therefore the ISCA not only evaluated data exchange capabilities but assurances of confidentiality.

This is an example of Mercer's subject matter expertise and end-to-end support in assisting our state clients to receive the greatest value in determining compliance with defined standards from the federal level to unique and more rigorous State requirements.

2.1.1.4 Network Adequacy Validation.

CMS signaled its intent to align Medicaid network adequacy standards with those in other insurance products with the issuance of 42 CFR Part 447.203 Medicaid Program; Methods for Assuring Access to Covered Medicaid Services (Final Rule) and the subsequent Managed Care Final rule in May 2016. Through these rules and related regulatory guidance CMS provided a stronger framework and more modernized approach to help states establish and monitor network adequacy requirements across Medicaid delivery models. Specific to Medicaid managed care, CMS has enhanced requirements pertaining to network adequacy including: considerations for capitation rate development on network adequacy, enhanced state responsibilities for development of adequacy standards, stronger state monitoring and oversight requirements and the role of the EQRO in validating network adequacy. Prior to publication of the enhanced requirements, Mercer was attuned to the importance of network adequacy, and for more than 10 years Mercer has led various network adequacy assessments and assisted states with each of the requirements listed above.

Mercer understands that the DHCFP has adopted its Access to Care Monitoring Review Plan for its fee-for-service (FFS) population and plans on adopting network adequacy standards as established by the Division of Insurance (DOI) for its managed care program. Additionally, we understand that you will require assistance from the EQRO to establish adequacy standards for the remaining provider specialties identified within 42 CFR 438.68(b) for which the DOI has not developed standards. Mercer further confirms that until CMS finalizes the EQR protocol for Validation of Network Adequacy we will apply the existing network standards to review network adequacy in the preceding 12 months for each MCO and DBA/PAHP, as requested by the DHCFP.

As depicted below, our team of clinicians, healthcare analysts, and informatics specialists stand ready to provide assistance to you in validating compliance to existing network adequacy standards and in developing new standards for specialty providers not currently contemplated by the DOI. We have been working with states over the past several years to develop network standards, complete geo-spatial mapping to support network validations and identify primary and specialty care referral patterns. We utilize Quest Analytics (Quest) version 2016.2 software to complete our geo-coding analyses. Quest is an industry leading software firm dedicated to performing network access and adequacy analyses.

Our experience in developing network adequacy standards and validation has varied widely across our clients from basic geo-spatial coding to more complex multi-pronged analyses that include surveys, focus group interviews and analysis of utilization data. Our work has helped states determine time/distance standards as well as adopt standards appropriate for providers who may visit members in their home. Upon request, Mercer can create a scope of work that includes a utilization report and analysis of the high volume specialists that are unique to recipients in Nevada. Mercer can complete an environmental scan to further identify and recommend standards for compliance in all required areas of 42 CFR 438.68.

We believe that the breadth of our work in this area covering FFS and managed care delivery systems including acute, behavioral health and home- and community-based services (HCBS)/long-term services and supports (LTSS) network studies sets us apart from our competitors and gives us valuable insights that you can benefit from. These experiences and insights provide an excellent foundation for our EQRO team to not only complete the network validation tasks, but also provide valuable technical assistance in areas where reported results may vary, or ability to meet and/or maintain the network standards is inconsistent.

Examples of our wide array of network access and adequacy studies in comparable engagements include the following:

- ***In Delaware, Mercer was asked to provide assistance to develop the state's access monitoring review plan (AMRP). This work was unique in that Delaware***

currently has a managed care penetration rate of over 93%. Mercer provided support to the State during discussions with CMS to seek relief from the AMRP requirements; however CMS indicated that Delaware must submit an AMRP reflective of the services and utilization. Mercer provided assistance to develop those standards as well as support during the public comment period.

- ***In Arizona, Mercer designed a network analysis study to review behavioral health service utilization in Maricopa County. This study was focused on reviewing the provider network for specific covered services provided to persons with serious mental illness. This included identification and validation of data sources to assess network adequacy in Maricopa County and utilized a multi-faceted approach combining direct testing activities such as phone calls, office visits, provider forums, and other mechanisms such as review of satisfaction data and member complaints regarding access and availability to triangulate on areas or services that may be under-served or even inappropriately served. Mercer implemented the study over two periods and generated a report for the State with the findings. In consultation with the State, Mercer also developed technical assistance on ensuring network sufficiency.***
- ***In New Jersey, Mercer helped to develop network adequacy standards for the State's new MLTSS program. While this work was not geared towards ensuring MCO compliance with State standards, the steps taken are directly pertinent to the steps that may be taken under the new Network Validation protocol. This work also unique in that it deviated from the standard time/distance requirements to explore alternative measures of adequacy for providers that travel to the member's place of residence.***

Mercer In Action:

In Delaware, Mercer was asked to independently validate each MCOs submitted geo-spatial report. To complete this work we reviewed pediatric and adult primary and specialty care provider access reports submitted by the MCOs. We then requested each MCO submit, direct to Mercer, the provider data in a format specified by Mercer.

Our informatics team worked with the informatics leads at each MCO to review the data request in detail to ensure understanding and consistency in data submission. Each MCO data file was scrubbed and outstanding questions resolved; updated MCO data was submitted when necessary; Mercer then geo-coded the data, using Quest software, to recreate the reports. Our lead clinician and assigned healthcare analyst reviewed the results and identified several inconsistencies. Mercer presented the results to the State and made recommendations for next steps, which included a collaborative meeting between Mercer, the State, and its MCOs to review the results and discuss the data findings.

Through this process we learned that differences in how the MCOs identified pediatric specialists led to significant variation between MCOs in compliance with network pediatric specialty standards; this required the state to issue a standard definition for identification of pediatric specialist. There were also variations in how distance was calculated, global positioning vs. "as the crow flies" as well as, inconsistent inclusion of cross-border providers. These "lessons learned" underscore the importance of having a partner with proven experience performing network review activities to ensure accurate and consistent results.

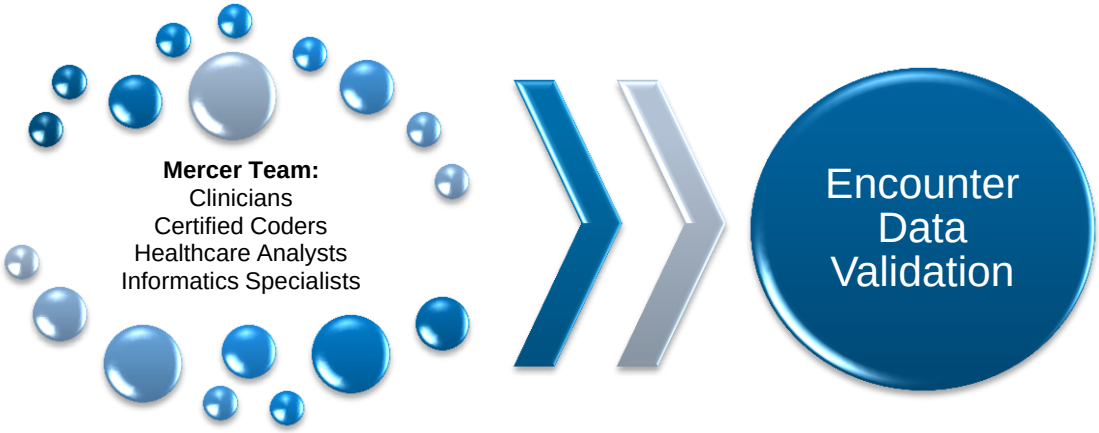
2.1.2 During the length of the contract, work requests may be made of the Vendor at the sole discretion of the DHCFP for optional activities described in 42 CFR 438.358(c) or comparable activities that assess the quality of care or provide for the control of utilization of the DHCFP fee-for-service program. Optional activities may include:

2.1.2.1 Validation of encounter data;

Mercer has many years of hands-on experience in working with data from some of the nation's largest Medicaid programs (e.g., California, New Jersey, New York, and Pennsylvania). We take in over 1 billion records annually to support a variety of activities including actuarial rate development, FFS fee schedule development, risk adjustment, and data modeling to support program and policy changes. We consider data validation and data use is a core competency and an integral component of our daily work

To effectively use this array of data, Mercer has established our own in-house technical infrastructure, software tools and programming, and analytical expertise that allow us to receive, store, manipulate, and analyze millions of records for detailed claims, encounters, eligibility, enrollment, demographics, provider, level of care assessment, and other types of data. We have over 35 informatics specialists trained in industry standard SAS, PLSQL, and Cognos software products that support our informatics work.

To support our informatics specialists, we round out our EQR encounter data validation (EDV) team to include clinicians, certified coders, and healthcare analysts. Our clinicians not only perform medical chart abstraction, but they have deep expertise in performing encounter file reviews and understand various coding schemas including international classification of disease (ICD-9/ICD-10), current procedural terminology (CPT), healthcare common procedure coding system (HCPCS), and different groupers (e.g., MS-DRG and APR-DRG) and work in concert with our certified coders. Our coders take the lead in developing coding analytic frameworks to address topics, such as EPSDT and Family Planning services and work directly with our informatics team to ensure accurate programming of the coding schemas.



Mercer is aware that the State's Medicaid Management Information System (MMIS) has not been updated for many years and no longer aligns with CMS standards for modularity and leveragability. This has resulted in DHCFP's embarking on the Core MMIS Modernization project, with an expected completion date of 2020. We believe that based on our experience working with other states to accomplish similar goals to respond to the increasing pressure to utilize and recognize the full

potential of encounter data throughout the full spectrum of Medicaid program management we can provide valuable insight and experience.

One of the reasons Mercer is different than limited-focus EQROs is that we help our clients move beyond standard compliance with federal regulations to provide a comprehensive assessment of the system and to identify priorities that can drive synergies across the system.

A sampling of our demonstrated experience includes:

- ***Completing encounter data intake and validations for 28 different states.***
- ***Designing and implementing encounter data systems for Connecticut, District of Columbia, and Pennsylvania. This work entailed collecting encounter data directly from the health plans, performing edits on the incoming files and records, creating and updating databases, and producing reports for the clients on a monthly basis.***
- ***Developing data analytics and specialized dashboard reports to display results for physical health, behavioral health, LTSS, transportation, and pharmacy benefit services utilization and cost trend data.***
- ***Hosting national encounter data roundtables to provide a forum for states to gather technical assistance and support based on lessons learned from other states.***

Mercer In Action:

In Delaware, Mercer was asked to conduct an EDV. Mercer's EQR team worked with the State to develop a multi-phase, multi-year approach that considered how the EDV results would be used to identify potential enhancements to the State's MMIS as it underwent its T-MMIS redesign and improve overall administration of the encounter submission process.

Using the results of the most recent ISCA, our informatics consultants and clinicians worked together to complete the EDV and identified several opportunities for the State to enhance the operational effectiveness of its MCOs and MMIS vendor, including recommendations to implement an 835 response process for MCO voided transactions to improve MCO tracking and submission, adjust MMIS vendor's limitations on file size and/or volume that may negatively impact timeliness of encounter data submission, develop and implement encounter data monitoring reports and an encounter submission guide to monitor timeliness and improve consistency in encounter submissions and implement enhancements to the MMIS to capture key data elements currently collected by the MCO such as birth weight data, patient payment liability, and MCO paid date.

As a follow up to our work the client requested additional assistance from the Mercer team to develop training and education for internal State staff regarding encounter data management and oversight and requested that Mercer's informatics consultant sit in on the initial T-MMIS scope meetings to supplement the states knowledge on critical areas requiring extensive revision to support the transition from the historical FFS processing of the MMIS core to the required encounter focused processing core. We believe our experience and insight gained in Delaware can be beneficial to DHCFP as you begin your MMIS transformation project journey.

2.1.2.2 Administration or validation of consumer or provider surveys of quality of care;

We have a strong desire to assist our clients in moving beyond the Triple Aim of health care (i.e., better care, lower costs, improved health) to achieve the Quadruple Aim. The fourth dimension recognizes the critical role provider satisfaction plays in achieving improved clinical and system outcomes and improving overall member experience of care. Mercer achieves accurate and reliable data collection and analysis through a thoughtful and consistent approach in administering and validating surveys. All of our survey work is rooted in the key pillars of sound survey design and include: ensuring survey objectives are measurable, represent a sound research design, including effective question

structure, have effective strategies to promote high response rates, include a robust data analytics plan and effectively display and report results so that even the most technical information can be understood in layman terms. Adhering to this process ensures crucial information comes to light and allows for interventions that have real impact. When not using nationally normed and validated survey instruments we rely on our experience working with various Medicaid populations, our population health research knowledge and the subject matter expertise of our staff.

As shown below, Mercer's team includes clinicians (e.g., RNs, LCSWs, MDs, PharmDs, and DDSs), statisticians, quality professionals and healthcare analysts with a variety of experience in the administration and the validation of consumer and provider surveys through EQR and stakeholder contracts for various Medicaid populations. Additionally, Mercer brings our partnership with the non-partisan and objective research organization National Opinion Research Center (NORC) to Nevada to provide additional expertise and assistance as needed. NORC is an NCQA certified CAHPS 5.0 survey vendor who brings national renowned expertise to survey administration and validation. Additional information about NORC can be found in our response at Section 2.2.7.

Historically within DHCFP's program the MCOs have administered the CAHPS. Mercer has noted that continuous recommendations to improve CAHPS survey response rates have been issued. Strong survey response rates allow for survey results to be extrapolated to the broader population which helps to ensure that interventions to improve variances from benchmarks are targeted at the right populations for the right reasons. We have provided recommendations to our client states to improve survey results using various "carrots" and "sticks" for MCOs to improve response rates and would encourage further consideration of a

statewide CAHPS survey, sampling stratification and results which can be done at the MCO specific level and used for comparison across FFS populations.

Mercer has completed a number of survey administration and validation projects in comparable engagements over the course of the last several years including, but not limited to, the following:

- ***In New Jersey, Mercer created surveys to collect information from community based- care management organizations (CB-CMOs) and HCBS providers regarding perceived inadequacy or "service gaps" in the provision of certain HCBS. Each survey was uniquely designed to identify perceptions of network service gaps by waiver and within waiver services. Mercer worked with the State to develop a communication plan to ensure high response rates from both the CB-CMOs and the HCBS providers, which included periodic follow-up and outreach phone calls. At the conclusion of the study it was very clear that both care managers and providers identified the same network gaps; however, each experienced those gaps differently. For example, personal care assistant (PCA) services were identified as a shortage area on both surveys. However, care managers experienced this as a critical barrier, while PCA providers, mainly Home Health Agencies, experienced this as a temporary and variable gap. This work highlighted the importance of creating standards other than time/distance to ensure not only network adequacy but network capacity to provide the service.***
- ***Mercer worked with Pennsylvania on a Fidelity Monitoring project for behavioral health that included a telephonic survey and interviews with 43 Assertive Community Team (ACT)/Community Treatment Teams (CCT). The survey data was married with other cost and utilization data to analyze fidelity outcomes. The key finding from this work was that overall spending increased over seven times as much for consumers on low-fidelity teams compared to high-fidelity teams. The Commonwealth plans to use the findings to improve BH-MCOs monitoring of ACT teams and to target fidelity training.***

- ***Mercer worked with CMS and several of our state clients to help obtain approval for use of EQR enhanced federal match for the survey work outlined above – providing additional value as many states faced difficult challenges in developing their HCBS setting compliance plans.***

Mercer In Action:

Since 2014, Mercer has provided support to clients in implementing the HCBS final rule. We have worked with California, Connecticut, Delaware, Missouri, and New Mexico in developing assessment strategies and tools to determine the status of HCBS providers' compliance with the settings requirements of the final rule. Most notably, we have worked with our clients to develop and implement participant, case manager, MCO, and provider surveys to determine that HCBS are provided in appropriate provider settings. Our specific tasks have included:

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

With our support, Connecticut, Delaware, Missouri, and New Mexico were able to demonstrate successful compliance with the federal settings requirements. Delaware has received both initial and final CMS approval. Connecticut, Missouri, and New Mexico have received initial approval. We are now working with clients to develop monitoring strategies and tools to measure ongoing provider compliance with all applicable requirements.

2.1.2.3 Calculation of performance measures in addition to those reported by health plans;

Mercer clinical staff will work with the DHCFP to identify PMs that can be calculated and whose results will serve to inform DHCFP, MCOs, DBA/PAHP, the CMO and stakeholders about areas of interest, particularly as they relate to the DHCFP QAPIS. The measures will be calculated using the CMS Protocol for "Calculating Performance Measures." Mercer will utilize our knowledge of nationally recognized measures, as well as our considerable experience in defining, measuring and analyzing performance metrics for other Medicaid programs and applications. Our goal is to help inform and direct you on the most efficient and effective approach to ensure this activity meets your needs and is in keeping with the overall DHCFP Quality Improvement Strategy.

Mercer's team of informatics analysts, PM experts, certified professional coders, clinicians and statisticians can assist with the selection, calculation and reporting of optional PMs. Mercer will also incorporate the most recent findings from the ISCA (and EDV if conducted) to ensure a selected PM is appropriate based on the available participant and enrollment data, provider data, claims and encounter data, and pharmacy and laboratory data. Our data capabilities (noted in section 2.1.2.1 Validation of Encounter Data) allow us to take in large amounts of data, develop code to validate and analyze the data received, calculate PM results, all with a robust peer review process. Mercer evaluates the PMs calculated not only from the technical perspective, but also from the perspective of "is the information making sense based on what we know of the client's program, membership and MCO, DBA/PAHP, or CMO.

The following steps highlight some of the primary tasks associated with this activity.

For each state-specific PM selected for calculation that does not have an associated national measure steward, Mercer clinical and analytical staff will work with DHCFP to identify the most appropriate methodologies and specifications. We will develop PM documentation that contains specifications and calculation elements, including the following:

- ***Measure description, including numerator and denominator population specifications.***
- ***Data collection methodology.***

- ***Programming technical specifications:***
  - ***Denominator criteria***
  - ***Numerator criteria***

For each PM to be calculated, Mercer clinical and analytical staff will complete the following steps:

- ***Ensure all members who were eligible to receive the specified services are included in the initial population from which the denominator is produced. This "at risk" population will include both members who received the services, as well as those who did not:***
  - ***Mercer's clinical staff will review the denominator for reasonableness based on national comparisons and clinical knowledge.***
- ***Apply any required exclusion criteria to the denominator.***
- ***Write program logic that identifies, tracks and links member enrollment by age and gender criteria and applies enrollment specifications as applicable.***

Our clinical staff will peer review the clinical coding structure developed by the certified coders to ensure the completeness and accuracy of any codes used to identify medical events, such as diagnoses and procedures and ensure these codes are appropriately identified and applied as specified in each PM. This can also be done in direct collaboration with DHCFP staff if preferred:

- ***Adhere to any time parameters required by the specifications of the PM.***
- ***Perform calculations to produce rates for each PM.***

For each PM calculated, Mercer clinical and analytical staff will prepare a report comparing and interpreting results. The report format will be pre-approved by the DHCFP and will be designed to facilitate understanding of the results against appropriate available benchmarks or state established levels of performance or national/regional thresholds.

Mercer has calculated literally hundreds of PMs including those pertaining to cost, utilization, use of services, process, and outcomes. We are more than just competent in this area. These PM calculations have been used for a myriad of purposes included development of capitation rate trends, modeling program or policy changes, measure performance improvement and more recently to support VBP strategies from simple pay-for-performance models to more robust shared savings models and alternative payment

mechanisms such as bundled payments that include both cost and quality components. This is an exciting area where we would welcome the opportunity to partner with Nevada.

Mercer In Action:

Over the past several months Mercer's clinicians, actuaries, healthcare analysts, and informatics specialists have been working with a number of states including New Jersey and Virginia to explore the redesign of maternity kick payments to reflect a more value based payment approach. This work combines the calculation of utilization and cost metrics along with the addition of specific quality process and outcomes measures such as frequency of prenatal care, mix of vaginal versus cesarean delivery, and other factors to develop payment methodology that aligns cost to outcomes.

This work highlights Mercer's expertise in PM calculation and synthesis of results to drive performance innovation aimed at achieving better outcomes at lower cost.

2.1.2.4 Conduct of PIPs in addition to those conducted by health plans;

Our team of professionals have demonstrated expertise to assist DHCFP in identifying performance improvement areas and conducting PIPs to target the identified opportunity areas. As noted in our response found in Section 2.1.1.1 our team includes staff with quality experience in acute care, behavioral health, LTSS, Developmental Disabilities, special needs plans, and FFS models. Our experience includes partnering with state staff, MCOs or other identified stakeholders to support performance improvement activities beyond just validation of PIPs.

Mercer has utilized CMS Protocol 7: Implementation of PIPs to assist our EQR clients design and implement various activities. In these instances the state and its MCOs have worked collaboratively with Mercer to follow the various stepwise activities including:

- ***Selection of the study topic***
- ***Defining the study questions***
- ***Selecting the study variables***
- ***Defining the sampling plan***
- ***Identifying the data collection methodology and sources***
- ***Strategizing on intervention activities***

- ***Analyzing data and interpreting results***
- ***Evaluating improvement outcomes***

What is exciting about these PIP activities is the collaboration with the MCOs to identify and implement interventions as a result of the data. In a true laboratory testing environment each MCO implemented similar and unique strategies. Through this process we were able to quickly identify activities that produced results versus those that had little impact. Mercer commits to supporting Nevada in development and execution of PIPs within managed care, care coordination and FFS models.

Mercer In Action:

Mercer developed a PIP focused on reducing LANE emergency department utilization. This project relied on the data from Mercer's LANE algorithm, stratified by health plan and age bands, sex and day of week. Information utilized all claims data within the study period and allowed for a 90-day run out on claims. Results were reviewed with the MCOs and Mercer facilitated discussions on barrier analysis. Utilizing an Eisenhower matrix evaluating impact and effort, each MCO selected interventions. Mercer performed a remeasurement to determine the impact of the activities.

Lessons learned included low impact/low effort activities such as mailers had little impact on outcomes while higher impact/higher effort activities such as phone calls and face-to-face encounters improved outcomes. Seasonality was also noted as a factor and identified new strategies related to contracting for urgent care centers and telephonic triage services which had not previously been contemplated by the MCOs.

2.1.2.5 Conduct studies on quality that focus on a particular aspect of clinical or non-clinical services at a point in time; and

Upon request Mercer will work with the DHCFP to ensure the topic of the focused study is meaningful and actionable for the population served. Mercer will collaboratively work with you on the scope and timing of all focused studies and upon approval Mercer will create a project charter outlining the project team, responsibilities and contact information. Mercer has learned that focused studies proceed more efficiently when our client designates a steering committee or executive sponsor to champion the study and would encourage you to consider this approach.

Mercer then schedules a study kick-off meeting between the Mercer team and DHCFP staff. The intent of this meeting is to review the project plan, calendar

timelines, and key deliverables. As appropriate, Mercer would facilitate a second kickoff meeting that includes DHCFP staff and appropriate MCO and/or DBA/PAHP, CMO staff members. The intent of this meeting is to provide an overview of the project, present the timelines, and target deliverable dates for each activity. Mercer will facilitate all subsequent meetings with the MCOs or other program vendors as appropriate and agreed to by DHCFP.

Mercer will use this project management approach along with the CMS Protocol 8: Focused Studies to complete this optional activity. Throughout the process Mercer will work with the identified DHCFP study champion and identified vendor staff to walk through the eight (8) focused study activities.

The core focused study team always includes clinicians, statisticians, healthcare analysts, and informatics specialists. Additional our subject matter experts (SMEs) can be engaged, as needed, based on the topic being study. For example, we can access our pharmacy and substance use disorder clinicians for studies pertaining to opioid prescribing and management, or we can bring in our dental expert to address topics related to dental benefit management or our clinical quality specialists in children's health to address EPSDT and or Foster Children systems of care.

Mercer has a wealth of focused study experience from comparable engagements, recent highlights include the following:

- ***In Connecticut, Mercer conducted a focused study on Children in Foster Care to determine whether children in foster care were receiving adequate healthcare and services through Medicaid managed care. This study evaluated children in all types of foster care and identified their use of age-appropriate***

clinical services compared to children not in foster care. Utilization of services was used to identify opportunities for improvement.

- ***Connecticut hired Mercer to evaluate the cost impact of moving its behavioral health program from traditional service delivery settings toward more community-based treatment settings. Mercer worked with three separate divisions at the State, including the State Medicaid agency, to define the study population and develop a medical record abstraction tool and process to efficiently identify members who would be appropriately served under the new programs. The study involved integrating multiple databases to define the population universe, pull the sample, and model the results of the medical record abstraction with current utilization and unit cost data. This study was designed to yield statistically-valid and reliable results within agreed upon confidence intervals and error rates. To complete the study, Mercer also developed a medical record abstraction tool and processes, trained clinicians on the medical record abstraction process and oversaw the abstraction of over 850 medical records.***

- ***In Delaware, Mercer designed a Childhood Overweight and Obesity focus study to help understand the current practice patterns and barriers to effective screening, counseling and treatment that face healthcare providers. The study design was created to include both a medical record abstraction, as well as a targeted interview component. Where the medical record review could help quantify changes from the baseline study and adherence to specific practice recommendations, the targeted interviews provided a mechanism to engage providers and to identify root causes that impact their ability to adequately and effectively screen, counsel and treat childhood overweight and obesity, providing an independent and comprehensive assessment and review of the quality outcomes, Timeliness of and access to the services included in the contract between the State and the MCOs. The sampling plan included 166 providers who participated in the study, a total of 300 patient charts were abstracted and 49 interviews were conducted. Key recommendations included continuation of a stakeholder group which was capable of addressing a broad array of interventions focused on improving the screening, assessment and treatment of childhood overweight and obesity within the State of Delaware.***

Mercer In Action:

Mercer recently completed a pharmacy focused study to identify differences in treatment outcomes among Medicaid MCOs for members prescribed buprenorphine. This study was designed by our Pharmacist in consultation with the State's Medicaid Pharmacy Director, acting as the Executive Sponsor, and included subject matter expertise from our Psychiatrist with specialty expertise in substance use disorder.

The study was designed to compare Medicaid rates of initiation and engagement of alcohol and drug treatment visits to the national benchmarks, and evaluate outcomes including emergency room visits, overdose visits and opioid related deaths between each of the State's MCO vendors.

Utilizing pharmacy, claims and enrollment data Mercer analyzed the study population in calendar year 2016 data, with a 90-day run out period. No medical record abstraction was performed.

Key recommendations included continuation of emphasis on appropriate opioid prescribing protocols and alternative pain management approaches, and continued use of the prescription monitoring database. Results from the study were summarized and presented to the Medicaid Directory and Deputy Director by the Medicaid Pharmacist and Mercer was asked to perform a follow up study based on several of the recommendations from the base study.

2.1.2.6 Assistance with the Quality Rating System.

With the release of the Final Rule CMS advanced the Agency's mission of "better care, smarter spending, and healthier people." The QRS provisions found at 438.334 helps to recognize that mission by strengthening beneficiary's experience of care and improving quality, accountability, and transparency through alignment of Medicaid and Children's Health Insurance Program (CHIP) requirements with those of other health coverage programs.

A 2009 Annals of Internal Medicine Study found that public reporting of information helped providers improve performance by focusing on gaps in quality. Similar studies targeted at managed care plans found that entities that publicly reported quality information received higher consumer satisfaction ratings. The underlying message from these studies is that competition is good, especially when results help improve outcomes and drive greater efficiency.

Should DHCFP require assistance with the implementation of a QRS, Mercer's team of clinicians, statisticians, healthcare analysts, and our CHCA stand ready to ready

to help you assess the practicality and utility of implementing a QRS for your Medicaid program. As noted in our prior responses we have significant experience in PM calculation and validation to meet the needs of developing a QRS.

Mercer's team includes clinical and quality experts, healthcare analysts, and informatics specialist that have performed similar work in other states including New Jersey, Pennsylvania, Delaware, and Connecticut. We have extensive experience with data aggregation, PM calculation, and PM reporting and data display for public consumption.

There are many factors that DHCFP should consider as it plans for the potential implementation of a QRS. Some of those considerations include:

- ***Adoption of CMS' QRS or development of a Nevada specific QRS?***
- ***How the Medicaid QRS align with the Nevada Health Link QRS?***
- ***What impact will public dissemination of information have on continuity and coordination of care should results lead to significant membership turnover by MCO?***
- ***How will QRS data be used to improve health literacy?***
- ***What lessons learned from the implementation of Nevada Health Link will be used to streamline implementation of the Medicaid QRS?***

Not only do our EQR consultants provide expertise in PM calculation, validation and data display, we are experts at providing technical assistance to our clients to work through the nitty-gritty considerations. As needed, we have a host of technical advisors standing by to provide additional support and guidance.

2.1.3 Validation of MCO, DBA/PAHP and CMO Performance Indicators

2.1.3.1 Performance measures are calculated and submitted annually to the DHCFP by the contracted MCOs; the DBA/PAHP; and the CMO. The Contractor will evaluate the accuracy and the extent to which Medicaid-specific performance measures followed Health Effectiveness Data and Information Set (HEDIS®) Specifications for the calculation of performance measures using one of two methods: 1) A HEDIS® Compliance Audit™ Standards, Policies and Procedures or 2) the Center for Medicare and Medicaid (CMS) Validating Performance Measures Protocol.

2.1.3.2 Verification of methods used to collect HEDIS performance measures. The validation process will be accomplished through methods descried in the most recent version of the National Committee for Quality Assurance (NCQA) HEDIS Compliance Audit™ Specifications or the CMS Validating Performance Measures protocol. The audit will be conducted for SFY contract years 2019 and each subsequent EQRO contract renewal years.

A. Validation of HEDIS and performance measures reported (as required by the State) during the preceding 12 months.

B. Audited HEDIS Data using Interactive Data Submission System (IDSS). Submit information to NCQA, if applicable.

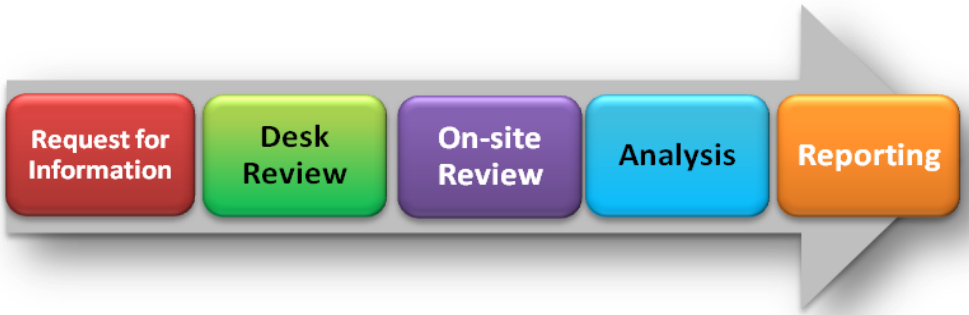
C. HEDIS™ Comparative Analysis for SFY 2019 and each subsequent EQR contract renewal year.

D. The awarded vendor is required to submit a comparative analysis and production of a HEDIS report using HEDIS performance measures data submitted by each MCO and DBA/PAHP.

PM AND HEDIS VALIDATION APPROACH

In the following section we are addressing 2.1.3.1 and 2.1.3.2 collectively. Mercer will utilize the CMS "Protocol 2: Validation of Measures Reported by the MCO" Version 2.0, September 2012 and Mercer's internal Performance Measure Validation Worksheets that are based on the CMS "Attachment A: Performance Measure Validation Worksheets" but enhanced to improve functionality, data display and reporting. The protocol is built to execute three activities. Activity 1 is Pre-onsite Activities, Activity 2 is On-site Activities and Activity 3 is Post-on-site Activities consistent with CMS protocols for validating PMs.

To adhere to the CMS protocol Mercer will follow the basic "EQR Arrow" depicted on the following page:



REQUEST FOR INFORMATION AND DESK REVIEW

The following steps outline the project management approach and information to be gathered prior to Mercer completing the on-site review/interviews:

1. ***Define the scope of the validation. The Mercer PM Team lead will initiate a PM project planning meeting with DHCFP to discuss your expectations for PM validation of the MCOs, DBA/PAHP, and CMO. This discussion will result in detailed information on the PMs required, methods for reporting measures (administrative vs hybrid), expectations for reporting format, identification of the technical specification measure stewards, timelines for performing the activity, and soliciting input on areas of concern in MCO, DBA/PAHP, and CMO performance and/or data availability. Following the initial planning discussion, Mercer will develop a formal methodology document and submit it for DHCFP review prior to the initiation of the PM activity. The formal methodology document will detail the contract year's methods for conducting the PM validation activity, including the number and types of entities required to report PM for a given year, the DHCFP-selected PM set, and a proposed work plan that includes key milestones, targeted dates of completion, and the responsible organization. Upon approval of the methodology document, the Mercer team will develop a PM reporting template for non-HEDIS measures that will be reported by the MCOs, DBA/PAHP, and CMO outside of the NCQA interactive data survey system (IDSS) for HEDIS-measures. The reporting template will include the following information as outlined in the CMS protocol including:***

    a. ***The eligible population***
    b. ***Data collection methodology***
    c. ***Sampling methodology (if used)***
    d. ***Denominator calculations***
    e. ***Numerator calculations***
    f. ***Calculated and reported rates***

2. ***Mercer will develop a PM validation worksheet to assess the accuracy of the reported results and the extent to which the MCOs, PAHP, and CMO followed the measures specifications. Mercer will employ the MercerConnect® site to support within-team and between-team project efficiencies for validation and performance measurement activities. MercerConnect® will allow secure documents such as source code, medical record data, and large data sets to be shared easily and securely. Additional information about MercerConnect can be found in our response in Section 2.3.1.2.***

3. ***Assess the integrity of the MCO's Information System. This step in the protocol occurs in conjunction with the ISCA. The ISCA results are fundamental to determining if the required PM data are complete and accurate and if MCO, PAHP, and CMO data (e.g., membership/enrollment, provider data, claims/encounter data, medical record data, and ancillary and supplemental data) are integrated appropriately to calculate PM rates. The PM validation team will participate in these portions of the ISCA review.***

4. ***Select measures for detailed review. Concurrent with Step 1, the Mercer team will meet with DHCFP to discuss the PMs selected for validation. For these measures, Mercer will request additional information, including programming source code, through a Request for Information (RFI) communication provided to the MCOs, PAHP, and CMO. If a MCO, PAHP, and CMO utilizes a vendor to calculate HEDIS PMs and the vendor received NCQA measure certification, Mercer will accept the validated source code. However, for non-certified measures, the MCOs, PAHP, and CMO will be required to submit source code for Mercer review. Once all information is received, Mercer will complete PM validation worksheets as appropriate based on measurement approach.***

5. ***Initiate review of medical record data collection. For the PMs using hybrid methodology, the Mercer team will validate that the following activities are assessed:***
   - ***The medical record review staff has the appropriate experience and credentials.***
   - ***The review tools collect the information required for the measure.***
   - ***The training provided was sufficient to ensure accurate data collection.***
   - ***A statistically sound assessment of the reviewer's performance was conducted.***

6. ***Mercer will conduct medical record validation on a sample of records for some or all hybrid measures depending on the similarity and complexity of the hybrid PMs. Mercer proposes the use of a modified NCQA review approach. In this model, Mercer randomly selects 16 numerator compliant files for submission. If the 16 records contain no errors, the measure passes medical record validation. If there is one error detected, another sample of 16 records is reviewed and if no additional errors are detected, the measure passes. If two or more errors are detected on the original sample or the second set of 16 records fails, then Mercer will work with the MCO, DBA/PAHP, or CMO to correct the errors. If errors cannot be corrected and the medical record review fails, then Mercer will work with DHCFP to determine if the MCO, DBA/PAHP, or CMO can report an administrative only rate or if Mercer will determine the PM rate biased.***

7. ***Prepare the MCO on-site visit. Prior to the on-site visit, the Mercer team will inform the MCOs, DBA/PAHP, and CMO of the PM validation activities that will take place while on-site, discuss the process for reviewing confidential information, and ensure the appropriate staff and resources will be available. Mercer will prepare all agendas and share those in advance with the MCOs, DBA/PAHP, and CMO. Mercer will conduct a pre-onsite conference call with each MCO, PAHP, and CMO in advance of the on-site visit to address on-site logistics and address any questions that the MCOs, DBA/PAHP, and CMO may have.***

ON-SITE REVIEW AND ANALYSIS

After the pre-onsite activities are underway, Mercer will focus on the on-site review and analysis steps. Mercer will conduct on-site reviews to gather additional information provided in the ISCA.

Review IS underlying PM. As noted in the steps above, the ISCA is a fundamental component of the PM validation protocol. In addition to participating in and reviewing the ISCA findings, the Mercer team will complete the following steps as appropriate for each PM:

- ***Interview key staff involved in PM (e.g., quality, business intelligence, IS etc.).***
- ***Review primary source data s and data input processes.***
- ***Review systems and processes for calculating PMs.***
- ***Observe staff members involved in various steps of calculating and reporting PMs.***
- ***Review data files to ensure data are stored and processed as described.***
- ***Evaluate the peer review or quality assurance processes that ensures a "second set of eyes" reviews and signs off on all PM reporting data.***

1. ***Assess data integration and control for PM calculation. The Mercer team will evaluate each MCO's, DBA/PAHP's, and CMO's ability to integrate data from all data sources used to calculate each PM rate. This evaluation will include an assessment of the data flows from the source systems to a data warehouse/repository and the control processes surrounding the PM production data.***

2. ***Review PM Production. Mercer approaches this step in the validation protocol as the culmination of each of the individual steps described above and evaluates them as a whole. Understanding that a breakdown in any one aspect of the process can result in inaccurate calculation and reporting of PMs from collecting data, to integrating data, to programming, calculating and reporting. A full review of the process is critical.***

3. ***Conduct detailed review of selected measures. For those measures that the State selects, Mercer will do in an in-depth analysis to assess the accuracy of the identification of the population eligible to be included in the measure denominator, the measure numerator and the resulting calculation. The in-depth analysis includes assessment of the source code to ensure that all specifications, such as age, gender, continuous enrollment criteria, exclusionary criteria, medical event codes, etc. are programmed correctly. In addition to the review of specifications for generating the denominator and numerator, the Mercer team will ensure that measures are calculated as required. That is, the team will confirm that measures reported in member months or rates per 1,000 are correct. Furthermore, Mercer will conduct primary source verification on a sample of cases across several measures and trace the sample members back through the source systems to ensure that the programming code logic is working correctly.***

4. ***Assess the sampling process. For any measures for which the MCOs, DBA/PAHP, and CMO has conducted sampling, the Mercer team will review the sampling process to validate that the sample is representative of the full population for which the measure is being calculated and reported. Mercer has a team of statisticians available to consult on appropriate sampling methodologies and to assess the validity of the sample for a specific measure.***

5. ***Preliminary findings and outstanding items. At the conclusion of the on-site portion of the review, Mercer will provide a verbal preliminary assessment of the validity of the PM process. Mercer will request any outstanding documentation and will provide a timeline for submission so those items can***

be reviewed by the team prior to developing the preliminary validation assessment.

REPORTING

1. ***Determine preliminary validation findings for each measure. The PM Team Lead will produce a written preliminary validation assessment. The MCOs, DBA/PAHP, and CMO will have the opportunity to review the assessment to identify errors or omission in the assessment and as needed provide additional documentation to support a recommended correction.***

2. ***Assess accuracy of vendor PM reports to the State. This step in the validation process will assess if the MCOs, DBA/PAHP, and CMO submitted reports to the State timely, in the required format, with the appropriate level of review and attestation of such.***

3. ***Submission of validation report to the State. Based on the final submitted PM rates, Mercer will determine whether the rates are valid and reliable for reporting. Mercer will use industry standard audit bias methodology. The Mercer team's validation of the PM report will include the following:***

   - ***A list of measures that underwent validation review.***
   - ***A description of the methodology used to conduct activities that were part of the validation process.***
   - ***Supporting documentation such as worksheets or tools used in the PM validation process (e.g., Mercer PM Validation worksheet).***
   - ***PM rates and conclusions from the validation process.***
   - ***Validation findings and recommendations for improvement.***

   Mercer will produce a summary of the PM validation results for inclusion in the EQR Technical Report with sufficient detail to meet CMS requirements. The MCOs, DBA/PAHP, and CMO will be required to develop a CAP plan to address all PM validation findings. The Mercer team will review the CAP plan and as needed meet with the MCOs, DBA/PAHP, and CMO to ensure the CAP will result in improved compliance results in subsequent review years. Based on our experience, we consider this approach a best practice.

4. ***Submission to IDSS. For those measures that are appropriate to report to NCQA Mercer will work with the DHCFP to ensure accurate and timely collection and submission of audited HEDIS data using the NCQA IDSS. The team will plan EQR activities to align with the submission timeline published by NCQA. The team will ensure that templates for both Audit Review Table and XML submissions are developed appropriately for MCO data submission and***

to reduce error probability. Validation reports will be reviewed, corrections made, and the submission will be locked for auditing.

5. ***Comparative Analysis. Comparative analysis of the HEDIS results can be very informative to the DHCFP and stakeholders, not just to track and trend results, but to answer broader questions such as, "Is the State getting the most value of its MCOs for the premium dollars it is paying?" Mercer will work with DHCFP to present the Medicaid (Title XIX population) and Nevada Check Up (Title XXI population) HEDIS results in a "reader friendly" approach. As appropriate based on the stability of HEDIS measure specifications, year over year comparative analysis of individual MCO performance as well as between MCO performance will be conducted.***

The comparative analysis will act as the nexus of the report of the PM data submitted by the MCOs and the DBA/PAHP. We note that the CMO is not included in this requirement, but as data are available, inclusion of this information could provide a full picture of the activities and performance of the DHCFP program. Mercer's annual license to NCQA's Quality Compass Medicaid information will allow us to include national and regional benchmark information in the comparison report. The comparison of results across entities and with national information will help assist DHCFP in assessing its value position with the MCOs and DBA/PAHP. Mercer has prepared this type of comparative report for a number of clients in a variety of formats please see Section VIII for an example.

As a value-added benefit, Mercer has corporate resources that as an expanded scope of work, can develop brief (one or two page) infographics to "tell the story" of the Medicaid program and the progress toward meeting QAPI goals. Our clients have found this tool to be useful as not only an internally informative means of disseminating information but also useful for wide distribution of program progress to the general public.

2.1.3.3 Validation of Performance Improvement Projects (PIPs). The awarded vendor will be required to annually evaluate and validate two clinical PIPs and three non-clinical PIPs for the MCO; and one clinical PIP and one non-clinical PIP for the DBA/PAHP.

PIP VALIDATION APPROACH

Mercer will utilize the CMS "Protocol 3: Validation of PIPs" Version 2.0, September 2012 and Mercer's internal PIP Validation Worksheets that are based on the CMS

"Attachment A: PIP Review Worksheet", but enhanced to improve functionality, data display and reporting. The protocol is built to execute three activities. Activity 1 is Pre-onsite Activities, Activity 2 is On-site Activities and Activity 3 is Post-on-site Activities consistent with CMS protocols for validating IPs. To adhere to the CMS protocol Mercer will follow the basic "EQR Arrow" depicted below.

