



Invitation for Bid:

**710-19-1020**

## **Expanded Medicaid Evaluation**

Presented to:



Arkansas Department of Human Services  
Office of Procurement  
700 Main Street  
Little Rock, Arkansas 72201

*May 9, 2019*

### **BID RESPONSE PACKET**

Presented by:

**Dave Mosley**  
Managing Director  
3325 Paddocks Parkway, Suite 425  
Suwanee, Georgia 30024  
678.845.7644  
david.mosley@navigant.com

navigant.com

## Table of Contents

### Section 1 Bid Signature Page

<b>Section 2 Minimum Qualifications .....</b>	<b>1</b>
A. Vendor Experience .....	1
B. Vendor References .....	10
C. Conflict of Interest / Independence .....	10
D. Sanctions, Corrective Actions, or Adverse Medicaid Program Occurrence .....	10
E. Bondability .....	10
F. Organizational Chart and Staffing.....	12

### Section 3 Required Forms

- A. EO Disclosure Form (Attachment A)
- B. Equal Opportunity Policy
- C. Signed Addenda
- D. Agreement and Compliance Pages
- E. Proposed Subcontractors Form

### Appendix A Navigant Staff Resumes

## Section 1 Bid Signature Page

Please see the following page for Navigant's Bid Signature Page.

[Balance of page intentionally left blank.]

# BID SIGNATURE PAGE

Type or Print the following information.

PROSPECTIVE CONTRACTOR'S INFORMATION				
Company:	Navigant Consulting, Inc			
Address:	3325 Paddocks Parkway, Suite 425			
City:	Suwanee	State:	GA	Zip Code: 30024
Business Designation:	<input type="checkbox"/> Individual <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Public Service Corp <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> Nonprofit			
Minority and Women-Owned Designation*:	<input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> American Indian <input type="checkbox"/> Asian American <input type="checkbox"/> Service Disabled Veteran <input type="checkbox"/> African American <input type="checkbox"/> Hispanic American <input type="checkbox"/> Pacific Islander American <input type="checkbox"/> Women-Owned			
	AR Certification #: <u>Not Applicable</u>		* See <i>Minority and Women-Owned Business Policy</i>	

PROSPECTIVE CONTRACTOR CONTACT INFORMATION			
Provide contact information to be used for bid solicitation related matters.			
Contact Person:	Dave Mosley	Title:	Managing Director
Phone:	678.845.7644	Alternate Phone:	
Email:	david.mosley@navigant.com		

CONFIRMATION OF REDACTED COPY
<input type="checkbox"/> YES, a redacted copy of submission documents is enclosed. <input checked="" type="checkbox"/> NO, a redacted copy of submission documents is <u>not</u> enclosed. I understand a full copy of non-redacted submission documents will be released if requested.  <i>Note: If a redacted copy of the submission documents is not provided with Prospective Contractor's response packet, and neither box is checked, a copy of the non-redacted documents, with the exception of financial data (other than pricing), will be released in response to any request made under the Arkansas Freedom of Information Act (FOIA). See Bid Solicitation for additional information.</i>

ILLEGAL IMMIGRANT CONFIRMATION
By signing and submitting a response to this <i>Bid Solicitation</i> , a Prospective Contractor agrees and certifies that they do not employ or contract with illegal immigrants. If selected, the Prospective Contractor certifies that they will not employ or contract with illegal immigrants during the aggregate term of a contract.

ISRAEL BOYCOTT RESTRICTION CONFIRMATION
By checking the box below, a Prospective Contractor agrees and certifies that they do not boycott Israel, and if selected, will not boycott Israel during the aggregate term of the contract.  <input checked="" type="checkbox"/> Prospective Contractor does not and will not boycott Israel.

**An official authorized to bind the Prospective Contractor to a resultant contract must sign below.**

The signature below signifies agreement that any exception that conflicts with a Requirement of this *Bid Solicitation* will cause the Prospective Contractor's bid to be disqualified:

Authorized Signature:  Title: Managing Director  
Use Ink Only.  
 Printed/Typed Name: Dave Mosley Date: May 08, 2019

## Section 2 Minimum Qualifications

### A. Vendor Experience

#### Introduction to Navigant

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

Navigant’s Healthcare segment is composed of more than 600 consultants, former provider administrators, clinicians, and other experts with decades of strategy, operational, clinical, managed services, revenue cycle management, and outsourcing experience. Our professionals collaborate with hospitals and health systems, physician enterprises, payers, government agencies, and life sciences entities, providing strategic, performance improvement, and business process management solutions that help them meet quality and financial goals.