REQUEST FOR INFORMATION AND DESK REVIEW

1. ***Define the scope of the validation. The Mercer PIP Team Lead will meet with the DHCFP to discuss which PIPs should be selected for validation. While we understand that two clinical and three non-clinical PIPs will be validated for each MCO and one clinical and one non-clinical PIP for the DBA/PAHP, we would anticipate each MCO and the DBA/PAHP would have multiple PIPs addressing areas of either care or service that require improvement. This initial meeting will also help us understand in what format the DHCFP has instructed the MCO's and the DBA/PAHP to document and report PIP activities. While many states and MCOs prefer NCQA's QIA format, there are many states who have homegrown PIP documents or who allow each vendor to create their own reporting template. Mercer considers it a best practice to use a standardized format to ensure comparability and ease for both the State and EQRO across all PIPs. However, we can be flexible in our approach and can work with the DHCFP to discuss how to build the greatest efficiencies in the PIP process.***

2. ***Issue RFI. Once we have an understanding of the PIP reporting document, we can begin to address which data elements may be required for validation. From this conversation we can begin to build our RFI. Documents that could be requested as part of the RFI include:***

    - ***Performance Measure specifications including detail of the numerator and denominator.***
    - ***Eligible population.***
    - ***Underlying research.***

- ***Methodology and reasoning for selecting certain benchmarks or performance improvement thresholds.***
- ***Tools used to support barrier analysis (i.e., pareto charts, fish bone diagrams, etc.) and the results of such analysis.***
- ***Approach to selecting interventions (i.e., four quadrant grid, cost benefit analysis, etc.).***
- ***Mechanisms and forums in place to monitor progress and ensure rapid cycle process improvement.***
- ***Short written responses to specific questions outlining the MCOs approach to PIPs.***

We will work with the DHCFP to adjust our RFI based on whether selected PIPs are in a foundational versus a re-measurement phase. It is also important to understand that the focus of the RFI between initial baseline validation and subsequent remeasurement years will look different as many of the foundational elements of the PIP validation worksheet do not need to be revalidated in subsequent years unless changes to the study questions or study measures occur.

To exchange information between the MCOs and the EQRO, the MercerConnect® site can be used to safely transmit data.

3. ***Performed detailed review of submitted documentation. Using the Mercer PIP validation worksheet our PIP Team Lead and Healthcare Analyst will begin the review process; one of our Statisticians is available to review PIP documentation and provide input and technical assistance. The following elements provide a detailed overview of the types of validation activities and criteria used to complete the process:***

   - ***Clear definition of the study question(s): The study questions will be examined to verify that they are simple, clearly stated, and adequately structured to enable the researchers to maintain the focus of the PIP and set the appropriate framework for data collection, analysis, and interpretation.***
   - ***Accurate definition and integrity of selected study indicators: Mercer will ensure that the study indicators (quantitative or qualitative) used for tracking performance and improvement in the PIPs are relevant, objective, measurable, clearly and unambiguously defined, and based on current clinical knowledge or health services research. Additionally, the reviewers will verify that indicators are specifically selected and designed based on the ability to measure changes in health status, functional status, enrollee satisfaction, or valid proxies of these outcomes.***

- ***Adequacy of identified study population: The reviewers will validate that measurement and improvement efforts are targeted to the entire Medicaid enrolled population to which the PIP study indicators apply and ensure that this entire population is correctly identified.***
- ***Sampling methods: Mercer will verify that the sampling methodology is statistically valid and reliable and that results that have been obtained through sampling can be generalized to the entire study population. In general, Mercer seeks to ensure a 95% level of confidence, plus or minus five percentage points. Furthermore, Mercer will validate that all the assumptions made in arriving at the sample are reasonable.***
- ***Completeness of the data collection tools and procedures: Mercer will ensure that a sound and comprehensive data collection plan was utilized for the studies including:***
  - ***Clear identification of the data to be collected.***
  - ***Identification of the data sources and how and when the baseline and repeat indicator data were collected.***
  - ***Appropriate tool use for gathering data.***
  - ***Specification of who collected the data.***
- ***When data has been collected from automated data systems, Mercer will validate that specifications for automated retrieval of the data were devised and appropriately used. If data were obtained from visual inspection of medical records or other primary source documents, Mercer will ensure that the researchers selected the right number of medical records, established clear guidelines, provided staff education for obtaining and recording data, and used appropriate methods for ensuring data accuracy and reliability.***
- ***Thoroughness of data analysis and adequacy of interpretation of study results: Mercer will conduct a thorough review of the calculated performance on the selected clinical or non-clinical indicators. The review will examine the appropriateness of, and adherence to, the statistical analysis techniques defined in the data analysis plan and the addressing of factors that threaten the internal or external validity of the findings.***
- ***Assess whether improvements are real and that sustained improvement is documented: Mercer will perform a review of the results and improvement strategies to verify that any of the stated improvements are a result of valid and sustainable changes in the processes of health care delivery. Such changes should result in sustained improvements and not be "one time" improvements resulting from unplanned accidental occurrences or random chance. For example, in one of the states that Mercer performed this type***

of assessment, it was found that reported improvements in performance were related to enhanced data reporting and capture mechanisms and were not related to specific changes in health care delivery.

- ***Assess improvement strategies: Mercer will evaluate that any documented improvements in performance are clearly linked to a continuous cycle of measuring and analyzing performance and the development and implementation of system-wide improvements in care. If repeat measures of performance indicate that the quality improvement initiatives were not successful (i.e., did not achieve significant improvement), Mercer will ensure that a valid and appropriate problem-solving process was performed (with data analysis when possible), root causes were identified, action plans were developed, and solutions were implemented. If the interventions were successful, Mercer will verify that the new processes have been appropriately standardized and monitored.***

ON-SITE INTERVIEWS AND ANALYSIS

1. ***Assess MCO and DBA/PAHP PIP management approach. The PIP Task Lead will work with the Healthcare Analyst to evaluate each MCOs and the DBA/PAHPs approach to PIP management. This evaluation will include a review of the staff involved in PIP development and implementation activities and the general approach and processes used to conduct research, develop benchmarks and thresholds, select measures, complete barrier analysis and select interventions to address identified barriers to success. The intent of the evaluation is to ascertain whether the MCO and DBA/PAHP has allocated appropriate numbers of staff, with the requisite subject matter expertise and/or training, provided access to appropriate tools and resources, including budget, to ensure that PIP activities have a high probability of meeting and/or exceeding established goals.***

2. ***Preliminary Findings and Outstanding items. During the PIPs foundational year, there is a subset of elements within the PIP Validation worksheet that focus on the framework of the PIP. For example, during the foundation year, there will be a focus on assessing the study methodology; this includes review of the study topic, the population included and the study questions. Also during the foundation year, the sampling methods and the collection procedures shall be clearly defined. Once these elements are defined and approved, they will not need to be reviewed during the remeasurement years. During the remeasurement years, a review of the data analysis and interpretation takes place. Verification that appropriate tools were used and review of the results is the focus are two examples of information that is reviewed to determine if statistically significant improvements are evident and***

to identify opportunities for success. At the conclusion of the interview, Mercer will provide a preliminary assessment of the PIP's validity. The PIP lead will request any outstanding documentation and will provide a timeline for submission so these items can be reviewed by the team prior to developing the preliminary validation assessment.

REPORTING

1. ***Determine preliminary validation findings for each PIP. Following the analysis of all available information, the Mercer PIP lead will develop a preliminary validation assessment. The MCOs and the DBA/PAHP will have the opportunity to review the assessment and identify errors or omissions in the assessment and, as needed, provide additional documentation to support a recommended correction.***

   PIP validation requires several levels of scoring and includes the individual elements of each PIP, such as the evaluation of the study question or review of selected indicators, as well as overall PIP confidence in reporting results and success and sustainability. Individual PIP elements are scored using a three-point scale (Met, Partially Met and Not Met) and an option for Not Applicable (NA). However, once the individual PIP elements are scored, the EQRO is directed to look at the totality of the PIP from approach to outcomes and score two key elements: Confidence in Reported Results and Confidence in Success and Sustainability of Improvement Efforts. The tables below are excerpted from our tools and illustrate the individual element scoring of the PIP along with the overall PIP validation determinations.

2. ***Submission of validation report to state. Once all the necessary data is collected and reviewed, Mercer will provide a report that outlines each of the areas of review and the extent to which the MCOs and the DBA/PAHP has met each element. The validation of PIPs report will include the following:***

   - ***A list of PIPs that were validated.***
   - ***A description of the activities that were part of the validation process.***
   - ***Supporting documentation including validation worksheets and score tables.***
   - ***Conclusion of the validation process.***
   - ***Validation findings and recommendations for improvement.***

   The detailed PIP results as described above will be shared with each MCO and the DBA/PAHP and an analysis in a distilled format will appear in the Annual Technical Report. The MCOs and the DBA/PAHP will be required to develop a CAP to address all of the findings from the PIP validation. The Mercer PIP lead will review the CAP and as needed, meet with the MCOs and the DBA/PAHP to

ensure each entities cap approach will result in improved compliance results in subsequent validation.

2.1.3.4 Validation of MCO and DBA/PAHP network adequacy during the preceding 12 months.

NETWORK ADEQUACY VALIDATION APPROACH

Mercer will utilize the CMS protocol for network validation and associated worksheets upon release of the finalized documentation. In the absence of the protocol Mercer has put forth a similar approach to validate network adequacy of the MCOs and DBA/PAHP based on current CMS protocols for conducting validation activities which includes: Activity 1 is Pre-onsite Activities, Activity 2 is On-site Activities and Activity 3 is
Post-on-site Activities consistent with other CMS protocols used for performing validations. To adhere to the standard CMS protocol approach Mercer will follow the basic "EQR Arrow" depicted below. Should DHCFP have an established network validation process already in place, Mercer is happy to adopt such a process until such time CMS issues its protocol for network validation.

REQUEST FOR INFORMATION AND DESK REVIEW

1. ***Define the scope of the validation. Mercer's process to access and validate network adequacy begins with a kick-off meeting with DHCFP. This meeting will be conducted in-person (with telecommunication options) with the State. The kick-off meeting is to ensure Mercer fully understands DHCFP's MCO and DBA/PAHP contract, exception process, and exceptions granted. Mercer will discuss DHCFP's process for monitoring the MCO and DBA/PAHP network compliance, directions that DHCFP, has given to the MCO and DBA/PAHP to operationalize the standards, and any network reports completed to avoid duplication of effort. Another goal of the kick-off meeting is to develop the approach to review the network adequacy standards by MCO and DBA/PAHP and statewide.***

Following the kickoff meeting, a detailed work plan will be generated that includes ongoing meetings with the State both in-person and telephonically as needed and timeline for deliverables. Mercer will submit the work plan to the DHCFP, in an agreed upon timeframe. Whenever possible, Mercer will use the most current MCO and DBA/PAHP submitted reports including geographical access and appointment availability reports to conduct the desk review. If additional layers of validation are required, Mercer will create a scope of work that includes network provider and member information data transfer from the appropriate data sources.

2. ***Develop the RFI. Mercer will design a RFI for the MCOs and the DBA/PAHP to complete with a timeframe for information and data to be submitted via Mercer's Connect® site. Mercer will host a meeting with the vendors to answer any questions related to the RFI, and allow for a process for follow up questions and answers. The RFI may include but is not limited to a provider network data request, questions related to geographical access software used by the MCO and DBA/PAHP, credentialing process and systems used to generate and validate active network providers, MCO and DBA/PAHP out of network exceptions process and information on exceptions granted, as well as any information on network access grievances and appeals. Mercer may also request any previous CAPs or supplemental data as necessary to meet the needs of the DHCFP in performing the adequacy evaluation.***

3. ***Prepare for the on-site. A desk review of the data and information will be conducted. Mercer will evaluate and make determinations and validate submitted data (using any CMS validation worksheets that may be included within the protocol). Mercer may review a sample of the network provider's information submitted by the MCOs and DBA/PAHP against the published provider directory and geo-access reports to determine if what is being displayed is accurate. Mercer may also, at the request of DHCFP for this enhanced scope of work, conduct a sample of secret shopper calls to provider offices to determine in the provider is excepting Medicaid members or validate appointment wait times.***

ON-SITE REVIEW AND ANALYSIS

1. ***Assess Data integration and control of provider data. The Mercer team will evaluate the MCO and DBA/PAHP's provider data management activities and systems. This evaluation will include an assessment of how the MCO and DBA/PAHP's systems and processes related to quality and accuracy of provider data maintenance. If the MCO has delegated network arrangements***

this would review frequency of delegate data submission and the internal quality controls in place to ensure "clean" provider files.

2. ***Review production of geo-spatial and other required reports. Mercer will conduct an on-site review of each MCO and DBA/PAHP to further evaluate the mechanisms in place to monitor and oversee the provider network, including the network of any delegated entities. This may include a system demonstration, review of processes to validate provider accuracy, review of geographical access reporting, MCO and DBA/PAHP validation of appointment availability, disability access, etc. The purpose of the on-site review is to understand fully how MCO and DBA/PAHP s ensure network adequacy standards are met, oversee any subcontractor network adequacy and validate information is accurately reported.***

3. ***Preliminary findings and outstanding items. At the conclusion of the on-site portion of the review, Mercer will provide a preliminary assessment of the network validation process. The team will request any outstanding documents and will provide a timeline for submission so items can be reviewed by the EQR team prior to developing the preliminary validation assessment.***

REPORTING

1. ***Determine Validation Findings. At the conclusion of the steps outlined above, the Mercer Network Task Lead will develop a preliminary validation assessment. The MCO and DBA/PAHP will have an opportunity to review the assessment to identify errors or omissions and as needed, provide additional documentation to support a recommended correction.***

2. ***Assess accuracy and report to the State. This step in the validation process will assess if the MCO and DBA/PAHP is submitting reports to the State timely, in the required format, with the appropriate level of review and attestation, if required. The Mercer team will gather information from the DHCFP, the MCO and DBA/PAHP and review previously submitted reports to identify any concerns in the ongoing accuracy of MCO and DBA/PAHP network reporting.***

3. ***Submit final network validation report to the State. The threshold for compliance with network validation reporting will be developed based on the state expectation and CMS's final Network Validation protocol. The Mercer team anticipates the report will include the following:***

- ***A description of activities that were part of the validation process.***
- ***Supporting documentation such as worksheets, tools or reports that were used in the validation process.***
- ***Validation results and conclusions from the validation process.***
- ***Validation findings and recommendations for improvement.***

Mercer will work with the DHCFP, to ensure that the network validation reporting is synergistic with and not duplicative of what the State is reporting to CMS through its annual reporting requirement. Mercer will generate its network adequacy validation report to feed into Nevada's CMS report.

The final network validation will be incorporated into the Individual MCO and DBA/PAHP assessment reports and summarized in the Annual EQR Technical Report. Mercer will continue to work with the DHCFP to revise this approach upon receipt of the final protocol from CMS and to ensure that all validation and reporting is streamlined with state reporting requirements so as to build greater efficiencies.

2.1.3.5 Validation of the Nevada DHCFP State Quality Assessment and Performance Improvement Strategy (QAPIS) in SFY 2019 and each subsequent EQR contract renewal year. The comprehensive quality assessment and performance improvement program must include PIPs; collection and submission of performance measurement data; mechanisms to detect both underutilization and overutilization of services; and mechanisms to assess the quality and appropriateness of care furnished to recipients with special healthcare needs as defined by the State in the quality strategy under 438.340.

A. The awarded vendor will evaluate the completeness of the state quality assessment and performance improvement strategy, examining strengths, limitations, and recommending improvements in the description or implementation of the strategy.

B. The awarded vendor will provide technical assistance to the Division as needed to incorporate changes and recommendations for the development of the Quality Strategy and performance tracking tool for the MCOs, DBA/PAHP, and CMO.

C. The evaluation in each year should include information about the State's progress and status of goals; trends in clinical or service quality performance improvement programs; corrective actions and sanctions; progress and status of value based purchasing; and an assessment of the overall structure and process of the State Quality Assessment and

Performance Improvement Strategy. Findings from this assessment will be incorporated as a chapter in the EQR Technical Report described below, entitled "External Quality Review Technical Report".

D. DHCFP requires an electronic copy of the final report in PDF and Word Format annually and three (3) hard copies of the final report for distribution.

We are excited by how DHCFP operationalizes its QAPIS to drive continuous quality improvement efforts and to maintain a quality framework that adapts to emerging needs and trends. The dynamic use of the QAPIS provides for an evolving and comprehensive quality system that aligns priorities, allows for judicious allocation of resources and creates a collaborative environment in which innovation and excellence can thrive.

APPROACH TO EVALUATE THE QAPIS

Annually Mercer will validate the effectiveness of the QAPIS in meeting its defined goals and objectives. To complete the analysis Mercer will use the Quality Strategy Tracking Table found in Attachment B of the QAPIS to track progress of and trends in each of the identified objectives under each of the six (6) QAPIS goals. Goal attainment will be validated against the Quality Improvement System for Managed Care (QISMC) methodology to increase rates by 10% each year and will include identification of trends within measures, across MCOs and in aggregate across all goals and measures.

In addition to the review of the QAPIS objective measures, Mercer will utilize the results of the validation of PIPs and the evaluation of each entity's Internal Quality Assurance Plan (IQAP) to assess the QAPIS' effectiveness. We appreciate the incorporation of the MCO's IQAP evaluation into the broader QAPIS evaluation as it provides consistency in the application and review of the quality assurance and performance improvement framework as it moves from the micro (MCO level) to the macro (Statewide) level. This comprehensive systems analysis help assist DHCFP in its mission to purchase and provide quality healthcare services and to promote equal access to healthcare at an affordable cost by incorporating assessment findings, PM trends and other information from the MCOs, DBA/PAHP and the CMO to provide context and to paint a holistic view of the successes, strengths and opportunities for improvement within the Nevada Medicaid and Nevada Check Up program.

TECHNICAL ASSISTANCE

Nevada has a vested interest in the success of its QAPIS and Mercer's team is ready to assist DHCFP as necessary with resolving issues discovered during the QAPIS evaluation. Once the assessment of the effectiveness of the QAPIS is completed, Mercer proposes a meeting with DHCFP to review the results of the assessment and to discuss findings and recommendations.

The Mercer team has extensive experience providing technical assistance on a broad array of topics germane to this engagement including, but not limited to:

- ***Benefit management and benefit integration. Topics include pharmacy, physical health, behavioral health, LTSS, transportation, and dental benefits.***
- ***VBP models. Topics include development of straight forward pay-for-performance VBP to more robust shared savings arrangements.***
- ***Performance improvement strategies. Topics include activities and interventions to drive year-over-year and sustained improvements in PM results.***
- ***Policy guidance. Topics include maximizing federal authorities, waiver and funding opportunities, including maximizing enhanced match under EQR.***

- ***State staff assistance. Topics include state staff education, as well as building capacity and efficiency in oversight and monitoring activities through the use of disruptive tools.***
- ***Cross system collaboration. Topics include cross-system collaboration to incent synergies and build collaborative and innovative models of care.***
- ***Encounter data submission. Topics include support for downstream activities such as PM reporting, capitation rate setting and risk adjustment.***
- ***Federal and state regulatory requirements. Topics include 2008 Mental Health Parity and Addiction Equity Act (MHPAEA), the 2016 Medicaid Managed Care Finial Rule, the HCBS Final Rule and the 21st Century Cures act as well as, options in state plan amendments and federal waiver options.***
- ***Outcome measurement tools. Topics include tool selection, use in treatment planning, case management, and care coordination.***
- ***Outcomes data collection. Topics include best practices research for the collection of outcomes data (i.e., tools and processes for collection and use of the data).***

In preparing our response, Mercer reviewed the 2016–2017 QAPIS, previous EQRO Technical Reports and other assessments of the Nevada Medicaid and Nevada Check Up programs. Our approach is built on asking the internal question "Are the performance metrics used to evaluate the QAPIS goals measuring what really matters? Do I have a clear understanding of what I should be measuring and why?"

Mercer recognizes that the process of selecting and evaluating PMs is critical to DHCFP's monitoring and oversight efforts. We provide the following observations of where Mercer can bring our expertise to bear to assist DHCFP in meeting its QAPIS goals.

- ***DHCFP has taken a number of steps over the past several years to improve the results of its identified PMs including implementation of Specific, Measurable, Attainable, Realistic and Timely (SMART) goals, QISMC methodology for measuring improvements and a pay-for-performance framework to address key populations including children, adolescents, moms-to-be and individuals with chronic conditions (diabetics). We have noted that during the same time approximately 70% of all PMs that were the same between SFY 2015–2016 and SFY 2016–2017 have demonstrated increases, many achieving the QISMC threshold. However, we also noted that this improvement is dampened by the 30% of measures that saw a decrease in the same period.***
- ***We also note the absence of PMs (VBP and other) pertaining to behavioral health in general and opioid management in particular. We would welcome the opportunity to work with DHCFP to discuss strategies that would allow PM improvements without converse losses and discuss how to build cross-system collaborations to support Nevada's opioid abuse issues including how to build synergies with MCOs, the CMO and DBA/PAHP to support Nevada's new Prescription Drug Abuse Prevention Act. This type of technical assistance can cover a wide range of activities including implementation of PIPs and PMs as well as, engaging MCOs to provide education and support to their respective provider networks. NCQA is releasing its new HEDIS measures targeting opioid usage and treatment which could provide valuable data to DHCFP and its stakeholders. We bring extensive experience on this topic and recently conducted a focused study in Delaware to evaluate "Treatment Outcomes and Prescribing Patterns among Delaware Medicaid Managed Care Plans for Members Prescribed Buprenorphine."***

We consider part of our role in providing technical assistance is to include the development of the necessary materials to present any revisions to the QAPIS to other vested parties including Medicaid Leadership, the Department of Health and Human Services, MCOs the DBA/PAHP, consumers and other stakeholders. Public comment and public input is a critical part of ensuring success of any interventions that may be implemented.

In addition to the described technical assistance following the annual evaluation of the QAPIS, Mercer views the quarterly on-site meetings with DHCFP and the MCOs as an opportunity to "check-in" to ensure ongoing goal alignment and to provide detailed support and on-going technical assistance as needed and approved by DHCFP for each MCOs PIPs and other quality measure reporting requirements.

REPORT FINALIZATION

It is our understanding that DHCFP expects an Annual QAPIS Evaluation Report as well as a summary of the Annual QAPIS Evaluation report to be included as a chapter within the Annual EQR Technical Report. As with all of our report formats we work directly with DHCFP staff to draft a report template that meets the needs of DHCFP and its audience

Once all approved entities have reviewed the report, Mercer will finalize the document. We are happy to amend our approach to meet the needs of DHCFP. Mercer will provide one electronic Microsoft® Word and one electronic Adobe PDF version of the final Report along with three (3) hardcopies of the report. We will work with Mercer's in-house production services to create the hardcopy report to your specifications from report binding style, color options and paper, to choice of front/back covers – we can produce any type of hard copy report you desire. Mercer can also produce the report to ensure compliance with Section 508 of the Rehabilitation Act for stakeholders who may request the information. More information on our Section 508 capabilities is found our "Report Finalization" response in section 2.1.3.6 below.

2.1.3.6 Annual External Quality Review Technical Report – The vendor will be required to produce a detailed technical report that must include:

A. Objectives; technical methods of data collection and analysis; description of data obtained, including validated performance measure data for each activity; and conclusions drawn from the data.

B. An assessment of each MCO's and DBA/PAHP's strengths and weaknesses for the quality, timeliness, and access to healthcare services furnished to Medicaid beneficiaries.

C. Recommendations for improving the quality of healthcare services furnished by each MCO and DBA/PAHP including how the State can target goals and objectives in the quality strategy, to better support improvement in the quality, timeliness, and access to healthcare services furnished to Medicaid recipients.

D. Methodologically appropriate, comparative information about all MCOs and DBA/PAHP, consistent with guidance included in the EQR protocols issued in accordance with §438.352(e).

E. An assessment of the degree to which each MCO and PAHP, has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's EQR.

F. Revision. States may not substantively revise the content of the final EQR technical report without evidence of error or omission.

G. Availability of information. (1) The State must contract with a qualified EQRO to produce and submit to the State an annual EQR technical report in accordance with paragraph (a) of this section. The State must finalize the annual technical report by April 30th of each year.

H. Each year the Vendor will include a Chapter in the EQR Technical Report summarizing the findings from the assessment of the DHCFP's implementation of the State Quality Assessment, Performance Improvement Strategy and Performance Tracking Tool. DHCFP requires an electronic copy of the final report in PDF and Word Format annually and three (3) hard copies of the final report for distribution.

REPORT CONTENT

Compliant with CFR 438.364, Mercer will provide DHCFP with an Annual Technical Report summarizing the findings for all EQR activities. The Technical Report is a comprehensive look at all activities completed by the EQRO or validated by the EQR over the past year. The report will present a balanced and cohesive summary of the value that the MCOs and DBA/PAHP provide to the Medicaid population while meeting and exceeding federal requirements and State contract standards. The report will note developing trends in healthcare quality by highlighting notable achievements throughout the year and tracking areas of concern and the solutions, if resolved, or steps taken to ameliorate the situations, if not resolved. The report will also include a brief discussion of activities planned for the upcoming year and potential changes to the work plan and is organized to share information in a variety of areas including:

- ***Methodology: The Methodology section will include the objectives of the EQR and our approach to collecting data, sampling plans and other pertinent information; the type of information gathered; an overview of the CMS EQR Protocols relevant for the various activities; how data was accessed (administrative interviews, desk reviews, chart reviews, research) and whether it was on-site or offsite; and the types of tools utilized for the different portions of the review. Compliance and ISCA data collection information PIP and PM validation information will be summarized here, in the relevant sections of the report and will include a description of the scoring system for the PIP, PM and compliance review (see below).***
- ***Executive Summary: This 5–8 page stand-a-lone summary is a condensed version of EQR activities conducted, methodologies used, findings, recommendations and general themes of strengths and opportunities. We have found that our clients appreciate this condensed summary and find it useful for messaging Medicaid Leadership, the Department Secretary and other key stakeholders. We are happy to work with DHCFP to incorporate this approach into our Annual Technical Report.***
- ***Strengths and Opportunities: This section describes the strengths and opportunities of each MCO, the DBA/PAHP and the CMO regarding the quality of, access to and timeliness of services that are detailed in the review areas of the report. This section looks at individual entities and identifies themes across the system of care.***
- ***PIP Validation: PIP validation results will be displayed in tables and graphs and will include a summary assessment of findings and recommendations for improvement, as well as actions taken as a result of the prior year's recommendations. The PIP summary will note trends gathered from the data when possible.***
- ***PM Validation: The PM validation section will include the background of the process, PMs that were validated and the methodology of the review process. Results will be displayed in tables and graphs and include summary assessment of findings and recommendations for improvement, and actions taken as a result of the prior year's recommendations. Validation protocols will be included in the specific PM reports.***
- ***Compliance and ISCA: Performance consistent with CMS managed care regulations and State contract standards will be evaluated in accordance to the QAPIS schedule for review for the MCOs and the overall assessment of the DBA/PAHP and CMO entities. Conclusions as to the overall quality of care and recommendations for improvement, and actions taken as a result of the prior year's recommendations are incorporated. These recommendations encompass potential updates to the goals and objectives in the State's QAPIS***

to further align and support improvements and innovations in the quality, access and timeliness of healthcare services.

- ***Corrective Action: The corrective action review will be derived from the prior Annual Report and detail how the MCOs and DBA/PAHP responded to the EQR recommendation and implemented corrective actions; what activities were undertaken, which initiatives were begun, any program changes that were made, process improvements that were initiated. If any outstanding corrective actions exist from prior EQRs, these will also be noted in the report. Mercer will assess how successfully each MCO has addressed Mercer's corrective action recommendations from the previous year's reviews when applicable.***
- ***A section of the report will be dedicated to addressing the summarized findings for Mercer's assessment of DHCFP's implementation of the QAPIS and will contain progress updates in the Performance Tracking Tool.***

REPORT REVIEW

Mercer's typical approach to finalize the Annual Technical Report includes key milestones that consider DHCFP's review of the report for errors and omissions, and submission of the Report to the MCOs and the DBA/PAHP, as appropriate, to capture their review of the report for errors and omissions. Once all approved entities have reviewed the report, Mercer will finalize it. When recommendations for revision are not accepted by Mercer, we will respond, in writing with the list of rejected revisions and the reason for the rejection. Through this iterative process we believe the most accurate report is produced while still meeting the CMS requirements governing the extent to which EQR reports can be revised found at 438.364(b). We are happy to amend our approach to meet the needs of DHCFP.

REPORT FINALIZATION

Mercer's Technical Report will be compliant with all the CMS requirements found at 42 CFR 438.364 and presented in a format approved by DHCFP, formatted in accordance with information requirements found at 438.10(d) and ready for posting to the State website, should DHCFP require such formatting. Mercer agrees to produce the report in accordance with the agreed upon work plan and timeline and certifies that the final approved will be delivered to DHCFP to ensure that you can meet the April 30 due date imposed by CMS.

In addition, Mercer recognizes the need for the Technical Report to be shared with the public and evaluates the content and language to meet this need. The Technical Report will integrate and summarize information from each MCO and the DBA/PAHP and will include comparisons across MCOs and any themes identified across the care delivery system.

The final work product will be produced in formats preferred by the State and Mercer will provide one electronic Microsoft® Word and one electronic Adobe PDF version of the final Annual Technical Report along with three (3) hardcopies of the report. We will work with Mercer's in-house production services to create the hardcopy report to your specifications from report binding style, color options and paper to choice of front/back covers – we can produce any type of hard copy report you desire.

Mercer can also work with DHCFP to address the need of developing printed copies, and formats that are accessible to persons with sensory disabilities, including large print, and compliant with Section 508 of the Rehabilitation Act requirements. The Mercer team understands many States and stakeholder's have expectations for Section 508 compliance and we acknowledge expectations within the Final Rule for accessibility of beneficiary information. The Mercer team has built relationships with partner companies to ensure our team is prepared to generate reports accessible to individuals with sensory disabilities, if requested. For example, a likely partner, Word Wizards, Inc. uses advanced technology and methods to offer premium Section 508 accessibility remediation services. Their experts specialize in Section 508 remediation solutions for a variety of types of digital media. Their philosophy is to make the extra effort to ensure that the remediation process yields media that is comprehensible to the end user and ". . . believe that accessibility goes beyond compliance. Accessibility is about real people who deserve a fair playing field."

2.1.4 Conduct a compliance review evaluating the effectiveness of the quality strategy within the previous 3 years. This review will be broken out in sections to be reviewed annually.

COMPLIANCE REVIEW APPROACH

Mercer will utilize the CMS "Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations" Version 2.0, September 2012 and Mercer's tools that are based on the CMS Attachments A–D that support compliance review activities" and the CMS Protocol Appendix V, "Information Systems Capabilities Assessment", for ISCA activities but enhanced to improve functionality, utility, data display and reporting. The protocol is built to execute three activities. Activity 1 is Pre-onsite Activities, Activity 2 is On-site Activities, and Activity 3 is Post-on-site Activities consistent with CMS protocols for validating PMs.

To adhere to the CMS protocol Mercer will follow the basic "EQR Arrow" depicted below:

Mercer understands that Nevada currently approaches the compliance review in a three-year cycle that parses annual review areas into subject matter sections. For each of these areas, as a component of the annual compliance reviews, Mercer will evaluate the progress toward to QAPIS goals aligned with that years' EQRO review areas and support updates to the QMS where appropriate. In addition, Mercer can provide feedback on potential changes to support your quality improvement goals. To support the QMS annual updates, Mercer will provide a summary of strengths and opportunities based on the annual review of the MCOs, DBA/PAHP, and CMO within the program. The upcoming review cycle would be as follows:

2018

- Credentialing and Recredentialing
- Availability and Accessibility of Services
- Provider Dispute and Complaint Resolution
- Provider Information

2019

- Member Rights and Responsibilities
- Member Information
- Continuity and Coordination of Care
- Grievance and Appeals
- Coverage and Authorization of Services

2020

- Internal Quality Assurance Program
- Cultural Competency Program
- Confidentiality and Recordkeeping
- Enrollment and Disenrollment
- Program Integrity

Mercer's approach to compliance reviews offers Nevada over a decade of experience through, which we identified best practices and developed state-of-the-art tools to aid in the efficiency and effectiveness of our approach. This includes our proprietary electronic

tool that houses a framework for all review areas and elements to be evaluated and includes findings of the desk review and on-site interviews and assigns a compliance designation (i.e., met, partially met, not met). Our tool improves efficiency in report development and provides a historical database to compare year-over-year findings, recommendation and corrective actions. At the end of the day, there is no process or tool that can replace the value of the individual subject matter expertise that our consultants bring to the table. Our extensive experience, tools, and subject matter expertise truly distinguish us from our competitors.

In preparing for this activity, Mercer will meet with DHCFP to discuss changes to program requirements and/or contractual requirements. This will include exploring specific issues of concern for the sections to be reviewed in the current review cycle and your priorities for the year.

Step 1: RFI: Mercer will develop a detailed RFI tailored to the MCOs and the, DBA/PAHP or CMO being reviewed and the areas targeted for review and validation. Through our past experiences, we have determined that a combined data request makes it significantly less cumbersome for an MCO to respond and collect the necessary information in a timely and efficient manner.

In general, the compliance RFI requests detailed information required in order to evaluate the targeted review areas, including but not limited to:

- ***Organizational charts, staffing ratios, and caseloads.***
- ***Training and education plans for staff, members and providers.***
- ***Policies, procedures, and desktop aides.***
- ***Program descriptions, annual evaluations, and work plans.***
- ***Examples of management information reports used in day-to-day activities.***
- ***Call scripts.***
- ***Member Handbook, Provider Directory, and website uniform resource locator.***
- ***Provider Manual and payment dispute resolution procedures.***
- ***Grievance and appeal information.***
- ***Delegation oversight tools, reports, and audit results.***
- ***Pharmacy benefit manager information and integration protocols.***
- ***Quality Committee structure, associated meeting minutes, and agendas.***

In addition, a separate RFI targeting claims and IS will be developed as part of the ISCA evaluation. Mercer develops separate RFIs as we have found that different internal staff complete these documents and this approach streamlines the process and provides additional efficiency. The purpose of the ISCA review is to evaluate the collection and

processing of data by the MCOs and DBA/PAHP and documentation requested will include but isn't limited to information such as:

- ***Business continuity plans, data back up, and data breach procedures.***
- ***Organizational charts, staffing levels, and staff productivity requirements.***
- ***System architecture, workflows, and data integration pathways.***
- ***Claims edits and claims audits.***
- ***Procedures to capture, control, and validate vendor and delegate data.***
- ***Encounter submission processes.***

In addition, Mercer will work with DHCFP to identify appropriate files for review such as: Care Coordination/Care Management, Provider Credentialing and Provider Termination Files, Appeals and Grievance files, claims files. Mercer has found a file review in these areas provides significant detail into the operational compliance with managed care and contract standards and requirements. To support our file review process we develop detailed file review layouts in excel that each MCO and the DBA/PAHP would populate and submit. From these submissions Mercer would select a random sample of 30 files. We use a modified NCQA 8/30 file review approach.

Mercer will employ the MercerConnect® site to support within-team and between-team project efficiencies and to support the streamlined and confidential submission of all review documentation.

Step 2: Desk Review
For the desk review, Mercer reviews all available MCO, DBA/PAHP, or CMO and program data, submitted documents (manuals, policies and procedures, flow charts), and the updated CAP to evaluate the progress toward resolving corrective action items, identification of new issues, and to evaluate maintenance of effort for closed or "met" items.

Our EQR review team utilizes our proprietary on-line tool to evaluate information submitted against defined standards and metrics that are consistent with BBA requirements and modified to include any Nevada specific requirements. Our SME in each area complete their evaluations and once evaluations are complete our EQR team meets internally to review findings and identify items of concern requiring cross-collaboration and follow up. For example our pharmacy SME may discuss the process of adjudicating pharmacy denials and issuing appeals with the grievance and appeals SME. Through this discussion they may identify the need to ask additional questions on-site about how pharmacy appeal decisions are documented and denial letters issued to ensure consistency in medical and pharmacy denial processing. At the conclusion of our desk review our team is fully prepared and had developed on-site interview questions. When this is complete we schedule a meeting with DHCFP staff to present preliminary findings and discuss concerns or areas of emphasis that may be

required during the on-site. This allows for collaboration and deeper understanding between the Mercer EQR team and DHCFP.

Step 3: Onsite Review
Mercer has found that a cross-functional team of reviewers with a strong understanding of each functional area greatly enhances the review process, as well as the review recommendations. We anticipate that our review team will be accompanied by appropriate DHCFP staff responsible for MCO, DBA/PAHP or CMO oversight and monitoring. The review will begin with a combined introduction with appropriate vendor staff after which the interviews with identified staff will begin. Staff interviews will be conducted during the on-site reviews to assess the compliance, accuracy, and efficiency of clinical management, operational management, financial reporting, claims processing, and program integrity operations of the MCOs, DBA/PAHP, or CMO and adherence to state, federal and contract requirements.

Transferring knowledge and enhancing internal skills are often a part of a state's ongoing oversight and monitoring goals. To this end, Mercer welcomes the involvement of DHCFP staff in the desk review and interview process.

Interviews maybe conducted in groups with each vendor's cross-functional staff member representation as appropriate so that information can be gathered in a time efficient and instructive manner for all participants. The interviews will be focused so that the knowledge gained supplements and verifies what was learned during the desk review, particularly regarding compliance with regulations and DHCFP focus areas.

The on-site review will begin with introductions, an explanation of the purpose of the review, and an opportunity for the vendor to highlight accomplishments and challenges during the previous year. Afterward, the interviewers will break off into different tracks and separately interview staff as validation of the desk review material for compliance, ISCA, PIP, and PM activities.

Mercer will team with DHCFP staff to perform the staff interviews to assess compliance in day-to-day operations. At the on-site review, Mercer and AMA staff will interview senior management of the MCOs. DBA/PAHP or CMO to determine the effectiveness of the administrative functions, including provider contracting, member services, utilization management, medical directors, care management and care coordination, financial management, reporting, claims processing, IT, and program integrity to measure compliance, efficiency, and accuracy; and to complete an overall assessment of business operations. Mercer suggests conducting interviews and ISCA reviews at the same time as part of the comprehensive EQR process to gain a full view of operations and business practices and to reduce the burden on the MCOs, DBA/PAHP, CMO, and DHCFP staff.

Mercer recommends closing the on-site review with an exit conference to give high-level feedback on findings, to address issues that remain open, and to lay out the timeline for the report and next steps. While Mercer understands that formal corrective action may be required, Mercer leverages the site visit and exit conference to present review findings as opportunities to collaborate with the DHCFP and other system stakeholders towards continuous improvement of the system of care.

Interviews will be conducted with the following personnel, based on the established DHCFP review cycle and at a minimum:

- ***Administration: Chief Executive Officer, Chief Operating Officer or Vice-President, Chief Financial Officer, Compliance/Program Integrity Officer.***
- ***Clinical Management: Medical Director(s), Directors/Managers of Quality Management, Utilization Management, Care Management, and Care Coordination. Select staff of each of these areas will also be interviewed.***
- ***Operational Management: Directors/Managers of Marketing, Member Services, and Provider Services.***
- ***Information Systems: Directors/Managers of Information/Data Management and Claims Management.***

Additional staff will be interviewed based upon the review priorities.

Mercer's review will include an evaluation of IS capacity; data audits; screening of data for completeness, logic, and consistency; data use within health plans; and results of independent assessments. It captures MCO, DBA/PAHP, or CMO data relating to IS structure and usage, and identifies any issues surrounding data capture, analysis, and reporting. Mercer recommends that the ISCA review take place at the same time as the compliance review.

It is important to note that, at times, the on-site review identifies area gaps in materials submitted by the MCO, DBA/PAHP, or CMO to demonstrate compliance. Mercer may request these materials be submitted immediately following the on-site review to finalize the evaluation against requirements.

Step 4: Analysis
Following the on-site reviews, Mercer will evaluate any additional follow up information submitted. Mercer will re-evaluate any previously partially-met or not-met items from the desk review and issue a final score for each metric. This final scoring will feed the technical reports and allow for comparisons across MCOs and identify strengths and opportunities for each entity.

Step 5: Report and Corrective Action Plans
Compliant with CFR 438.364, Mercer will provide DHCFP with a summary EQR Technical Report summarizing the findings for all entities reviewed. Mercer's Technical Report will be compliant with CMS requirements and in a format DHCFP can post to their State website. Detailed information about the Annual EQR Quality Review Technical Report can be found in our response to Section 2.1.3.6.

2.1.5 Technical Assistance and Optional Activities

The vendor may be required to provide technical assistance and/or optional activities described in 42 CFR 438.58(c) or comparable activities that assess the quality or utilization of services in the fee-for-service program to DHCFP and the participating MCOs, PAHP, and CMO during the contract period. The specific nature of the technical assistance will be defined on a case-by-case basis, but at a minimum, may include educational sessions to enhance the use of EQR results, identification of healthcare trends or "best practices" in performance measures or quality improvement activities; providing clinical consultation and/or expertise; and conducting evaluations of healthcare initiatives. Optional activities described in 42 CFR 438.358(c) may include:

2.1.5.1 Nevada Medicaid FFS population activities such as:

A. Clinical focused studies;

B. Healthcare Effectiveness Data and Information Set (HEDIS®) or HEDIS like calculations and audits;

C. Encounter data validation and omission studies; and

D. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys.

Mercer's team can provide technical assistance to support any of the mandatory or optional activities encompassed under this scope of work. All of our technical assistance is targeted to meet the audience where they are and to bring them along to a place of understanding. It has been our experience over the years that turn-over of key staff within managed care entities and other vendors often results in a drain of organizational knowledge and understanding. While one of our goals when performing compliance reviews is to assess the systems in place to guard against this "brain drain" we recognize that there are occasions where reinforcement and on-going collaboration and technical assistance are necessary in order to create the right environment for continued success. Technical assistance is also a critical tool when introducing new requirements, processes, and/or populations. In this environment technical assistance acts more as real-

time training and education for vendors to quickly operationalize new aspects of program operations.

Our approach to hosting technical assistance sessions is to engage proven learning retention strategies to ensure that the state and its vendors get the most value from the resources spent. These strategies include information-chunking, this approach provides information in bite sized, digestible pieces and then we weave these pieces into a story or we develop hands-on exercises so that participants can apply and work with their new knowledge. Examples of stories and exercises include the use of scenarios, break-out sessions where a smaller group must work on applying the new knowledge or homework assignments. In the latter example we developed a series of technical assistance trainings aimed at integrating rapid-cycle process methods into PIPs. Each session included an hour of training followed by a homework assignment, over a series of several days we provided chunks of information that built on the previous day and asked the participants to go back and apply the knowledge to their PIPs. We then reviewed the PIP submissions (the homework assignments) and provided refocusing and reinforcement of prior trainings. This was a highly successful approach to engage various levels of staff and create a safe and effective learning environment.

All of our technical assistance materials are developed and presented so that the target audience can use the documentation and maintain a training binder. We have also recorded training sessions and created YouTube videos as a method to support maintenance of organizational knowledge.

CLINICAL FOCUSED STUDIES

Should DHCFP wish to implement a clinical focused study for its FFS population, Mercer would apply the CMS protocol 8 for Conducting Focused Studies of Healthcare Quality. See additional description of Mercer's expertise and approach to clinical focused studies in Section 2.1.2.5.

Mercer has conducted multiple focused studies within FFS populations, including assessing inappropriate emergency room utilization in Oklahoma, assessing outcomes between managed care and FFS disease management programs in Texas and analyzing utilization patterns during Connecticut's transition from managed care to an administrative service model.