**NAVIGANT HEALTHCARE CLIENTS INCLUDE:**

More than <b>300</b> health systems	<b>8</b> of the <b>20</b> "Honor Roll Hospitals" as rated by U.S. News & World Report
<b>36</b> of the <b>50</b> top pharmaceutical companies, based on 2017 data from PharmExec	<b>50%</b> of the largest health systems in the U.S listed by Definitive Healthcare

We take a unique interdisciplinary approach to our clients’ challenges. This means Navigant works as one team with one goal, leveraging the strengths and expertise of our senior-level consulting professionals in the delivery of integrated solutions.

Our primary solutions are in three areas:

- **Strategic Advisory** – We provide healthcare executives with objective, practical, results-oriented assistance to set strategic directions that enable long-term growth.
- **Operations Management and Implementation** – We have extensive experience and a successful record helping healthcare organizations implement solutions to improve financial, operational, and quality performance.
- **Outsourcing and Technology Solutions** – We provide revenue cycle outsourcing and technology solutions to help clients improve efficiency and make more informed decisions based on better information management.

Navigant continues to build a strategic platform for payers and providers, supporting the development and implementation of solutions that enable our clients to enhance the patient experience, reduce costs, and improve the health of populations they serve.

### **Awards**

Navigant ranked No. 3 on Modern Healthcare's 2018 list of "Largest Healthcare Management Consulting Firms." We have also received five Best in KLAS Awards since 2012 for our revenue cycle outsourcing solutions and were rated in the top quadrant for leading complex projects and leaving major impact in KLAS' *Healthcare Management Consulting 2017* report.

### **Research and Thought Leadership Expertise**

Navigant subject matter experts provide industry-leading research and thought leadership on a variety of topics, including:

- An analysis of health systems comprising 47 percent of U.S. hospitals found broad-based deterioration of operating margins following the Affordable Care Act insurance coverage expansion, with an average operating margin decline of 38.7 percent.
- An analysis of academic medical centers (AMCs) showed Medicare median wage and CMI-adjusted cost per case was 5.8 percent higher at AMCs versus non-AMCs in 2017. This equates to an estimated \$3.1 million in average added annual operating expenses for traditional fee-for-service Medicare patients per AMC analyzed.
- Executives are facing continued shortages of physicians, nurses, and mental health providers that may be challenging them to reduce labor costs, according to a Navigant / HFMA survey of CFOs.
- Providers are struggling to maximize the benefits of technology to better manage uncompensated care and revenue integrity, the Navigant / HFMA survey of CFOs and revenue cycle management executives also suggests.
- A study of 2,300 hospitals suggests they are spending approximately \$25.4 billion more annually on the supply chain than necessary, representing:
  - A 10.2 percent or \$2.4 billion savings opportunity increase compared to 2017.
  - A 17.7 percent average total supply expense reduction opportunity or up to \$11 million a year per hospital, without negatively impacting quality.

### **Discussion of Minimum Qualifications**

We believe that our extensive experience developing waivers and demonstrations – and conducting related evaluations – while working with CMS puts us at an advantage in modernizing Medicaid programs. Waiver and demonstration development work requires thorough policy analysis, assessment of federal regulations, national research description of new policies, cost-effectiveness analyses, and other support that is similar to what will be required for Arkansas' deliverables.



Our experience includes the following:

- Work with Medicaid programs across the country on waiver development, renewal, and evaluation projects
- Working with the various types of stakeholders across all related issues
- Writing applications for 1115 demonstrations and 1915(b) and 1915(c) waivers
- Participating in negotiations with CMS
- Conducting waiver and demonstration evaluations

Navigant has extensive experience conducting program evaluations and providing strategic decision-making support, including conducting environmental scans, collecting, and analyzing data and developing recommendations and reports to support that process – as well as with convening, facilitating, and staffing internal workgroups and taskforces charged with making recommendations for program design and reform.

We have worked with states across the nation to develop and conduct waiver evaluation plans, as well as to define reporting requirements for Managed Care Organizations (MCOs). We have prepared reports to legislatures in response to required oversight for managed care programs. We have, for example, developed 1115 Family Planning Waiver Evaluation Plans that outlined the evaluation timeline and deliverables, evaluation criteria, and research methodology, and our team has assisted with drafting the proposed approach to monitoring and evaluating primary care referrals.

In addition to the references we provide on further pages, we have performed work for the following clients:

- 1115 Demonstration for State of Wyoming
- 1115 Demonstration for State of Idaho
- Pennsylvania Department of Public Welfare (DPW) Development of a 1915(b) waiver for ACCESS Plus (the Commonwealth's EPCCM and disease management program)
- Evaluation of the Pennsylvania, North Carolina, and Wyoming Family Planning Waivers
- Evaluation of Piedmont Behavioral Health Managed Care Waiver
- Pennsylvania DPW 1115 demonstration proposal to Implement Premium Requirements for Select Populations
- Ohio 1915(b) and (c) waiver program for behavioral health
- Georgia 1915(B) waivers
- Indiana 1915(b) waivers
- Texas 1115 Demonstration Evaluation

**Navigant is ready to provide a team of seasoned consultants who have performed Medicaid managed care program administration and oversight for more than 25 years. Furthermore, we have experience with Medicaid programs in more than 45 states, and our project team has combined experience exceeding 100 years.**

Below, we provide a summary of our experience in selected states across the key focus areas associated with this engagement; however, it is not an exhaustive list.

Example No. 1: Montana Hospital Association	
<b>Services</b>	Navigant analyzed the impact of Medicaid expansion on Montana’s economy and access to care, given that legislation authorizing Montana’s Medicaid expansion program was set to expire in June 2019. We found that Montana’s Medicaid expansion had a significant positive economic impact and improved access to care for Medicaid expansion beneficiaries. Specifically, Medicaid expansion in Montana led to more than \$2 billion in new economic activity between fiscal year 2016 and fiscal year 2018 and created and supported 9,715 jobs annually. Medicaid expansion also helped “keep the doors open” for Montana hospitals, including hospitals that are essential to their communities. Finally, we identified that more Montanans had access to healthcare services due to Medicaid expansion. Navigant presented its findings to stakeholders in Montana and members of the media in March 2019: <a href="https://www.navigant.com/insights/healthcare/2019/hospital-funded-study-medicare-expansion">https://www.navigant.com/insights/healthcare/2019/hospital-funded-study-medicare-expansion</a> . Navigant dedicated 1-2 FTEs over the course of the project.
<b>Beneficiaries</b>	Our work was on behalf of the Montana Hospital Association and thus we did not work directly for the State; the State of Montana has approximately 278,000 Medicaid and CHIP enrollees.
<b>Contract Length</b>	2018 - 2019
<b>Contract Amount</b>	\$50,000
<b>Contact Information for Manager</b>	<b>Name and Title:</b> Rich Rasmussen, President / CEO <b>Organization:</b> Montana Hospital Association <b>Ph:   Em:</b> 406.442.1911   rich@mtha.org <b>Address:</b> 2625 Winne Avenue, Helena, Montana 59601

Example No. 2: State of Kansas	
<b>Services</b>	Since 2015, Navigant has supported the Kansas Department of Health and Environment to enhance its Medicaid managed care program, KanCare. As part of this work we have assisted KDHE <b>with two 1115 waiver renewals</b> – a one-year renewal and a five-year renewal. KDHE pursued two different waiver renewals because it wanted to use the time during the one-year renewal period to plan and prepare for the changes it requested for the five-year waiver renewal. All of the 1115 waiver negotiation activities that Navigant has supported have occurred during the



**Example No. 2: State of Kansas**

current Trump administration. The size of our project teams fluctuated over the different tasks described below:

**1115 Waiver One-Year Renewal**

We first supported KDHE with completing an 1115 waiver application to request a one-year renewal of Kansas’ current 1115 waiver. We gathered supporting documentation and materials from KDHE staff (e.g., external quality review organization reports, 1115 waiver quarterly and annual reports, budget neutrality summaries) and used this information to serve as the lead writer for the 1115 waiver renewal application. We participated in weekly calls with CMS, developed public notice materials, and provided comments on presentations used for the public hearings.

As part of the one-year renewal request, KDHE requested minimal changes to the current waiver. However, to approve the renewal of Kansas’ safety net care pools (which are approved as part of the 1115 waiver), CMS required that KDHE prepare a Safety Net Care Pool report. This report reviewed the cost of uncompensated care in Kansas and the financing involved with the current safety net care pools. Navigant completed this report on behalf of KDHE. CMS approved the one-year waiver renewal in October 2017.