CALCULATION AND VALIDATION OF PERFORMANCE MEASURES

Mercer can provide both calculation and validation of PMs across any population or program. These activities if selected would utilize the CMS protocols 2 and 6 for the Validation and Calculation of Performance Measures respectively. See additional description of Mercer's expertise and approach to calculation and validation of PMs in Sections 2.1.2.3 and 2.1.3, respectively.

ENCOUNTER DATA VALIDATION

Mercer takes in over a billion lines of claims and encounter data annually. We use this data primarily to set managed care capitation rates and FFS fee-schedules; we consider EDV a core competency of our daily work.

All EDV activities will follow the CMS Protocol 4: "Validation of Encounter Data Reported by the MCO" and will include an ISCA, conducted within the last three years, as the foundation from which to initiate the validation process. Given that Mercer is not the DHCFP's actuary, all EDV activities would need to include time to address the data intake and loading process. This process includes volume charts of encounter data, diagnoses population and validation, and field frequencies.

We are very skilled at detecting potential data issues and working with states and plans to identify promising solutions.

Below is a high-level overview of Mercer's Data Validation Process.
Review State Requirements (Intake/Load Process):

- ***Data Dictionary/File Layouts — Mercer obtains file layouts and data dictionaries to guarantee a thorough understanding of the data contents.***
- ***Review of encounter/claims submission guides.***
- ***Control Total Verification — It is vital that all data are collected and properly transmitted. As part of all file loads, Mercer requires control totals be sent with the data to ensure all data has been successfully transmitted and loaded.***
- ***Field Check — All files are checked to make sure all fields requested are included in the files.***
- ***Interviews with DHCFP and/or MMIS staff as necessary.***

Data Analysis/Validation Process includes but is not limited to the following:

- ***Referential Integrity — Procedures are performed to ensure files can be joined for analysis. Common verifications are that header and detail records can be linked, claims match eligibility, and claims match provider files. Strong referential integrity is critical for all projects to ensure no data loss.***

- ***Valid Values — National standard fields are checked to ensure they contain valid values. These fields include ICD 9/ICD 10 codes, CPT codes, HCPCS, revenue codes and national drug codes.***
- ***Missing Values — Records are checked to identify unpopulated fields, as well as the corresponding percent of total records this represents. This is done for each field in the data. This provides an overview of the completeness of the data.***
- ***Duplicates — Data are run through processes to identify possible duplicate payments/claims for the same service. In order to perform a project that utilizes claims data, the information must be as accurate as possible. Having additional claims/services in the data that do not belong can introduce bias in downstream analysis.***
- ***Micro Analyses — Mercer conducts an evaluation of encounter data by category of service. The measures used to evaluate the completeness of encounter data include:***
  - ***Utilization rate per 1,000 members per month***
  - ***Average number of encounters per enrollee***
  - ***Percentage of enrollees that received services***
  - ***Average cost per recipient***
  - ***Average cost per encounter***
  - ***Average cost per user***
  - ***Total number of submitted diagnoses***
  - ***Total number of valid diagnoses***
  - ***Percent of encounters with one, two, three, or more diagnoses***
- ***Encounter to Cost Report Comparison — A comparison of provider payment amounts contained in encounter data with medical expenses reported on the MCO's financials is performed. The comparison is preceded by adjustments to the data to reflect sub capitation amounts, incurred but not reported claims, settlements, risk pools, risk sharing, reinsurance and any other items that are reflected in the MCO's financials but are not included in the encounter data line items.***

Upon completing each of these validation reports for each applicable data file, Mercer will review the results to determine if there are any data problems or issues that need to be discussed with the client and will make any appropriate data corrections based on these conversations.

Medical Record Review:

Should the data quality support a medical record review, Mercer would work with DHCFP to identify claim types and/or populations of interest from which to select medical records for review. Mercer will work with DHCFP to create the sampling

frame and the data abstraction tool. Mercer has three certified coders on-staff and a host of clinical resources adept at performing medical record review.

CAHPS SURVEYS

Should DHCFP wish to implement a FFS CAHPS survey or a statewide survey of all Nevada Medicaid and Nevada Check Up populations we will work with our NCQA Certified CAHPS vendor NORC to administer the survey in accordance with CMS protocol 5: Validation and Implementation of Surveys and NCQA requirements for CAHPS administration. Additional information about our vendor NORC can be found at Section 2.2.7.

2.1.5.2 Nevada Medicaid Care Coordination program activities such as:

A. A comprehensive on-site contract compliance audit of DHCFP's Care Coordination Vendor.

B. Validation of up to 5 Performance Measures for DHCFP's CMO Vendor. The EQRO will conduct the Validation of Performance Measures review in compliance with the CMS Protocol, Validating Performance Measures.

COMPREHENSIVE COMPLIANCE AUDIT

Our consultants have significant experience conducting contract compliance audits and operational efficiency reviews specific to behavioral health or physical health contracts, integrated physical and behavioral health models, health home models and LTSS entities, including Programs of All-Inclusive Care for the Elderly (PACE) and Community Based Organizations (CBOs). Populations included under these reviews have encompassed standard TANF populations to more complex populations such as aged, disabled, dual eligible, and other special needs groups including those with chronic conditions. Many of the program design elements in these reviews have included complex systems of care like New York's HARPs. The HARPs provide specialty behavioral health services for individuals with serious and persistent mental illness through the State's managed care delivery system, under 1915(i) waiver authority using the State's health home program which emphasizes the use of health home CBO providers. We have also worked with Massachusetts to assess its PACE provider and evaluated Texas' Medicaid Wellness Program administered by McKesson. These reviews leverage the CMS protocols for Assessing Compliance and conducting ISCA. We believe that the approach to these reviews, as outlined in the protocols, provides a best in class approach to conducting reviews, regardless of whether the review is targeted at a managed

Mercer can help you assess if you are getting the value expected from your vendors.

care entity or FFS contractor. We perform extensive review of the contract that governs the relationship, in this instance between DHCFP and its CMO vendor and adjust our Request for Information to specifically target those areas identified under contract. We then adapt our desk review and on-site review tools to ensure that we address all aspects of contract compliance. As requested by DHCFP we can modify our record review tools to address contract specific standards that may be different from standards required under federal regulations for managed care.

Years of experience have allowed us to develop best practices and state-of-the-art tools to aid in the efficiency and effectiveness of our approach. However, at the end of the day, there is no process or tool that can replace the value of the individual subject matter expertise that our consultants bring to the table. Our extensive experience, tools and subject matter expertise truly distinguish us from our competitors. Our vision for approaching these types of reviews is to be your trusted advisor. We believe that when your CMO vendor is successful, your members receive the best possible care and services and DHCFP receives the value it deserves for the rate it pays.

PERFORMANCE MEASURE VALIDATION

Mercer is prepared to validate up to five (5) CMO specific PMs. We will follow the same approach as outlined in our response to 2.1.3.1 and 2.1.3.2. We recognize that the measures selected may not be HEDIS measures and that they could represent HEDIS-like measures or some other measure steward. We have a wealth of experience in validating all types of PMs and consider it a core competency of our EQR work. In addition to HEDIS and HEDIS-like measure, we currently validate other measure stewards including those contained within the Medicaid Adult and Child core measurement sets, and the Agency for Healthcare Research and Quality Quality Indicator and Pediatric Quality Indicator measurement sets.

When validating PMs across vendors and populations our goal is to standardize the approach to the extent possible in order to analyze results, identify findings and make recommendations that are consistent across the program and can be extrapolated to the broader Nevada Medicaid and Nevada Check Up programs.

All PM validations must include an ISCA as a precursor to measure validation. The ISCA must have been completed within the last three years in order to be considered valid. Additionally, significant changes in the vendor's IS platform within the three-year period signals the need to conduct an interim evaluation aimed at assessing any impacts as a result of the system changes. If requested to perform this activity we will work with DHCFP and its CMO vendor to identify the

last ISCA data and determine if any interim updates to system platforms have occurred to determine whether a full or interim ISCA must be completed prior to the measure validation.

2.1.5.3 The awarded vendor may be asked to assist with the development and/or implementation of the Medicaid managed care quality rating system within 3 years of the date of the final notice in the FEDERAL REGISTER by:

A. Adopting the Quality Rating System developed by CMS, in consultation with States and other stakeholders and after providing public notice and opportunity to comment, will identify performance measures and a methodology for a Medicaid managed care quality rating system that aligns with the summary indicators of the qualified health plan quality rating system; or

B. Adopting an alternative Medicaid managed care rating system approved by CMS that utilizes different performance measures or applies a different methodology as long as the ratings generated by the alternative rating system yield information regarding the MCOs, and PAHP performance is substantially comparable to that yielded by the system developed by CMS.

As proposed by CMS the Medicaid and CHIP QRS will include three (3) summary indicators consistent with those found on the Marketplace QRS which include the following:

- ***Clinical Quality Measurement***
- ***Member Experience***
- ***Plan Efficiency, Affordability, and Management***

However, CMS has signaled its intent to allow states autonomy and flexibility to adopt different measures under each of the summary indicators. We would anticipate DHCFPs interest to develop a QRS consistent with the look and feel of the Nevada Health Link marketplace while considering the populations served under the Nevada Medicaid and Nevada Check Up programs.

Mercer can provide consultation, technical assistance, PM calculation, and measure reporting services to support this task, should DHCFP request this optional task.
Our experience providing PM consultation and technical assistance includes:

- ***Research to support measure selection.***
- ***Identification of measures.***
- ***Stakeholder presentation and support for question and answer sessions.***

- ***Development of measure specifications.***

Research to support measure selection is a vital part of the process and ensures that what is measured matters. Our experience is that many states make what they measure matter – which leads to incorrect assumptions around results and findings and can lead to lack of confidence and buy-in from stakeholders.

While it is anticipated that CMS and DHCFP would prefer the use of nationally recognized measures such as those represented in HEDIS and/or the CMS Adult and Child Core Measures, there is flexibility to develop state specific measures. Mercer always encourages states to use measures that are nationally recognized and/or National Quality Forum endorsed; this ensures the appropriate rigor in measure development and general consensus on measure validity.

Mercer can assist in presentation of measures to stakeholders through a number of mechanisms including preparing "mock-ups" of the QRS display and modeling of QRS results across the MCOs. We believe it is imperative that results of any QRS approach be modeled in advance to determine whether QRS rating will result in confusion or lead to "negative" press regarding the results.

Should DHCFP request Mercer's assistance in the calculation of QRS PMs we will use the CMS EQR protocol 6: Calculation of Performance Measures and associated worksheets to define the measure specifications. In the event that the QRS uses HEDIS measures, Mercer will utilize the appropriate HEDIS measure technical specifications. We current have over 20 different HEDIS measures programmed for current clients and can easily program additional measures as needed. Should non-HEDIS measures be selected for inclusion, Mercer will develop the Measure specifications to include data elements such as: age, gender, continuous enrollment, index events, numerator, and denominator information, etc. Additional information as to the frequency, timing will also be captured to ensure all details of the measure is documented. This approach ensures transparency as well as, reliability and validity in PM calculations. Once measure calculations are complete Mercer will work with the appropriate DHCFP or other resource to share information in a format for easy upload and display.

2.1.5.4 The awarded vendor may be asked to perform the following quality activities for a new Nevada Medicaid Aged Blind and Disabled (ABD) managed care expansion program. Tasks may include:

A. Provide consulting to DHCFP for ABD performance measures. The EQRO will identify/recommend new or revised performance measures applicable to the ABD population;

B. Conduct an Information Systems (IS) Readiness Review on selected ABD MCO Vendors; and

C. Evaluate implementation of performance measures.

Mercer has been partnering with states and other stakeholder organizations for over 30 years to support healthcare outcomes for low-income and the most vulnerable populations. Our team of diverse clinicians, policy leaders from Medicaid agencies, CMS, and Health Information Technology and Health Information Exchange bring a comprehensive review to the implementation of new membership. Confidence in knowing that at the start efficient administration of the expansion is what Mercer will offer.

The goal to deliver quality healthcare is key to any program, within this goal is the objective to decrease costs while improving health outcomes. Performance measures allows for a consistent and objective oversight for quality of care. Mercer's approach to the development of PMs within a program is to ask the right questions. What is driving the cost or lack of care for the population served? The identification of barriers that deny consumers access to care.

The expansion of managed care for aged, blind and disabled (ABD) signals data is available. This population has been identified as having chronic and/or complex health issues. Gathering and analyzing the known health issues is a key beginning point. Mercer has experience providing the technical assistance to validate and analyze data to identify the areas of importance to this complex population by using the data available and partnering with the state agency to define the priorities that identify value of the MCO for the ABD membership.

Mercer has provided technical assistance to various states in comparable engagements on the evaluation of PMs. Through our EQR contract in Delaware, we have assisted with the analysis and recommendations from this analysis on the measures identified. In New York and Pennsylvania, Mercer has provided technical assistance in the identification of members with high probability for preventive re-admissions, LANE emergency room visits and potentially preventable admissions. Mercer will provide technical assistance on the evaluation of the PMs and feedback for the MCO vendors.

Completion of ISCAs and EDVs are both part of the work Mercer has completed through EQR and other contracts. Again, leveraging the expertise within Mercer to not only include those with Health Information Technology and Health Information

Exchange experience but to also include those with clinical and operations experience brings front to back and back to front review of systems. Mercers experience in conducting IS readiness reviews include the detail needed for report specifications to be accurate and available.

2.1.5.5 The awarded vendor may be asked to perform the following quality activities for expansion of Managed Care for the TANF/CHAP and CHIP populations into the rural counties. The awarded vendor may be asked to provide consulting to DHCFP's MCOs. Tasks may include:

A. Provide consulting for expansion performance measures applicable to the TANF/CHAP and CHIP populations;

B. Conduct an Information Systems (IS) Readiness Review on selected expansion MCO Vendor(s);

C. Provide technical assistance to the MCOs on the development of performance measures; and

D. Conduct a HEDIS Compliance Audit or validate the measures using the CMS Validating Performance Measures protocol on the contracted MCOs.

As noted above Mercer has extensive experience providing technical assistance for various Medicaid populations. Technical assistance for managed care of TANF/CHAP and CHIP populations would also begin by evaluating what is known about the population being served. In contrast with the ABD population, this population will have limited known healthcare needs. Therefore, information may want to be gathered via a health risk assessment or screening prior to the development of PMs. This would assist in ensuring that the measures are crucial to the population. In addition to the exploration of health needs, the consideration of accessibility in rural areas may be an area of assessment.

Mercer has provided technical assistance with the development of quality services in rural areas. Delaware, Kansas, Arizona are three examples where the location of the membership and providers was crucial information to the development of a quality strategy. The focus of prevention, wellness and accessibility would be recommended starting points in evaluating the appropriate PMs for TANF/CHAP and CHIP. Mercer has designed performance-based incentive structures and PMs with technical specifications to establish accurate and consistent reporting across contractors in Delaware, District of Columbia, New Mexico, and Pennsylvania. Drawing on this experience and utilizing the specific

information on the state of Nevada's identified quality strategy would guide the technical assistance for the MCOs development of PMs.

The IS readiness review process and would be similar to what has been discussed above for the ABD expansion as Mercer would leverage our multi-level experience to ensure that compliance and readiness review tools accurately measure and report performance.

Mercer's experience with quality strategy includes interpreting and implementing nationally recognized PMs such as HEDIS, measures endorsed by the National Quality Forum, and CMS core set of adult and pediatric healthcare quality measures for Medicaid in Connecticut, Delaware, District of Columbia, New Jersey, New Mexico, and Pennsylvania. Mercer has provided technical assistance regarding which measures to prioritize and which measures to use for financial incentives.

2.1.5.6 At the discretion of the DHCFP, the EQRO may be asked to provide additional technical assistance or consultative services related to EQR activities. All requests for technical assistance or consultative services shall be transmitted in writing from the DHCFP to the EQRO. Each request, at a minimum, will include the following:

A. A description of the major functions, tasks, and activities required;

B. The timeline/due date for any reports or identified deliverables;

C. Specifications as to the medium and/or format of the desired deliverable;

D. A listing of the EQRO's project requirements; and

E. Any other instructions, definitions, specifications, requirements, outcomes, tangible items, or projects expected.

The EQRO will submit to the DHCFP, for approval, its cost proposal for completing the technical assistance or consultative project according to the scope of work detailed in the DHCFP's request.

Mercer understands and will comply with the terms and conditions as set forth in this Request for Proposal (RFP).

2.2 QUALIFICATIONS OF EXTERNAL QUALITY REVIEW ORGANIZATIONS

2.2.1 The vendor and all subcontractors must meet all requirements of 42 CFR 438.354 and the mandatory DHCFP contract requirements as follows:

Mercer's qualifications as an EQRO extend beyond the standard competence and independence requirements set forth at 42 CFR 438.354 and the mandatory DHCFP contract requirements; when leveraged or desired by our state clients, we can provide Medicaid program design, policy guidance, and quality improvement support that is not typical of our competitors.

Mercer is an extremely competent EQRO and we have been providing EQR and EQR-like services for over 14 years to more than nine states.

Mercer exceeds EQRO federal regulation competency requirements. We have been providing EQR and EQR-like services for over 14 years to several states including Arizona, Connecticut, Delaware, District of Columbia, Kansas, Louisiana, Minnesota, North Carolina, and Virginia. In addition to our competence as an EQRO, the additional value we bring to DHCFP is our knowledge of and participation in the transformation of other Medicaid managed care programs, an understanding of where they are going, and ongoing participation in current advancements for quality improvement and VBP strategies.

Mercer differs from our competitors in that Mercer's Government Health Services Consulting specialty practice is primarily dedicated to providing services to government healthcare purchasers. We are a full service Medicaid consulting firm that, for the past 30 years, has been dedicated to assisting over 35 states to design, implement, monitor, and evaluate Medicaid programs.

Throughout our entire response, we have endeavored to describe and highlight our breadth and depth of experience to assure you that Mercer has more than demonstrated our competency and experience to be your EQRO going forward. We are eager and excited about the opportunity to bring fresh ideas, new perspectives and lessons learned from other state Medicaid programs to the betterment of Nevada and your important programs.

2.2.1.1 The vendor must have staff with demonstrated experience, knowledge and skills of:

A. Medicaid recipients, policies, data systems, and processes;

Medicaid Recipients:

As noted in the Nevada Medicaid Delivery Model Recommendation Report, January 3, 2017 draft, themes from stakeholders included difficulty "navigating the system" and "customer service and communication." Healthcare is complex and resources are scarce which is why we believe that understanding "the face"

of the Medicaid population is critical for developing sound policy guidance, allocating resources, analyzing the impact of interventions and ultimately – for improving the system, driving and sustaining year-over-year results. Our team of EQR consultants is well versed in the different populations that may be encompassed under a single Medicaid program and we use that knowledge to collaborate with our clients and their vendors to ensure that resources spent to improve the quality, access and timeliness of services result in the best possible member and provider experience and improved health outcomes.

Our consultants have conducted EQR activities in Delaware that directly impact the lives of Medicaid recipients. As an active participant on Delaware's Quality Improvement Initiatives Task Force we have helped to improve information exchange and to reduce fragmentation through conducting PIPs, assisting in the development and refinement of the State's Quality Strategy (held out by CMS as being an excellent example of a well written strategy), and engaging MCOs as key collaborators with other State organizations. We have worked with the Department of Health, Division of Substance Abuse and Mental Health and the Department of Services for Children, Youth and Families. These collaborative efforts have led to improved coordination of services for foster children, improved service arrays and service coordination for individuals with persistent mental illness. The results of these efforts have been synergies across organizations which have focused on same/similar topics, including opioid prescribing practices, behavioral health integration and development of value based performance measurement approaches. In addition to our work with the Division of Medicaid & Medical Assistance, the Mercer team has worked with the Delaware Health Care Commission on their State Innovation Model including alternative payment arrangements, quality and cost benchmark efforts and public reporting and transparency. All of these efforts work toward accomplishing the state's Quality Strategy goals and providing the best care to Medicaid recipients.

In addition, our EQR clinicians, statisticians and data analysts have conducted multiple focused studies targeting client priority topics such as: Childhood Overweight and Obesity, Opioid Prescribing and Treatment Practices, Identification of Potential Over- and Under-Utilization of HCBS and Managed Care Network Access Compliance. The recommendations from these studies have helped to set policy, drive improved access and enhance the quality of services available to a state's most vulnerable citizens.

In addition to the improved clinical quality of services we have improved the access to and availability of service through our work analyzing the sufficiency and availability of critical provider types and services. For example, Mercer completed a geospatial analysis and produced heat maps of primary care

availability and emergency department utilization for the Oklahoma Health Care Authority. In Arizona, Mercer conducted a network sufficiency evaluation of the priority mental health services (i.e., supported employment, supported housing, consumer operated services and assertive community treatment) to assess and estimate unmet needs and in Delaware our utilization and geo-spatial mapping analyses were used to develop the State's network adequacy standards to support compliance with Final Rule.

Medicaid Policies:

Our policy and state operations group is an interdisciplinary team of consultants with broad knowledge and experience in Medicaid and CHIP rules for Medicaid managed care and how states and managed care plans design high-quality programs within these expectations.

With a cadre of former federal and state officials, Mercer brings unparalleled knowledge of how states can operate a high-quality Medicaid managed care program within the federal quality framework for managed care.

We understand the barriers and opportunities faced by those involved in systemic change. This team of consultants complements our talented team of EQRO consultants to address both issues of federal compliance and opportunities to leverage EQR to inform and drive policy. Our policy and operations group also actively supports our EQRO team and states on the emerging federal landscape as the federal rules for Medicaid managed care and quality oversight continue to evolve in the 2016 Final Rule, the Mental Health Parity rules, waiver terms and conditions, and now the pending new revisions to the managed care rules. Mercer often produces "Mercer Flash" notices of current events that we share with our clients and prospects as a complementary service.

Our EQR consultants are actively engaged with a number of states to usher in the new quality landscape that emphasizes value over volume. We work with the National Committee for Quality Assurance (NCQA), the Center for Health Care Strategies (CHCS) and other quality focused organizations to develop and implement innovative models aimed at improving healthcare quality. We worked with New Jersey to operationalize their new quality measurement framework for nursing homes that will set the stage for a managed long term services and supports VBP model. Mercer facilitated the presentation of this work along with our partners from CMS, and Tennessee at the 2017 National Association for State's United for Aging and Disabilities (NASUAD) fall conference. Our team currently is working to redesign New Jersey's maternity kick payment model to integrate quality measures and outcomes into payment.

Our team was also intimately involved with Connecticut's transition from a managed care environment to a provider focused model. This work was a testament to a true paradigm shift that required significant focus on quality measurement and monitoring. Connecticut's experience with Mercer as an EQRO was one of the keys to our team's continued participation even though the state moved away from managed care.

Mercer's expertise as a full service consulting firm highlights the sophistication of our knowledge pertaining to Medicaid data and data systems. Our knowledge extends beyond our own internal systems and includes specialty knowledge and expertise in the operation of State MMIS, integration of vendor systems (i.e., managed care, dental, pharmacy benefit managers, transportation etc.) and the impact of delegated relationships, benefit coordination and third-party liability have on the capture and control of critical claims and encounter information. This end-to-end knowledge is critical to performing key EQR activities including conducting Information Systems Capabilities Assessments, Performance Measure Validation and EDV. This experience can be leveraged in FFS delivery models as well.

Mercer has received data for more than 25 state agencies and takes in over a billion lines of claims and encounter data annually.

Tools and Data Systems to Support any Analysis:

To support the data management process, Mercer has invested in commercially recognizable and globally supported technology and tools to provide for the intake, validation, storage, analysis, and reporting of large claims and encounter data sets. Our information technology system configuration provides for scalability and expansion of both disk space and processing power, as needed, for data warehousing and other analytics. System backups allow for recoverability and business continuity, enabling stored data to be retrieved within hours. All application servers are connected to each other and to the mass storage device with gigabit fiber network connections.

All analysis tools currently used support our open architecture and are open database connectivity compliant. Our technical platform assures a seamless interface between our systems and those of other parties including:

- ***State Medicaid agencies.***
- ***MCOs.***
- ***State fiscal agents.***

We have a comprehensive, automated, and integrated information technology system that is capable of:

- ***Exchanging files.***
- ***Receiving, storing, analyzing, and reporting on state data in order to meet project timelines.***
- ***Supporting large data sets and exponential growth in a repository over the life of the contract.***

Our data warehouse utilizes Oracle database management software. Our primary tools used to support intake, validation, analysis, and reporting of data are industry standard SAS, PLSQL, and Cognos software products. The Cognos product enables us the ability to provide clients with access to data, which can be manipulated by the client, without the need for programming knowledge, via our secured web interface. All of our data systems have state of the art security and privacy features with multiple layers of redundancy for maximum protection.

Mercer has received data for more than 25 state agencies and takes in over a billion lines of claims and encounter data annually. Below is a list of the states in which Mercer has acquired and validated claim, encounter, eligibility/enrollment, or other health data.

Alabama	Florida	Missouri	Ohio
Arizona	Georgia	Montana	Oklahoma
California	Kansas	Nebraska	Pennsylvania
Colorado	Louisiana	New Jersey	Texas
Connecticut	Massachusetts	New Mexico	Utah
Delaware	Minnesota	New York	Virginia
District of Columbia	Mississippi	North Carolina	Washington

This data and Mercer's experience has been accumulated on projects that have ranged in focus across the following:

- ***Validating (completeness and accuracy) encounter and FFS data.***
- ***Developing actuarially sound capitation rates for various states' Medicaid programs for physical health, behavioral health, and LTSS.***
- ***Evaluating efficiency analyses for Medicaid managed care programs.***

- ***Conducting risk adjustment, selection, and case mix analyses using diagnosis based risk adjustment models or pharmacy based models.***
- ***Shadow pricing of Medicaid encounters with Medicare or commercial fee schedules.***
- ***Benchmarking data across state clients.***
- ***Providing provider quartiling and profiling with identification of potentially aberrant providers.***
- ***Conducting utilization review, disease management, and case management.***
- ***Calculating quality indicators.***
- ***Conducting geo spatial analysis and mapping to determine provider network adequacy.***
- ***Creating dashboard reporting for the evaluation and assessment of health programs.***

END-TO-END SYSTEMS CONSULTING

In addition to our ability and expertise in capturing and controlling various data sources, we have deep subject matter expertise in the data systems used by State MMIS vendors, pharmacy benefit managers, managed care entities and other state vendors (e.g., transportation vendors). We believe this knowledge, insight and experience is critical when performing an ISCA as issues in system operations and data exchange often lead to increased claims rejections, poor encounter data submission, claims payment timeliness and inaccuracies in PM calculations.

During the State of Delaware's T-MMIS transformation project our EQR informatics consultants were used by the State Medicaid agency to provide technical assistance during the design process. Delaware's system was initially built when FFS was the predominant delivery model. As managed care became more prevalent the system was "tweaked" to accept encounters, but still functioned very much like a FFS claims payment engine. Our EQR consultants used the information and insight gained during our ISCA and EDV work to inform the State and its MMIS vendor of areas where specific re-engineering towards a more encounter friendly processing environment would result in more streamlined, efficient and effective use of data. Implementation of these changes will have a significant positive impact on downstream functions that support activities such as managed care rate setting, risk adjustment, and will lead to the development of more robust data analytic capacity as well as support expanded dash-board development to bolster monitoring and oversight activities.

B. Managed care delivery systems, organizations, and financing;

MANAGED CARE DELIVERY SYSTEMS AND ORGANIZATIONS

As a full service Medicaid consulting firm we believe our knowledge and understanding of managed care delivery systems and managed care plan operations is unparalleled. We have over 30 years of experience helping states build and implement managed care programs from the ground up and many on our team are previous managed care executives. We are more than just an EQRO. Our clients benefit from the depth and breadth of expertise and experience that Mercer offers. We are excited about partnering with you to move Nevada's program forward and help make DHCFP a more informed and effective program sponsor.

Our consultants have worked in some of the largest and most complex Medicaid programs in the Country including California, New York, New Jersey, Pennsylvania, Ohio, Florida, and Massachusetts. Our understanding of healthcare delivery models stretches beyond managed care and includes a wealth of experience with broader delivery system elements including: FFS, enhanced primary care models and medical/health home programs, pre-paid ambulatory health plans and dual Medicare/Medicaid integration models.

Mercer's key EQR staff members possess exceptional consulting skills and a unique breadth and depth of understanding of the Medicaid program and of Managed Care delivery models, which allow us to deliver to you the greatest value in assessing, designing, and implementing EQR activities to address your most pressing issues and concerns of today while helping you build your vision for the Medicaid managed care program of tomorrow.

FINANCING

Mercer is a nationally known and respected Medicaid actuarial and financial consulting firm; our knowledge and understanding of healthcare financing is beyond compare. We perform managed care rate setting, risk adjustment, development of FFS rate schedules for acute, behavioral health, HCBS and non-emergent transportation providers and we have provided these services to over 30 different states. From an EQR perspective, knowledge of healthcare financing is only a portion of what we bring to the table.

Our EQR key staff understands the linkage between healthcare, financing, and delivery of healthcare quality. As many Medicaid programs have focused system transformation efforts to incent value over volume our EQR key team has been on the cutting edge of developing new and innovative approaches.

Heather Huff our EQR Program Director has been delivering EQR services for over ten years. She is currently assisting Delaware's Health Care Commission with the development of a VBP strategy to support the State's Innovation Model work. Son Yong Pak, our EQR project manager, is a Certified Professional in Healthcare Quality and a Certified Professional Coder. She has extensive experience in Arizona, Idaho, and Pennsylvania in the development of value based payment models, and is the co-lead for Mercer's Program Integrity work which is focused on developing critical processes to assess, quantify and develop systems to reduce fraud, waste, and abuse. Rachel Wright is the EQR team's Clinical Quality Lead and is a Master's prepared Registered Nurse and a designated Public Health Nurse. Rachel's experience in delivering sustainable clinical quality programs includes the implementation of clinical efficiency analyses and alternative delivery systems to support a variety of clients including New Jersey, Pennsylvania, New Mexico, and California.

2.2.1.2 Quality assessment and improvement methods; and

As an experienced EQRO Mercer has extensive knowledge and experience in the application of quality assessment and performance improvement methods. We utilize the CMS' Quality Framework which incorporates both quality assurance and performance improvement activities and we recognize the primacy of the Quality Strategy in establishing the structure through which these QA and PI activities occur. We appreciate DHCFP's efforts to align the State's Quality Strategy to the CMS and National Strategies; this serves as a strong and coordinated message to all stakeholders of Nevada's intent on delivering on the Triple Aim to "achieve better care for patients, better health for communities, and lower costs through improvement in the healthcare system."

We understand the six (6) goals and the underlying objectives for the Nevada Medicaid and Nevada Check Up programs and we understand the important role the EQRO plays in assisting DHCFP in achieving those goals. We believe EQR activities are more than just a "check box" in compliance. We view our role as the EQRO as a vital instrument in the State's tool belt. We have implemented the following performance improvement techniques in many states including Arizona, Delaware, Pennsylvania, New Jersey, and New Mexico.

- ***Plan-Do-Study-Act (PDSA): this model for performance improvement is used by CMS and the Agency for Healthcare Research and Quality. We routinely apply this model when conducting PIPs or when providing technical assistance to MCOs.***

- ***Rapid-cycle techniques: while the PDSA model is meant to be used in a rapid-cycle environment our experience working with States and managed care plans is that HEDIS measures are often selected as they represent the "gold standard" for performance measurement. However, it can take a year or more to determine whether statistically significant improvement has been made. Therefore, we have engaged states to use the concept of rapid-cycle "lead" and "lag" measures. Lead measures are interim measures that determine whether interventions have a likelihood of success while HEDIS represents the "lag" measure. Rapid-cycle approaches also set a window of 3-months for which interventions and follow-ups are performed, which keeps the concept of "continuous quality improvement" at the heart of all improvement efforts. This approach is just as effective when measures other than HEDIS are selected.***
- ***Specific to our quality assurance work under our EQR and EQR-like engagements our experience encompasses conducting managed care compliance and process reviews. These reviews utilize the standard EQR protocol approach of requesting information, completing a desk review and conducting on-site interviews. We believe these steps are critical in evaluating highly complex matrixed environments that are the hallmark of managed care organizations. Additionally, our team has developed novel approaches including:***

- ***Tracer Methodology: this work modifies a proven technique used by The Joint Commission. Our tracers are built to examine a provider's or member's experience through the managed care matrix. Our EQR key team has developed these scenarios to encompass complex, real life member and provider scenarios. We present these scenarios directly to the front line staff at a managed care plan to gain a greater understanding of how systems integrate across the organization, the tools and training each staff member brings to the analysis and resolution of these situations and the process used to track and trend activities for the purposes of quality assurance and performance improvement. We've used this approach in Delaware, New York, and Pennsylvania to help state staff and MCOs quickly identify missed opportunities for providing high quality member and provider services and areas requiring further training, education, and process streamlining.***

- ***Secret Shopper: While not new, secret shopper approaches are invaluable for understanding what occurs on a day-to-day basis and for understanding the member's experience of working with a managed care plan. Secret shopper activities include performing an in-depth review of each MCO's public website,***

outreaching to member services and provider services including the member and provider call lines of any delegates or sub-contracted vendors. We have used this technique in Connecticut, Delaware, and New Jersey.

2.2.1.3 Research design and methodology, including statistical analysis.

Mercer's has a wealth of experience in developing and implementing research and analytical projects from conducting chart reviews to performing 1115 waiver program evaluations. We bring years of research design, analysis, and reporting experience to the table.

Our experience ranges from sampling and tool development, including data mining algorithms and medical record abstraction databases, to performing statistical analysis such as descriptive, inferential, and multivariate statistics. Our expertise has been applied to clinical and non-clinical areas and covers selecting, calculating and validating HEDIS and non-HEDIS outcome and PMs, performing medical record abstraction, geo-spatial mapping to detect utilization and referral patterns, analyzing impact of pay-for-performance and other VBP strategies and a host of other quality of care and service studies.

Our key EQR team includes doctoral level bio-statisticians, healthcare researchers, licensed clinicians and pharmacists, healthcare data analysts and informatics specialists with expertise in all aspects of research design, data validation, measure calculation, statistical analysis and report writing. We are experts in taking technical information and presenting it in easy to read, easy to understand language so that a broad range of audiences can benefit from the information.

Some examples of research and analytical projects we have conducted include:

- ***Acting as the Independent Evaluator for the St. Louis Regional Health Commission's Gateway to Better Health 1115 Demonstration Waiver.***
- ***Conducting a focused study on "Treatment Outcomes and Prescribing Patterns among Delaware Medicaid Managed Care Plans for Members Prescribed Buprenorphine."***
- ***Analyzing Oklahoma's Non-emergency Transportation Utilization and Payment Rates.***
- ***Oklahoma Emergency Department Utilization: July 2012 through June 2015.***
- ***Analyzing Geo-spatial positioning and utilization trends of primary and specialty providers to inform Delaware's Network Adequacy standards.***

2.2.2 Sufficient physical, technological, and financial resources to conduct EQR or EQR-related activities

Mercer is a wholly owned subsidiary of Marsh and McLennan a fortune 500 company. As such we have access to vast amount of resources, unparalleled by other EQRO firms. Today, Mercer's specialized government healthcare consulting practice has over 275 dedicated professionals with backgrounds in Medicaid and the CHIP administration and program operations, federal healthcare policy and reform, clinical expertise, quality and performance measurement and monitoring, behavioral health needs, research, large data/information management, pharmacy reimbursement and benefit management, actuarial/financial analyses and rate work, and project management. Our mission – to assist governments in becoming more efficient purchasers of healthcare services – has remained unchanged since we began helping state Medicaid and other healthcare programs in 1985.

Our mission – to assist governments in becoming more efficient purchasers of healthcare services – has remained unchanged.

To supplement our staff's individual subject matter expertise, Mercer's Washington Resource Group (WRG) provides assistance and in-depth research and intellectual capital development to consultants and clients on legal, technical, and marketplace issues. A key area of WRG expertise is healthcare policies and practices. Most recently, WRG has been steeped in information research and analysis of national healthcare reform legislation, the new Managed Care Final Rule and the MHPAEA implications, including staying abreast of the impact of the recent Administration change and its potential impact on our clients. As it relates to this engagement, our EQRO consultants have access to WRG services to assist in "at your fingertips" research to assist in the development and provision of technical assistance in areas of clinical quality and outcomes measurement rooted in national evidence-based and emerging promising practices.

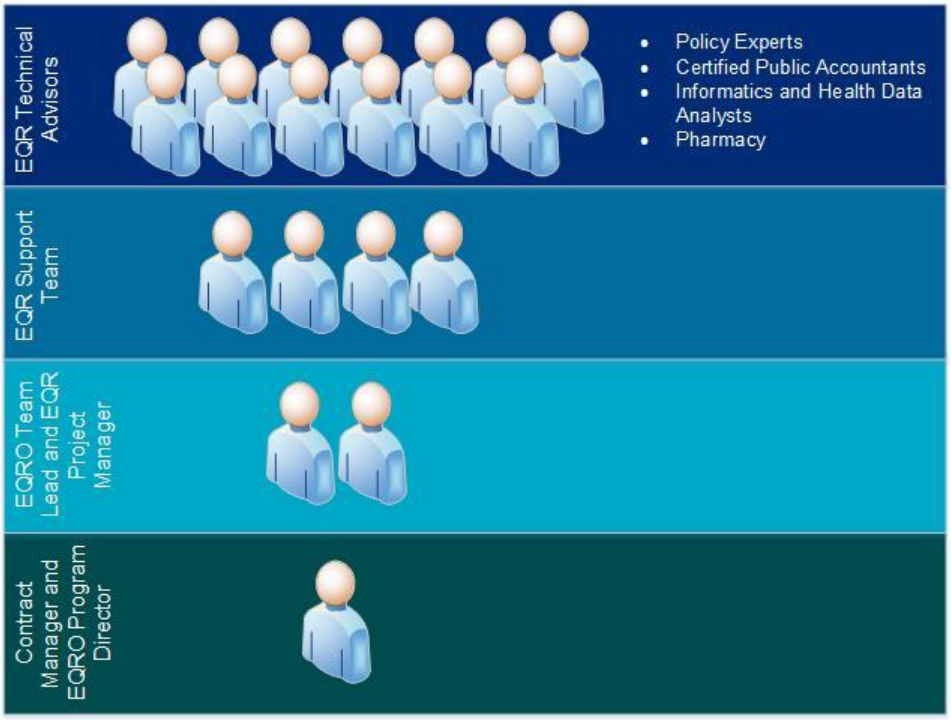
2.2.3 Other clinical and nonclinical skills necessary to carry out EQR or EQR-related activities and to oversee the work of any subcontractors.

We have learned over more than a decade of providing EQR services on comparable engagements that there is often need to access technical experts on a variety of topics. That is why Nevada will have access to our hundreds of talented professionals in addition to the core team listed within this proposal. As a result, we have a host of support resources that stand ready to assist as needed including:

- ***Policy experts – who can provide guidance on interpretation of federal rules and insight into CMS concerns, many whom are former CMS staff members and leaders.***

- ***Certified public accountants – who act as technical advisors for nuanced and/or complex questions related to financial concerns and issues. Medicaid transformation efforts have increasingly focused on payment for value over volume and understanding fiscal concerns can often go a long way in resolving issues or contemplating interventions/recommendations for improvement.***
- ***Informatics, statisticians, and health data analysts – who, from an EQR perspective, have provided an increasing level of subject matter expertise relating to data capture, control, validation, statistical analysis reporting, and data display/presentation. This trend is a result of Medicaid reform efforts that are data intensive and rely on the ability to harness and make healthcare data "actionable."***
- ***Other licensed clinicians – who provide expert technical advice in best practice clinical management, including use of therapeutic pharmacy regimens to improve clinical outcomes, application of evidence based practice and innovative strategies to improve outcomes of care all who have deep understanding in Medicaid pharmacy and dental benefit management. While we understand that the pharmacy, dental, vision, and other key benefits intersect with clinical and quality outcomes and should be managed in a holistic and person-centered fashion.***

The following graphic illustrates our staffing approach for this EQR engagement:



Our key EQRO project team possesses deep knowledge and experience working with:

- ***Protocols for EQR of Medicaid MCOs.***
- ***Continuous quality improvement methodologies and quality assurance standards aimed at incenting value over volume.***
- ***Managed care delivery models and internal managed care operations from the most basic to the complex and highly integrated.***
- ***Social and medical models of care rooted in best practices that promote integrated and "whole-person" care.***
- ***Measuring and evaluating the efficiency and effectiveness of Medicaid programs and populations including PM calculation, validation and reporting.***
- ***Study research and design including development of sample frames, statistical analysis and data interpretation.***
- ***Medicaid and CHIP programs and federal rules and regulations as they relate to medically and categorically needy programs for all populations.***
- ***Claims payment and encounter data processing activities including ISCA and EDV.***

While we believe that we possess a deep bench of EQRO consultants and technical advisors to address any areas of concern that may arise during the course of this contract, we recognize we cannot predict the future. To the extent that Mercer cannot immediately address a specific topic or it is determined that the question or issue requires direct access to other states or SMEs, we are prepared to outreach to other organizations such as the NASUAD, CHCS, and the NCQA and/or other state Medicaid agencies. We frequently work with these partners on a host of topics and are accustomed to making connections between states and working with other consultants and contractors.

2.2.4 Independence. The EQRO and its subcontractors must be independent from the MCO, PAHP, or CMO entities. To qualify as "independent":

2.2.4.1 A State agency, department, university, or other State entity:

2.2.4.2 May not have Medicaid purchasing or managed care licensing authority; and

2.2.4.3 Must be governed by a Board or similar body the majority of whose members are not government employees.

Mercer attests to our and our subcontractor's (Quality Review Solutions, LLC) independence as an EQRO. We are not a state agency or university, nor do we have Medicaid purchasing or managed care licensing authority. Our employees are not government employers. We have no control over the State of Nevada or any Nevada government agency or any MCO in Nevada that precludes us now, or in the future, from providing an independent EQR.

We also certify that we shall refrain, for the life of the contract, from entering into any contractual relationships that would violate the independence requirements set forth by federal rule under 42 CFR 438.354.

Mercer's Board of Directors is comprised of 11 individuals, none of whom are government employees.

2.2.5 As described in (described in §438.310(c)(2)) an EQRO may not:

2.2.5.1 Review any MCO, PIHP, PAHP, or PCCM entity or a competitor operating in the State, over which the EQRO exerts control or which exerts control over the EQRO (as used in this paragraph, "control" has the meaning given the term in 48 CFR 19.101) through:

A. Stock ownership;

B. Stock options and convertible debentures;

C. Voting trusts;

D. Common management, including interlocking management; and

E. Contractual relationships.

Mercer does not exert control over any MCO, prepaid inpatient hospital plan (PIHP), PAHP, or primary care case management entity or any competitor operating in Nevada, including relationships such as stock ownership, stock options and convertible debentures, voting trusts, common management including interlocking management, and contractual relationships.

2.2.5.2 Deliver any healthcare services to Medicaid beneficiaries;

Mercer is a full service, nationally-known Medicaid consulting firm, and as such does not deliver any health services either directly or indirectly to Medicaid beneficiaries.

2.2.5.3 Conduct, on the State's behalf, ongoing Medicaid managed care program operations related to oversight of the quality of MCO, PAHP, or CMO entity services, except for the related activities specified in §438.358;

We will not conduct, on the State's behalf, ongoing Medicaid managed care program operations related to oversight of the quality of MCO services, except for EQR protocol-related activities and technical assistance related to those topics.

2.2.5.4 Review any MCO, PAHP or CMO entity for which it is conducting or has conducted an accreditation review within the previous 3 years; or

Mercer certifies that it is not an accrediting body and has not conducted and will not in the future conduct any accreditation review any Nevada MCO, PAHP, or CMO entity.

2.2.5.5 Have a present, or known future, direct or indirect financial relationship with an MCO, PAHP, or CMO entity that it will review as an EQRO.

Mercer certifies that it does not have any current direct or indirect financial relationship with an MCO, PAHP, or CMO entity that would be reviewed as part of its scope of work with DHCFP. We also certify that we shall refrain for the life of this contract entering into any direct or indirect financial relationship.

2.2.6 The vendor must designate a contract manager to work with the assigned DHCFP program specialist or contract monitor(s).

Mercer strives to be your "Trusted Advisor" and to help achieve that vision our dedicated EQR Program Director (contract manager) is responsible for collaborating with DHCFP to set the project direction, oversee team activities, manage team dynamics, provide technical leadership, collaborate, and manage subcontracted entities.

Heather Huff is Mercer's EQR Program Director and the designated contract manager that is assigned to DHCFP's program specialist and/or contract monitor. Heather has a Master's Degree in Sociology and she brings over 10 years of EQR experience to this engagement. Heather has led EQR engagements and performed all mandatory and optional activities encompassed under this scope of work. She has deep experience in leading engagements of this size and complexity and has done so successfully in Connecticut, prior to its transition to an Administrative Services model, and Delaware. Furthermore, within Mercer, every client state is assigned a "client leader" who is responsible for overall client satisfaction across all accounts as we often have more than one contract within in a state. For Nevada, that individual is Fred Gibison, a Partner in Mercer with nearly 20 years Medicaid consulting experience specializing in payment/rate setting, policy and LTSS. Fred is also a member of Mercer's business leadership group and will support Heather in contract matters as needed.

2.2.7 The awarded vendor is, or will subcontract with, a National Committee for Quality Assurance (NCQA) certified Consumer Assessment of Health Plans Survey (CAHPS) vendor, if this optional activity is assigned.

Mercer is pleased to present our partnership with National Opinion Research Center (NORC). NORC is a nationally known independent social research company and an NCQA certified CAHPS 5.0 vendor. In 2014 and 2015, under contract with the CMS, NORC

conducted a multi-mode (telephone and mailing) national Medicaid CAHPS survey sampling over 1.5 million adults. NORC brings a wealth of social research survey experience and intimate knowledge regarding survey success in a Medicaid population. Should DHCFP assign this optional activity Mercer and NORC stand ready to conduct statewide, regional and/or MCO specific CAHPS surveys.

2.2.8 The awarded vendor is or has on staff, or will subcontract with, an NCQA- Certified Health Employer Data Information Set (HEDIS) Compliance Auditor.

Mercer is pleased to present our partnership Jennifer Lenz of QRS, LLC. Jennifer is an NCQA certified HEDIS compliance auditor and President of QRS. Prior to opening her firm in May of 2015 Jennifer was the Executive Director of State and Corporate Services for the Health Services Advisory Group. Jennifer brings over eight years of EQR experience and has performed various audit and quality improvement activities including interfacing with NCQA Licensed Organizations to conduct HEDIS Compliance Audits™, CMS data validation audits, and PM validation audits for Commercial, Medicare, Medicaid, and Marketplace populations.

2.9 Contractor must maintain current International Classification of Diseases (ICD) and Electronic Data Interchange (EDI) compliance as defined by CMS regulation and policy and no funding will be provided for contractor's compliance.

Mercer will maintain current International Classification of Diseases (ICD) and Electronic Data Interchange (EDI) compliance as defined by CMS regulation and policy.

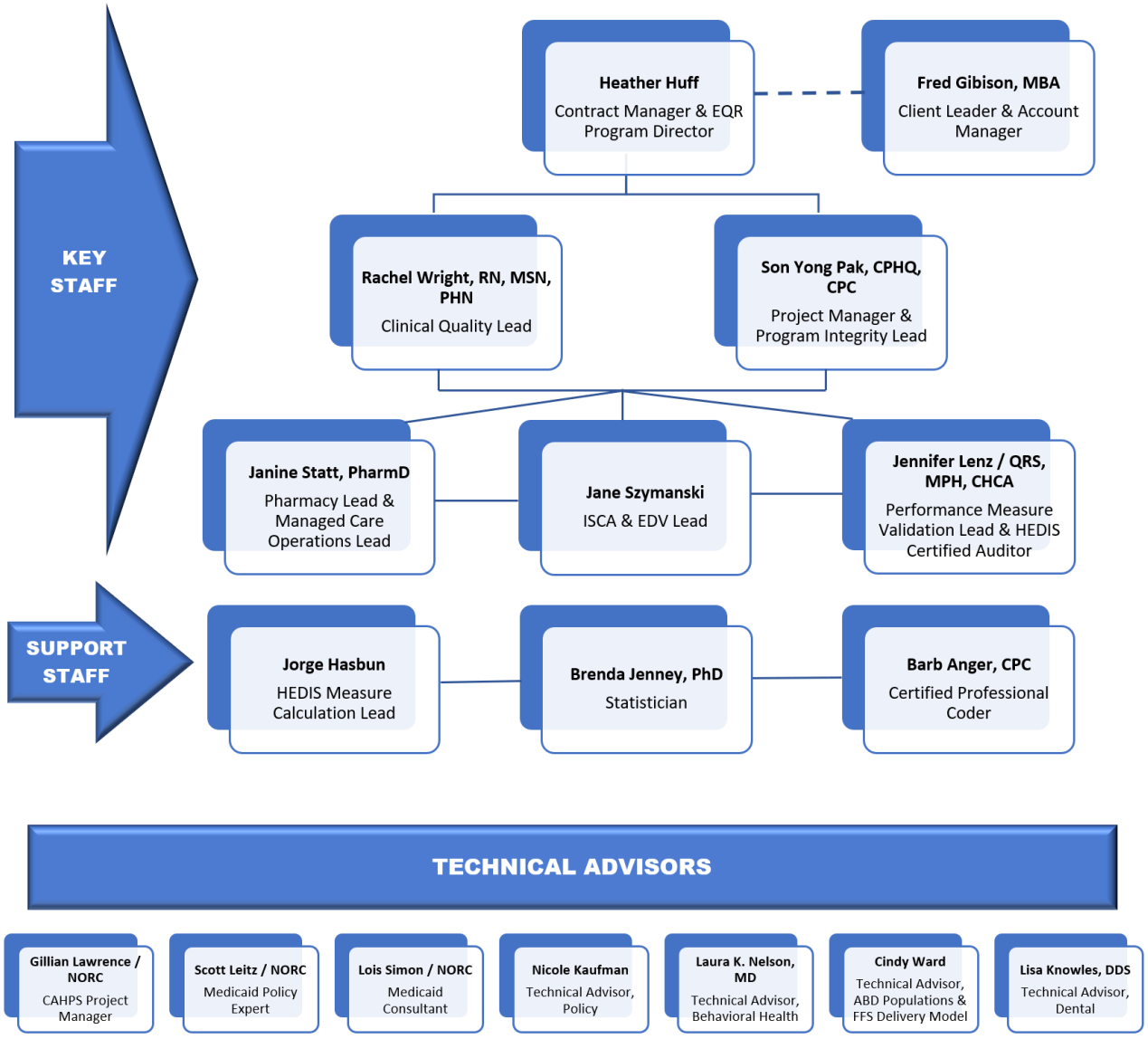
2.3 VENDOR OPERATING STRUCTURE AND STAFFING

2.3.1 The vendor must assure DHCFP that the organization is adequately staffed with experienced, qualified personnel. The vendor shall provide such assurances as follows:

2.3.1.1 Provide DHCFP with an updated organizational chart whenever a significant change in the organization occurs. The organizational chart must depict each functional unit of the organization, numbers and types of staff for each function identified, lines of authority governing the interaction of staff, and relationships with all subcontractors. The organizational chart must also identify key personnel and senior-level management staff and clearly delineate lines of authority over all functions of the Contract. The names of key personnel must be shown on the organizational chart;

Mercer certifies that it will submit to DHCFP's contract monitor or other designated liaison an updated organizational chart whenever a significant change in the organization occurs. As the world's largest human resources consulting firm with offices in over 40 countries for the purposes of this engagement Mercer

interprets "significant change" in the organization as changes that directly impact Mercer's ability to fulfill its obligations under this contract, including changes to EQR key staff and identified subcontractors. Should DHCFP wish to expand this interpretation we are happy to provide the requisite information at the identified level of detail within the agreed upon timeframe. Please see the organizational chart on the next for this engagement.



2.3.1.2 The vendor must have in place the organizational, management, and administrative systems capable of fulfilling all contract requirements; and

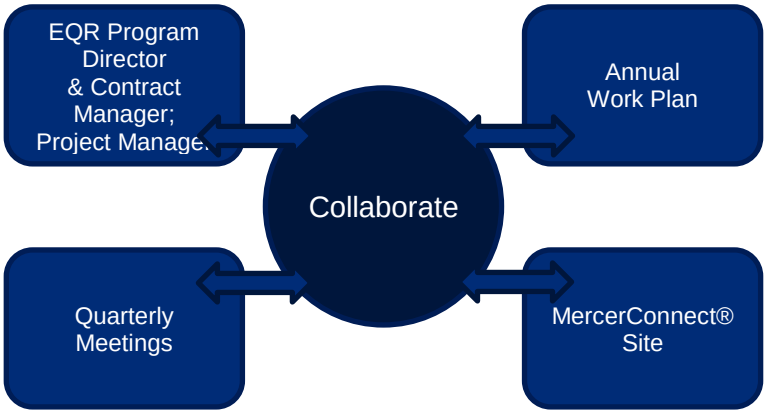
Mercer is a wholly owned subsidiary of Marsh and McLennan a fortune 500 company. As such we certify that we have the requisite organizational, management, and administrative systems as well as, access to vast amount of resources, unparalleled by other EQRO firms. This is our business and this is what we do.

Mercer's project management approach is highly collaborative to ensure we are aligned with expectations and program goals

A key service that is included in all Mercer government consulting business is comprehensive project management designed to ensure the entire EQR process is structured and organized. As shown in the previous organizational chart, Mercer will have a dedicated EQR Project Manager who will assist the EQR Program Director and individual task team leads to develop and maintain a comprehensive EQR work plan, schedule and manage project meetings with DHCFP staff, complete meeting agendas and meeting minutes, and ensure that all project tasks and milestones are monitored, tracked and completed timely. The EQR Project Manager will continually measure and monitor the three project drivers: results (deliverables), resources (people and information) and time (project timeline). We have found that these interdependent project drivers are the key elements to all projects. The EQR Project Manager will immediately engage the EQR Team Lead to discuss any variances in any of the three project drivers and together they will determine next steps and communicating those proposed steps with DHCFP.

Our goal with any project is to work collaboratively with our clients to deliver solutions that meets and exceeds your expectations. Our project management approach helps clarify expected results, confirm progress and scope against agreed-upon deliverables and project plan, and escalate risk, approval and project issues quickly. Underlying this process is collaborative decision-making to drive progress of the work plan, role clarification, articulation of project dependencies, timely project communication, and project documentation. To support this collaborative approach, Mercer will utilize the quarterly meetings with the EQR Program Director, and EQR Project Manager and DHCFP staff as an opportunity to "check-in", review progress to timelines and adjust priorities to meet the needs of DHCFP. Additionally, we recommend an annual kick-off meeting (for each year of the contract) to close out the previous year's scope of work, review any program or MCO contract changes, and review the upcoming year's tasks, timelines and deliverables that will build the annual project plan.

On other comparable engagements, Mercer also maintains a user friendly, secure and HIPAA compliant online site that is used as the repository for all project materials. This site is known as Connect® and allows DHCFP identified staff the ability to access this site at any time. The EQR Project Manager acts as the EQR site administrator and will be available to assist your staff in use or access to the DHCFP folder(s) on Mercer's Connect® site. Designated staff within an MCO, DBA/PAHP, and CMO can also be given access to our Connect® site to aid in the exchange of information required as a result of EQR activities. Use of the site is optional for our client's, however, many clients have found the centralized location, ease of use and ability to access historical as well as current documents to be very beneficial for their oversight and management of the EQR process. Should DHCFP have an established site already that is used for MCO and other program vendor communication, we are happy to tailor our approach to be as seamless as possible. The image below provides a diagram of how Mercer and DHCFP can collaborate to ensure the most efficient and effective project management process.



2.3.1.3 The vendor is accountable for and must oversee all subcontractor functions.

Mercer assures the State that we will maintain effective oversight responsibility and final accountability for all subcontracted functions. To ensure high-quality consulting and work products, all work performed by Mercer, and by extension its subcontracted entities, is subject to a strict quality assurance process.

We have clear, professional standards regarding the process of "peer review" (i.e., quality control) at various steps in product development. Mercer believes peer review of professional work delivers the highest-quality service to our clients.

Peer review ensures our work is consistent with best practice and conforms to our objective of delivering work that is both excellent and error free. Mercer requires that all our professional work and work performed by our subcontractors be thoroughly peer reviewed by properly qualified Mercer colleagues before being released to our client. Professional work includes, but is not limited to, letters, reports, spreadsheets, proposals, presentations, speeches, and articles, as well as internal documents that our consultants may rely upon in providing advice to clients. Professional work also includes material advice provided orally or transmitted by facsimile or other electronic means.

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

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

Mercer will work closely with our subcontractors, Jennifer Lenz, Certified HEDIS Compliance Auditor and our certified CAHPS vendor, NORC, if the optional CAHPS activity is requested, throughout this project and will ensure peer reviews are completed and work is of the highest quality before it is provided to the DHCFP.

2.4 IMPLEMENTATION

2.4.1 The vendor shall develop and submit to DHCFP for approval, no later than one month after notification that the vendor has been awarded the Contract, a detailed work plan and timeline for performing the obligations set forth in the Contract for the first contract year.

Mercer has extensive experience managing large, complex projects many with multi-million dollar budgets. We have modern project management tools, honed over years of use and we have invested in project management training for all of our staff. We warrant that we will submit to DHCFP for approval, no later than one month from notification of award, a detailed work plan and timeline. Please see Section VIII for an example of a detailed EQR project timeline. We agree to provide DHCFP a work plan and timeline specific to this contract work within the required timeframe.

Mercer proposes Son Yong Pak as its dedicated EQR Project Manager who will assist the EQR Program Director to develop and maintain the comprehensive DHCFP EQR work plan, schedule, and manage project meetings with DHCFP, complete meeting agendas and meeting minutes, and ensure that all project tasks and milestones are monitored, tracked and completed timely. She has over five years of experience managing similar types of projects and has an excellent track record of working successfully with Medicaid leadership, program staff, and stakeholders. Son Yong Pak will follow our project management processes outlined in our response to Section 2.3.1.2 above.

2.4.2 Provide DHCFP with updates to the initial work plan and timeline, identifying adjustments that have been made to either and describing the vendor's current stage of readiness to perform all Contract obligations. All such updates shall be reviewed and approved by the DHCFP.

Our goal with any project is to work collaboratively with our clients to deliver solutions that meet and exceed your expectations. Our project management approach helps clarify expected results, confirm progress and scope against agreed-upon deliverables and project plan, and escalate risk, approval and project issues quickly. Underlying this process is collaborative decision-making to drive progress of the work plan, role clarification, and articulation of project dependencies, timely project communication and project documentation. To support this collaborative approach, Mercer proposes an initial in-person kick-off meeting within two weeks of contract award. The purpose of this meeting will be to review the draft detailed work plan and timeline. Any changes as a result of this meeting will be submitted to DHCFP for approval in order to meet the one month requirement identified in 2.4.1 above. Upon DHCFP's approval, Mercer will finalize the project plan and publish the finalized documents, including key dates to appropriate stakeholders including MCOs, CMO, and others as identified by DHCFP.

Monthly telephonic and quarterly on-site meetings between DHCFP and the EQR Program Director and Project Manager will provide additional opportunity to review progress on the work plan and timeline. Any revisions based on interim status updates will be submitted to DHCFP for approval.

Additionally, we recommend an annual kick-off meeting (for each year of the contract) to close out the previous year's scope of work, review any program or MCO contract changes, and review the upcoming year's tasks, timelines and deliverables that will build the annual project plan.

2.4.3 Unless otherwise agreed to by the DHCFP, submit to the DHCFP, within a minimum of ten (10) working days of the service start date, all deliverables to permit any DHCFP identified modifications. The DHCFP will have a maximum of twenty (20) working days upon receipt in which to respond with modifications to the vendor. If the DHCFP does

not respond by the twentieth work day after receipt of the deliverable, the DHCFP's approval of the submission will be assumed to be granted.

Mercer agrees that we will submit to DHCFP, within ten (10) working days of the service start date (unless otherwise agreed to an alternative schedule), all deliverables to provide DHCFP the opportunity to review and respond with modifications. We will build into our timelines and work plan the twenty (20) day review period and a five (5) business day Mercer finalization period. This five (5) day finalization period is used to incorporate any changes and to complete our peer review process. As noted in our response in 2.3.1.3 our peer review process helps us to ensure that our deliverables demonstrate the highest professional standards and accuracy.

For certain deliverables that are more detailed or contain more complex information or data tables (e.g., focused studies, EDV etc.) our experience has demonstrated they can be reviewed more efficiently when Mercer hosts a meeting with DHCFP to walk through the document. We welcome the opportunity to work with DHCFP to develop an approach that allows for the greatest efficiency of DHCFP staff in reviewing and approving EQR deliverables.

2.5 PRESENTATION OF FINDINGS

The awarded vendor must obtain DHCFP's approval prior to publishing or making formal public presentations of statistical or analytical material that includes information about enrolled recipients. This material must protect specific individual recipient privacy and confidentiality to the extent required by both federal and state law and regulation.

Mercer agrees to obtain DHCFP's approval prior to publishing or making formal public presentations of statistical or analytical material that includes information about enrolled recipients. We agree to follow all DHCFP protocols and Federal, State rules to ensure compliance regarding recipient privacy and confidentiality. As a further safeguard Mercer shall make all such requests for approval in writing through the DHCFP identified contract liaison. Such requests shall be made by Mercer on a "per occurrence" basis and are not considered blanket approvals unless otherwise stated in writing by DHCFP.

2.6 HIPAA COMPLIANCE REQUIREMENTS

2.6.1 The vendor represents and warrants that:

2.6.1.1 It will conform to all applicable Health Insurance Portability and Accountability Act (HIPAA) requirements and regulations no later than the compliance date of each of those requirements or regulations;

2.6.1.2 It will ensure compliance with all HIPAA standards for themselves and any Business Associate(s), including transaction, code sets, identifier, privacy, confidentiality, and security standards, by the effective date of those rules;

2.6.1.3 As a Business Associate, the Vendor and all subcontractors will comply with the Business Associate Addendum, ("BAA") found in Attachment J that is made a part of the contract.

Mercer understands and will comply with the terms and conditions as set forth in this RFP and will include the applicable BAA in our subcontractor agreements

VI

SECTION VI – COMPANY BACKGROUND AND REFERENCES

3.1.1 Vendors shall provide a company profile in the table format below.

Question	Response
Company name:	***Mercer Health & Benefits LLC***
Ownership (sole proprietor, partnership, etc.):	***Corporation***
State of incorporation:	***Delaware***
Date of incorporation:	***1976***
# of years in business:	***31***
List of top officers:	***Julio A. Portalatin*** ***President and CEO*** ***Helen Shan*** ***Chief Financial Officer*** ***Ken Haderer*** ***Chief Operating Officer***
Location of company headquarters, to include City and State:	***New York***
Location(s) of the office that shall provide the services described in this RFP:	***2325 E. Camelback Road, Suite 600*** ***Phoenix, AZ 85016***
Number of employees locally with the expertise to support the requirements identified in this RFP:	***0 in the State of Nevada***
Number of employees nationally with the expertise to support the requirements in this RFP:	***Over 280***
Location(s) from which employees shall be assigned for this project:	***Mercer currently has four offices focused on government healthcare consulting (Atlanta, Minneapolis, Phoenix, and Washington DC) plus many remote staff. We intend to use our Phoenix office to provide services on this project.*** ***2325 E. Camelback Road, Suite 600***

Question	Response
	Phoenix, AZ 85016

3.1.2 A Nevada-based business may apply for a five percent (5%) preference on its proposal. This preference may apply if a business has its principal place of business within Nevada. This preference cannot be combined with any other preference, granted for the award of a contract using federal funds, or granted for the award of a contract procured on a multi-state basis. To claim this preference a business must submit a letter with its proposal showing that it qualifies for the preference.

Mercer does not have a principal place of business within Nevada. Mercer does have a local office in Las Vegas, but employees in that office do not specialize in the services required in this RFP and therefore we do not expect to use our Las Vegas office in support of this engagement.

3.1.3 Please be advised, pursuant to NRS 80.010, a corporation organized pursuant to the laws of another state shall register with the State of Nevada, Secretary of State's Office as a foreign corporation before a contract can be executed between the State of Nevada and the awarded vendor, unless specifically exempted by NRS 80.015.

Mercer is currently registered with the State of Nevada, Secretary of State's Office.

3.1.4 The selected vendor, prior to doing business in the State of Nevada, shall be appropriately licensed by the State of Nevada, Secretary of State's Office pursuant to NRS76. Information regarding the Nevada Business License can be located at http://nvsos.gov.

Question	Response
Nevada Business License Number:	***NV20041250294***
Legal Entity Name:	***Mercer Health & Benefits LLC***

Is "Legal Entity Name" the same name as vendor is doing business as?

Yes	***X***	No	

If "No", provide explanation.

N/A

3.1.5 Has the vendor ever been engaged under contract by any State of Nevada agency?

Yes	***X***	No	

If "Yes", complete the following table for each State agency for whom the work was performed. Table can be duplicated for each contract being identified.

Question	Response
Name of State agency:	***Nevada Department of Health and Human Services***
State agency contact name:	***Philip Nowak and Charles Duarte***
Dates when services were performed:	***1994 to 2002***
Type of duties performed:	***Actuarial Consulting***
Total dollar value of the contract:	***Not available***

3.1.6 Are you now or have you been within the last two (2) years an employee of the State of Nevada, or any of its agencies, departments, or divisions?

Yes		No	***X***

If "Yes", please explain when the employee is planning to render services, while on annual leave, compensatory time, or on their own time?

If you employ (a) any person who is a current employee of an agency of the State of Nevada, or (b) any person who has been an employee of an agency of the State of Nevada within the past two (2) years, and if such person shall be performing or producing the services which you shall be contracted to provide under this contract, you shall disclose the identity of each such person in your response to this RFP, and specify the services that each person shall be expected to perform.

3.1.7 Disclosure of any significant prior or ongoing contract failures, contract breaches, civil or criminal litigation in which the vendor has been alleged to be liable or held liable in a matter involving a contract with the State of Nevada or any other governmental entity. Any pending claim or litigation occurring within the past six (6) years which may adversely affect the vendor's ability to perform or fulfill its obligations if a contract is awarded as a result of this RFP shall also be disclosed.

Does any of the above apply to your company?

Yes		No	***X*** ***(see below)***

Mercer does not have any contracts containing services similar in scope to those proposed here that have been subject to significant prior or ongoing contract failures, contract breaches, civil or criminal litigation in which the vendor has been alleged to be liable or held liable in a matter involving a contract with the State of Nevada or any other governmental agency.

In the ordinary course of business, Mercer companies are involved with litigation and other legal proceedings, investigations, and inquiries, some of which are conducted on an industry-wide basis. Based on information currently available, the outcomes of currently pending litigation, investigations, and inquiries are not expected to have any material adverse effect upon Mercer or its ability to service its clients in the ordinary course. Details regarding certain outstanding legal proceedings pertaining to Mercer and its affiliates are disclosed in the public Securities and Exchange Commission filings of Marsh & McLennan Companies, (http://irnews.mmc.com/phoenix.zhtml?c=113872&p=irol-sec), Mercer's ultimate parent company.

If "Yes", please provide the following information. Table can be duplicated for each issue being identified.

Question	Response	
Date of alleged contract failure or breach:		
Parties involved:		
Description of the contract failure, contract breach, or litigation, including the products or services involved:		
Amount in controversy:		
Resolution or current status of the dispute:		
If the matter has resulted in a court case:	Court	Case Number
Status of the litigation:		

3.1.8 Vendors shall review and provide if awarded a contract the insurance requirements as specified in Attachment D, Insurance Schedule for RFP 3491.

Agreed and we acknowledge the RFP's language in Section 10.2.2 on page 31 and in item G of Attachment D related to insurance.

3.1.9 Company background/history and why vendor is qualified to provide the services described in this RFP. Limit response to no more than five (5) pages.

Mercer's qualifications to carry out the scope of work requested through this RFP are derived from decades of directly related experience our specialized government health care consulting practice has in providing clinical quality, pharmacy benefit management, program development and implementation, policy consulting and actuarial services to our state Medicaid and CHIP clients.

Beginning in 1985, a group of consultants within Mercer began working with publicly-funded health care programs across the country, developing actuarially sound Medicaid managed care capitation rates and helping states design, develop, and implement innovative solutions to improve quality of care while saving state general fund dollars. In 1992, after seven years of working to meet the specialized needs of publicly-sponsored health care programs, primarily Medicaid, Mercer formally established a separate specialty consulting practice – Mercer Government Human Services Consulting. Since that time, we have provided innovative clinical quality, actuarial and related consulting on issues related to Medicaid, CHIP, and other state health programs for more than 35 states and territories.

Mercer has been providing innovative solutions to improve quality of care and services for Medicaid and CHIP agencies since 1985.

Today, Mercer's government healthcare practice boasts a staff of more than 275 dedicated professionals with expertise and experience in Medicaid and CHIP programs. This experience includes consulting work in dozens of states with 20 of those state contracts having clinical quality, performance measurement, and managed care operations components. Our dedicated government staff includes:

- ***More than 13 credentialed clinicians.***
- ***Five licensed pharmacists.***
- ***Three bio-statisticians, three certified coders.***
- ***Two certified project managers along with a host of healthcare analysts, informatics, and actuarial specialists.***

In addition, our other staff expertise and experience includes Medicaid and CHIP administration and operations, Federal health care policy, an ability to easily work with large data set/information management, pharmacy management, health policy analysis, clinical quality, behavioral health, actuarial/financial analyses, and project management. Please see more specific details on our proposed staffing

plan and staff qualifications in Section VII Proposed Staff Resumes in this response.

We have been performing EQR and EQR-like services since 2000 and were a designated Quality Improvement Organization (QIO) when this was a requirement for EQROs. We were the EQRO in Connecticut for eight years, until their transition to an administrative services model in 2012, and have been providing EQRO services in Delaware since 2000 and their sole EQRO since 2006. Our EQR services have spanned more than 15 years across several comparable state engagements.

Our core EQRO project team possesses deep knowledge and experience working with:

- ***CMS protocols for EQR of Medicaid MCOs.***
- ***Continuous quality improvement methodologies and quality assurance standards aimed at incenting value over volume.***
- ***Managed care delivery models and internal managed care operations from the most basic to the complex and highly integrated.***
- ***Social and medical models of care rooted in best practices that promote integrated and "whole-person" care.***
- ***Measuring and evaluating the efficiency and effectiveness of Medicaid programs and populations including PM calculation, validation, and reporting.***
- ***Study research and design including development of sample frames, statistical analysis, and data interpretation.***
- ***Medicaid and CHIP programs and federal rules and regulations as they relate to medically and categorically needy programs for all populations.***

Recent feedback from our clients

"Remained faithful to and furthered core values of ...Medicaid reform, and kept beneficiary rights and interests top of mind"

The Mercer team "came together and produced a solid, comprehensible model design"

"Worked rapidly, thoughtfully and in a manner that has reflected respect for our various disciplines"

"Consistently met or anticipated hair-raising deadlines"

"Walked the walk of excellent stakeholdering process"

"Good, good, good . . . I love all of the aspects of the shared savings design"

"You have really done a great job . . . Mercer has been extremely helpful"

"I couldn't have done it without Mercer"

- ***Claims payment and encounter data processing activities including ISCA and EDV.***

Mercer's EQR team consists of credentialed clinicians, a licensed pharmacist, healthcare analysts, a certified coder, informatics specialists and a statistician all who have collaboratively worked to become "trusted advisors" to our state clients by providing relevant consulting advice and technical assistance – the longevity of our contracts are a testament to the value we bring to clients. The following are examples of our client engagements summarizing our experience that demonstrate our qualifications to provide EQRO services under this scope of work.

Connecticut — EQRO 2004–2012
As Connecticut's EQRO, Mercer provided the federally mandated EQRO services as well as the following optional services:

- ***Conducted a behavioral health provider satisfaction survey.***
- ***Conducted an access and availability secret shopper survey.***
- ***Provided technical assistance on elements of a comprehensive quality strategy.***
- ***Performed EDV.***
- ***Calculated PMs through analysis of encounter data.***
- ***Conducted multiple focused studies including:***
  - ***Comparative analysis of service utilization between children in the foster care system and those not in foster care:***
    - ***Identification and service utilization patterns of children and adolescents, up to 18 years of age, with Type 2 diabetes.***

As a key partner, Mercer assisted Connecticut with the transition from a managed care delivery model to an Administrative Services Organization (ASO) model by performing readiness review activities for the ASO contractor and provided implementation technical assistance and post-implementation operational re-review services and assisted in PM development.

Delaware — EQRO 2000–Current
As Delaware's EQRO, Mercer provided the federally mandated EQRO services as well as the following optional services:

- ***Active participation on Delaware's Quality Improvement Initiatives Task Force.***
- ***Conducted a surveys of members and providers to support compliance with the HCBS Final Rule setting of service requirement.***

- ***Provided technical assistance on elements of a comprehensive quality strategy and amends to the strategy to support implementation of the MLTSS and VBP program.***
- ***Performed readiness and post-implementation reviews for the state's new MLTSS program and for new MCO contractors entering the market.***
- ***Provided technical assistance to support implementation of an Accountable Care model.***
- ***Performed EDV.***
- ***Calculated PMs through analysis of encounter data.***
- ***Conducted multiple focused studies including:***
  - ***Assessing fidelity to practice guidelines for treatment of childhood overweight and obesity.***
  - ***Assessing MCO prescribing patterns and treatment of individuals prescribed buprenorphine.***

Delaware has also requested Mercer to provide services outside the scope of EQRO protocols including development of clinical practice guidelines, assistance with the 2016 Managed Care Final Rule implementation – including development of network adequacy standards, and systems consulting advice to support MMIS transformation efforts to the T-MMIS requirements.

New Jersey — MCO Reviews/Long Term Care Readiness Reviews/Technical Assistance – 2010–2017

Mercer has conducted a number of EQR and EQR-like services including:

- ***Conducted MCO compliance reviews to ensure readiness of the state's five (5) contracted MCOs to implement the state's MLTSS program.***
- ***Performance measure calculation on clinical quality measures including potentially preventable admissions, re-admissions and LANE emergency room utilization.***
- ***Provided technical assistance in areas such as identification of potential MLTSS PMs, development of a comprehensive State Quality Management Strategy and implementation of a robust care management program to encompass Medicaid/CHIP and MLTSS populations.***
- ***Provided design and implementation assistance to support the state's MLTSS VBP program.***
- ***Conducted a focused study on the impact of preventive dental care on emergency room and admission admissions for dental related sequelae.***

Pennsylvania — Medicaid Behavioral Health Program Review – 1996–Current
The Commonwealth of Pennsylvania (Commonwealth) has contracted with Mercer to perform a wide spectrum of EQR-like quality review activities related to its Medicaid behavioral managed care program including:

- ***Conducting annual compliance reviews of 25 county-based behavioral managed care organizations (BMCOs). This involves conducting clinical and operational reviews of large national BMCOs, regional university-based BMCOs, county owned and operated BMCOs, and local, privately held BMCOs.***
- ***Calculating PMs to evaluate clinical efficiency in behavioral health readmissions and duplication of services.***
- ***Development and maintenance of a web-based reporting dashboard to support transparency of financial and encounter data.***
- ***Conducting surveys of consumer/family and providers.***
- ***Developing dashboards and calculating and aggregating PMs.***
- ***Conducting EDV including identification of outcome frequencies, analyzing the sequence of the outcomes, and evaluating overlapping records and co-occurring services.***
- ***Conducting focused studies evaluating impact on cost and utilization between high and low fidelity assertive community treatment team program (ACT/CCT) models, identification of service duplication for individuals receiving ACT or CCT services and analysis of potentially preventable inpatient behavioral health admissions.***
- ***Assessing compliance with program integrity standards.***

3.1.10 Provide a brief description of the length of time vendor has been providing services described in this RFP to the public and/or private sector.

Starting in 1985, Mercer's has been providing specialized government health care consulting services. Mercer has and continues to provide services consistent with EQR activities, including performing managed care plan reviews, calculating PMs, conducting focused studies on quality as well as, administering surveys, and validating encounter data. Soon after the issuance of the Balanced Budget Act in 1997, and the resulting EQR regulations Mercer began operating as an EQRO in the State of Delaware under a primary contractor. Four (4) years later Mercer successfully procured the EQRO contract for the State of Connecticut and in 2006 we successfully procured the Delaware EQRO contract and have continued as their sole EQRO to this day. While Connecticut transitioned to an administrative services model in 2012 and no longer is required to procure EQRO services, Mercer has continued to perform EQR-like activities for the state.

3.1.11 Financial information and documentation to be included in accordance with Section 8.5, Part III – Confidential Financial Information.

3.1.11.1 Dun and Bradstreet Number

Mercer Health & Benefits, LLC: 616213125

3.1.11.2 Federal Tax Identification Number

Mercer Health & Benefits, LLC: 34-2015463

3.1.11.3 The last two (2) years and current year interim:

A. Profit and Loss Statement
B. Balance Statement

Mercer has included its parent company's Balance Sheet and Summary of Operations in Appendix VIII. We have also included a link to Mercer's Annual Report below, which includes additional financial information.

http://irnews.mmc.com/phoenix.zhtml?c=113872&p=irol-reportsAnnual

3.2 SUBCONTRACTOR INFORMATION

Subcontractors are defined as a third party, not directly employed by the contractor, who shall provide services identified in this RFP. This does not include third parties who provide support or incidental services to the contractor.

3.2.1 Does this proposal include the use of subcontractors?

Yes	***X***	No	

If "Yes", vendor shall:

3.2.1.1 Identify specific subcontractors and the specific requirements of this RFP for which each proposed subcontractor shall perform services.

Mercer is including two subcontractors in this proposal:

- ***Quality Review Solutions, LLC.***
- ***National Opinion Research Center (NORC)***

3.2.1.2 If any tasks are to be completed by subcontractor(s), vendors shall:

A. Describe how the work of any subcontractor(s) shall be supervised, channels of communication shall be maintained and compliance with contract terms assured; and

Mercer takes pride in our ability to effectively coordinate, communicate, manage, and monitor the efforts of our subcontractors. It will be the responsibility of the EQR Program Director, and Project Manager to set expectations, provide training on any internal processes, obtain commitment to the project plan, and keep in regular communication with the subcontractor(s). Our subcontractor agreements will include specific contract requirements stemming from Mercer's prime contract with Nevada that are applicable to subcontractors (e.g., "flow-downs") in addition to standard terms and conditions that are included in all of Mercer's subcontractor agreements.

Our subcontractors truly become part of our team and are included in relevant project communication and team meetings. Our subcontractors will have a direct line of communication to our Project and Contract Managers and related team members. Any work product in which our subcontractors assist with will be peer reviewed by a designated Mercer team member before being issued to the State. We will also hold our subcontractors to a high standard of work quality as specified in the Mercer subcontractor agreement.

We regularly use subcontractors in our engagements and we have established policies and procedures for ensuring smooth working relationships.

B. Describe your previous experience with subcontractor(s).

Mercer routinely leverages talent of external subcontractors to either add a specialized skillset or general bandwidth to our team. With many state clients, our subcontractors provide added capacity to meet the needs of our clients and often we choose subcontractors, like NORC and QRS, that have experience with different states and/or markets so that our clients get an even broader exposure to ideas, innovations and experience. While Mercer always maintains primary responsibility for the client relationship and quality of work, our subcontractors are considered team members and will be exposed to our clients in settings that are most aligned to their areas of expertise. As a national leader in Medicaid consulting, Mercer has a long contact list of subcontractors that we can choose from given the unique needs of a given project or client.

In terms of subcontractor contract management, Mercer will either use our standard Professional Services Agreement or Vendor Agreement depending on the organizational structure of the subcontractor (e.g., corporation or solo

vendor). To our standard agreements, we execute a Work Order Addendum that establishes the specific requirements of a defined project including any additional terms and conditions. We have dedicated staff based in our Phoenix office that maintains all subcontractor agreements, work orders, and other related addendums.

3.2.1.3 Provide the same information for any proposed subcontractors as requested in Section 3.1, Vendor Information.

SUBCONTRACTOR #1: QUALITY REVIEW SOLUTIONS, LLC

Question	Response
Company name:	***Quality Review Solutions, LLC.***
Ownership (sole proprietor, partnership, etc.):	***Sole Proprietor***
State of incorporation:	***Arizona***
Date of incorporation:	***May 5, 2015***
# of years in business:	***2.75***
List of top officers:	***Jennifer A. Lenz***
Location of company headquarters, to include City and State:	***4527 E. Villa Maria Dr. Phoenix, AZ 85032***
Location(s) of the office that shall provide the services described in this RFP:	***4527 E. Villa Maria Dr. Phoenix, AZ 85032***
Number of employees locally with the expertise to support the requirements identified in this RFP:	***0***
Number of employees nationally with the expertise to support the requirements in this RFP:	***1***
Location(s) from which employees shall be assigned for this project:	***4527 E. Villa Maria Dr. Phoenix, AZ 85032***

3.1.2 A Nevada-based business may apply for a five percent (5%) preference on its proposal. This preference may apply if a business has its principal place of business within Nevada. This preference cannot be combined with any other preference, granted for the award of a contract using federal funds, or granted for the award of a contract procured on a multi-state basis. To claim this preference a business must submit a letter with its proposal showing that it qualifies for the preference.

N/A

3.1.3 Please be advised, pursuant to NRS 80.010, a corporation organized pursuant to the laws of another state shall register with the State of Nevada, Secretary of State's Office as a foreign corporation before a contract can be executed between the State of Nevada and the awarded vendor, unless specifically exempted by NRS 80.015.

N/A

3.1.4 The selected vendor, prior to doing business in the State of Nevada, shall be appropriately licensed by the State of Nevada, Secretary of State's Office pursuant to NRS76. Information regarding the Nevada Business License can be located at http://nvsos.gov.

Question	Response
Nevada Business License Number:	***If required, subcontractor agrees to obtain the appropriate State of Nevada license pursuant to NRS76 upon contract award.***
Legal Entity Name:	***Quality Review Solutions, LLC***

Is "Legal Entity Name" the same name as vendor is doing business as?

Yes	***X***	No	

If "No", provide explanation.

3.1.5 Has the vendor ever been engaged under contract by any State of Nevada agency?

Yes		No	***X***

If "Yes", complete the following table for each State agency for whom the work was performed. Table can be duplicated for each contract being identified.

Question	Response
Name of State agency:	
State agency contact name:	
Dates when services were performed:	
Type of duties performed:	
Total dollar value of the contract:	

3.1.6 Are you now or have you been within the last two (2) years an employee of the State of Nevada, or any of its agencies, departments, or divisions?

Yes		No	***X***

If "Yes", please explain when the employee is planning to render services, while on annual leave, compensatory time, or on their own time?

If you employ (a) any person who is a current employee of an agency of the State of Nevada, or (b) any person who has been an employee of an agency of the State of Nevada within the past two (2) years, and if such person shall be performing or producing the services which you shall be contracted to provide under this contract, you shall disclose the identity of each such person in your response to this RFP, and specify the services that each person shall be expected to perform.

3.1.7 Disclosure of any significant prior or ongoing contract failures, contract breaches, civil or criminal litigation in which the vendor has been alleged to be liable or held liable in a matter involving a contract with the State of Nevada or any other governmental entity. Any pending claim or litigation occurring within the past six (6) years which may adversely affect the vendor's ability to perform or fulfill its obligations if a contract is awarded as a result of this RFP shall also be disclosed.

Does any of the above apply to your company?

Yes		No	***X***

If "Yes", please provide the following information. Table can be duplicated for each issue being identified.

Question	**Response**	
Date of alleged contract failure or breach:		
Parties involved:		
Description of the contract failure, contract breach, or litigation, including the products or services involved:		
Amount in controversy:		
Resolution or current status of the dispute:		
If the matter has resulted in a court case:	Court	Case Number
Status of the litigation:		

3.1.8 Vendors shall review and provide if awarded a contract the insurance requirements as specified in Attachment D, Insurance Schedule for RFP 3491.

The subcontractor (QRS) has met all of the insurance requirements specified in Attachment D, Insurance Scheduled for RFP 3491 and is prepared to provide them to the State of Nevada upon contract award.

3.1.9 Company background/history and why vendor is qualified to provide the services described in this RFP. Limit response to no more than five (5) pages.

QRS, LLC is an Arizona-based, women-owned, small business organization established in 2015. QRS is an independent auditing and consulting firm with expertise in quality improvement science and auditing services.

QRS has been selected to serve as the project lead for Mercer for the PM validation activity based on its extensive subject matter expertise and experience related to conducting HEDIS Compliance Audits™, PM validation audits, EQR compliance audits, and CMS data validation audits.

QRS maintains an NCQA Certified HEDIS Compliance Auditor who has conducted over 100 HEDIS, PM validation, and CMS data validation audits for the past nine years. QRS was selected to serve on NCQA's electronic clinical delivery system's expert workgroup, which has provided input to NCQA on its most recently added "ECDS" reporting methodology.

QRS meets the definition of independence for conducting EQR work for the State of Nevada as it does not have a direct financial relationship with any Medicaid plan in the State of Nevada.

3.1.10 Provide a brief description of the length of time vendor has been providing services described in this RFP to the public and/or private sector.

Since its inception in 2015, QRS has been contracted to provide HEDIS Compliance Audits and PM validation audits for seven NCQA Licensed Organizations and has been contracted by three EQROs to perform various audit-related activities across both public and private sectors. QRS' audit engagements span various populations including Medicaid, Medicare, Commercial, Marketplace, Medicare-Medicaid populations, as well as specialty populations and stratified population reporting.

QRS has provided consultation to state-agencies regarding the selection of PMs including technical interpretation and considerations to help inform

state agencies' decision-making process. This assistance has included analysis of measures across multiple measure sets including NCQA, CMS adult and child core set measures, URAC, internally-developed, and other measure stewards.

3.1.11 Financial information and documentation to be included in accordance with Section 8.5, Part III – Confidential Financial Information.

3.1.11.1 Dun and Bradstreet Number

N/A

3.1.11.2 Federal Tax Identification Number

QRS: 47-3988324

3.1.11.3 The last two (2) years and current year interim:

A. Profit and Loss Statement
B. Balance Statement

The last two (2) years and current year interim are attached. Per Section 8.5.1 "if needed…", there was no need for QRS to provide our financial information in separate Part III.

Quality Review Solutions, LLC.

BALANCE SHEET

As of December 31, 2016

	TOTAL
ASSETS	
Current Assets	
Bank Accounts	
BUSINESS CHECKING (XXXXXX 7972)	79,768.02
BUSINESS MARKET RATE SAVINGS (XXXXXX 3824)	69,027.90
Cash on hand	-13.19
J. Lenz Personal Checking	-173.05
Total Bank Accounts	$148,609.68
Other Current Assets	
Uncategorized Asset	0.00
Total Other Current Assets	$0.00
Total Current Assets	$148,609.68
TOTAL ASSETS	$148,609.68
LIABILITIES AND EQUITY	
Liabilities	
Current Liabilities	
Credit Cards	
BUSINESS CARD (XXXXXXXXXXXXXXXX 7464)	-146.69
J. Lenz Personal Credit Card	0.00
Total Credit Cards	$ -146.69
Total Current Liabilities	$ -146.69
Total Liabilities	$ -146.69
Equity	
Capital - J. Lenz	0.00
Contributions - J. Lenz	9,843.88
Draw	-91,330.00
Total Capital - J. Lenz	-81,486.12
Retained Earnings	24,216.89
Net Income	206,025.60
Total Equity	$148,756.37
TOTAL LIABILITIES AND EQUITY	$148,609.68

Cash Basis Tuesday, February 6, 2018 07:44 AM GMT-8 1/1

Quality Review Solutions, LLC.

PROFIT AND LOSS

January - December 2016

	TOTAL
Income	
Refunds-Allowances	-1.68
Sales	156,807.08
Sales of Product Income	11,506.66
Services	80,373.50
Travel Expense Reimbursement	4,452.17
Unapplied Cash Payment Income	0.00
Total Income	**$253,137.73**
GROSS PROFIT	**$253,137.73**
Expenses	
Bank Charges	89.00
Dues & Subscriptions	584.05
Job Materials	593.00
Legal & Professional Fees	1,600.00
Meals and Entertainment	873.06
Office Expenses	63.72
Office Supplies	194.87
Other General and Admin Expenses	54.90
Postage And Delivery	19.20
Promotional	42.81
Shipping and delivery expense	18.00
Subcontractors	587.50
Taxes & Licenses	29,891.00
Telephone Expense	1,992.47
Travel	9,676.69
Travel Meals	773.31
Uncategorized Expense	5.00
Total Expenses	**$47,058.58**
NET OPERATING INCOME	**$206,079.15**
Other Income	
Interest Earned	9.88
Total Other Income	**$9.88**
Other Expenses	
Miscellaneous	63.43
Total Other Expenses	**$63.43**
NET OTHER INCOME	**$ -53.55**
NET INCOME	**$206,025.60**

Cash Basis Tuesday, February 6, 2018 07:39 AM GMT-8 1/1

Quality Review Solutions, LLC.

BALANCE SHEET

As of December 31, 2017

	TOTAL
ASSETS	
Current Assets	
Bank Accounts	
BUSINESS CHECKING (XXXXXX 7972)	155,676.02
BUSINESS MARKET RATE SAVINGS (XXXXXX 3824)	137,283.66
Cash on hand	-225.95
J. Lenz Personal Checking	-173.05
Total Bank Accounts	$292,560.68
Other Current Assets	
Uncategorized Asset	-5,416.91
Total Other Current Assets	$ -5,416.91
Total Current Assets	$287,143.77
TOTAL ASSETS	$287,143.77
LIABILITIES AND EQUITY	
Liabilities	
Current Liabilities	
Credit Cards	
BUSINESS CARD (XXXXXXXXXXXXXXXX 7464)	-11,889.03
J. Lenz Personal Credit Card	248.16
Total Credit Cards	$ -11,640.87
Total Current Liabilities	$ -11,640.87
Total Liabilities	$ -11,640.87
Equity	
Capital - J. Lenz	0.00
Contributions - J. Lenz	9,843.88
Draw	-189,630.00
Total Capital - J. Lenz	-179,786.12
Retained Earnings	230,242.49
Net Income	248,328.27
Total Equity	$298,784.64
TOTAL LIABILITIES AND EQUITY	$287,143.77

Cash Basis Tuesday, February 6, 2018 07:43 AM GMT-8 1/1

Quality Review Solutions, LLC.

PROFIT AND LOSS

January - December 2017

	TOTAL
Income	
Sales	381,630.09
Services	235,558.25
Unapplied Cash Payment Income	0.00
Uncategorized Income	23,100.00
Total Income	**$640,288.34**
GROSS PROFIT	**$640,288.34**
Expenses	
Bank Charges	89.00
Commissions & fees	4.28
Disposal Fees	44,708.50
Dues & Subscriptions	1,995.43
Insurance	1,089.90
Insurance - Liability	467.10
Job Materials	620.00
Legal & Professional Fees	2,832.97
Meals and Entertainment	671.10
Meals and Entertainment - NCQA meeting	498.43
Office Expenses	944.48
Office Supplies	364.52
Other General and Admin Expenses	14.61
Postage And Delivery	19.20
Promotional	331.46
Shipping and delivery expense	10.78
Subcontractors	189,805.84
Supplies	37.18
Taxes & Licenses	94,991.00
Telephone Expense	3,496.64
Travel	45,218.88
Travel Meals	3,667.42
Travel Meals NCQA Meeting	79.18
Uncategorized Expense	20.93
Total Expenses	**$391,978.83**
NET OPERATING INCOME	**$248,309.51**
Other Income	
Interest Earned	18.76
Total Other Income	**$18.76**
NET OTHER INCOME	**$18.76**
NET INCOME	**$248,328.27**

Cash Basis Tuesday, February 6, 2018 07:38 AM GMT-8 1/1

Quality Review Solutions, LLC.

BALANCE SHEET

As of February 6, 2018

	TOTAL
ASSETS	
Current Assets	
Bank Accounts	
BUSINESS CHECKING (XXXXXX 7972)	203,390.87
BUSINESS MARKET RATE SAVINGS (XXXXXX 3824)	107,385.75
Cash on hand	-231.13
J. Lenz Personal Checking	-173.05
Total Bank Accounts	**$310,372.44**
Other Current Assets	
Uncategorized Asset	-5,416.91
Total Other Current Assets	**$ -5,416.91**
Total Current Assets	**$304,955.53**
TOTAL ASSETS	**$304,955.53**
LIABILITIES AND EQUITY	
Liabilities	
Current Liabilities	
Credit Cards	
BUSINESS CARD (XXXXXXXXXXXXXXXX 7464)	-12,831.94
J. Lenz Personal Credit Card	248.16
Total Credit Cards	**$ -12,583.78**
Total Current Liabilities	**$ -12,583.78**
Total Liabilities	**$ -12,583.78**
Equity	
Capital - J. Lenz	0.00
Contributions - J. Lenz	9,843.88
Draw	-194,630.00
Total Capital - J. Lenz	**-184,786.12**
Retained Earnings	478,570.76
Net Income	23,754.67
Total Equity	**$317,539.31**
TOTAL LIABILITIES AND EQUITY	**$304,955.53**

Cash Basis Tuesday, February 6, 2018 07:45 AM GMT-8 1/1

Quality Review Solutions, LLC.

PROFIT AND LOSS

January 1 - February 6, 2018

	TOTAL
Income	
Sales	47,426.04
Services	6,316.07
Total Income	**$53,742.11**
GROSS PROFIT	**$53,742.11**
Expenses	
Dues & Subscriptions	32.57
Health Insurance	3,021.84
Insurance	2,229.00
Job Materials	355.00
Legal & Professional Fees	7.99
Office Supplies	303.13
Payroll Expenses	69.30
Payroll tax expense	185.51
Payroll tax withholding	349.58
Postage And Delivery	3.21
Salary Expenses	2,989.69
Shipping and delivery expense	10.00
Subcontractors	875.00
Taxes & Licenses	17,857.20
Telephone Expense	338.59
Travel	1,356.74
Travel Meals	5.18
Total Expenses	**$29,989.53**
NET OPERATING INCOME	**$23,752.58**
Other Income	
Interest Earned	2.09
Total Other Income	**$2.09**
NET OTHER INCOME	**$2.09**
NET INCOME	**$23,754.67**

Cash Basis Tuesday, February 6, 2018 07:46 AM GMT-8 1/1

SUBCONTRACTOR #2: NORC

Question	Response
Company name:	***National Opinion Research Center (NORC)***
Ownership (sole proprietor, partnership, etc.):	***Non-profit corporation***
State of incorporation:	***Colorado***
Date of incorporation:	***1941***
# of years in business:	***77***
List of top officers:	• ***Daniel S. Gaylin, President and CEO*** • ***Chet Bowie, EVP of Research*** • ***Michael Davern, EVP of Research*** • ***Angela DeBello, SVP of Business Development*** • ***James E. Dunne, CFO and EVP of Finance and Administration*** • ***Ronald J. Jurek, CIO and EVP of Operations*** • ***Michele Nachbar, EVP of Business Ventures and Innovation*** • ***Greg Lanier, SVP of Strategic Communications and External Affairs*** • ***Jeffrey Telgarsky, EVP of Research*** • ***Kirk M. Wolter, Chief Statistician and EVP of Statistics and Methodology***
Location of company headquarters, to include City and State:	***55 East Monroe Street, 30th Floor Chicago, IL 60603***
Location(s) of the office that shall provide the services described in this RFP:	• ***55 East Monroe Street, Chicago, IL 60603*** • ***2021 North Amidon, Suite 1300, Wichita, KS 67203*** • ***10500 Copper Avenue NE, Albuquerque, NM 87123*** • ***4350 East-West Highway, 8th Floor, Bethesda, MD 20814***
Number of employees locally with the expertise to support the requirements	***5***

Question	Response
identified in this RFP:	
Number of employees nationally with the expertise to support the requirements in this RFP:	***10***
Location(s) from which employees shall be assigned for this project:	• ***55 East Monroe Street, Chicago, IL 60603*** • ***2021 North Amidon, Suite 1300, Wichita, KS 67203*** • ***10500 Copper Avenue NE, Albuquerque, NM 87123*** • ***4350 East-West Highway, 8th Floor, Bethesda, MD 20814***

3.1.2 A Nevada-based business may apply for a five percent (5%) preference on its proposal. This preference may apply if a business has its principal place of business within Nevada. This preference cannot be combined with any other preference, granted for the award of a contract using federal funds, or granted for the award of a contract procured on a multi-state basis. To claim this preference a business must submit a letter with its proposal showing that it qualifies for the preference.

N/A

3.1.3 Please be advised, pursuant to NRS 80.010, a corporation organized pursuant to the laws of another state shall register with the State of Nevada, Secretary of State's Office as a foreign corporation before a contract can be executed between the State of Nevada and the awarded vendor, unless specifically exempted by NRS 80.015.

N/A

3.1.4 The selected vendor, prior to doing business in the State of Nevada, shall be appropriately licensed by the State of Nevada, Secretary of State's Office pursuant to NRS76. Information regarding the Nevada Business License can be located at http://nvsos.gov.

Question	Response
Nevada Business License Number:	***NORC is not currently licensed in the State of Nevada, but the prime vendor, Mercer is licensed. If required upon contract, NORC will register with the State of Nevada***
Legal Entity Name:	***National Opinion Research Center***

Is "Legal Entity Name" the same name as vendor is doing business as?

Yes		No	X

If "No", provide explanation.

The registered dba name is NORC.

3.1.5 Has the vendor ever been engaged under contract by any State of Nevada agency?

Yes		No	X

If "Yes", complete the following table for each State agency for whom the work was performed. Table can be duplicated for each contract being identified.

Question	Response
Name of State agency:	
State agency contact name:	
Dates when services were performed:	
Type of duties performed:	
Total dollar value of the contract:	

3.1.6 Are you now or have you been within the last two (2) years an employee of the State of Nevada, or any of its agencies, departments, or divisions?

Yes		No	***X***

If "Yes", please explain when the employee is planning to render services, while on annual leave, compensatory time, or on their own time?

If you employ (a) any person who is a current employee of an agency of the State of Nevada, or (b) any person who has been an employee of an agency of the State of Nevada within the past two (2) years, and if such person shall be performing or producing the services which you shall be contracted to provide under this contract, you shall disclose the identity of each such person in your response to this RFP, and specify the services that each person shall be expected to perform.

3.1.7 Disclosure of any significant prior or ongoing contract failures, contract breaches, civil or criminal litigation in which the vendor has been alleged to be liable or held liable in a matter involving a contract with the State of Nevada or any other governmental entity. Any pending claim or litigation occurring within the past six (6) years which may adversely affect the vendor's ability to perform or fulfill its obligations if a contract is awarded as a result of this RFP shall also be disclosed.

Does any of the above apply to your company?

Yes		No	***X***

If "Yes", please provide the following information. Table can be duplicated for each issue being identified.

Question	Response	
Date of alleged contract failure or breach:		
Parties involved:		
Description of the contract failure, contract breach, or litigation, including the products or services involved:		
Amount in controversy:		
Resolution or current status of the dispute:		
If the matter has resulted in a court case:	Court	Case Number
Status of the litigation:		

3.1.8 Vendors shall review and provide if awarded a contract the insurance requirements as specified in Attachment D, Insurance Schedule for RFP 3491.

Agreed.

3.1.9 Company background/history and why vendor is qualified to provide the services described in this RFP. Limit response to no more than five (5) pages.

Founded in 1941, NORC is a public policy and social science research organization affiliated with the University of Chicago (UChicago). Our mission is to conduct high-quality research in the public interest. Our work frequently helps to inform decision-makers about the issues facing society through data collection and interpretation. NORC expands the reach and power of this research through policy analysis and technical assistance activities that support the aims of many government and nonprofit organizations.

Headquartered in Chicago, NORC has offices in Bethesda, Maryland, Atlanta, Boston, and San Francisco as well as field operations staff members around the country, and telephone interviewing facilities in Albuquerque, New Mexico, and Wichita, Kansas.

CAHPS SURVEYS

NORC has long participated in CAHPS efforts and we have used CAHPS instruments, protocols, and data extensively in critical evaluation efforts for federal and state agencies. We supported the methodological development of the Hospital CAHPS survey through multiple survey data collection efforts, and recently completed the Nationwide Adult Medicaid CAHPS survey. We have also served as the data collection organization for evaluation of the Texas Medicaid program for the last several years. Building on this experience, we obtained NCQA certification to administer the HEDIS CAHPS survey beginning in 2016. Below we explore in greater detail key CAHPS projects at NORC.

HOSPITAL CAHPS®: HCAHPS

NORC's earliest CAHPS work was assisting in the development of the HCAHPS survey instrument. As part of the CAHPS II initiative, NORC conducted the HCAHPS pilot survey in four states – Arizona, Connecticut, Maryland, and New York – for the Delmarva and Qualidigm QIOs. We tested the HCAHPS questionnaire using both telephone and mail data collection modes on a sample of almost 55,000 discharges who had a recent inpatient event at a participating hospital. NORC also conducted a follow-up project that tested Interactive Voice Recording as a survey administration mode for the survey. NORC produced data files and a Lessons Learned report for the CAHPS grantees. This work demonstrates our experience with conducting CAHPS surveys and producing CAHPS data files.

NATIONWIDE ADULT MEDICAID CAHPS

NORC has expanded its CAHPS experience through our work on the Nationwide Adult Medicaid CAHPS survey for the CMS. NORC sampled approximately 1.2 million Medicaid beneficiaries across 50 states and administered a slightly modified CAHPS 5.0H questionnaire, strictly adhering to a mixed-mode (mail/telephone) NCQA protocol. In close collaboration with CMS, NORC adapted the standard adult CAHPS questionnaire for the adult Medicaid population to capture demographics of the beneficiaries and more finely assess access for the disabled. To perform sample selection, NORC was granted access to the CMS secured storage of state Medicaid beneficiary files and executed sample selection that was sensitive to the data structure and other state-specific needs. Data collection was carried out by Thoroughbred Research Group, an NCQA certified vendor, under NORC's supervision.

This project presented an opportunity to capture baseline national and state-level estimates of adult Medicaid enrollees' experiences with the health care system by collecting measures of access, barriers to care, and satisfaction with providers.

Because Medicaid data is maintained by states, NORC worked with each of the 50 states and the District of Columbia to select state-based samples — a challenging task highlighting NORC's sampling and statistical skills as well as our experience working with multiple stakeholders. NORC sought to maintain consistent sample design standards across the states and provide statistical consulting services to the states and to CMS. NORC created and implemented the appropriate dual-frame weighting plan, creating weighted key metrics, and provided assistance with the final methodology reports for statistical related sections — experiences that make NORC well-suited to meet the sampling and final reports needed for the FFS CAHPS, and any other survey work the State may need related to EQRO activities.

TEXAS MEDICAID CAHPS SURVEYS

As the EQRO for Texas the Medicaid Program, the Institute for Child Health Policy (ICHP) at the University of Florida regularly evaluates the experiences of enrollees in the Texas Medicaid STAR and STAR+PLUS programs. NORC has served as the data collection organization for this work since 2011. Each year, NORC conducts CAHPS-based surveys via telephone to collect information from Texas Medicaid beneficiaries on their experiences with their Medicaid health plans. NORC conducts computer assisted telephone interviewing and prepares and delivers the final data sets to ICHP. The results of the surveys are used to make recommendations to the State of Texas and Texas Medicaid MCOs for improving health care delivery and quality. This work demonstrates NORC's ability to conduct CAHPS data collection with Medicaid health plan members and prepare and deliver datasets following set specifications.

Our CAHPS projects lead, Gillian Lawrence, M.P.H. is currently managing development of the Medicare Beneficiary Experience of Care Surveys on behalf of the CMS' Office of Minority health. This survey system will explore the healthcare experiences of key minority groups enrolled in Medicare. Surveys will be fielded using a multi-mode (web, mail, and telephone) protocol based on the Fee for Service CAHPS questionnaire and methodology. Gillian is a Survey Director with over 14 years of experience in research and survey management work, and extensive experience managing large survey projects throughout their lifecycles. She has previously served project director for the Texas Medicaid STAR and STAR+PLUS surveys and is the project manager for NORC's HEDIS CAHPS and other CAHPS certifications. She has also served as project manager for the Sentinel Communities Health Values survey for the Robert Wood Johnson Foundation, a mixed mode (web, mail, telephone) survey of health values. Gillian previously served as Data Collection Lead for the National Children's Study (NCS) Central Regional Operations Center. The NCS involved multi-mode data collection including phone, mail, and in-person activities for participants spread across the central United States. In this role she oversaw all aspects of the data collection

process including Information Management System (IMS) development and implementation, staffing planning, training, operational implementation, and production and progress reporting. In addition to survey management work, Gillian also works with NORC Web Survey team on innovations in web survey methodology and implementation strategies and training.

ADDITIONAL NORC EXPERTISE

In addition to our CAHPS experience, NORC offers Mercer and the State of Nevada talented, well-regarded staff with experience and expertise in areas such as:

- ***Medicaid enrollment and eligibility.***
- ***Questionnaire design.***
- ***Conducting mixed-mode survey protocols (including mail, web, and telephone).***
- ***Focus groups.***
- ***Data analytics and reporting for a variety of stakeholders.***
- ***Technical assistance.***
- ***Health care quality measurement and specifically.***
- ***Patient and beneficiary satisfaction data collection, as well as provider surveys.***

In addition to NORC's support of any CAHPS tasks, NORC also has many staff members with deep expertise in Medicaid programs, policy, evaluation, and statistical sampling and analytics which could be leveraged as needed to support Mercer and the State of Nevada. Please see resumes for select NORC staff in Section VII.

OTHER RELEVANT WORK

In addition to collecting primary data for the Nationwide Adult Medicaid (NAM) CAHPS survey, mentioned previously, NORC also contracted with CMS's Center for Medicaid and CHIP Services to provide access to and facilitate the use of the NAM CAHPS survey data files containing data from over 272,000 completed surveys. The analytic framework and data dissemination activities of the NAM CAHPS Analytic Support contract included: developing a productive analytic framework through meetings with federal and non-federal stakeholders; generating a data repository with clean, well-documented data files that are platform and technology independent; developing user support and outreach for data files; facilitating the use of CAHPS data by developing reports and substantive briefs as well as communication tools to encourage policy analysis; developing a Public Use File to provide states with microdata; and, partnering with subcontractors to assist state Medicaid agencies in obtaining access to the state data files and using the data. This work demonstrates our expertise in

providing our clients analytic and technical assistance related to Medicaid programs and developing user-friendly reports and data products.

3.1.10 Provide a brief description of the length of time vendor has been providing services described in this RFP to the public and/or private sector.

NORC has been conducting rigorous social science and survey research for over 75 years, focusing on issues ranging from health care and public health; education and child development; economics and social justice; international affairs; and statistics and methodology. NORC has long participated in CAHPS efforts and we have used CAHPS instruments, protocols, and data extensively in critical evaluation efforts for federal and state agencies. We supported the methodological development of the Hospital CAHPS survey through multiple survey data collection efforts beginning in 2003, and recently completed the NAM CAHPS survey. We have also served as the data collection organization for evaluation of the Texas Medicaid program for the last several years. Building on these experiences, NORC obtained NCQA certification to administer the HEDIS CAHPS survey beginning in 2016 and continue to maintain this certification.

3.1.11 Financial information and documentation to be included in accordance with Section 8.5, Part III – Confidential Financial Information.

3.1.11.1 Dun and Bradstreet Number

NORC: 069512291

3.1.11.2 Federal Tax Identification Number

NORC: 36-2167808

3.1.11.3 The last two (2) years and current year interim:

A. Profit and Loss Statement
B. Balance Statement

Per Section 8.5.1 "if needed…", NORC has opted to provide financial information in separate Part III. Please see the Income Statement and Balance Sheet Summary 2015-2017 included in Part III, Confidential Financial Information. There is no information yet available for 2018.

3.2.1.4 Vendor shall not allow any subcontractor to commence work until all insurance required of the subcontractor is provided to the vendor.

Mercer agrees.

3.2.1.5 Vendor shall notify the using agency of the intended use of any subcontractors not identified within their original proposal and provide the information originally requested in the RFP in Section 3.2, Subcontractor Information. The vendor shall receive agency approval prior to subcontractor commencing work.

Mercer agrees

3.3 BUSINESS REFERENCES

3.3.1 Vendors shall provide a minimum of three (3) business references from similar projects performed for private and/or public sector clients within the last three (3) years.

3.3.2 Vendors shall submit Attachment E, Reference Questionnaire to their business references.

3.3.3 It is the vendor's responsibility to ensure that completed forms are received by the Purchasing Division on or before the deadline as specified in Section 7, RFP Timeline for inclusion in the evaluation process. Reference Questionnaires not received, or not complete, may adversely affect the vendor's score in the evaluation process.

3.3.4 The State reserves the right to contact and verify any and all references listed regarding the quality and degree of satisfaction for such performance.

References were requested and provided following the instructions in Attachment E.

VII

SECTION VII – ATTACHMENT F, PROPOSED STAFF RESUMES

Resumes (Attachment F) of key and support staff are included in this Section. Mercer is proud to have much depth of expertise that may be called upon during the course of this engagement.

As illustrated in our organization chart, in addition to our key and support staff, we are providing resumes for a sample of our team's Technical Advisors. In the case of NORC, we provided all requested information for them as a subcontractor because if Nevada requests the optional activity of a CAHPS vendor (see Section 2.2.7), NORC would support this activity. The other Technical Advisors illustrate the additional resources and skill sets that we can draw upon to meet your needs. Indeed, all of our employees and long contact list of professional resources are available to Nevada by choosing Mercer to be your EQRO.

KEY AND SUPPORT STAFF RESUMES

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***Mercer Health & Benefits LLC***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	√	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Frederick Gibison Jr, MBA***	**Key Personnel: (Yes/No)**	***Yes***
Individual's Title	***Client Leader & Account Manager / Partner***		
# of Years in Classification:	***12***	**# of Years with Firm:**	***19.5***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

With Fred's many years' of Medicaid/health care experience, he combines his client leadership, analytical aptitude, and team leadership/organization to effectively manage and lead some of Mercer's largest client engagements. Fred helps drive the strategic planning process, assess policy review and implications, collaborates with senior team leaders to ensure Mercer's clients get the right advice at the right time, guides the project management process as well as ensuring Mercer complies with the legal requirements/contract terms. Fred is a member of Mercer's business leadership group and a member of Mercer's long-term services and supports (LTSS) strategic initiative team.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

Timeframe	2008 to Present
Company Name	Mercer Health & Benefits LLC
Company Location	Phoenix, AZ
Position/Title	State of Delaware – Team Leader/Client Leader/Account Manager
Details of Project	• **Delaware EQR Contract**: As Delaware's EQRO, Mercer provides comprehensive services to the State to conduct review of compliance with federal regulations, contract standards and internal MCO policies and procedures; validate PIPs; validate performance measures; conduct focused studies on buprenorphine prescribing patterns and initiation and engagement in alcohol or other drug treatment, overweight and obesity in childhood; lead readiness reviews; participate in information systems capabilities assessments; participate in quality improvement initiative task force; participate in program integrity reviews; develop and provide technical assistance to MCOs; develop and manage measurement and reporting projects.

	• **Delaware Actuarial/Financial Services Contract**: Mercer is the Delaware Medicaid actuary of record. In this role, the Mercer team develops prospective Medicaid managed care capitation rates on an annual basis that involves numerous encounter data and fee-for-service data analyses, medical trend evaluation (e.g., Hepatitis C), program/policy adjustments, managed care quality/efficiency adjustments (e.g., avoidable hospital readmissions, pharmacy generic drug reference pricing), risk mitigation including risk sharing/risk corridors, and non-medical expense loads and regular financial monitoring of the MCOs' financial statements. Mercer also implemented diagnostic-based risk adjustment using the CDPS+Rx model for all populations excluding newborns and LTSS. In 2012, Mercer collaborated with the State to expand risk-based managed care to LTSS populations including dual eligibles. Services also include health/Medicaid policy and program design, 1115 waiver work, strategic planning, development of new behavioral health delivery system (PROMISE program), and technical support of Delaware's efforts to comply with the HCBS Settings Rule (statewide transition plan). Mercer created new Medicaid MCO contract language mandating VBP objectives and quality/metric monitoring. Our team also supports the State's PACE program with developing the annual UPLs/AOPs. • **Accelerate Payment Reform - State Innovation Model (SIM) Contract**: Late in 2017, Mercer was awarded a competitive procurement to provide payment reform consulting services on Delaware's SIM initiative. Work has included writing a Benchmark Legislative Report, strategic planning around developing all-payer cost and quality benchmarks, stakeholder meetings, and collaboration across multiple State agencies to strategically move Delaware further along the continuum of VBP.

Timeframe	2005 – 2018
Company Name	Mercer Health & Benefits LLC
Company Location	Phoenix, AZ
Position	Commonwealth of Pennsylvania - Team Leader/Account Manager/Client Leader
Details of Project	• **Pennsylvania Rate Setting, Financial Management and Consulting Services Contract**: Mercer is Pennsylvania's Medicaid actuary of record as well as a general consultant on all things Medicaid-related. This is a very broad and large contract that averages $10-$12 million a year in related consulting services. Project work is diverse and includes actuarial rate setting for the statewide mandatory HealthChoices managed care program, encounter/fee-for-service data analyses and reporting, 1915b waiver development/cost effectiveness, MCO rate negotiations, CDPS+Rx risk adjustment, risk sharing, risk pools, health policy research and application, managed care/ACA adult expansion, managed LTSS program design and development (duals/integrated care), PACE UPLs, financial analyses, analysis of program/policy changes and impact on cost/risk, new cutting-edge managed care efficiency/value-based payment adjustments (e.g., avoidable ER use, poly-pharmacy), HCBS provider fee development/1915c waiver renewals, and contract management. This contract covers five different Offices within Pennsylvania's Department of Human Services including: – Office of Medical Assistance Programs (OMAP): Responsible for the physical health/acute care operations.

	– Office of Mental Health and Substance Abuse Services (OMHSAS): Responsible for the behavioral health/substance abuse operations. – Office of Long Term Living (OLTL): Responsible for elderly/physically disabled populations, HCBS waivers and the new managed LTSS program called "Community HealthChoices." – Office of Developmental Programs (ODP): Responsible for the intellectually/developmentally disabled (I/DD) populations, I/DD HCBS waivers, and autism services. – Office of Children's Health Insurance Program (OCHIP): Responsible for the Title XXI population which is served exclusively through risk-based managed care.

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

University of Phoenix, Phoenix, AZ, Master of Business Administration (MBA), 2007
Central Washington University, Ellensburg, WA, Bachelor of Science (BS) in Mathematics/Statistics, 1993

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

Not applicable

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

Name	Steve Groff
Title	Director
Organization	State of Delaware; Division of Medicaid & Medical Assistance
Phone #	+1 302 255 9663
Fax #	+ 1 302 255 4425
Email Address	Stephen.Groff@state.de.us

Name	Lisa Zimmerman
Title	Deputy Director
Organization	State of Delaware; Division of Medicaid & Medical Assistance
Phone #	+1 302 255 9535
Fax #	+1 302 255 4425
Email Address	lisa.zimmerman@state.de.us

Name	George Rhyne
Title	Director, Division of HealthChoices Rates
Organization	Commonwealth of Pennsylvania, Department of Human Services, Bureau of Fiscal Management

Phone #	+1 717 705 8256
Fax #	+1 717 772 6328
Email Address	GRHYNE@pa.gov

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***Mercer Health & Benefits LLC***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	√	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Heather Huff***	**Key Personnel: (Yes/No)**	***Yes***
Individual's Title	***Contract Manager & EQR Program Director / Principal***		
# of Years in Classification:	***25***	**# of Years with Firm:**	***11***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

As part of the Clinical and Behavioral Health Solutions Sector, Heather has led and participated in multiple projects such as clinical quality, clinical efficiency and behavioral health projects for Medicaid/ Children's Health Insurance Program (CHIP) and long term care (LTC) populations. Heather has led performance-based contracting, compliance, quality measurement and management activities for Connecticut, Delaware, District of Columbia, Florida, New Jersey, Oklahoma, Pennsylvania, and Texas. Her knowledge of nationally recognized performance measures, accuracy with data analysis, ability to translate data into actionable steps and project management skills result exceptional deliverables for client projects.

Heather's core competencies include performance-based contracting; quality measurement and reporting; focus study design, data collection analysis and presentation; EQR and regulatory compliance; and project management.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

Timeframe	February 2007 to Present
Company Name	Mercer
Company Location	Phoenix, Arizona
Position/Title	Principal
Details of Project	Delaware EQR: coordinate full scope of work and manage cross-sector project team; conduct review of compliance with federal regulation, contract standards and internal MCO policies and procedures; validate PIPs; validate performance measures; conduct focused studies on buprenorphine prescribing patterns and initiation and engagement in alcohol or other drug treatment, overweight and obesity in childhood; lead readiness reviews; participate in information systems capabilities assessments; participate in quality

	improvement initiative task force; participate in program integrity reviews; develop and provide technical assistance to MCOs; develop and manage measurement and reporting projects. Facilitate quarterly onsite meetings with Delaware Managed Care Operations, Planning, Policy and Quality and Case Management staff and Medicaid Director and Deputy Director. Serve as HEDIS and Quality Compass subject matter expert advising on VBP initiatives and quality alignment for alternative payment methods. District of Columbia Pay for Performance Initiative: facilitate discussions with District regarding initiative objectives, research and select appropriate performance measures, benchmarks and performance goals, develop MCO training materials, assist with performance measurement analysis. Commonwealth of Pennsylvania MCO Operational and Clinical Efficiency Reviews: led project initiation, developed scope of work and budget, coordinated cross-sector team effort for desk review and onsite interviews, developed reporting template, facilitated onsite review, peer reviewed report, facilitated post-review discussion with Medicaid Director.

Timeframe	June 2005 – February 2007
Company Name	Health Services Advisory Group
Company Location	Phoenix, Arizona
Position	Associate
Details of Project	Medicare Health Outcomes Survey: Assisted with data intake, programmed SAS code for managing data, conducted data validity analysis, parsed data for distribution and posted data to secure FTP site.

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

University of Akron, Akron, Ohio, Master's degree in Sociology, May 1993
Mount Vernon Nazarene University, Mt. Vernon, Ohio, Bachelor's degree in Sociology, May 1990

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

Not applicable

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

Name	Kathleen Dougherty
Title	Chief, Managed Care Operations
Organization	Delaware Division of Medicaid & Medical Assistance
Phone #	+1 302 255 9937
Fax #	+1 302 255 9529

Email Address	kathleen.dougherty@state.de.us

Name	Laurie Rock
Title	Director, Bureau of Managed Care Operations
Organization	Commonwealth of Pennsylvania Office of Medical Assistance Programs
Phone #	+1 717 772 6197
Fax #	+1 717 772 6328
Email Address	lrock@pa.gov

Name	Lisa Truitt
Title	Director, Health Care Delivery Management Administration
Organization	Department of Health Care Finance
Phone #	+1 202 442 9109
Fax #	+1 202 722 5686
Email Address	lisa.truitt@dc.gov

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***Mercer Health & Benefits LLC***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	√	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Rachel Wright, RN, MSN, PHN***	**Key Personnel: (Yes/No)**	***Yes***
Individual's Title	***Clinical Quality Lead / Senior Associate***		
# of Years in Classification:	***13***	**# of Years with Firm:**	***3***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Rachel brings a unique understanding of state Medicaid and Public Health systems. She has 13 years of nursing experience in physical, behavioral and long-term health care. Rachel is a former Quality Bureau Chief for New Mexico Medicaid, former Director of Nursing Services Coordinator for New Mexico Public Health, and former Diversion Program manager for the New Mexico Board of Nursing.

Rachel's core competencies include: Managed care program operations; EQR, Provider network access and availability, utilization management and, clinical care coordination strategies and clinical quality improvement analysis.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

Timeframe	February 2015 to Present
Company Name	Mercer Health & Benefits, LLC
Company Location	Phoenix, Arizona
Position/Title	Mercer Senior Associate
Details of Project	Since February of 2015, Rachel has been the EQRO Project Manager for Mercer's State of Delaware EQRO contract. Rachel leads the Delaware Medicaid compliance reviews (desk and onsite) for service and care coordination, long-term services and supports, and utilization management as well as a 2017 managed care readiness review for a new Medicaid health plan. Technical assistance: Rachel provided PIP technical assistance for the MCO on lead and

	lag measures and created a Delaware specific MCO quarterly reporting tool. Network Adequacy: Rachel created network adequacy analysis using Delaware's contract standards and geographical access reports. Rachel co-led a workgroup with DHHS that reviewed the Center for Medicare & Medicaid Services (CMS) final rules and Delaware contract compliance. Rachel created utilization reports for unique members accessing specialists to review Delaware specific needs. Rachel created time, distance, and accessibility recommendations based on Delaware's specific population for physical, behavioral health, managed long tern services and supports (MLTSS), hospitals and pharmacies.

Timeframe	December 2013 – January 2015
Company Name	New Mexico Human Services Department, Medical Assistance Division
Company Location	Santa Fe, New Mexico
Position	New Mexico Medicaid Quality Bureau Chief
Details of Project	New Mexico Medicaid Quality oversight: EQRO contract owner, created the request for procurement, oversaw the MCO performance of contract measures and reports, annual review and creation of new contract performance measures, lead quality and clinical areas for MCO readiness reviews, and quality file reviews. Clinical oversight of the Medicaid program including but not limited to: patient centered initiatives, performance measurement, implementation of quality improvement and CAPs, Medicaid adult quality grant.

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

Benedictine University, Lisle, Illinois, Master's degree in Nursing, (12/2010)
Regis University, Denver, Colorado, Bachelor's degree in Nursing, (12/2004)

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

Licensed Registered Nurse, Minnesota (02/2005)
Licensed Registered Nurse New Mexico (compact license), (09/2006)
Certified Public Health Nurse, Minnesota, (11/2014)
MLC Certified Medicaid Professional, (07/2016)

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

Name	Kathleen Dougherty
Title	Managed Care Operations
Organization	Delaware Health and Social Services, Medicaid and Medical Assistance
Phone #	+1 302 255 9500
Fax #	+1 302 255 4454
Email Address	Kathleen.Dougherty@state.de.us

Name	Nancy Smith Leslie
Title	New Mexico Medicaid Division Director
Organization	New Mexico Human Services Department, Medical Assistance Division
Phone #	+1 505 827 3100
Fax #	+1 505 827 3185
Email Address	Nancy.Smith-Leslie@state.nm.us

Name	Dr. Anne Foster
Title	(Former) New Mexico Medicaid Medical Director
Organization	(Former) Human Services Department, Medical Assistance Division
Phone #	+1 575 770 2501
Fax #	N/A
Email Address	afr@newmex.com

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***Mercer Health & Benefits LLC***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	√	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Son Yong Pak, CPHQ, CPC***	**Key Personnel: (Yes/No)**	***Yes***
Individual's Title	***Project Manager & Program Integrity Lead / Senior Associate***		
# of Years in Classification:	***20***	**# of Years with Firm:**	***5***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Son Yong combines her experience in operations and project management and in clinical quality and efficiency in physical and behavioral health for Medicaid, children's health insurance program, and long-term care (LTC) populations to plan and monitor project implementations to ensure initiatives are completed with the scope, on time, and within the budget. Also, she is a key contributor to the internal Mercer medical coding team and has contributed medical coding knowledge to almost every Mercer's Medicaid clients. Son Yong researches federal and state regulations and guidelines as well as clinical and medical coding guidelines and provides coding expertise and support to the actuarial and clinical teams.

Son Yong's core competencies include project management, medical coding, health care data analysis and interpretation, regulatory and operations compliance, practice transformation, quality improvement and evaluating MCO readiness and compliance.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

Timeframe	January 2013 to present
Company Name	Mercer
Company Location	Phoenix, Arizona
Position/Title	Senior Associate
Details of Project	Arizona Health Care Cost Containment System (AHCCCS) State Innovation Models (SIM) and Targeted Investments Program: coordinate full scope of work, oversee budget and manage cross-sector and subcontractor project team; draft public comments summary, develop core components and milestones for each project; participate in justice system stakeholder sessions; draft stakeholder and steering committee presentations, facilitate

	client update meetings, support the implementation of some of the delivery strategies identified in the SIM process. Commonwealth of Pennsylvania Technical Assistance: participate in multiple technical assistance projects including, but not limited to, mental health parity analysis, behavioral health managed care organization (BH-MCOs) compliance review to include desk review, onsite interviews and report writing; program integrity assessment of BH-MCOs to include desk review, onsite interview, develop reporting template and report card, review CAPs, provide technical assistance presentation; behavioral health procurement and contractor readiness manual to include key staff interview, document responsibilities and procurement processes. Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) development of a request for proposal (RFP) and evaluation approach for selecting a qualified vendor to function as an Administrative Services Organization (ASO): coordinate full scope of work, oversee budget and manage cross-sector and subcontractor project team; facilitate client update meetings; oversee project budget and timelines. All client actuarial teams with medical coding support: review of medical codes and service categorizations, including ICD-9 and ICD-10 diagnosis and procedural codes, CPT-4 and HCPCS procedure codes, DRGs and ADA dental codes as well as codes specific to UB04 and CMS-1500 forms for rate development, clinical efficiency reviews and maternity kick-payment; develop medical coding logic for enhanced federal Medicaid assistance percentage analysis for family planning and preventive services.

Timeframe	June 2010−December 2012
Company Name	Arizona Chapter of the American Academy of Pediatrics
Company Location	Phoenix, Arizona
Position	Improvement Coach
Details of Project	Recruited and coached primary care practices to participate in a practice transformation process in implementing Patient-Centered Medical Home (PCMH) processes to improve their operational systems, outcomes and patient satisfaction; served as a liaison to community, MCOs and government organizations in promoting PCMH and improving healthcare delivery system; served as a liaison to the Arizona Health-E Connection and recruited providers to participate in the meaningful use incentive program and health information exchange; Reviewed and provided feedback to the national American Academy of Pediatrics on a new product line that is designed to aid practices in achieving the NCQA PCMH Recognition.

Timeframe	September 2008–June 2010
Company Name	Health Choice Arizona
Company Location	Phoenix, Arizona
Position	Director of Early Periodic Screening, Diagnosis and Treatment (EPSDT) and Performance Improvement
Details of Project	Developed and implemented operational processes and improved full- compliance rating

	from 75% to 100% for the EPSDT program; engaged in cross-departmental strategies to implement PIPs; developed performance improvement strategies, goals and work plan working in cross-sector departments to improve state required HEDIS measures; provided member and provider outreach on recommended services based on the EPSDT visits.

Timeframe	February 2007−August 2008
Company Name	State of Arizona, Arizona Department of Economic Security, Comprehensive Medical and Dental Program
Company Location	Phoenix, Arizona
Position	Chief Operations Officer
Details of Project	Provided ongoing operational process analysis, communicated project status, identified and resolved operational issues, and implemented processes to ensure Medicaid regulatory compliance; supervised 20 staff members involving mentoring, training and providing feedback on their performance to accomplish their goals; orchestrated four project teams and successfully transitioned to a new Pharmacy Benefits Management (PBM) for three programs covering over 12,000 lives; serviced as a liaison to the regulator, State Attorney General's Office and Child Protective Services.

Timeframe	May 2001−February 2007
Company Name	State of Arizona, Arizona Health Care Cost Containment System (AHCCCS)
Company Location	Phoenix, Arizona
Position	Acute Care Operations and Compliance Officer, Behavioral Health Senior Clinical and Quality Officer Behavioral Health Clinical Program Analyst
Details of Project	Assessed regulatory compliance of contracted Medicaid MCOs in accordance with the federal and state rules and regulations; oversaw three state carve-out programs: Children's Rehabilitative Services, children in the foster care system and behavioral health program; provided cross-functional team leadership in Medicaid contractors' operational and financial audits; developed, reviewed and monitored multidisciplinary CAPs of Medicaid contractors; developed contract provisions and managed contract negotiation processes; served as a member of the 2006 Arizona Long Term Care System (ALTCS) Program Request for Proposal (RFP) evaluation team.

Timeframe	September 1996−May 2001
Company Name	ValueOptions/ComCare
Company Location	Phoenix, Arizona
Position	Quality Management Analyst Homeless Outreach Specialist Seriously Mentally Ill (SMI) Case Manager
Details of Project	Co-developed and implemented provider monitoring audit tool and processes to ensure regulatory compliance of behavioral health providers; hand selected by the Office of the Court Monitor to participate in its Independent Review of the exit stipulation; performed outreach activities to homeless SMI individuals and engaged individuals in services.

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

University of California, Berkeley, California, Bachelor's degree in Sociology, December 1995

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

Certified Professional in Healthcare Quality, April 2010
Certified Professional Coder, August, 2008

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

Name	Michael Bailit
Title	President
Organization	Bailit Health Purchasing, LLC
Phone #	+1 781 453 1166
Fax #	+1 781 453 1167
Email Address	mbailit@bailit-health.com

Name	Melissa Sperbeck
Title	Director, Division of Performance Management and Quality Improvement
Organization	State of Georgia, Department Behavioral Health and Developmental Disabilities
Phone #	+1 404 657 2258
Fax #	+1 770 342 4849
Email Address	melissa.sperbeck@dbhdd.ga.gov

Name	Sayeh Shirvani
Title	Chief – LTSS Analysis
Organization	Ohio Department of Medicaid
Phone #	+1 614 752 3642
Fax #	+1 614 466 6945
Email Address	sayeh.shirvani@medicaid.ohio.gov

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***Mercer Health & Benefits LLC***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	√	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Janine Statt, PharmD***	**Key Personnel: (Yes/No)**	***Yes***
Individual's Title	***Pharmacy Lead & Managed Care Operations Lead / Senior Associate***		
# of Years in Classification:	***10***	**# of Years with Firm:**	***1***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Janine is a pharmacist within Mercer's Government Human Services Consulting group, a part of Mercer Health & Benefits LLC (Mercer) in the Phoenix, AZ office. She comes to Mercer from a MCO setting, managing the pharmacy benefit for various Medicaid, Medicare, Exchange and Commercial health plans in several states. She oversaw benefit design, clinical program and performance measure development, stakeholder engagement, and vendor contract oversight. Janine's experience at Mercer includes similar work consulting on pharmacy projects for New Mexico, New Jersey, California and North Carolina, in addition to drug utilization and efficiency projects across other states.

Janine's core competencies include Medicaid MCO pharmacy program design, implementation and evaluation; Medicaid pharmacy policy; Encounter data validation; Medicaid PIP implementation and analysis; CAHPS survey evaluations; HEDIS reporting; Pharmacy trend analysis and projections; Prior authorization and PDL analysis; Pharmacy benefit management.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

Timeframe	2018
Company Name	Mercer Health & Benefits, LLC
Company Location	Phoenix, AZ
Position	Senior Associate, Pharmacist
Details of Project	Manage data and financial analytical work on large and complex state managed health and welfare capitation projects; provide guidance in developing the data model and assumptions for the project. Ensure the project is consistent with federal regulations and actuarial standards; determine the appropriate data sources for the specific project's data analysis.

	Collaborate with client team and project team to finalize rates; educate and consult with client on the impact of their policies on the data and rates. Present results and analysis to clients and key stakeholders; answer detailed and challenging questions regarding the data.

Timeframe	2015 – 2017
Company Name	Tenet Healthcare
Company Location	Phoenix, AZ
Position/Title	Clinical Program Manager
Details of Project	Management of pharmacy operations including pharmacist and technician oversight, inter-departmental collaboration with compliance, eligibility, finance, medical, case management, grievance and appeals departments. Build strategy at plan level, inclusive of federal and state (AZ, TX, MI) regulations, template filings, draft pharmacy communications to members, providers, state and federal. Co-Chair P&T Committee (commercial), custom formulary management, and formulary conversion strategies. Propose cost savings initiatives, collaborate with plan's actuaries and medical economics team to provide cost effective value based care, financial analysis and reconciliation of Cost-Sharing Reduction monitor FWA, oversee drug rebating potential, and improve specialty pharmacy outcomes. Prior authorization (PA) oversight, project management to bring pharmacy PA in house from PBM, process change to move pharmacy appeals from the grievance and appeals department, clinical review of pharmacy appeal cases. Reporting of quality and financial measures to committee, Quality of Care (QOC) reporting, provider trending. Audit representation (internal, state departments of insurance, CMS), audit preparation and response, URAC accreditation application support, mock audit with Integral Healthcare Solutions consultants, PIP selection and implementation. Vendor management oversight of delegated functions (ESI, CVS, Navitus, EQuIPP, Agadia/PA Hub, MRIOA, CareAnalyzer/DST Health Solutions).

Timeframe	2014 – 2015
Company Name	Tenet Healthcare
Company Location	Phoenix, AZ
Position	Medicaid Clinical Pharmacist
Details of Project	Prior authorization (PA) reviews, heavy focus on cost containment strategies and compliance with state regulations. P&T Committee co-chair (Medicaid), criteria development, and Hepatitis C adherence program creation. Inter-collaborative Care Team (ICT) team member, medication reviews, clinical detailing

	pieces, nurse case manager medication training sessions. Audit support, medical and pharmacy reporting to the state, Arizona Health Care Cost Containment System (AHCCCS) and Notice of Action (NOA) audits. Provider Forum presentations throughout the valley on behalf of Phoenix Health Plan pharmacy services department. Medical Management collaborative projects, J Code clinical reviews, J Code PA list management. Additional support: EQuIPP Implementation for pay for performance pilot study, PBM conversion, HEDIS measure strategy and reporting, Medicare Part D STARS team creation and oversight, MTM Medicare clinical reviews with members and providers.

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

University of Hawaii at Hilo, PharmD, (2014)
University of Hawaii at Hilo, Bachelor's degree, Pharmacology, (2014)
University of California at Los Angeles, Bachelor's degree in Psychobiology, (2005)

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

Licensed pharmacist, Arizona, (2014)
Licensed pharmacist, Texas, (2015)

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

Name	Andy Le
Title	Pharmacy Program Manager
Organization	Care 1st Health Plan
Phone #	+1 602 778 4140
Fax #	N/A
Email Address	ale@care1staz.com

Name	Stephanie Sanders
Title	Pharmacy Director
Organization	Tenet Healthcare
Phone #	+1 602 824 3984
Fax #	N/A
Email Address	Stephaniem.sanders@tenethealth.com

Name	Anissa Marzuki
Title	Pharmacy Community Residency Coordinator, Clinical Pharmacist
Organization	Midwestern University, Safeway
Phone #	+ 1 301 920 4340
Fax #	N/A
Email Address	Anissa.marzuki@safeway.com

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***Mercer Health & Benefits LLC***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	√	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Jane Szymanski***	**Key Personnel: (Yes/No)**	***Yes***
Individual's Title	***ISCA (Information Systems Capabilities Assessment) & Electronic Data Validation (EDV) Lead / Senior Associate***		
# of Years in Classification:	***37***	**# of Years with Firm:**	***16***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Jane's expertise is in managed care systems and claims payment processes. Since joining Mercer, Jane has worked with more than 20 states, including Delaware, North Carolina, Pennsylvania, and the District of Columbia. She has 35+ years of experience in the health care claims industry. With her expertise in managed care and encounter data, Jane has worked with numerous actuarial, clinical, and financial teams on data issues related to risk adjusted rates, EQR, and the collection, validation and analysis of encounters.

Jane's core competencies include Information systems capabilities assessments, Data management; Claims/encounter processing expertise; Claims/clinical edit efficiency analysis; Encounter data.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

Timeframe	2001 – Current
Company Name	Mercer
Company Location	Phoenix, AZ
Position/Title	Senior Associate
Details of Project	Delaware information systems capability assessment: Performed the CMS ISCA along with expanded encounter data validation activities since 2002. Also performed reviews for readiness of a new MCO, benefit expansions and encounter submissions. A detailed technical report was produced with strengths and opportunities to allow for CAPs to be created as needed to enhance MCO performance. District of Columbia encounter data completeness and accuracy: Since 2004 when encounter data collection began, assist the District with MCO submissions to verify

	completeness and accuracy with monthly quality reporting to monitor the processes. North Carolina prepaid inpatient hospital plans (PIHPS): Oversee the implementation, ongoing activities, and mergers of PIHPs for 1915(b)(c) services. Mercer provided annual technical assistance for the PIHPs to improve data collection, data verification, payment accuracy, and encounter submission completeness. District of Columbia encounter data collection: Oversee the claims/encounter activities of MCOs for encounter data projects. Various projects including encounter data collection, data verification, system edits, payment accuracy and timeliness, and encounter submission completeness and accuracy. Onsite projects include additional needs to review and enhance financial reporting, home health data, and third-party liability processes.

Timeframe	1999 – 2001
Company Name	First Health
Company Location	Scottsdale, AZ
Position	Manager of data Integrity for corporate quality assurance
Details of Project	First Health data integrity: Review intra-company processes for data integrity and accuracy in data sharing between departments such as provider demographics and fee schedules and clinical authorizations with the claims department. In addition, we audited customer service calls and documentation, claim system edits, and system documentation for information systems and claims processing procedures.

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

Western International University, Phoenix, AZ, Bachelor's degree in Business Management, (May 2000)

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

Not applicable

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

Name	Lawrence Williams
Title	Management Analyst
Organization	DC Division of Managed Care, Department of Health Care Finance
Phone #	+1 202 724 8864
Fax #	+1 202 722 5686
Email Address	Lawrence.Williams2@dc.gov

Name	Katherine Nichols
Title	Assistant Director for Policies and Programs,
Organization	NC Division of Mental Health Developmental Disabilities and Substance Abuse Services
Phone #	+1 919 715 2027
Fax #	+1 919 508 0951
Email Address	Katherine.Nichols@dhhs.nc.gov

Name	John Miller
Title	Financial Analysis and Reporting
Organization	Pennsylvania Office of Medical Assistance Programs
Phone #	+1 717 705 8129
Fax #	+1 717 705 8112
Email Address	johnmil@pa.gov

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***Mercer Health and Benefits, LLC***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:		**Subcontractor:**	√

The following information requested pertains to the individual being proposed for this project.			
Name:	***Jennifer Lenz, QRS, MPH, CHCA***	**Key Personnel: (Yes/No)**	***Yes***
Individual's Title	***Performance Measure Validation (PMV) Lead & HEDIS Certified Auditor / Independent Consultant***		
# of Years in Classification:	***2.75***	**# of Years with Firm:**	***2.75***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Jennifer is highly qualified professional with more than 18 years of experience in the healthcare industry, with expertise in implementing and managing EQR activities, managing teams, and driving quality improvement initiatives. She has experience in conducting evaluation of public health programs, compliance reviews, and performance measure validation. She has a working knowledge of Medicaid, Medicare, the Children's Health Insurance Program (CHIP), Marketplace, Medicare-Medicaid plan demonstration projects, and federal employee benefit plans. Jennifer also has experience as a National Committee for Quality Assurance (NCQA) Certified HEDIS Compliance Auditor (CHCA) and a Centers for Medicare & Medicaid Services (CMS) data validation evaluator with extensive knowledge of performance measures, information systems, and auditing techniques.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

Timeframe	June 2015 – Present
Company Name	Quality Review Solutions, LLC. (QRS)
Company Location	Phoenix, AZ
Position/Title	President/Independent Consultant
Details of Project	Serves as an independent consultant for conducting various audit and quality improvement activities. Has responsibility for interfacing with NCQA Licensed Organizations to conduct HEDIS Compliance Audits™, CMS data validation audits, and performance measure validation audits for Commercial, Medicare, Medicaid, and Marketplace populations. Interfaces with EQROs to conduct compliance and care management audits, provide staff training, and technical assistance. Provides consultation to NCQA and the Centers for Disease Control and Prevention (CDC) on the Million Hearts Hypertension Control Project.

Timeframe	November 2008 – August 2015
Company Name	Health Services Advisory Group, Inc. (HSAG)
Company Location	Phoenix, AZ
Position	Executive Director, State & Corporate Services
Details of Project	Served as the EQR primary point of contact for the Georgia Department of Community Health with oversight of Project Directors who served as main points of contacts for the states of California, Ohio, and Virginia. Had responsibility for oversight of the HSAG teams for PIPs, community collaboratives, and HEDIS and performance measure validation audits. This included communications, project planning and budgeting, tracking project timelines and task schedules, overseeing timely and quality contract deliverables, developing written reports, identifying project improvement opportunities, developing and facilitating quality improvement activities, and coordination and communication with internal departments on project activities. Provided technical assistance on strategic planning and quality strategy development to Medicaid state clients and health plans with project facilitation that incorporated logic models and key driver diagrams, as well as introduced quality improvement science techniques to evaluate quality improvement effectiveness. Served as the principal investigator on the Ohio Department of Health, Quality Improvement Project for Type II Diabetes Mellitus Post-Partum Screening Among Women with a History of Gestational Diabetes Mellitus.

Timeframe	January 2006 – November 2008
Company Name	Arizona Department of Health Services (AZDHS), Bureau of Chronic Disease Prevention and Control, Well Woman HealthCheck Program
Company Location	Phoenix, AZ
Position	Well Woman HealthCheck Program Director
Details of Project	Responsible for implementation of the National Breast and Cervical Cancer Early Detection Program in Arizona providing breast and cervical cancer screening and diagnostics to approximately 8,000 low-income, uninsured, and underinsured women annually. Oversaw cooperative agreement requirements with the CDC for all aspects of the program including program management, professional development, public education, recruitment, quality assurance, screening, tracking, case management, surveillance and evaluation. Developed the annual work plan containing specific goals, activities, and performance measures for the program. Identified grant opportunities, wrote applications for grant funding, and oversaw implementation and reporting of grant activities. Secured more than $1 million dollars in non-federal grants between 2007 and 2008. Responsible for Arizona Proposition 303 (tobacco tax) funds, including project management, budget management, development of evaluation plan, and surveillance activities.

Timeframe	October 2002 – January 2006
Company Name	PacifiCare Health Systems, Desert Region (AZ, NV, CO)
Company Location	Phoenix, AZ
Position	Regional Project Manager, Healthcare Quality
Details of Project	Responsible for project management of NCQA accreditation for the Desert Region, including knowledge of regulatory standards related to quality improvement, utilization management, credentialing, and member rights and responsibilities, HEDIS, and CAHPS. Provided training to internal staff related to accreditation requirements and was responsible for coordination of all aspects of audit preparation including mock audits and final review. Prepared annual quality improvement documentation, including work plan, program description, and program evaluation. Participation on community collaborative project with multiple state, private, and non–profit agencies. Performed ambulatory medical record reviews in physician offices for regulatory compliance.

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

University of Arizona, Tucson, Arizona, Master of Public Health in Health Administration and Policy, 2004
Arizona State University, Tempe, Arizona, Bachelor of Science in Psychology, 1997

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

Certified HEDIS Compliance Auditor; 10/2011–Present

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

Name	Wendy Talbot, MPH
Title	Director, Measure Validation and Data Collection
Organization	National Committee for Quality Assurance (NCQA)
Phone #	+1 202 955 1708
Fax #	N/A
Email Address	talbot@ncqa.org

Name	Cassandra Eckhof
Title	Project Director, Massachusetts External Quality Review Program
Organization	KEPRO Acquisitions, Inc.
Phone #	+1 617 913 8093
Fax #	N/A
Email Address	ceckhof@kepro.com

Name	Catherine Basham
Title	Project Associate, MassHealth Quality Office
Organization	Massachusetts Executive Office of Health and Human Services (EOHHS)
Phone #	+ 1 617 847 3720
Fax #	N/A
Email Address	Catherine.Basham@MassMail.State.MA.US

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***Mercer Health & Benefits LLC***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	√	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Jorge Hasbun***	**Key Personnel: (Yes/No)**	***Yes***
Individual's Title	***HEDIS Measure Calculation Lead / Associate***		
# of Years in Classification:	***3***	**# of Years with Firm:**	***1.5***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Jorge's SAS programming and statistical knowledge are combined to assist with clients' data management, summarization, visualization, and analysis needs. Jorge is a team member for the client states of Missouri, Mississippi, Minnesota, Pennsylvania, and Wisconsin. In addition, Jorge supports the department's work on the Health Plan Employer Data and Information Set (HEDIS) quality performance measures.

Jorge's core competencies include data acquisition, data validation, analyzing and interpreting health care data using descriptive and inferential statistics.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

Timeframe	2016 – Present
Company Name	Mercer
Company Location	Phoenix, AZ
Position/Title	Associate
Details of Project	Calculate rates for clients on a quarterly basis and maintain and update performance measure library to align with most current specifications.

Timeframe	2014 – 2016
Company Name	Health Services Advisory Group
Company Location	Phoenix, AZ
Position	Analyst
Details of Project	Calculated rates and generated weekly, monthly, and quarterly reports for CMS' Hospital Inpatient and Outpatient Reporting Programs (HIQR and HOQR). Calculated rates for five states on a quarterly and annual basis including healthcare consumer survey-based rates. Created performance-based plan comparison scorecards and incentive programs for over 10 states. Conducted cost savings analysis for state Medicaid programs. And validated IDSS data sets for over 50 plans across four product lines in preparation for final submission to NCQA.

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

Texas A&M University, College Station, TX, Master's degree in Statistics, 2013
Portland State University, Portland, OR, Bachelor's degree in Mathematics, 2010

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

Not applicable

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

Name	Julie Pearson
Title	CCBHC Project Manager
Organization	Minnesota Department of Human Services, Mental Health Division
Phone #	651.431.4879
Fax #	651.431.7566
Email Address	Julie.Pearson@state.mn.us

Name	Brian Starr
Title	Analyst / Statistician
Organization	Health Services Advisory Group
Phone #	520.977.6736
Fax #	
Email Address	bstarr@hsag.com

Name	Jalal Haddad
Title	Associate Analyst
Organization	Department of Health Care Services (CA), Integrated Systems of Care Division
Phone #	916.750.3586
Fax #	N/A
Email Address	Jalal.Haddad@dhcs.ca.gov

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***Mercer Health & Benefits LLC***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	√	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Brenda Jenney, PhD***	**Key Personnel: (Yes/No)**	***Yes***
Individual's Title	***Statistician / Senior Associate***		
# of Years in Classification:	***6***	**# of Years with Firm:**	***7***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Brenda combines statistical knowledge and SAS programming skills, and over five years of analytical expertise to assist with clients' data management and analysis needs. Brenda is a team member for the client state of New Jersey.

Brenda's core competencies include Designing statistically valid studies; Analyzing and interpreting health care data using descriptive and inferential statistics.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

Timeframe	July 2013-present
Company Name	Mercer
Company Location	Phoenix, AZ
Position	Senior Associate
Details of Project	California HCBS Statewide Transition Plan: Recommending data collection strategies, statistical analysis, and reporting methodology for the settings assessment methodology for compliance with the Home and Community Based Services (HCBS) final rule. Arizona First Things First Statistical disclosure control (SDC): Utilizing statistical and summarization algorithms to protect the privacy of individuals, when health care data tables must be released publicly. Oregon Cost of Dispensing (COD) Survey: Providing statistical analysis of pharmacy survey data, including: determining usable survey responses, outlier analysis, creating weights for

	nonresponse, regression analysis, and calculation of average cost of dispensing overall and for pharmacy subgroups. Oklahoma Emergency Department Utilization: Developing statistical comparisons of program interventions.

Timeframe	August 2006 – May 2007
Company Name	Arizona State University
Company Location	Tempe, AZ
Position	Statistical Consultant
Details of Project	Advised ASU faculty, employees and graduate students on statistical problems from diverse areas of research, including: biology, engineering, business, and fitness. Consulting topics included design and analysis of experiments, multiple regression, analysis of variance, sampling and survey methodology and categorical data analysis. Also advised on the use of statistical software, including: SAS, SPSS, JMP, R, and Minitab.

Timeframe	May 2004 – January 2006
Company Name	Mercer
Company Location	Phoenix, AZ
Position	Health Care Informatics Analyst
Details of Project	Analyzed health care utilization and encounter data for commercial and state government clients. Used SAS programming skills to load, summarize and analyze large datasets. Programming team member on rate-setting, risk-adjusted rate-setting, and payment error rate measurement projects. Member of the peer-review committee, instituted to improve peer-review practices within the programming team.

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

Arizona State University, Tempe, Arizona, Doctoral degree in Statistics, 2009
Arizona State University, Tempe, Arizona, Master's degree in Statistics, 2005
Duke University, Durham, North Carolina Bachelor's degree in Mathematics, 1996

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

Not applicable

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

Name	Roopa Iyer
Title	Senior Director, Research and Evaluation
Organization	State of Arizona, Early Childhood Development and Health Board, First Things First

Phone #	+1 602 771 5075
Fax #	N/A
Email Address	riyer@asftf.gov

Name	Jalal Haddad
Title	Associate Analyst
Organization	State of California, Department of Health Care Services, Integrated Systems of Care Division
Phone #	+1 916 750 3586
Fax #	N/A
Email Address	Jalal.haddad@dhcs.ca.gov

Name	Sharon Lohr
Title	Professor Emerita
Organization	Arizona State University
Phone #	Email contact preferred
Fax #	N/A
Email Address	sharon.lohr@asu.edu

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***Mercer Health & Benefits LLC***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	√	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Barbara Anger, CPC***	**Key Personnel: (Yes/No)**	***Yes***
Individual's Title	***Certified Professional Coder / Analyst***		
# of Years in Classification:	***20***	**# of Years with Firm:**	***6***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

As an Analyst and Coding Specialist with Mercer, Barbara concentrates on clinical quality and clinical efficiency in physical and behavioral health projects. She is a key contributor to the internal Mercer ICD-10 workgroup by educating internal Mercer teams about the ICD-10 transition and assisting state clients with the ICD-10 implementation and impact analysis.

Barbara's core competencies include Medical coding; EQR and regulatory compliance; Contract management; Readiness review tools; Policy and rate setting support.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

Timeframe	March 2012 to Present
Company Name	Mercer Health & Benefits LLC
Company Location	Phoenix, Arizona
Position/Title	Consultant
Details of Project	Delaware EQR: provide project management; budget tracking and invoicing; participate in onsite compliance reviews; produce multi-project timeline; coordinate various update meetings across multiple projects; provide monthly data collection analysis and presentation; create quality measurement and reporting dashboards; provide technical assistance to MCOs. Connecticut Medicaid's Person-Centered Medical Home Plus (PCMH+): provide project management; conduct compliance review of PCMH+ program which includes on-site

	interviews, desk reviews, tool development and data analysis, report writing, and report editing; provide monthly quality data collection analysis and presentation; provide technical assistance to PEs. New York System Transformation for Improved Behavioral Health and Physical Health: assist with the development and implementation of New York's Request for Qualifications (RFQs); evaluation criteria and scoring; readiness review tool development.

Timeframe	September 1999 – March 2012
Company Name	FM GROUP INC
Company Location	Scottsdale, Arizona
Position	Project Coordinator
Details of Project	Environmental Project Coordinator: Generated proposals and co-authored environmental reports, tracked project budget, reviewed and approved project submittals and Requests for Information, coordinated technical trainings and seminars for EPA certifications.

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

East Stroudsburg University, East Stroudsburg, PA, Bachelor's degree in Elementary Education, Minor in Psychology, 1993

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

Certified Professional Coder, May 2015

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

Name	Kathleen Dougherty
Title	Chief, Managed Care Operations
Organization	Delaware Division of Medicaid & Medical Assistance
Phone #	+1 302 255 9937
Fax #	+1 302 255 9529
Email Address	kathleen.dougherty@state.de.us

Name	Robert W. Zavoski, MD
Title	Medical Director
Organization	Connecticut Department of Social Services
Phone #	+1 860 424 5583
Fax #	+1 860 424 5799

Email Address	robert.zavoski@ct.gov

Name	Elizabeth Vose
Title	Director, Bureau of MCO Oversight and Monitoring
Organization	New York Office of Mental Health Division of Managed Care
Phone #	+1 518 486 5821
Fax #	+1 518 391 9472
Email Address	elizabeth.vose@omh.ny.gov

TECHNICAL ADVISOR RESUMES

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***Mercer Health & Benefits LLC***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:		**Subcontractor:**	√

The following information requested pertains to the individual being proposed for this project.			
Name:	***Lois Simon***	**Key Personnel: (Yes/No)**	***No***
Individual's Title	***Medicaid Consultant / Principal Research Scientist /***		
# of Years in Classification:	***3***	**# of Years with Firm:**	***4***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Lois Simon, MHS, is a Principal Research Scientist in the Health Care Research Department at NORC. She has more than 25 years of experience in health policy and analysis, program development, implementation, and administration, and health care operations with a specific expertise in Medicaid and managed care. Ms. Simon has spent many years focusing on improving Medicaid program at both the managed care plan level and at the state level.

She is working on a number of projects currently underway at NORC related to the Medicaid program. She is the project director for Improving Oversight of Managed Care Quality in Medicaid and CHIP, a project supporting CMS' efforts to advance and improve the EQR process for monitoring and overseeing the quality of state Medicaid and CHIP managed care programs. She is also the project director for the Home and Community-Based Services (HCB) Settings Characteristics project, which is assisting CMS in the national implementation of new regulations to ensure that beneficiaries receiving HCBS live in settings that are home and community-based and that are integrated into the community. In addition, she serves as a senior advisor for NORC's project to support the CMS' Financial Alignment Demonstration.

Most recently, Ms. Simon was at MACPAC, where she was responsible for the Commission's research and analytic work on Medicaid managed care. Before joining MACPAC, she was the Director of the Bureau of Program Planning and Implementation in New York State's Office of Health Insurance Programs. In this position, she managed policy and implementation activities related to the state's federal Section 1115 demonstration waiver for the Medicaid managed care and Family Health Plus programs, which provided, at the time, health coverage for approximately three million New Yorkers. Overseeing a staff of 35, she managed efforts related to the implementation of strategies for expanding Medicaid managed care to new populations and service areas throughout the state. At EmblemHealth (formerly HIP Health Plan of New York), Ms. Simon's key responsibilities included the development, implementation and monitoring of the company's Corporate Compliance program, HIPAA privacy activities and

disaster recovery. She has a Masters of Health Sciences in Health Policy at the Johns Hopkins Bloomberg School of Public Health.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

Timeframe	October 2014 to Present
Company Name	NORC at the University of Chicago
Company Location	Bethesda, MD
Position	Project Director
Details of Project	Home and Community-Based Settings (HCBS) Characteristics Centers for Medicare and Medicaid Services (CMS). NORC is assisting CMS in CMS in the national implementation of new regulations to ensure that beneficiaries receiving home and community-based services live and work in settings that are home and community-based and that are integrated into the community. NORC is developing education and training for states, assuring state compliance with HCBS statue and regulation and performing data-collection and analysis. Responsibilities on the project include managing the project budget and day-to-day project activities and coordinating between CMS, and NORC's team of subcontractors and consultants.

Timeframe	April 2014 to Present
Company Name	NORC at the University of Chicago
Company Location	Bethesda, MD
Position	Project Director
Details of Project	Improving Over*sight of Managed Care Quality in Medicaid and CHIP.* For CMS' Center for Medicaid and CHIP Services (CMCS), NORC supports CMS' efforts to advance and improve the EQR process for monitoring and overseeing the quality of state Medicaid and CHIP managed care programs. NORC is developing, populating and maintaining both a data abstraction tool and a web-based relational database management system that will provide the means for analyzing the contents of state 2013-2014 EQR Technical Reports and creating profiles of each states' EQR activities. NORC will also provide analysis and recommendation on several specific substantive topics, and help CMCS better to understand MCOs' performance with regard to quality, access, and timeliness.

Timeframe	New York State Department of Health, Division of Managed Care, Office of Health Insurance Programs
Company Name	December 2014 to Present
Company Location	Albany, NY
Position	Senior Advisor
Details of Project	CMS' Financial Alignment Initiative Operation Support Contract. NORC supports CMS in implementing state Demonstration programs for individuals enrolled in both Medicare and Medicaid (MMEs). These demonstration programs are opportunities for states to test new approaches to providing integrated, high quality care to MMEs through managed fee-for-

	service (FFS) or capitated models of care. NORC conducts readiness reviews for participating states or health plans, monitors the states' and health plans' progress in implementing the Demonstrations, creates beneficiary materials and educates stakeholders about the Demonstrations, tracks and analyzes public comments about the Demonstrations, and assists CMS in general project management.

Timeframe	September 2010 – November 2013
Company Name	Medicaid and CHIP Payment and Access Commission
Company Location	Washington, DC
Position/Title	Director of Managed Care
Details of Project	Staff lead for MACPAC's Medicaid and CHIP analytic work on managed care issues and various other research and policy issues. Responsible for setting research agendas, scoping research tasks, reviewing and evaluating Medicaid and CHIP policies, programs, and proposed federal regulations, managing vendor contracts, and developing program and policy options for consideration by the Commission. Functioned as a primary author and presenter of ongoing policy and analytic work at public Commission meetings for MACPAC's annual March and June reports to the Congress. Led analytic work and staff efforts for the Commission's June 2011 Report to the Congress: The Evolution of Managed Care in Medicaid.

Timeframe	December 2007 – September 2010
Company Name	New York State Department of Health, Division of Managed Care, Office of Health Insurance Programs
Company Location	Albany, NY
Position	Director, Bureau of Program Planning and Implementation
Details of Project	Responsible for policy and program implementation activities related to the State's Medicaid Managed Care (MMC) and Family Health Plus (FHP) programs, which provide health coverage to more than three million New Yorkers. Managed staff and activities related to federal Section 1115 demonstration waiver programs that enable New York State to operate its Medicaid managed care program. Responsible for determining and setting policies on coverage and service requirements for MMC and FHP and implementing strategies for expanding the program to new populations and service areas throughout the State. Led the operations of local social services districts and the management of MMC/FHP managed care contracts, stop-loss program and retroactive disenrollment review process. Played a lead role on the NYS Partnership for Coverage initiative for expanding high quality, affordable health care to all New Yorkers.

Timeframe	June 1995 – June 1998
Company Name	The Commonwealth Fund
Company Location	New York, NY
Position	Program Officer

Details of Project	Responsible for the development and management of a grant-making portfolio of national projects related to Medicare, long-term care, women's health and academic health centers. Served as program staff to the Fund's Commission on Women's Health, Task Force on Academic Health Centers, and the Advisory Committee for the Picker/Commonwealth Program on Long-Term Care for Frail Elders and Program on Medicare's Future. Designed and analyzed population-based survey research.

Timeframe	June 1993 – June 1995
Company Name	Kaiser Commission on Medicaid and the Uninsured
Company Location	Washington, DC
Position	Policy Analyst
Details of Project	Conducted research and policy analysis on issues related to the role of Medicaid in providing health care to low-income populations. Prepared an in-depth review and synthesis of more than 20 years of literature on evaluating managed care's impact on access, quality, enrollee health status and the cost of care for the Medicaid population.

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

Johns Hopkins University, Bloomberg School of Public Health, Baltimore, MD, MHS, Health Policy, 1994
Emory University, Atlanta, GA, BA, Economics and Political Science, 1983

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

Not Applicable

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

Name	Michael Brea
Title	Government Task Lead
Organization	Center for Medicaid and CHIP Services, CMS
Phone #	+1 410 786 4961
Fax #	N/A
Email Address	Michael.Brea@cms.hhs.gov

Name	Rachel Garfield
Title	Senior Researcher
Organization	Kaiser Family Foundation
Phone #	+1 202 347 5270
Fax #	+1 202 347 5274

Email Address	RachelG@kff.org

Name	Barbara Dailey
Title	Deputy Director, Division of Quality and Health Outcomes
Organization	Center For Medicaid and CHIP Services, CMS
Phone #	+1 410 786 9012
Fax #	N/A
Email Address	Barbara.Dailey@cms.hhs.gov

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***Mercer Health & Benefits LLC***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:		**Subcontractor:**	√

The following information requested pertains to the individual being proposed for this project.			
Name:	***Gillian Lawrence***	**Key Personnel: (Yes/No)**	***No***
Individual's Title	***CAHPS Project Manager / Research Director II***		
# of Years in Classification:	***4***	**# of Years with Firm:**	***11***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Gillian Lawrence, M.P.H. is a Survey Director in the Health Sciences Department at NORC and has extensive experience managing large survey projects throughout their lifecycles. Lawrence has over 14 years of experience in research and survey management work. She recently served as project manager for the Sentinel Communities Health Values survey for the Robert Wood Johnson Foundation (RWJF), a mixed mode (web, mail, telephone) survey of health values. She is also managing the development of the Medicare Beneficiary Experience of Care Surveys (MBECS) on behalf of the Centers for Medicare and Medicaid Services' Office of Minority health. These surveys will explore the healthcare experiences of key minority groups enrolled in Medicare. Surveys will be fielded using a multi-mode (web, mail, and telephone) protocol. Lawrence previously served as Data Collection Lead for the National Children's Study (NCS) Central Regional Operations Center (ROC). The NCS involved multi-mode data collection including phone, mail, and in-person activities for participants spread across the central United States. In this role she oversaw all aspects of the data collection process including Information Management System (IMS) development and implementation, staffing planning, training, operational implementation, and production and progress reporting. Lawrence also maintains NORC's suite of CAHPS certifications. In addition to survey management work, works with NORC Web Survey team on innovations in web survey methodology and implementation strategies including corporate documentation and training. Lawrence earned her M.P.H. in Maternal and Child health from the University of Minnesota.

RELEVANT EXPERIENCE ***Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.***	
Timeframe	2017 to Present
Company Name	NORC at the University of Chicago
Company Location	Chicago, IL
Position	Survey Director II
Details of Project	**Medicare Beneficiary Experience of Care Survey.** This suite of surveys explores the healthcare experiences of key minority groups enrolled in Medicare. Surveys will be fielded using a multi-mode (web, mail, and telephone) protocol. NORC setting up this survey system on behalf of the Centers for Medicare and Medicaid Services' Office of Minority health and plans to field the first survey in late 2018. Role: Manage all aspects of this survey including preparing the work plan and project schedule, preparing the OMB submission package, and managing the data collection, data file preparation, and final client deliverables.

Timeframe	2016 -– 2017
Company Name	NORC at the University of Chicago
Company Location	Chicago, IL
Position	Survey Director II
Details of Project	**Sentinel Communities Health Values Survey**. ORC conducted this survey on behalf of the Robert Wood Johnson Foundation (RWJF) as part of their new Culture of Health (CoH) vision which embraced a broadly integrated and comprehensive approach to health where well-being lies at the center of every aspect of American life. This survey builds on the previously fielded American Health Values Survey (AHVS) which was a nationally-representative survey of American health values. The Sentinel Communities survey was conducted in five communities across the county to further test and refine the findings from the AHVS. Data are collected following a multi-mode protocol involving web, mail, and telephone modes of collection. Role: Lawrence served as project manager for data collection activities. In this role she oversaw questionnaire development, web, mail, and telephone (CATI) data collection activities, sample planning and release, data review, production monitoring, creation of final data files, and vendor management.

Timeframe	2016
Company Name	NORC at the University of Chicago
Company Location	Chicago, IL
Position/Title	Survey Director II
Details of Project	**STAR and STAR+PLUS Annual Report Card (ARC) and Member CAHPS surveys.** As the EQRO for Texas the Medicaid Program, the Institute for Child Health Policy (ICHP) at the University of Florida regularly evaluates the experiences of enrollees in the Texas Medicaid STAR and STAR+PLUS programs. For the 2016 Texas Medicaid STAR CAHPS surveys NORC conducted telephone interviews to collect information from Texas Medicaid beneficiaries on their experiences and satisfaction with their Medicaid health plans. The surveys collect information on members' experiences and satisfaction across four domains of care: 1) Access and timeliness of care 2) Patient-centered medical home 3) Care coordination and 4) Health plan information and customer service. The results of the survey will be used to make recommendations to the State of Texas and Texas Medicaid MCO for improving health care delivery and quality to Medicaid members. The recommendations will be translated into PIPs and other interventions designed to address gaps and inadequacies in care. Role: Served as project director including overseeing the project from inception through data delivery; oversaw CATI systems and questionnaire development, managed client relationship, supervised staff, coordinated with telephone operations staff, developed training materials and production tracking reports, produced final data sets and client reports.

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

University of Minnesota, Minneapolis, MN, BA Psychology, 2004
University of Minnesota, Minneapolis, MN, MPH, Maternal and Child Health 2007

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

Lawrence is NORC's CAHPS project manager and has been responsible for maintaining NORC's NCQA's HEDIS CAHPS approved vendor status since 2016. Most recently she attended HEDIS CAHPS Survey Vendor training on 10/11/2017.

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

Name	Christina Dragon
Title	Health Scientist
Organization	CMS Office of Minority Health
Phone #	+1 575 649 4144
Fax #	N/A
Email Address	Christina.Dragon@cms.hhs.gov

Name	Magali Jorand-Fletcher
Title	Research Coordinator III
Organization	University of Florida, College of Medicine, Health Outcomes and Biomedical Informatics
Phone #	+1 352 627 9142
Fax #	N/A
Email Address	magali20@ufl.edu

Name	Carolyn Miller
Title	Senior Program Officer, Research, Evaluation and Learning
Organization	Robert Wood Johnson Foundation
Phone #	+1 609 627 6257
Fax #	+1 609 419 8257
Email Address	cmiller@rwjf.org

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***Mercer Health & Benefits LLC***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:		**Subcontractor:**	√

The following information requested pertains to the individual being proposed for this project.			
Name:	***Scott Leitz***	**Key Personnel: (Yes/No)**	***No***
Individual's Title	***Medicaid Policy Expert / Senior Fellow***		
# of Years in Classification:	***2***	**# of Years with Firm:**	***2***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Scott Leitz, MN, MA is a senior fellow with the Health Care department at NORC, and is the former CEO of MNsure, the state-based health insurance marketplace serving the state of Minnesota. There he oversaw the enrollment of more than 500,000 Minnesotans in the MNsure program. Leitz focused his efforts on improving the customer experience, enhancing the functionality of the state's website, and expanding marketing strategies used to promote it. Immediately before joining NORC, Leitz worked with the Washington DC-based Health Care Cost Institute.

Prior to his role at MNsure, Leitz served as Assistant Commissioner at the Minnesota Department of Human Services, where he oversaw the state's $10 billion Medicaid program. Earlier he served as Assistant Commissioner for Health Policy at the Minnesota Department of Health where he held major responsibility for development and passage of Minnesota's landmark 2008 health care reform law, which pre-dated passage of the Affordable Care Act.

Leitz also served for six years as Minnesota's State Health Economist. Leitz has a Master's Degree from the Humphrey School of Public Affairs at the University of Minnesota and a Bachelor's Degree in Economics and Mathematics from the University of Wisconsin-Eau Claire.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

Timeframe	June 2016 to Present
Company Name	NORC at the University of Chicago
Company Location	Chicago, IL
Position/Title	Senior Fellow
Details of Project	Responsible for providing expert leadership for the NORC health care department with particular emphasis on state health care policy. Brought program expertise in Medicaid, state health care exchanges, health care data analytics, cost and quality measurement, payment reform, and service costs. Helped NORC position itself relative to the evolving roles of commercial entities, federal and state government, and other stakeholders in cost, quality and delivery of health care services. Oversees a portfolio of work focused on improving the health outcomes of state populations, including through improved health care purchasing models through Medicaid and statewide health improvement efforts, through the CMS State Innovation Model program. In first three months of employment, successfully organized, authored and lead team that won $7 million contract to assist the Centers for Medicaid and Medicare Services expand alternative payment models, such as ACOs, to state Medicaid programs. Responsible for leading and coordinating NORC's efforts to respond to and position itself in the changing health care landscape in light of past and ongoing political and policy environment changes.

Timeframe	June 2015 – May 2016
Company Name	Health Care Cost Institute
Company Location	Washington, DC
Position/Title	Vice President and Chief Transformation Officer
Details of Project	Responsible for strategic vision and implementation of HCCI's efforts on health care price and quality transparency. Responsible for establishing, developing and maintaining stakeholder relationships to ensure HCCI's unique data resource of 13 billion commercial insurance claims is used to inform and develop health policy at the state and national level. Developing the organizational structure, vendor relationships, staffing and work plan to deliver health care price and quality information through the establishment and refinement of www.guroo.com. Establishing and maintaining relationships with key state, federal, employer, and health care delivery stakeholders to ensure effective use of HCCI's data assets. Working with HCCI and academic research teams to ensure data and information produced by HCCI is effectively translated to policymakers and stakeholders. Working with state Medicaid programs and other state entities to develop opportunities to use HCCI information as effective state and regional quality and utilization benchmarks. Plan and gain acceptance for a cross-state research consortium to allow for comparable

	analysis on key drivers of health care cost and utilization using All-Payer Claims Databases.

Timeframe	December 2013 – May 2015
Company Name	MNSure: Minnesota's Health Insurance Exchange
Company Location	St. Paul, MN
Position	Chief Executive Officer
Details of Project	Responsible for providing vision, strategic direction, and oversight for Minnesota's health insurance on-line marketplace, MNsure. Establish strong relationships with MNsure's governing board, legislative leadership, key stakeholder groups, advocacy organizations, and consumers. Accomplishments and Responsibilities included: Setting a strong strategic vision for MNsure, including future growth pathways, current improvement strategies, and communication and marketing strategies. Working closely and actively with the Board of Directors to ensure MNsure is positioned for future growth from both an infrastructure as well as budget perspective. Re-establishing broad stakeholder trust and communications upon being hired; Dramatically improving customer experience and website functionality, as well as creating an environment of trust and communication with Minnesotans. Restructuring staff and organizing and recruiting key leadership roles to bring greater stability and management flow to MNsure. Enrolling over 500,000 Minnesotans into comprehensive, affordable health coverage.

Timeframe	January 2011 – December 2013
Company Name	Minnesota Department of Human Services
Company Location	St. Paul, MN
Position	Assistant Commissioner
Details of Project	Responsible for providing vision, strategic direction, and oversight for Minnesota's health insurance on-line marketplace, MNsure. Establish strong relationships with MNsure's governing board, legislative leadership, key stakeholder groups, advocacy organizations, and consumers. Accomplishments and Responsibilities included: Setting a strong strategic vision for MNsure, including future growth pathways, current improvement strategies, and communication and marketing strategies. Working closely and actively with the Board of Directors to ensure MNsure is positioned for future growth from both an infrastructure as well as budget perspective. Re-establishing broad stakeholder trust and communications upon being hired; Dramatically improving customer experience and website functionality, as well as creating an environment of trust and communication with Minnesotans. Restructuring staff and organizing and recruiting key leadership roles to bring greater

	stability and management flow to MNsure. Enrolling over 500,000 Minnesotans into comprehensive, affordable health coverage.

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

University of Minnesota, Humphrey Institute of Public Affairs, Minneapolis, MN, MA, Public Affairs, with a concentration in Policy Analysis and Quantitative Methods, 1993
University of Wisconsin, Eau Claire, Eau Claire, WI, BS, Economics, 1988

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

Not Applicable

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

Name	Negussie Tilahun
Title	Social Scientist
Organization	U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services
Phone #	+1 410 786 2058
Fax #	N/A
Email Address	Negussie.tilahun@cms.hhs.gov

Name	Jan Malcolm
Title	Commissioner of Health
Organization	Minnesota Department of Health
Phone #	+1 651 201 5000
Fax #	N/A
Email Address	Jan.malcolm@state.mn.us

Name	Karen Llanos
Title	Director, Medicaid Innovation Accelerator Program
Organization	U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services
Phone #	+1 410 786 9071
Fax #	N/A
Email Address	Karen.Llanos@cms.hhs.gov

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***Mercer Health & Benefits LLC***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	√	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Nicole Kaufman, JD, LL.M***	**Key Personnel: (Yes/No)**	***No***
Individual's Title	***Technical Advisor – Policy / Senior Associate***		
# of Years in Classification:	***8***	**# of Years with Firm:**	***2***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Nicole is a Senior Associate in Mercer's Government Human Services Consulting Policy and Operations Sector, a part of Mercer Health & Benefits LLC (Mercer) in the Phoenix office. As a former Technical Director for Medicaid Managed Care Policy and Health Insurance Specialist for section 1115 demonstration programs for the Centers or Medicare & Medicaid Services (CMS), she has a unique understanding of the federal legal and policy framework for Medicaid managed care and delivery system reform design.

Nicole's core competencies include Medicaid laws and regulation; Medicaid managed care rate setting and payment policies; Medicaid state plan and waiver authorities.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

Timeframe	2017 to Present
Company Name	Mercer Health & Benefits LLC
Company Location	Phoenix, AZ
Position	Senior Associate
Details of Project	Assisting several clients and Mercer client teams in reviewing and modifying managed care contracts and policies for compliance with the quality-related aspects of the Medicaid Managed Care Final Rule.

Timeframe	2014 – 2016
Company Name	Centers for Medicare and Medicaid Services (CMS)
Company Location	Baltimore, MD
Position/Title	Technical Director for Medicaid Managed Care Policy

Details of Project	Primary author and project manager for CMS' Medicaid Managed Care Proposed Rule (2015) and Final Rule (2016).

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

Saint Louis University School of Law, Saint Louis, MO, Master of Laws (LL.M) in Health Law, May 2008
Southern Illinois University School of Law, Carbondale, IL, Juris Doctor (JD), May 2007
University of Illinois, Urbana-Champaign, IL, Bachelor of Arts in History and Political Science, May 2003

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

Not applicable

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

Name	Camille Dobson
Title	Deputy Executive Director
Organization	NASUAD
Phone #	+1 202 304 0336
Fax #	N/A
Email Address	cdobson@nasuad.org

Name	Debbie Anderson
Title	Deputy Division Director, Division of Managed Care Plans
Organization	Center for Medicaid and Medicare Services (CMS)
Phone #	+1 410 786 5545
Fax #	N/A
Email Address	debbie.anderson@cms.hhs.gov

Name	James (Jim) Golden
Title	Division Director, Division of Managed Care Plans
Organization	Center for Medicaid and Medicare Services (CMS)
Phone #	+1 410 786 7111
Fax #	N/A
Email Address	james.golden@cms.hhs.gov

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***Mercer Health & Benefits LLC***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	√	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Laura K. Nelson, MD***	**Key Personnel: (Yes/No)**	***No***
Individual's Title	***Technical Advisor – Behavioral Health / Principal***		
# of Years in Classification:	***21***	**# of Years with Firm:**	***5.5***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Laura is a Principal within Mercer's Government Human Services Consulting group, a part of Mercer Health & Benefits LLC (Mercer) in the Phoenix office. Laura brings extensive Medicaid managed care clinical and administrative expertise to the Mercer team in the areas of mental health (MH), substance use disorders (SUD), and intellectual/developmental disabilities (I/DD). Laura is a board-certified psychiatrist with experience ranging from direct care within inpatient and outpatient settings to state-level executive leadership positions in public health, behavioral health, and I/DD.

Laura's core competencies include serious mental illness; substance use disorders, including medication assisted treatment; Intellectual/developmental disabilities; state behavioral health systems; managed care, including procurement, program implementation, readiness reviews, and ongoing monitoring.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

Timeframe	2013 to Present
Company Name	Mercer Health & Benefits LLC
Company Location	Phoenix, AZ
Position/Title	Principal
Details of Project	Commonwealth of Pennsylvania, Department of Hunan Services, Office of Mental Health and Substance Abuse Services: The goal is to provide a comprehensive and fair assessment of each Medicaid managed care county-based primary contractor's (PCs) and sub-contracted Behavioral Health Managed Care Organization's (BH-MCOs) level of compliance with the BBA of 1997 regulations, contractual requirements, and specific standards of care. Laura currently leads the onsite review component of these triennial

	reviews in Pennsylvania, which entails interviews with PC and BH-MCO executive leadership, clinical leadership and supervisors, and direct-line utilization/care management and member services staff. Laura also participated in the care management record review component, which uses a standardized tool. Laura serves as the gold standard for inter-rater reliability testing. These reviews evaluate strengths-based assessments, individualized treatment planning, medical necessity, care coordination, and planning for transition/discharge to lower levels of care. This current review cycle focuses on children with autism spectrum disorder, adolescents in residential treatment facilities, and adults with opioid use disorder. Delaware Health and Social Services, Division of Substance Abuse and Mental Health: As part of comprehensive claims review training for State staff developing audit protocols, Laura recently supported development and implementation of a medical record review of Assertive Community Treatment (ACT) services in Delaware. The review focused on medical necessity for ACT level of care and assessment of provision of services consistent with best practices and fidelity to the model. Medical necessity was reviewed in relation to the approved plan of care, provider treatment plan, and associated medical record documentation. Findings and recommendations were summarized and shared with the State. New York State Office of Mental Health: Laura is currently supporting the readiness review component for New York State to redesign and implement managed care for children/youth. This redesign includes merging six HCBS 1915(c) waivers under an 1115 waiver authority, including: an Office for People with Developmental Disabilities (OPWDD) Care at Home (CAH) waiver, Department of Health Care at Home (CAH) I/II waiver, Office of Children and Families (OCFS) Bridges to Health (B2H) SED, Developmental Disability (DD) and Medically Fragile waivers, and the Office of Mental Health (OMH) Serious Emotional Disturbance (SED) waiver. Activities include: • Drafting contract standards and requirements and evaluation criteria • Training State staff to participate in readiness review activities • Participating in desk review and onsite reviews with 17 health plans Laura also supported the Mercer team in drafting a request for qualification and evaluation criteria to quality existing NYS Health Plans to administer behavioral health services for adults, including Plans interested in developing a separate Health and Recovery Plan (HARP) line of business to administer integrated physical health, behavioral health, and HCBS for adults with SMI and SUD. Laura participated on the Mercer team of clinical, member services, network, QM, information systems, claims, and finance SMEs to evaluate readiness review desk materials from 10 New York City Plans and 13 Plans outside of New York City. Laura was involved with development of a comprehensive desk review request and evaluation criteria, facilitation of consensus meetings with the State, documentation of findings, and development of the onsite interview guide. She co-led clinical/program track onsite readiness reviews and drafted Plan specific reports of findings and recommendations

Timeframe	April 2008 to August 2012
Company Name	Arizona Department of Health Services (ADHS)
Company Location	Phoenix, AZ
Position	Deputy Director, Division of Behavioral Health Services (DBHS)
Details of Project	As the executive leader of Arizona's public behavioral health system, serving as both the Single State Agency (SSA) Director for Substance Abuse Services and for Mental Health Services, responsible for: • The Medicaid managed care carve-out program for substance abuse and mental health services. • The allocation and oversight of an annual budget of approximately $1.4 billion inclusive of Medicaid, Federal Grants (e.g. SAPT, CMHS, PATH, DIG, and DASIS) and discretionary grants, state General Fund appropriations and city/county Intergovernmental Agreements. • Providing comprehensive community-based services to a diverse population of children and adults in rural and urban communities; currently serving approximately 160,000 individuals statewide, including 52,000 children/adolescents, 21,000 adults with substance abuse conditions, 34,000 adults with serious mental illness, and 52,000 adults with general mental health conditions. • Partnering with local community coalitions and other stakeholders to strengthen Arizona's prevention infrastructure and outcomes related to tobacco, alcohol, and other substance abuse prevention, suicide prevention, and mental health promotion. • Serving as a voting member of the Arizona Substance Abuse Partnership (ASAP), which was established in 2007 via Executive Order to serve as the single statewide council on substance abuse issues. ASAP brings together stakeholders at the federal, state, tribal and local levels to improve coordination across state agencies; address identified gaps in prevention, treatment, recovery, and enforcement efforts; and improve funding allocation. ASAP utilizes data to develop effective methods for integrating and expanding services across Arizona, maximizing available resources. ASAP also studies current policy and recommends relevant legislation for the Arizona Legislature's consideration. • Maintaining a positive relationship with community stakeholders that welcomes input, feedback, and collaborative, solution-focused dialogue. This includes regular meetings with the (a) Pacific Southwest Addiction Technology Transfer Center (ATTC), (b) the Arizona Council of Human Service Providers, a 40-year-old, member driven, not-for-profit association of human service organizations that provide public and private sector services in the mental health, substance abuse, child welfare, prevention and court systems, and (c) Arizona's numerous peer and family-run organizations and advocacy groups. • Strategic leadership for behavioral health-physical health integration activities, including current development of a solicitation that will fully integrate mental health, substance abuse and physical health care services for Medicaid-eligible adults with serious mental illness in Maricopa County. The solicitation will integrate funding at the administrative level and will require the successful bidder to also be a Medicare Special Needs Plan to

	better serve dual eligible members. • Oversight of contract development, implementation and monitoring; quality assurance and performance monitoring; medical management and care management; grievance, appeal, and claim dispute management; policy development; financial oversight and actuarially sound capitation rate development. • Strategic and performance oversight of ADHS' responsibilities in two Arizona class action lawsuits: Arnold v. Sarn, in which class members include all individuals with Serious Mental Illness in Maricopa County, and Jason K., in which class members include all enrolled TXIX members under the age of 21. • Oversight of the Arizona State Hospital, which treats civilly committed, forensic, and sexually violent patients. • Leading a staff of approximately 970 individuals, including 800 state hospital employees

Timeframe	July 2010 to August 2012
Company Name	Arizona Department of Health Services (ADHS)
Company Location	Phoenix, AZ
Position/Title	Chief Medical Officer
Details of Project	As the executive-level clinical leader for the Arizona Department of Health Services (ADHS), responsible for: • Leading ADHS efforts to integrate public physical healthcare with behavioral healthcare prevention, screening, evaluation, and treatment. Examples include fostering partnership opportunities within the agency to collaborate on activities related to (a) Recovery Month (b) tobacco cessation (c) chronic disease self-management (d) Project LAUNCH and home visiting grants, and (e) Quarterly Health Initiatives that educate individuals with mental health or substance abuse conditions and their providers about common physical health conditions. • Identifying opportunities to positively impact overall health and wellness of Arizonans through focused and strategic efforts that bring public health preparedness and prevention together with behavioral health prevention and treatment. • Leading ADHS efforts to plan for and implement the Patient Protection and Affordable Care Act (ACA; Health Care Reform). • Leading the ADHS Medical Advisory Board, which includes the multidisciplinary ADHS medical staff responsible for advising the Director on clinical and medical policy issues related to public health prevention, public health preparedness, medical marijuana, vital records and statistics, behavioral health, special health care needs for children, licensing, clinical laboratory, and state hospital care. • Coordinating ADHS medical responses with the Governor's Office, the Legislature, the Media, and other external entities.

Timeframe	Jan 2006 to May 2007; August 2007 to April 2008
Company Name	Arizona Department of Health Services (ADHS), Department of Behavioral Health Services (DBHS)
Company Location	Phoenix, AZ
Position/Title	Chief Medical Officer
Details of Project	As the executive-level clinical leader for the Division of Behavioral Health Services (ADHS/DBHS), responsible for: • Providing medical and clinical leadership for statewide, contracted, Regional Behavioral Health Authorities (RBHAs) and Tribal Regional Behavioral Health Authorities (TRBHAs). • Providing medical and clinical leadership for all quality management and medical management activities, including morbidity and mortality reviews, Quality of Care reviews, Peer Review, and Pharmacy and Therapeutics functions • Review and approval of Preadmission Screening and Resident Review (PASRR) to ensure that individuals are not inappropriately placed in nursing homes for long-term care. • Providing medical and clinical leadership in contract and policy development. • Providing medical and clinical leadership of ADHS' responsibilities in two Arizona class action lawsuits: Arnold v. Sarn, in which class members include all individuals with Serious Mental Illness in Maricopa County, and Jason K., in which class members include all enrolled TXIX members under the age of 21.

Timeframe	September 2005-January 2006
Company Name	Arizona Department of Health Services (ADHS), Department of Behavioral Health Services (DBHS)
Company Location	Phoenix, AZ
Position/Title	Associate Medical Director
Details of Project	As a supportive clinical leader for the Division of Behavioral Health Services (ADHS/DBHS), responsible for assisting the ADHS/DBHS Chief Medical Officer with the functions noted above and serving as back-up when the Chief Medical Officer is unavailable.

Timeframe	May 2007-Aug 2007
Company Name	Schaller Anderson, Inc
Company Location	Phoenix, AZ
Position/Title	Senior Medical Director
Details of Project	In this newly established position identified as Senior Medical Director for the Integration Solutions Unit, responsible for: • Strategic leadership and development of a Behavioral Health/Physical Health Integration model to enhance collaboration and integration of healthcare services across all Schaller Anderson contracted lines of business. • Development of a methodology for return on investment related to integrated services. • Development of a training curriculum for health plan care managers to enhance pharmacy adherence.

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

Banner University Medical Center, Phoenix, Arizona, Internship and Psychiatric Residency, (1998)
Medical University of South Carolina, Charleston, South Carolina, Doctorate of Medicine, (1994)
Middlebury College, Middlebury, Vermont, Bachelor of Arts degree in Biology, Magna Cum Laude, (1990)

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

Medical License, Arizona, (1996 to present)
Board Certified, American Board of Psychiatry and Neurology, (2000 to present)
Physician waiver for buprenorphine, American Society of Addiction Medicine, (2006)

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

Name	Kellie Wayda, MSW, LSW
Title	Director, Western Operations
Organization	Commonwealth of Pennsylvania, Department of Human Services, Office of Mental Health and Substance Abuse Services
Phone #	+1 717 772 7471
Fax #	+1 717 705 8386
Email Address	kwayda@pa.gov

Name	Karen Records, MA
Title	Director, Contracts Unit
Organization	Delaware Health and Social Services, Division of Substance Abuse and Mental Health
Phone #	+1 302 255 9430
Fax #	+1 302 255 4428
Email Address	karen.records@state.de.us

Name	Elizabeth Vose
Title	Director of Bureau of Implementation and Oversight
Organization	New York State Office of Mental Health
Phone #	+1 518 486 5821
Fax #	N/A
Email Address	Elizabeth.Vose@omh.ny.gov

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***Mercer Health & Benefits LLC***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	√	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Cindy Ward, RN, MBA, LHRM***	**Key Personnel: (Yes/No)**	***No***
Individual's Title	***Technical Advisor, ABD populations and FFS delivery model / Principal***		
# of Years in Classification:	***22***	**# of Years with Firm:**	***5***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Cindy is a Principal within Mercer's Government Human Services Consulting group, a part of Mercer Health & Benefits LLC (Mercer) in the Phoenix office. Cindy brings extensive Medicaid healthcare quality experience to the Mercer team. She is a registered nurse with clinical proficiency in both physical and behavioral health settings, professional in healthcare quality improvement. Her experience and understanding of integrated physical and behavioral health service in managed care models provides a unique and invaluable level of expertise. In addition, she holds a MBA which ensures focus and sensitivity to fiscal and utilization risk issues for her clients.

Cindy's core competencies include: Clinical quality and external review, population health management, integrated care coordination models, value based purchasing, managed care operational oversight and clinical health analytics.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

Timeframe	May 2012 to Present
Company Name	Mercer Government Consulting
Company Location	Phoenix, Arizona
Position/Title	Principal Consultant, Clinical and Behavioral Solutions
Details of Project	Delaware: Serve as clinical lead for EQR activities focused on clinical file review, care coordination compliance, and PIP evaluation. Provided detailed series of technical assistance sessions to State's contracted MCOs regarding PIP development, rapid cycle improvement techniques and PIP evaluations. Assisted State in redesigning care coordination model to improve population health outcomes and address social

	determinants. Connecticut Integrated Care Coordination Shared Savings Model: Design state integrated care coordination model within a Shared Savings program including program clinical design and quality measure identification and development. Commonwealth of Pennsylvania Managed Care Organization Operational and Clinical Efficiency Reviews: led Clinical and Clinical Operations reviews including clinical file review and coordination with Pharmacy review team.

Timeframe	June 2011 – April 2012
Company Name	Amerigroup Corporation
Company Location	Tampa, Florida
Position	Quality Improvement Manager
Details of Project	Quality improvement lead for Medicaid managed care plan managing acute care, behavioral and long term care beneficiary benefits. Led accreditation and provider certification processes and clinical quality improvement activities.

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

Kennesaw State University, Kennesaw, Georgia, Master Business Administration (MBA), May 2010
Georgia Southern University, Statesboro, Georgia, Bachelor Science in Nursing (BSN), May 2005
Armstrong Atlantic State University, Savannah, Georgia, Associate of Science in Nursing (ASN), June 1995

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

Six Sigma Green Belt Certification, March 2010
Licensed Registered Nurse, Georgia since July 1995
Licensed Registered Nurse, Florida since October 2011

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

Name	Kathleen Dougherty
Title	Chief, Managed Care Operations
Organization	Delaware Division of Medicaid & Medical Assistance
Phone #	+1 302 255 9937
Fax #	+1 302 255 9529
Email Address	kathleen.dougherty@state.de.us

Name	Dr. Robert Zavoski

Title	Medicaid Medical Director State of Connecticut Department of Social Services
Organization	State of Connecticut Department of Social Services
Phone #	+1 860 424 5583
Fax #	N/A
Email Address	Robert.Zavoski@ct.gov

Name	Laurie Rock
Title	Director, Bureau of Managed Care Operations
Organization	Commonwealth of Pennsylvania Office of Medical Assistance Programs
Phone #	+1 717 772 6197
Fax #	+1 717 772 6328
Email Address	lrock@pa.gov

PROPOSED STAFF RESUME FOR RFP 3491

A resume must be completed for all proposed prime contractor staff and proposed subcontractor staff.

Company Name Submitting Proposal:	***Mercer Health & Benefits LLC***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:		**Subcontractor:**	√

The following information requested pertains to the individual being proposed for this project.			
Name:	***Lisa Knowles DDS***	**Key Personnel: (Yes/No)**	***No***
Individual's Title	***Technical Advisor / Dental***		
# of Years in Classification:	***19***	**# of Years with Firm:**	***1***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Dr. Knowles graduated from the University of Michigan school of dentistry and then completed a one-year general practice residency at the Veterans Affairs Medical center in Ann Arbor, Michigan. Since then, she has worked in a variety of work settings including owner of two private practices and working for other organizations as an associate. Most recently, she as an associate for My Community Dental Centers, a DSO based organization that serves a predominantly Medicaid based population. She serves on the Michigan Dental Association's (MDA) board of trustees, as well as the Points of Light Committee, the Finance Committee, and the Health & Well-Being Committee. She meets regularly with legislators for the MDA to help network and influence key points. Dr. Knowles speaks and writes nationally for her consulting business, Intentional Dental Consulting. She is a thought leader in her profession and is known for providing creative business solutions for leaders in practice. Her background in communications at Alma College proves most helpful in negotiating win-win solutions and providing colleagues better strategies for success.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

Timeframe	1998 to Present
Company Name	Lisa L. Knowles DDS, P.C., and Haslett East Lansing Dental Health & Wellness
Company Location	2024 Lansing Rd, Charlotte, Michigan, 1451 East Lansing Dr. East Lansing Dr. East Lasing and multiple other locations as an associate dentist in my tenure
Position/Title	Dentist, C.E.O
Details of Project	Provided insight and guidance to two small businesses. One as a take-over practice and one as a start-up business

Timeframe	2014 to Present

Company Name	Intentional Dental Consulting
Company Location	1451 East Lansing Dr. Suite 221, East Lansing, MI 48823
Position	C.E.O.
Details of Project	Dental consulting that predominately entails speaking, writing and consulting for the dental profession. Thought leader in industry and frequent writer for dental trade journals such as Dental Economics, and Dr.Bicuspid.com.

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

University of Michigan, Ann Arbor, Michigan, Doctor of Dental Surgery, May 1998
Alma College, Alma, Michigan, Bachelor of Arts in Communication with a Minor in Biochemistry, April 1994

CERTIFICATIONS

Information required should include: type of certification and date completed/received.

North East Regional Board (NERB) in Dentistry, Michigan Dental Board, 1998
Certified CE Instructor: State of Michigan Dental Board, 2015 (current)

REFERENCES

A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.

Name	Dr. Beth Ann Faber
Title	Dentist and Business Owner
Organization	N/A
Phone #	+1 517 285 8714
Fax #	N/A
Email Address	faberhenry@comcast.net

Name	Ms. Karen Burgess
Title	Executive Director
Organization	Michigan Dental Association
Phone #	+1 517 331 5885
Fax #	N/A
Email Address	kburgess@MichiganDental.org

Name	Dr. David Murphy
Title	Corporate Relations
Organization	My Community Dental Centers
Phone #	+1 269 217 8485
Fax #	N/A
Email Address	N/A

VIII

SECTION VIII – OTHER INFORMATIONAL MATERIAL

Mercer provides the following listed other information material within the section starting on the next page:

- ***Mercer Health & Benefits LLC Annual Report***
- ***Comparative Report Example***
- ***Sample of an EQR project timeline***

Mercer is a wholly-owned subsidiary of Marsh & McLennan Companies. A separate financial audit is not performed and reported on Mercer LLC (global corporation), Mercer (US) Inc., or Mercer Health & Benefits LLC individually. Instead, all operations are reported in the consolidated statements of Marsh & McLennan Companies.

Marsh & McLennan Companies is a public company traded on stock exchanges around the world with 2015 revenue of approximately $13 billion (2015 Annual Report, page 1). The Consolidated Statements of Income is provided on page 47 and the Consolidated Balance Sheet is provided on page 49 of the March & McLennan Companies 2015 Annual Report.

Mercer's 2015 Annual Report is available at http://irnews.mmc.com/phoenix.zhtml?c=113872&p=irol-reportsAnnual Annual Report includes three years (2013, 2014, and 2015) of financial information.

Specific information on Mercer is provided within the report as noted below.

- Mercer generated approximately 33% of the Company's total revenue in 2015. (2015 Annual Report, Introduction, page 5).
- Mercer's underlying revenue growth of 4% was strong and marked the fifth consecutive year of growth of 3% or higher. (2015 Annual Report, Introduction, page 3)
- Mercer's revenue was over $4.31 billion in 2015. (2015 Annual Report, page 28).
- Mercer's Health and Benefits LLC line of business increased 6% in 2015 and accounted for almost $1.56 billion of Mercer's total revenue. (2015 Annual Report, page 29).

MARSH & McLENNAN COMPANIES, INC. AND SUBSIDIARIES
CONSOLIDATED BALANCE SHEETS

December 31, *(In millions, except share figures)*	2016	2015
ASSETS		
Current assets:		
Cash and cash equivalents	$ 1,026	$ 1,374
Receivables		
Commissions and fees	3,370	3,198
Advanced premiums and claims	83	51
Other	286	309
	3,739	3,558
Less-allowance for doubtful accounts and cancellations	(96)	(87)
Net receivables	3,643	3,471
Other current assets	215	199
Total current assets	4,884	5,044
Goodwill	8,369	7,889
Other intangible assets	1,126	1,036
Fixed assets, net	725	773
Pension related assets	776	1,159
Deferred tax assets	1,097	1,138
Other assets	1,213	1,177
	$ 18,190	$ 18,216
LIABILITIES AND EQUITY		
Current liabilities:		
Short-term debt	$ 312	$ 12
Accounts payable and accrued liabilities	1,969	1,886
Accrued compensation and employee benefits	1,655	1,656
Accrued income taxes	146	154
Total current liabilities	4,082	3,708
Fiduciary liabilities	4,241	4,146
Less – cash and investments held in a fiduciary capacity	(4,241)	(4,146)
	—	—
Long-term debt	4,495	4,402
Pension, postretirement and postemployment benefits	2,076	2,058
Liability for errors and omissions	308	318
Other liabilities	957	1,128
Commitments and contingencies	—	—
Equity:		
Preferred stock, $1 par value, authorized 6,000,000 shares, none issued	—	—
Common stock, $1 par value, authorized		
1,600,000,000 shares, issued 560,641,640 shares at December 31, 2016 and December 31, 2015	561	561
Additional paid-in capital	842	861
Retained earnings	12,388	11,302
Accumulated other comprehensive loss	(5,093)	(4,220)
Non-controlling interests	80	89
	8,778	8,593
Less – treasury shares, at cost, 46,150,415 shares at December 31, 2016 and 38,743,686 shares at December 31, 2015	(2,506)	(1,991)
Total equity	6,272	6,602
	$ 18,190	$ 18,216

The accompanying notes are an integral part of these consolidated statements.

Item 6. Selected Financial Data.

Marsh & McLennan Companies, Inc. and Subsidiaries
FIVE-YEAR STATISTICAL SUMMARY OF OPERATIONS

For the Years Ended December 31, *(In millions, except per share figures)*	2016	2015	2014	2013	2012
Revenue	$ 13,211	$ 12,893	$ 12,951	$ 12,261	$ 11,924
Expense:					
Compensation and Benefits	7,461	7,334	7,515	7,226	7,134
Other Operating Expenses	3,086	3,140	3,135	2,958	2,961
Operating Expenses	10,547	10,474	10,650	10,184	10,095
Operating Income [a]	2,664	2,419	2,301	2,077	1,829
Interest Income	5	13	21	18	24
Interest Expense	(189)	(163)	(165)	(167)	(181)
Cost of Extinguishment of Debt	—	—	(137)	(24)	—
Investment Income	—	38	37	69	24
Income Before Income Taxes	2,480	2,307	2,057	1,973	1,696
Income Tax Expense	685	671	586	594	492
Income From Continuing Operations	1,795	1,636	1,471	1,379	1,204
Discontinued Operations, Net of Tax	—	—	26	6	(3)
Net Income Before Non-Controlling Interests	1,795	1,636	1,497	1,385	1,201
Less: Net Income Attributable to Non-Controlling Interests	27	37	32	28	25
Net Income Attributable to the Company	$ 1,768	$ 1,599	$ 1,465	$ 1,357	$ 1,176
Basic Net Income Per Share Information:					
Income From Continuing Operations	$ 3.41	$ 3.01	$ 2.64	$ 2.46	$ 2.16
Income From Discontinued Operations	—	—	0.05	0.01	—
Net Income Attributable to the Company	$ 3.41	$ 3.01	$ 2.69	$ 2.47	$ 2.16
Average Number of Shares Outstanding	519	531	545	549	544
Diluted Income Per Share Information:					
Income From Continuing Operations	$ 3.38	$ 2.98	$ 2.61	$ 2.42	$ 2.13
Discontinued Operations, net of tax per share	—	—	0.04	0.01	—
Net Income Attributable to the Company	$ 3.38	$ 2.98	$ 2.65	$ 2.43	$ 2.13
Average Number of Shares Outstanding	524	536	553	558	552
Dividends Paid Per Share	$ 1.30	$ 1.18	$ 1.06	$ 0.96	$ 0.90
Return on Average Equity	27 %	23 %	19 %	19 %	19 %
Year-end Financial Position:					
Working capital	$ 802	$ 1,336	$ 1,856	$ 2,027	$ 2,007
Total assets	$ 18,190	$ 18,216	$ 17,793	$ 16,960	$ 16,274
Long-term debt	$ 4,495	$ 4,402	$ 3,368	$ 2,619	$ 2,657
Total equity	$ 6,272	$ 6,602	$ 7,133	$ 7,975	$ 6,606
Total shares outstanding (net of treasury shares)	514	522	540	547	545
Other Information:					
Number of employees	60,000	60,000	57,000	55,000	54,000
Stock price ranges—					
U.S. exchanges — High	$ 69.77	$ 59.99	$ 58.74	$ 48.56	$ 35.78
— Low	$ 50.81	$ 50.90	$ 44.25	$ 34.43	$ 30.69

(a) Includes the impact of net restructuring costs of $44 million, $28 million, $12 million, $22 million and $78 million in 2016, 2015, 2014, 2013 and 2012, respectively.

See "Management's Discussion and Analysis of Financial Condition and Results of Operations", appearing under Part II, Item 7 of this report, for discussion of significant items affecting the results of operations in 2016, 2015 and 2014.

Mercer provides the following Comparative Report Example as referenced in 2.1.3.1.

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2016 MEDICAID MANAGED CARE COMPARISON

FOR INTERNAL USE ONLY

STATE, AGENCY

DECEMBER 28, 2016

SAMPLE

MARSH & McLENNAN COMPANIES

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EXAMPLE

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Executive Summary

The STATE (State) contracts Mercer Government Human Services Consulting (Mercer) to conduct a regulatory external quality review of their two Medicaid managed care organizations (MCOs) to ensure compliance with federal and State regulations. This process includes evaluating compliance and alignment with statewide goals for MCO's internal policies and procedures (P&Ps). In fulfillment of the contract's scope of work, this report provides the state's AGENCY (AGENCY) with a comparative summary incorporating the results of the annual external quality review organization's (EQRO) technical report. That report relies on 2015 and 2016 Healthcare Effectiveness Data and Information Set (HEDIS) performance measures and other state- and federally-selected measures from respective Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey responses. In 2015, two MCOs provided contracted services for Medicaid: MCO A (MCO A) and MCO B (MCO B).

Mercer consulted with AGENCY to identify performance-target ranges and benchmarks for each of the three sections of this document. These standards and definitions are reflected at the beginning of each section of the report. The format provides a dashboard-like visualization of how these MCOs perform in areas of interest. This report identifies high performance areas as well as areas requiring additional monitoring or MCO action. For more detail about results contained in this report, please refer to the corresponding annual EQRO technical report, the STATE Quality Management Strategy (QMS) and the Quality Care Management Monitoring report (QCMMR).

MCO A

STRENGTHS

- MCO A has taken the direction of AGENCY and the technical assistance provided throughout the first year of operation, and worked to move its processes and procedures from foundational to well-developed, with an emphasis on continuous quality improvement. The MCO is following the spirit of the contract, not just the detailed contract requirements.
- MCO A has developed strong relationships with its corporate partners. Teams have understanding of the contract expectations and are at the table sharing responsibility for the membership, with MCO A having clear final accountability for member and provider experiences and outcomes. This was evidenced when:

EXAMPLE

- Upon realizing there were challenges with utilization management (UM) decisions, particularly for the PROGRAM LTSS population, MCO A has been working to transition some UM responsibilities from the Gateway facility in Pittsburgh to in-house at the MCO A Wilmington facility.
- Attempting to facilitate strong resource coordination and clinical care coordination activities with members led MCO A to develop an innovative approach to embed care coordinators in two large facilities. These care coordinators go beyond standard utilization management review and leverage their onsite presence to engage in discharge planning, ensure gentle transitions from the facility to the community setting and arrange support services. This model is considered a best practice approach.

- MCO A is building a strong approach toward integrated physical health and behavioral health care.
- Quality is woven throughout the organization, which was well communicated through a thoughtful, thorough and well-articulated quality management program description.
- MCO A made significant progress in year one of operation towards building a strong and member-focused pharmacy program. The pharmacy staff and contractor are fully engaged both internally and with AGENCY's Director of Pharmacy Services.
- The stratification algorithm utilized to identify members for both Level 1 resource coordination and Level 2 clinical care coordination was revised and updated during 2015 with the new algorithm fully deployed starting in December of 2015. Although new, the addition of population health and social determinant of health factors is a promising addition to the stratification algorithm.
- MCO A has placed an emphasis on claims processing quality over production volume as evidenced by the relative absence of claims adjustments.

OPPORTUNITIES

- Program documents, policies, procedures and workflows, if not stand-alone documents for STATE, must contain STATE-specific information and be branded appropriately.
- MCO A has developed a robust four-phase plan to build the wellness registry, but at the time of the onsite review, only phase one had been completed, and the wellness registry was not yet functional or meeting all contract requirements. The MCO was encouraged to develop a detailed timeline and project plan for demonstrating compliance and completion of the registry, with search function available to members and providers.
- Throughout 2015, there was a disconnect between the UM team and the case/care managers which was evident from the inappropriate termination or reduction of needed services. There is currently no expectation that UM staff review long-term services and support (LTSS) assessments and other documentation or leverage LTSS case/care managers' knowledge of the member to support the UM determinations for pharmacy and non home and community-based services (HCBS) service requests. Case/care managers are not

EXAMPLE

alerted to service denials prior to the member's notification and the case/care manager is not consulted for additional information prior to a service denial.

- MCO A should develop a formal process for case/care managers to evaluate the Preadmission Screening and Resident Review II (PASSR) and ensure the member is receiving recommended services. MCO A agreed with file review findings that the PASSR was not reviewed and there were missed opportunities to engage behavioral health services.
- There is also an opportunity for MCO A case/care managers to strengthen relationships with nursing facilities (NFs). The case/care managers are not consistently notified regarding NF resident care meetings, contributing to a marked lack of case/care managers attending members' NF care planning meetings.
- An opportunity was identified for pharmacy staff to initiate additional claims processing tests to find errors and initiate needed updates on a regular basis. This was identified when it was recognized that the pharmacy claims adjudication system was mistakenly assessing a yearly $15 copay maximum per member as opposed to a monthly $15 copay maximum required by contract.
- Early in 2015, there was a strong approach to fraud, waste and abuse investigations and reporting; throughout the year, there was a change in staff and the robustness waned. New team members have been brought on board, and enhancements to the program are being implemented in 2016.
- MCO A has several opportunities to improve encounter data submission quality as noted in the reporting of payment and provider information.

MCO B

STRENGTHS

- As an MCO with more than seven years tenure providing service in STATE, MCO B local staff are invested in ensuring members receive high quality care in the most appropriate setting.
- The Provider Relationship, Insight and Service Model (PRISM) has been a strategic solution with support from corporate partners to resolve claims issues experienced by providers as a result of the migration to the CSP Facets system.
- The hiring of the pharmacy director, a key personnel required position, has resulted in the development of an organizational culture within that business unit characterized by a strong proactive approach for identifying and resolving pharmacy issues. Additionally, the pharmacy director is working toward proactively integrating pharmacy data into case management and care coordination activities in an effort to provide a more robust and meaningful set of tools and data points by which to manage and coordinate care of MCO B members.
- MCO B has successfully linked to the STATE Health Information Network and has access to real-time emergency department utilization information.

EXAMPLE

OPPORTUNITIES

- MCO B must ensure that all staff and corporate partners have a full understanding of all contract requirements and are meeting expectations for those services provided to the STATE MCO. This includes areas such as credentialing, contracting and oversight of subcontracted and delegated entities, management of grievances and appeals, claims payment, encounter data submissions, and performance measure reporting.
  - Matrix partner relationships should be developed to evidence a single point of ownership, at the MCO B of STATE level, to ensure overall accountability for compliance with federal regulations, State contract requirements and internal policies and procedures.
  - A system of checks and balances should be implemented that ensure DE specific contract requirements are being met and when opportunities are identified there are clear roles and responsibilities and adherence to timelines to resolve issues in a timely fashion, the first time.
- Program documents, policies, procedures, and workflows, if not stand alone documents for STATE, must contain STATE-specific information.
- Areas such as utilization management, PROGRAM LTSS case management, level 1 resource coordination and level 2 clinical care coordination exist as silos and lack a coordinated effort to provide holistic care to members.
- The wellness registry is not functional and Healthify, the proposed solution, in its current format does not meet expectations.
- There are several areas from previous annual compliance reviews and readiness reviews for which maintenance of effort around corrective action is lacking; MCO B leadership and senior managers would benefit from reviewing previous EQR reports and prior corrective action plans.
- Ongoing system barriers have negatively impacted the ability to successfully implement payment systems to support contractual requirements such as school-based wellness services and J-code editing to support pharmacy rebates.
- From an operational sustainability perspective, MCO B must implement corrective action to ensure correct application of patient payment liability and newborn claims processes. The later will ensure appropriate claiming of maternity kick-payments and serve to improve care coordination during the post-partum period for both mother and child.
- As CMS and by extension AGENCY place greater emphasis on accurate and robust encounter data, MCO B must place an increased priority level on resolving issues impacting timely submission of encounter data to the MMIS.
-
- Performance measure reporting for the QCMMR, has experienced ongoing data control and integrity issues. Although MCO B indicated it felt it had found the "right recipe" for success, maintenance of effort and consistent use of reporting fields will be required to ensure the State receives the necessary information in an accurate and timely fashion on an ongoing basis.

EXAMPLE

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External Quality Review

For purposes of this report, each MCO's compliance with Federal Regulations for Medicaid Managed Care (FRMMC), the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), and State regulations, contractual requirements, internal P&Ps, and State-defined standards communicated to the MCO through its managed care contract and the Medicaid/CHIP, PROGRAM LTSS QMS were applied. The 2016 external quality review (EQR) cycle, Mercer performed a comprehensive review of all compliance elements regardless of past performance or prior corrective action plans (CAPs). Detailed information about review methodology can be found in the individual 2016 annual MCO technical reports. To receive a score of "met," an MCO had to meet the three areas defined below. Or, for activities requiring a file review, the MCO must satisfy the established threshold. The assigned score of a review area reflects the minimum score of any of the compliance elements within that area.

The 2016 EQR process began with a request for information to each MCO for data related to compliance reporting. The subsequent desk review included analysis of all policies, procedures and supporting documents in accordance with external quality review protocol. Mercer also conducted extensive file reviews, including care management, provider selection, grievance and appeal records and subsequently submitted preliminary findings to each MCO prior to the onsite reviews. The EQRO conducted onsite reviews and staff interviews to evaluate operational compliance with state and federal regulations at each MCO. The review also evaluated internal policies and procedures for adherence to contractual standards for providing health care services to enrollees.

EXAMPLE

2016 MEDICAID MANAGED CARE COMPARISON REPORT **STATE**

	One or more elements of compliance review scored as "Partially Met".	One or more elements of compliance review scored as "Not Met".
Met all FRMMC and/or CHIPRA requirements.	Met the majority of FRMMC and/or CHIPRA requirements.	Did not meet the majority of FRMMC and/or CHIPRA requirements.
Maintained all elements of contractual compliance and applicable State-defined standards.	Maintained a majority of elements related to contractual compliance and applicable State-defined standards.	Did not maintain a majority of elements related to contractual compliance and applicable State-defined standards.
Demonstrated consistency with internal organizational P&Ps and processes.	Demonstrated inconsistency with internal organizational P&Ps and processes.	Consistently did not follow internal organizational P&Ps and processes.
For file reviews, the MCO must have achieved 90% compliance or greater.	For file reviews that scored between 75% and 89% compliance.	For file reviews that scored less than 75% compliance.

EXAMPLE

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2016 MEDICAID MANAGED CARE COMPARISON REPORT

STATE

Area of Review	MCO A	MCO B	Compliance Review Findings
Administration and Organization			
01 - NCQA Accreditation	**MCO A**	**MCO B**	
NCQA Accreditation			MCO A: The MCO will undergo NCQA accreditation review in 2016. MCO B: All requirements for this metric were met.
02 - Staffing	**MCO A**	**MCO B**	
Staffing Policies and procedures			MCO A: Policies are labeled inconsistently and often contain references to other markets but do not include STATE. Policies do not consistently reflect any organizational branding (i.e., Gateway, MCO A logo, etc.). However, several policies that are organizationally branded as "Gateway" (i.e., FI-27-ALL-ALL - Procedures for Obtaining Printed Materials in Alternate Formats) references only "Gateway members", which does not reflect STATE specificity or STATE MCO A membership. Policy header information does not include "committee date" evidence of annual review. MCO B: Policies are labeled inconsistently and often contain references to other markets but do not include STATE. Policies do not consistently reflect any organizational branding (i.e., Gateway, MCO A logo, etc.). However, several policies that are organizationally branded as "Gateway" (i.e., FI-27-ALL-ALL - Procedures for Obtaining Printed Materials in Alternate Formats) references only "Gateway members", which does not reflect STATE specificity or STATE MCO A membership. Policy header information does not include "committee date" evidence of annual review.

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Area of Review	MCO A	MCO B	Compliance Review Findings
Key Staff			MCO A: All key contract positions are filled with the exception of the chief data analytic coordinator. This candidate has been identified and will be presented to AGENCY for review and approval prior to an offer being extended. MCO B: Staffing turnover within the required key personnel positions, eight of the 20 positions have been with MCO B less than one year, resulting in loss of processes, organizational history, and ambiguity in roles and responsibilities. This was evidenced in the loss of institutional knowledge received through technical assistance sessions, loss of organizational history available through prior EQR reports, and findings and inconsistencies in the quality of completeness of mandated quality reporting via the Quality Care Management Monitoring Report (QCMMR) reporting template.
Notification of Personnel Changes			MCO A: Currently, the MCO does not have a formal policy or process/workflow in place to ensure appropriate notification to AGENCY within 7 calendar days of changes to key personnel. A new policy management software system, Archer, is being implemented that will allow for tracking and monitoring of key trigger events. MCO B: MCO B indicated the use of an "essential elements" document to capture key contractual requirements, including notification to the State of changes in key personnel; this document is then fed into the eGRC system. However, MCO B was not able to produce this document, and although it is the responsibility of the compliance officer to maintain this document, the turnover in this position leaves the role and/or responsibility for ongoing maintenance and adherence to these requirements unclear.

EXAMPLE

2016 MEDICAID MANAGED CARE COMPARISON REPORT **STATE**

Area of Review	MCO A	MCO B	Compliance Review Findings
Staffing Process	Yellow	Yellow	MCO A: The organizational chart includes key reporting relationships within the MCO and among the MCO operating entities. However, the chart, as submitted, does not clearly depict the care coordination and case management business units and reporting structures. Additionally, all organizational charts should clearly delineate matrix relationships with other business units and/or vendors. MCO B: Although the organizational chart for MCO B of STATE was shared, it did not clearly reflect the complexity of MCO B's matrix structure. Organizational charts should clearly specify direct reporting relationships, as well as dotted line or "matrix" relationships, especially between the local STATE plan and UCS, as well as delegated vendors.
Reporting Process	Green	Yellow	MCO A: All requirements for this metric were met. MCO B: MCO B utilizes the Filing Management System within the eGRC platform to ensure contractually required reporting is maintained. Ad hoc report requests and routine reporting can follow multiple pathways, including Business Intelligence at the corporate level for system-generated reports, through the local chief data analyst, or through manual collection of information by business owners and subject matter experts. Although the process is cumbersome, it appears to be understood. However, ownership and maintenance of the Filing Management system requirements was not well understood by MCO B leadership.

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2016 MEDICAID MANAGED CARE COMPARISON REPORT STATE

Area of Review	MCO A	MCO B	Compliance Review Findings
Reporting Accuracy			MCO A: Throughout 2015, MCO A experienced inconsistencies with the accuracy of data in the quality care management and measurement reporting (QCMMR) submissions. Additionally, MCO A currently lacks a chief data analytic coordinator, as required under key personnel within the contract. Coverage is in place to address this gap. This aside, MCO A has made significant effort and has demonstrated application of continuous quality improvement principles in improving the overall consistency and validity of required reports. MCO B: Throughout 2015, MCO B experienced ongoing issues with the accuracy of data in the QCMMR submissions. MCO B business owners act as the authorized signer for their individual section. There was no single accountable person, and it was evident that thorough review of the report submission did not occur at a senior level and was delegated to alternative staff, such as the chief data analytic coordinator and/or compliance manager. As a result, many pages were blank or period-to-period variances were not consistently addressed, and ongoing issues were not escalated in a timely fashion in order to reach final resolution.
09 - Confidentiality, Privacy, and Security	**MCO A**	**MCO B**	
Breaches of PHI			MCO A: Submitted policy identifies different activities for privacy breaches of >500 and <500 lives but does not indicate how AGENCY is notified. MCO B: MCO B submitted a global corporate policy outlining the process for handling breaches in data security and personal health information/personally identifiable information. The overarching corporate policy speaks in general terms but did not include STATE-specific processes or timeliness standards for reporting breaches.

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2016 MEDICAID MANAGED CARE COMPARISON REPORT **STATE**

10 - Contractor Responsibilities	MCO A	MCO B	
General Rule			MCO A: All requirements for this metric were met. MCO B: The system of checks and balances between MCO B and UCS has not consistently identified opportunities for improvement as evidenced by inconsistent grievance file processing and as detected during provider call center monitoring activities.
State Approval			MCO A: All requirements for this metric were met. MCO B: Although MCO B indicated during the interview process that it does provide formal notification to the State of new delegates, no formal policy or procedure was submitted.
Care Coordination			
01 - Organizational Structure	**MCO A**	**MCO B**	
Staff Supporting DE Population			MCO A: All requirements for this metric were met. MCO B: There are significant numbers of members identified as eligible for Level 2 CCC who receive no outreach. Attempts are not consistently within 15 days, and file reviews do not demonstrate that at least one face to-face attempt is made in a majority of cases. Staff for Level 2 CCCs does not appear sufficient to ensure outreach to members identified as Level 2, as the revised stratification models are identifying approximately 1,900 members in Quarter 4 of 2015, and there are currently nine Level 2 CCCs. Engagement rates for outreached members is poor.

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2016 MEDICAID MANAGED CARE COMPARISON REPORT **STATE**

Area of Review	MCO A	MCO B	Compliance Review Findings
Staff Supporting Level 2 Care Coordination	🟢	🟡	MCO A: All requirements for this metric were met. MCO B: The submitted organization chart and staff listing are not consistent. For clinical areas that support the STATE membership, the actual staff supporting STATE should be included in the organizational chart. For example, NICU Telephonic, Transplant Telephonic, and Healthy First Steps Telephonic, and Private Duty Nursing Team which was discussed but does not appear on the STATE organization chart.
Level 2 Case Loads	🟢	🔴	MCO A: All requirements for this metric were met. MCO B: Although the plan has a process to monitor and track caseloads to maintain the less than 50 per staff requirement, recent changes to the stratification model have significantly increased the number of Level 2 eligible members identified per quarter. MCO B does not have a full complement of CCCs. Staffing expansion of the Level 2 CCC team to seven FTEs does not support compliance with the 1:50 standard, even if only 50% of the eligible Level 2 members were successfully outreached.

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2016 MEDICAID MANAGED CARE COMPARISON REPORT **STATE**

06 - Level 1	MCO A	MCO B	
Discharge Planning- Level 1 Members			MCO A: MCO A has implemented a new staffing model utilizing a team 'pod' approach to providing care coordination, including resource coordination, UM, and transition and discharge support. The pod teams include three nurses embedded in key facilities providing UM and transition/discharge planning supports for members. This new model was implemented in late 2015, and the file review did not demonstrate consistent provision of active discharge planning for members. MCO B: MCO B has moved towards compliance with transition and discharge planning requirements by utilizing CHWs in this role. The IP UM staff take the lead in communicating with the hospital discharge planner, and in the event a member needs authorizations outside of IP, such as DME, OP services, or pharmacy, these must go to separate UM teams for approval. The process to communicate across these teams and number of staff is not fully developed, and it is not clear that this process is the most efficient or effective to ensure seamless and timely transition of care for members while fully ensuring the CHW is aware of all of the various staff involved in the member's discharge. The MCO was encouraged to reevaluate this process and identify areas for improvement.
Outreach of Members with Low Acuity Non Emerge			MCO A: The MCO has implemented an Urgent Response Outreach Team specifically targeting members with LANE utilization. The team includes five resource coordinators. This updated model was implemented in late 2015, and the file review demonstrated significant opportunity to improve outreach to members with high ED utilization. MCO B: All requirements for this metric were met.

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2016 MEDICAID MANAGED CARE COMPARISON REPORT **STATE**

07 - Level 2	MCO A	MCO B	
Level 2 Outreach			MCO A: For members actively engaged in Level 2 requirements were met, however there we many members, identified by the plan as eligible for Level 2 who were never outreached. MCO B: There are significant numbers of members identified as eligible for Level 2 who receive no outreach, there are not consistently at least five attempts made within 90 days, and file reviews do not demonstrate that at least one face-to-face attempt is made in a majority of cases.
Level 2 Access to Clinical Care Coordinators			MCO A: Engagement rates for members identified as eligible for Level 2 CCC is low. Rates provided by MCO for Level 2: Q1: 1,315 identified with 759 engaged, Q2: 1,368 identified with 631 engaged, Q3: 830 identified with 333 engaged, and Q4: 858 identified with 305 engaged. MCO B: Although members enrolled in Level CCC are provided phone contact information for their CCC, members attempting to self-refer to CCC may not have accurate phone information, and member services staff do not appear to have accurate information on the STATE CCC program. Secret shopper calls demonstrated an inability to get transferred to the STATE CCC program or health plan and were, instead, directed to call a number that routes to AGENCY.
Level 2 - CC Assessment Timeliness			MCO A: For members actually outreached for Level 2, requirements were met; however, significant numbers of members identified as eligible for Level 2 were not outreached. MCO B: Policies are consistent with this element, but file review indicates this is not always done, and not all members identified for Level 2 are outreached or assessed. Assessments are not always completed within 30 calendar days of eligibility for Level 2 CCC.

EXAMPLE

MERCER 14

2016 MEDICAID MANAGED CARE COMPARISON REPORT **STATE**

Level 2 Care Plan Development			MCO A: All requirements for this metric were met. MCO B: Policies were consistent with this requirement; however, there was markedly limited evidence of this in files reviewed.
rievance & Appeal System			
01 - Grievance & Appeal System	**MCO A**	**MCO B**	
Subcontractor Information			MCO A: All requirements for this metric were met. MCO B: MCO B considers grievances that are handled internally, including those through its UCS division, as part of MCO B and does engage in activities to ensure appropriate accountability. One person should be able to demonstrate knowledge of the entire grievance process and take ownership of it.
Training of Subcontractors			MCO A: All requirements for this metric were met. MCO B: Audit tools did not include evidence that delegates' training programs for grievance and appeal processing were evaluated.
Appeal Committee			MCO A: All requirements for this metric were met. MCO B: The timeframe for notifying members of the appeal committee date is tight; the letter is sent Friday for delivery Tuesday.
Authority to file			MCO A: Written member consent is required of providers and member representatives in order to file a grievance on behalf of a member.

EXAMPLE

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2016 MEDICAID MANAGED CARE COMPARISON REPORT **STATE**

Information Systems-Claims			
01 - General and Staffing	MCO A	MCO B	
STATE ad-hoc reporting responsibilities			MCO A: MCO A currently has an opening for the contractually required position of chief data analytics coordinator since January 2015. MCO B: MCO B's processes to program and prioritize ad hoc report requests that require assistance from other business units, such as business intelligence, appear cumbersome and may result in not meeting turn-around time for ad hoc report requests from the State, especially if traditional programming is required.
Claim Auditing			MCO A: MCO A performs an acceptable level of claims auditing of 4% for manual claims processing. MCO A audits the auditor claims, since DST is the claims processor. From the claims reviewed, there may be an issue of interim billings, final bills, and possible duplicates that may not be found in the high-dollar claim audit. MCO B: There were payment errors found in the sample of claims reviewed. MCO B states that it is conducting 32 claim audits per week. MCO B is not conducting enough claim audits to identify system or processor issues quickly.
Claim Payment			MCO A: MCO A did not meet claims processing timeliness in 2015; however, that is now resolved. Application of coordination of benefits occurs properly; however, if a claim is received with third party payment information that is not known to the claims system, the claim reviewed does not have the enrollment record updated with the primary carrier information to stop future claims.

EXAMPLE

MERCER 16

2016 MEDICAID MANAGED CARE COMPARISON REPORT **STATE**

LTSS Case Management			
01 - LTSS Case Management Requirements	**MCO A**	**MCO B**	
LTSS Resource Staff Person			MCO A: All requirements for this metric were met. MCO B: Mercer requested the updated LTSS Plus organizational chart, with the required LTSS member advocate position, to show contractual compliance. This key position was omitted from the resubmitted organizational chart.
LTSS CM Caseload			MCO A: All requirements for this metric were met. MCO B: The current case management staffing is not sufficient to meet caseload ratios that are required by the contract. The caseloads show that the case managers have been staffed more than the maximum of 120.
LTSS CM Caseload Ratios by Population			MCO A: All requirements for this metric were met. MCO B: The current staffing plan has not been effective in ensuring that the caseloads do not go over the maximum. There are two vacant supervisor positions, as well as one supervisor on leave, putting the ratio of supervisors to case managers out of compliance.
LTSS CM Supervisor Staffing Ratios			MCO A: All requirements for this metric were met. MCO B: The plan is not meeting the 1:8 staffing ratio due to two vacancies and one supervisor out on medical leave.

EXAMPLE

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2016 MEDICAID MANAGED CARE COMPARISON REPORT **STATE**

Quality			
04 - Quality Assessment & Performance Improvement	**MCO A**	**MCO B**	
Ongoing Assessment and Improvement Programs			MCO A: All requirements for this metric were met. MCO B: The Quality Management Committee monitors EPSDT and other preventive services through a variety of avenues: HEDIS data reviewed monthly, gaps in care reports, and provider profiling reports which are shared with providers quarterly. EPSDT reports are reviewed monthly and State performance measure data (non-HEDIS) are reviewed routinely to ensure services are performed. Critical incidents and quality of care reports routinely are reviewed. Utilization reports are monitored for over- or under-utilization. The MCO conducted a provider satisfaction survey, but had a low response rate of 5.9%. Member satisfaction is assessed through Consumer Assessment of Health Care Providers and Systems, quality of care, and grievances. The MCO has not assessed member satisfaction among the PROGRAM LTSS LTSS members and has not conducted a provider satisfaction survey for HCBS providers.
05 - Performance Improvement Projects	**MCO A**	**MCO B**	
Performance Improvement Project Development			MCO A: All requirements for this metric were met. MCO B: The Quality Management Committee in conjunction with the PIP work group subcommittee discusses and implements additional PIPs as needed; however, there is no description of the data reviewed to determine the need for a PIP or the process for determining which PIP topics become a priority and garner necessary support.

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3

HEDIS and the STATE Quality Management Strategy

STATE's Medicaid managed care program is focused on providing quality care to the majority of the Medicaid, CHIP, and PROGRAM LTSS eligible individuals through increasing access, and appropriate and timely utilization of health care services. Goals and objectives provide a persistent reminder of program direction and scope. The following four goals equate to areas of focus for clinical quality improvement in STATE as listed in the state's quality management strategy:

Goal 1: To improve timely access to appropriate care and services for adults and children, with an emphasis on primary and preventive care, and to remain in a safe and least-restrictive environment.
Goal 2: To improve quality of care and services provided to PROGRAM, PROGRAM LTSS, and CHIP members.
Goal 3: To control the growth of health care expenditures.
Goal 4: To assure member satisfaction with services.

The STATE Quality Management Strategy (QMS) prioritizes improvement of timely access to appropriate care and services for adults and children, with an emphasis on primary preventive care and remaining in a safe and least-restrictive environment. Providing timely access to preventive and primary care services promotes the goal of a comprehensive health care delivery system for STATE Medicaid members.

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HEDIS Results

These sections provide an overview of two critical domains: Access to Care and Quality of Care. Analysis using the Healthcare Effectiveness and Data Information set (HEDIS) classification schema for performance evaluation is industry standard for external reporting in the managed care industry. It has been developed and maintained by the NCQA. Data for this report include information from medical charts and provider claims (i.e. encounter data from electronic health records, claims data from billing systems, etc.) within STATE's Medicaid managed care network. The NCQA originally designed HEDIS to allow consumers to compare health plan performance against the quality of other health plans and national/regional benchmarks.

In this section, the following rating scale is used:

★	●	●	●
2016 HEDIS rating met or exceeded the national benchmark for the 90th percentile	2016 HEDIS rating fell between the national benchmarks for the 75th and the 90th percentile	2016 HEDIS rating fell between the national benchmarks for 50th and the 75th percentile	2016 HEDIS ratings fell below the national benchmark for the 50th percentile

MCO B's data from the previous reporting period was used for comparison of 2016 results as described in the table below. As 2016 was the first year of HEDIS data available for Highmark in STATE, a comparison with previous results is unavailable (denoted by * character in tables).

↑	↓	—
MCO's 2016 HEDIS rate was a one percentage point or greater improvement	MCO's 2016 HEDIS rate was a one percentage point or greater decline	MCO's 2016 HEDIS rate did not change by more than one percentage point

As the table below displays, there is opportunity for significant improvement in HEDIS results for both MCOs. Forty two select HEDIS measures across various domains of care area presented below. Please note that results for some MCO A measures are 'NR,' which is a

EXAMPLE

designation given by NCQA to indicate the organization followed the measure specifications, but the denominator was too small (<30) to report a valid rate. MCO A was able to report 33 measures in comparison to MCO B reporting all 42.

Of the 33 reportable measures for MCO A, only one measure, MH utilization — intensive outpatient and partial hospitalization, was at or above the 90th percentile. Seven measures were at or above the 75th percentile and 19 were below the 50th percentile.

As stated above, MCO B had sufficient data to report all 42 measures. The reader will also see an indication of directionality in resultsfrom the previous reporting period for MCO B. As with MCO A, only one measure, MH utilization — intensive outpatient and partial hospitalization, was at or above the 90th percentile. Three measures, Antidepressant medication management — acute phase, Inpatient utilization — maternity average length of stay, and Mental health (MH) utilization — inpatient services were at or above the 75th percentile. Most notably, 26 of MCO B's HEDIS results for these 42 measures, more than 60% were below the 50th percentile.

2016 HEDIS Measure	MCO A	Change	United Healthcare Community Plan	Change
Access and Availability of Services				
Children and adolescents' access to PCPs — 12 months to 24 months	🟢	*	🔴	═
Children and adolescents' access to PCPs — 25 months to 6 years	🟢	*	🔴	⬇
Children and adolescents' access to PCPs — 7 years to 11 years	NR	*	🔴	⬇
Children and adolescents' access to PCPs — 12 years to 19 years	NR	*	🔴	═
Adults' access to preventive services — 20 years to 44 years	🟡	*	🔴	⬇
Adults' access to preventive services — 45 years to 64 years	🟡	*	🔴	═
Adults' access to preventive services — 65 years and older	🔴	*	🔴	═

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2016 MEDICAID MANAGED CARE COMPARISON REPORT **STATE**

Inpatient utilization — total inpatient discharges/1,000	🟡	*	🔴	⬇
Inpatient utilization — total inpatient ALOS	🔴	*	🟡	⬆
Mental health (MH) utilization — inpatient services	🟢	*	🟢	⬆
MH utilization — intensive outpatient and partial hospitalization	★	*	★	⬆
MH utilization — outpatient and ED	🟢	*	🟡	⬆
MH utilization — any	🟢	*	🟡	⬆

*NR: The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

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4

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey captures reliable information from consumers about their experiences with health care and focuses on quality aspects such as communication skills of providers and ease of access to health care services. There are separate versions of the survey for adult and pediatric patients (administered to parents or guardians). A core set of questions grouped for composite scoring provide summary results for key areas of care and service. The NCQA uses survey results for health plan performance reporting, to inform accreditation decisions and to create nationally-comparative benchmarks for care.

Goal number 4 listed in the STATE Medicaid QMS relates to assurance of member satisfaction with services. STATE has emphasized the importance of the service experience of Medicaid enrollees. Enrollees possessing confidence in services delivered to them may engage those services more effectively and more often, which increases the likelihood of a healthier membership population. The following results include CAHPS composite scores developed by combining individual items to form a broader focus to assign to a single number.

STATE's Medicaid MCOs performance for 2016 varied internally—consistent for both MCOs. Quality and performance also varied in a side-by-side comparison of MCO ratings. Both of MCOs performed well when rated for the member's experience with care in a side-by-side comparison. Member ratings of the entire care delivery experience for children were very strong at MCO A and moderate at MCO B. Both MCO A and MCO B had nearly-identical, moderate results when members rated their health plans—a key indicator of a member's positive experience with the MCO.

While MCO A performed poorly on the adult CAHPS survey, results from the pediatric survey demonstrated strong performance delivering care to children. The MCO performed at or above the 90th percentile benchmark nationally on the child CAHPS composite measures, with the exception of the health plan rating that scored in the 75th percentile nationally. While this strong performance was consistent within the child CAHPS survey, the adult survey results for MCO A highlight opportunities for significant improvement. MCO members who completed the CAHPS survey scored four adult metrics as moderate (rating of health plan, getting needed care, getting care quickly and how well doctors communicate). However, respondents gave the lowest score when rating personal doctors, specialists and when asked to rate all health care.

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2016 MEDICAID MANAGED CARE COMPARISON REPORT **STATE**

Members rated MCO B's performance at or above the 90th percentile benchmark when asked how well doctors communicate in both the adult and child survey. Areas needing improvement include ratings for adult specialists (< 10th percentile) and for getting needed care for children (25th percentile). All other metrics reveal moderate performance between the 50th and 90th percentiles for MCO B.

The following shows the rating scale applied by EQRO evaluators to assess MCO and provider performance:

★	●	●	●
2016 CAHPS rating met or exceeded the national benchmark for the 90th percentile	2016 CAHPS rating fell between the national benchmarks for the 75th and the 90th percentile	CAHPS rating fell between the national benchmarks for 50th and the 75th percentile	2016 CAHPS ratings fell below the national benchmark for the 50th percentile

2016 STATE Medicaid MCO CAHPS Survey Results - Adults

2016 Adult CAHPS Ratings	MCO A	MCO B
Rating of personal doctor	●	●
Rating of specialist	●	●
Rating of all health care	●	●
Rating of health plan	●	●
2016 Adult CAHPS Composite Scores	**MCO A**	**MCO B**
Getting needed care	●	●
Getting care quickly	●	●
How well doctors communicate	●	★

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2016 STATE Medicaid MCO CAHPS Survey Results - Children

2016 Child CAHPS Ratings	MCO A	MCO B
Rating of personal doctor	★	●
Rating of specialist	★	●
Rating of all health care	★	●
Rating of health plan	●	●
2016 Child CAHPS Composite Scores	**MCO A**	**MCO B**
Getting needed care	★	●
Getting care quickly	★	●
How well doctors communicate	★	★

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MAKE TOMORROW, TODAY

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MARSH & McLENNAN COMPANIES

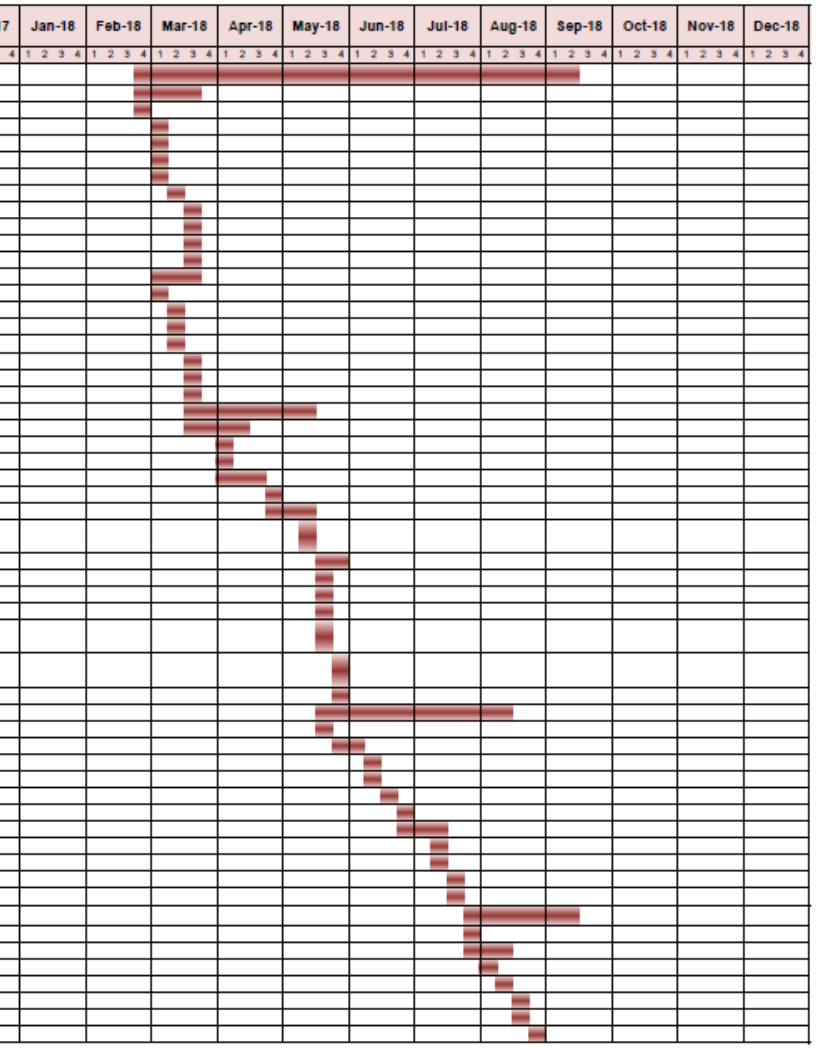
Mercer provides the following sample of an EQR project timeline referenced in 2.4.1.

Mercer Internal Timeline

Activity	Task Description		Start Date	End Date	Mercer Lead	State Lead	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
							1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4
Quality Improvement Initiative Task Force	1	Quality Improvement Initiatives (QII)																	
	1.1.1	Quarterly meeting with State, MCOs and Mercer	1/23/2018	1/25/2018															
	1.1.2	NCI-AD training (QII 2/22/2018)	2/20/2018	2/22/2018															
	1.1.3	Quarterly meeting with State, MCOs and Mercer (QII 4/26/2018)	4/24/2018	4/26/2018															
	1.1.4	Quarterly meeting with State, MCOs and Mercer (QII 7/26/2018)	7/24/2018	7/26/2018															
	1.1.5	Quarterly meeting with State, MCOs and Mercer (QII 10/25/2018)	10/23/2018	10/25/2018															
Meetings	2	State Meetings																	
	2.1.1	State/Mercer bi-weekly meetings	Recurring																
	2.1.2	Planning, policy & quality team monthly meetings	Recurring																
	2.1.3	Planning, policy & quality team (50th percentile QC)	Recurring																
	2.1.4	Care coordination case management monthly meeting	Recurring																
	2.1.5	Managed care liaison monthly meeting	Recurring																

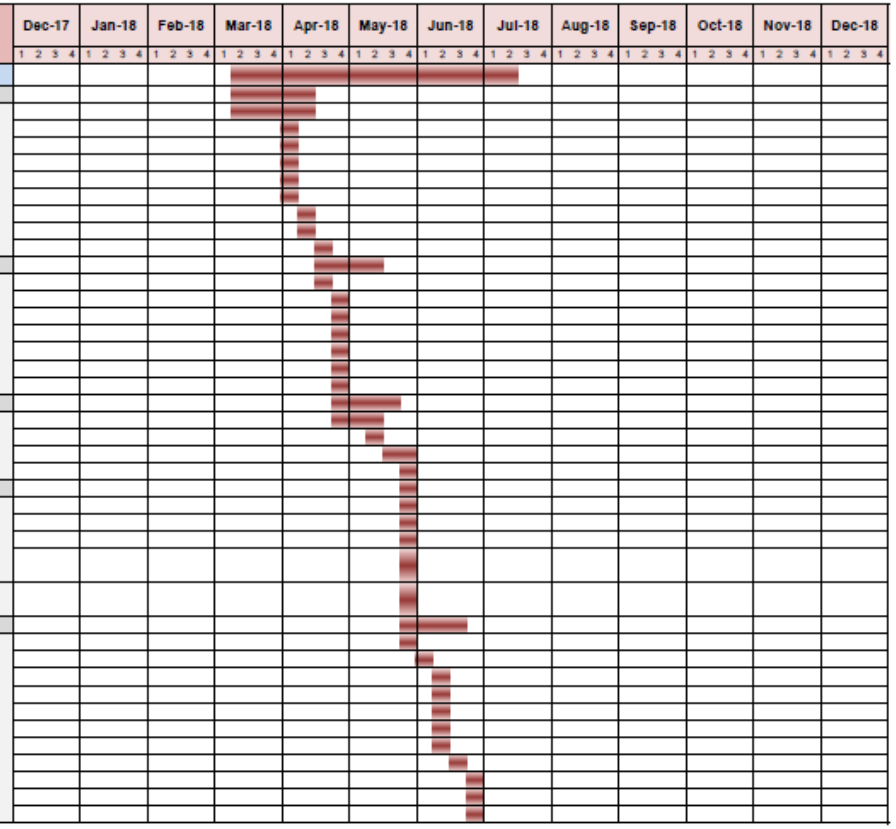
Mercer Internal Timeline

Activity		Task Description	Start Date	End Date	Mercer Lead	State Lead
MCO A: Balanced Budget Amendment	3	MCO A Balanced Budget Amendment (BBA)	2/26/2018	8/29/2018		
	3.1	RFI (BBA, Contract, VPM, VPIP, File Review)	2/26/2018	3/20/2018		
	3.1.1	Develop request for information	2/26/2018	3/2/2018		
	3.1.2	Technical peer review	3/5/2018	3/5/2018		
	3.1.3	Submit for compilation	3/5/2018	3/5/2018		
	3.1.4	Editorial peer review	3/6/2018	3/6/2018		
	3.1.5	Final look	3/7/2018	3/7/2018		
	3.1.6	State review of RFI	3/8/2018	3/14/2018		
	3.1.7	Revise RFI based on State feedback	3/15/2018	3/15/2018		
	3.1.8	Distribute to MCO A	3/16/2018	3/16/2018		
	3.1.9	Individual MCO A Q&A on RFI	3/19/2018	3/19/2018		
	3.1.10	Mercer updates file review tools as needed	3/20/2018	3/20/2018		
	3.2	Online Tool Revisions	3/6/2018	3/21/2018		
	3.2.1	Develop desk tool content	3/6/2018	3/12/2018		
	3.2.2	Technical peer review	3/13/2018	3/13/2018		
	3.2.3	Editorial peer review	3/14/2018	3/14/2018		
	3.2.4	Submit for entry	3/14/2018	3/14/2018		
	3.2.5	Enter into back office	3/15/2018	3/19/2018		
	3.2.6	Final consultant review	3/20/2018	3/20/2018		
	3.2.7	Set up Connect folders	3/21/2018	3/21/2018		
	3.3	Desk Review	3/19/2018	5/14/2018		
	3.3.1	MCO A generate file universe list	3/19/2018	3/30/2018		
	3.3.2	Mercer selects files for reviews	4/2/2018	4/3/2018		
	3.3.3	Mercer posts file request	4/4/2018	4/4/2018		
	3.3.4	MCO A submission of RFI and pdf files (3 weeks)	4/5/2018	4/25/2018		
	3.3.5	Mercer initial review of submission	4/26/2018	4/26/2018		
	3.3.6	Track team desk review	4/27/2018	5/10/2018		
	3.3.7	2 internal debriefs: A&O, ISCA, G&A, CC/CM, UM, Rx, HCBS Network Cred.	5/11/2018	5/14/2018		
	3.4	Onsite Review	5/15/2018	5/25/2018		
	3.4.1	State prep for onsite	5/15/2018	5/15/2018		
	3.4.2	Generate onsite materials (follow up questions, etc.)	5/16/2018	5/17/2018		
	3.4.3	Prep and ship all onsite materials	5/18/2018	5/18/2018		
	3.4.4	Mercer MCO A onsite review (1 travel + 3 review) includes staff interviews and observations	5/21/2018	5/24/2018		
	3.4.5	State MCO A onsite review (3 review days) includes staff interviews and observations	5/22/2018	5/24/2018		
	3.4.6	State debrief and reporting (1 day, day 4 of MCO A review)	5/25/2018	5/25/2018		
	3.5	Report Writing	5/15/2018	7/20/2018		
	3.5.1	Report template	5/15/2018	5/21/2018		
	3.5.2	Draft report writing	5/25/2018	6/7/2018		
	3.5.3	Technical Peer Review	6/8/2018	6/12/2018		
	3.5.4	Submit for compilation	6/13/2018	6/18/2018		
	3.5.5	Editorial Peer Review	6/19/2018	6/22/2018		
	3.5.6	Final review	6/25/2018	6/26/2018		
	3.5.7	State review	6/27/2018	7/10/2018		
	3.5.8	Revise based on State feedback	7/11/2018	7/12/2018		
	3.5.9	MCO A review for errors and omissions	7/13/2018	7/19/2018		
	3.5.10	Revise based on MCO A review	7/20/2018	7/20/2018		
	3.5.11	Final report distribution	7/20/2018	7/20/2018		
	4	Corrective Action Plan (CAP)	7/23/2018	8/29/2018		
	4.1.1	CAP template to MCO A	7/23/2018	7/23/2018		
	4.1.2	MCO A submits CAP	7/24/2018	8/6/2018		
	4.1.3	Mercer reviews CAP and either approves or rejects	8/7/2018	8/13/2018		
	4.1.4	Distribute approved/rejected CAP to MCO A	8/14/2018	8/14/2018		
	4.1.5	Meet with MCO A	8/15/2018	8/15/2018		
	4.1.6	CAP resubmission	8/16/2018	8/22/2018		
	4.1.7	Mercer re-review CAP	8/23/2018	8/29/2018		



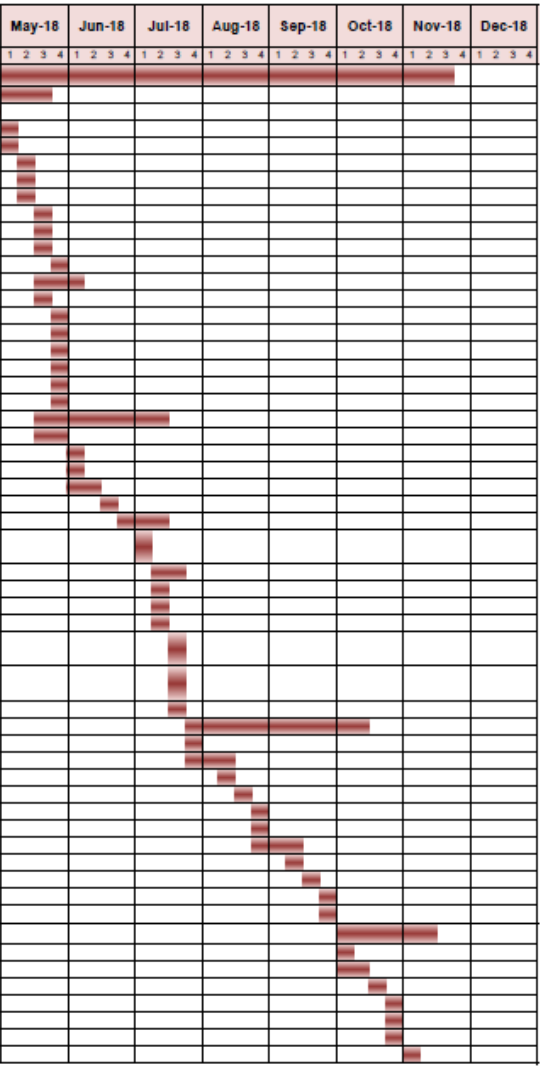
Mercer Internal Timeline

Activity		Task Description	Start Date	End Date	Mercer Lead	State Lead
MCO A: Information Systems Capabilities Assessment	5	MCO A ISCA	3/13/2018	6/27/2018		
	5.1	MCO A RFI (ISCA)	3/13/2018	4/3/2018		
	5.1.1	Develop request for information	3/13/2018	4/2/2018		
	5.1.2	Technical peer review	4/3/2018	4/3/2018		
	5.1.3	Submit for compilation	4/3/2018	4/3/2018		
	5.1.4	Editorial peer review	4/4/2018	4/4/2018		
	5.1.5	Final look	4/5/2018	4/5/2018		
	5.1.6	State review of RFI	4/6/2018	4/10/2018		
	5.1.7	Revise RFI based on State feedback	4/11/2018	4/12/2018		
	5.1.8	Distribute to MCO A	4/13/2018	4/13/2018		
	5.1.9	MCO A Q&A on RFI	4/16/2018	4/18/2018		
	5.2	MCO A Online Tool Revisions (ISCA)	4/19/2018	4/27/2018		
	5.2.1	Develop desk tool content	4/19/2018	4/20/2018		
	5.2.2	Technical peer review	4/23/2018	4/23/2018		
	5.2.3	Editorial peer review	4/24/2018	4/24/2018		
	5.2.4	Submit for entry	4/25/2018	4/25/2018		
	5.2.5	Enter into back office	4/26/2018	4/26/2018		
	5.2.6	Final consultant review	4/27/2018	4/27/2018		
	5.2.7	Set up Connect folders	4/27/2018	4/27/2018		
	5.3	MCO A Desk Review (ISCA)	4/30/2018	5/25/2018		
	5.3.1	MCO A submission of RFI and pdf files (2 weeks)	4/30/2018	5/11/2018		
	5.3.2	Mercer initial review of submission	5/14/2018	5/14/2018		
	5.3.3	Track team desk review	5/15/2018	5/25/2018		
	5.3.4	Internal debrief	5/25/2018	5/25/2018		
	5.4	MCO A Onsite Review (ISCA)	5/28/2018	5/31/2018		
	5.4.1	State prep for onsite	5/28/2018	5/28/2018		
	5.4.2	Generate onsite materials (follow up questions, etc.)	5/28/2018	5/28/2018		
	5.4.3	Prep and ship all onsite materials	5/28/2018	5/28/2018		
	5.4.4	Mercer MCO A ISCA onsite review (1 travel + 2 review) includes staff interviews and observations	5/29/2018	5/31/2018		
	5.4.5	State MCO A ISCA onsite review (2 review days) includes staff interviews and observations	5/30/2018	5/31/2018		
	5.5	MCO A Report Writing (ISCA)	5/31/2018	6/27/2018		
	5.5.1	Report template	5/31/2018	5/31/2018		
	5.5.2	Draft report writing	6/1/2018	6/7/2018		
	5.5.3	Technical peer review	6/8/2018	6/8/2018		
	5.5.4	Submit for compilation	6/11/2018	6/11/2018		
	5.5.5	Editorial peer review	6/12/2018	6/12/2018		
	5.5.6	Final review	6/13/2018	6/13/2018		
	5.5.7	State review	6/14/2018	6/20/2018		
	5.5.8	Revise based on State feedback	6/21/2018	6/21/2018		
	5.5.9	MCO A review for errors and omissions	6/22/2018	6/26/2018		
	5.5.10	Revise based on MCO A review	6/27/2018	6/27/2018		
	5.5.11	Final report distribution	6/27/2018	6/27/2018		



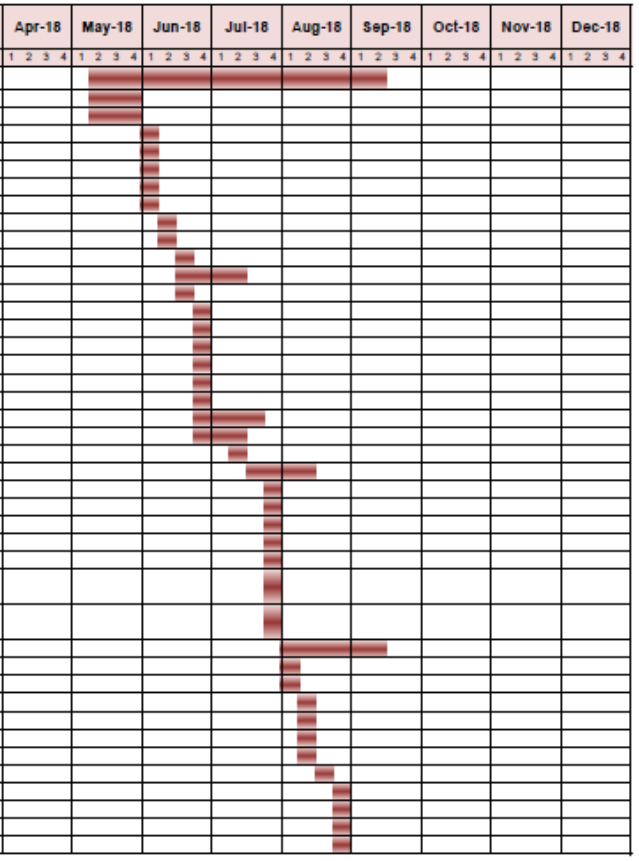
Mercer Internal Timeline

Activity		Task Description	Start Date	End Date	Mercer Lead	State Lead
MCO B: Balanced Budget Amendment	6	MCO B Balanced Budget Amendment (BBA)	4/30/2018	11/7/2018		
	6.1	MCO B RFI (CAP, VPM, VPIP, File Review)	4/30/2018	5/23/2018		
	6.1.1	Develop request for information	4/30/2018	5/4/2018		
	6.1.2	Technical peer review	5/7/2018	5/7/2018		
	6.1.3	Submit for compilation	5/7/2018	5/7/2018		
	6.1.4	Editorial peer review	5/8/2018	5/8/2018		
	6.1.5	Final look	5/9/2018	5/9/2018		
	6.1.6	State review of RFI	5/10/2018	5/16/2018		
	6.1.7	Revise RFI based on State feedback	5/17/2018	5/17/2018		
	6.1.8	Distribute to MCO B	5/18/2018	5/18/2018		
	6.1.9	Individual MCO B Q&A on RFI	5/21/2018	5/22/2018		
	6.1.10	Mercer updates file review tools as needed	5/23/2018	5/23/2018		
	6.2	Online Tool Revisions	5/15/2018	5/30/2018		
	6.2.1	Develop Desk Tool Content	5/15/2018	5/21/2018		
	6.2.2	Technical Peer Review	5/22/2018	5/22/2018		
	6.2.3	Editorial Peer Review	5/23/2018	5/23/2018		
	6.2.4	Submit for entry	5/23/2018	5/23/2018		
	6.2.5	Enter into back office	5/24/2018	5/28/2018		
	6.2.6	Final consultant review	5/29/2018	5/29/2018		
	6.2.7	Set up Connect folders	5/30/2018	5/30/2018		
	6.3	Desk Review	5/21/2018	7/9/2018		
	6.3.1	MCO B generate file universe list	5/21/2018	6/1/2018		
	6.3.2	Mercer selects files for reviews	6/4/2018	6/5/2018		
	6.3.3	Mercer posts file request	6/6/2018	6/6/2018		
	6.3.4	MCO B submission of RFI and pdf files (2 weeks)	6/7/2018	6/20/2018		
	6.3.5	Mercer initial review of submission	6/21/2018	6/21/2018		
	6.3.6	Track team desk review	6/22/2018	7/5/2018		
	6.3.7	2 internal debriefs: A&O, ISCA, G&A, CC/CM, UM, Rx, HCBS Network Cred.	7/6/2018	7/9/2018		
	6.4	Onsite Review	7/10/2018	7/20/2018		
	6.4.1	State prep for onsite	7/10/2018	7/10/2018		
	6.4.2	Generate onsite materials (follow up questions, etc.)	7/11/2018	7/12/2018		
	6.4.3	Prep and ship all onsite materials	7/13/2018	7/13/2018		
	6.4.4	Onsite MCO B review (1 travel + 3 review) Includes staff interviews and observations	7/16/2018	7/19/2018		
	6.4.5	State MCO B onsite review (3 day reviews) Includes staff interviews and observations	7/17/2018	7/19/2018		
	6.4.6	State debrief and reporting (1 day, day 4 of MCO B review)	7/20/2018	7/20/2018		
	6.5	Report Writing	7/24/2018	9/25/2018		
	6.5.1	Report template	7/24/2018	7/30/2018		
	6.5.2	Draft report writing	7/31/2018	8/13/2018		
	6.5.3	Technical peer review	8/14/2018	8/16/2018		
	6.5.4	Submit for compilation	8/17/2018	8/22/2018		
	6.5.5	Editorial peer review	8/23/2018	8/28/2018		
	6.5.6	Final review	8/29/2018	8/30/2018		
	6.5.7	State review	8/31/2018	9/13/2018		
	6.5.8	Revise based on State feedback	9/14/2018	9/17/2018		
	6.5.9	MCO B review for errors and omissions	9/18/2018	9/24/2018		
	6.5.10	Revise based on MCO B review	9/25/2018	9/25/2018		
	6.5.11	Final report distribution	9/25/2018	9/25/2018		
	7	Corrective Action Plan (CAP)	10/1/2018	11/7/2018		
	7.1.1	CAP template to MCO B	10/1/2018	10/1/2018		
	7.1.2	MCO B submits CAP	10/2/2018	10/15/2018		
	7.1.3	Mercer reviews CAP and either approves or rejects	10/16/2018	10/22/2018		
	7.1.4	Distribute approved/rejected CAP to MCO B	10/23/2018	10/23/2018		
	7.1.5	Meet with MCO B	10/24/2018	10/24/2018		
	7.1.6	CAP resubmission	10/25/2018	10/31/2018		
	7.1.7	Mercer re-review CAP	11/1/2018	11/7/2018		



Mercer Internal Timeline

Activity		Task Description	Start Date	End Date	Mercer Lead	State Lead
MCO B: Information Systems Capabilities Assessment	8	MCO B ISCA Follow Up	5/14/2018	8/28/2018		
	8.1	MCO B RFI (ISCA)	5/14/2018	6/4/2018		
	8.1.1	Develop request for information	5/14/2018	6/1/2018		
	8.1.2	Technical peer review	6/4/2018	6/4/2018		
	8.1.3	Submit for compilation	6/4/2018	6/4/2018		
	8.1.4	Editorial peer review	6/5/2018	6/5/2018		
	8.1.5	Final look	6/6/2018	6/6/2018		
	8.1.6	State review of RFI	6/7/2018	6/11/2018		
	8.1.7	Revise RFI based on State feedback	6/12/2018	6/13/2018		
	8.1.8	Distribute to MCO B	6/14/2018	6/14/2018		
	8.1.9	MCO B Q&A on RFI	6/15/2018	6/19/2018		
	8.2	MCO B Online Tool Revisions (ISCA)	6/20/2018	6/28/2018		
	8.2.1	Develop desk tool content	6/20/2018	6/21/2018		
	8.2.2	Technical peer review	6/22/2018	6/22/2018		
	8.2.3	Editorial peer review	6/25/2018	6/25/2018		
	8.2.4	Submit for entry	6/26/2018	6/26/2018		
	8.2.5	Enter into back office	6/27/2018	6/27/2018		
	8.2.6	Final consultant review	6/28/2018	6/28/2018		
	8.2.7	Set up Connect folders	6/28/2018	6/28/2018		
	8.3	MCO B Desk Review (ISCA)	6/29/2018	7/26/2018		
	8.3.1	MCO B submission of RFI and pdf files (2 weeks)	6/29/2018	7/12/2018		
	8.3.2	Mercer initial review of submission	7/13/2018	7/13/2018		
	8.3.3	Track team desk review	7/16/2018	7/26/2018		
	8.3.4	Internal debrief	7/26/2018	7/26/2018		
	8.4	MCO B Onsite Review (ISCA)	7/27/2018	8/1/2018		
	8.4.1	State prep for onsite	7/27/2018	7/27/2018		
	8.4.2	Generate onsite materials (follow up questions, etc.)	7/27/2018	7/27/2018		
	8.4.3	Prep and ship all onsite materials	7/27/2018	7/27/2018		
	8.4.4	Mercer MCO B onsite review (1 travel + 2 review) includes staff interviews and observations	7/30/2018	8/1/2018		
	8.4.5	State MCO B onsite review (2 review days) includes staff interviews and observations	7/31/2018	8/1/2018		
	8.5	MCO B Report Writing (ISCA)	8/1/2018	8/28/2018		
	8.5.1	Report template	8/1/2018	8/1/2018		
	8.5.2	Draft report writing	8/2/2018	8/8/2018		
	8.5.3	Technical peer review	8/9/2018	8/9/2018		
	8.5.4	Submit for compilation	8/10/2018	8/10/2018		
	8.5.5	Editorial peer review	8/13/2018	8/13/2018		
	8.5.6	Final review	8/14/2018	8/14/2018		
	8.5.7	State review	8/15/2018	8/21/2018		
	8.5.8	Revise based on State feedback	8/22/2018	8/22/2018		
	8.5.9	MCO B review for errors and omissions	8/23/2018	8/27/2018		
	8.5.10	Revise based on MCO B review	8/28/2018	8/28/2018		
	8.5.11	Final report distribution	8/28/2018	8/28/2018		



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