**1115 Waiver Five-Year Renewal**

Following the approval of Kansas’ one-year 1115 waiver renewal, KDHE wanted to make more significant changes to its waiver program. Navigant assisted the State with drafting a Concept Paper that outlined the major changes that KDHE was interested in pursuing as part of the five-year waiver renewal. Together with KDHE staff, we shared the Concept Paper with CMS representatives to receive initial feedback and understand if CMS had any concerns regarding Concept Paper topics. KDHE’s five-year 1115 waiver renewal application covers topics similar to those in MQD’s HOPE vision document, such as:

- Increased use of value-based purchasing contracts with MCOs
- State directed payments to support quality improvement among providers
- Increased focus on social determinants of health through expanding service coordination, including assisting members with accessing affordable housing; food security; and employment and increasing employment and independent living supports for members with behavioral health needs
- IMD exclusion waiver
- Increased use of data and analytics to achieve transformation goals

The Navigant team drafted the 1115 waiver renewal application, serving as the primary writer. Many of the elements included in this renewal application required Navigant to draw upon our deep knowledge of federal regulations to determine what was and was not permissible for KDHE to request. In addition, we provided guidance to KDHE leadership on the potential impact of initiatives requested in the 1115 waiver renewal application, such as work requirements and an IMD exclusion waiver. Navigant developed a schedule to review the draft waiver with KDHE leadership and incorporate their comments and suggested modifications. Navigant also supported

Example No. 2: State of Kansas	
	<p>the public comment process, including drafting public notices, preparing public hearing meeting materials, preparing stakeholder engagement materials, and responding to written public comments. We also prepared KDHE leadership and State legislators with talking points about the significant changes in the 1115 renewal application and how those changes will support KDHE’s objectives. Because these talking points were used with a broad audience, we focused on key messages and wrote them in an easy-to-understand manner.</p> <p>As part of KDHE’s 1115 waiver renewal, we provided guidance and expertise regarding state directed payments as described in 42 CFR 438.6(c). We conducted visioning sessions with KDHE leadership regarding the objectives for state directed payments and the types of providers that should be eligible to receive these payments. Our team also participated in a call with CMS regarding state directed payment programs to receive the most up-to-date guidance.</p> <p>Navigant is currently supporting KDHE in discussions and negotiations with CMS, including responding to CMS’ questions on the 1115 waiver renewal application. CMS approved Kansas’s one-year waiver renewal in October 2017 and the five-year waiver renewal in December 2018.</p>
<b>Beneficiaries</b>	The State of Kansas has approximately 390,000 Medicaid and CHIP enrollees.
<b>Contract Length</b>	We have worked with Kansas since 2011 – however, our current contract dates are August 1, 2017 – June 30, 2019.
<b>Contract Amount</b>	Current contract: \$3.5 million (August 1, 2017 – June 30, 2019)
<b>Contact Information for Manager</b>	<p><b>Name and Title:</b> Adam Proffitt, Medicaid Director</p> <p><b>Organization:</b> Kansas Department of Health and Environment</p> <p><b>Ph:   Em:</b> 785.296.3563   adam.proffitt@ks.gov</p> <p><b>Address:</b> 1000 SW Jackson, Suite 340, Topeka, KS 66601</p>

Example No. 3: State of Alabama	
<b>Services</b>	<p>Navigant was awarded a five-year contract with the Alabama Medicaid Agency (AMA) to implement a provider-based Regional Care Organization (RCO) model, design and implement a managed long-term care program [referred to as the Integrated Care Networks (ICN) program] and assist in other managed care program design and administration activities. Navigant supported 30+ task orders for AMA that involved more than two dozen project team members. Select activities include:</p> <p><b>Waivers</b></p> <ul style="list-style-type: none"> <li>Assisted with the development of AMA’s 1115 demonstration waiver, approved by CMS in February 2016; drafted the demonstration waiver, managed the public comment process, developed the Special Terms and Conditions, and supported AMA in its negotiations with CMS</li> </ul>

**Example No. 3: State of Alabama**

- Assisted AMA in the design of its Delivery System Reform Incentive Payment (DSRIP)-like program, approved under the 1115 demonstration waiver
- Drafted a 1915(b) waiver for a:
  - Proposed dental managed care program
  - Managed long-term care program
- Assisted AMA with the consolidation of three 1915(c) waivers

**Data Analysis**

- Analyzed State performance on population health and health services utilization to identify specific objectives and targets for a delivery system improvement initiative
- Analyzed long-term care cost and population trends to inform the design of a new managed long-term care program
- Analyzed data to determine the potential impact of managed care on community mental health center reimbursement rates

**Managed Care Contracts**

- Assisted AMA in developing a comprehensive contract for both the RCO and ICN programs; both contracts include federal requirements and best practices from other states, while incorporating provisions unique to AMA’s specific objectives
- Incorporated required elements of 2016 Medicaid and CHIP Managed Care Final Rule
- Facilitated discussions with CMS regarding the approval of the RCO contract

**Managed Care Monitoring**

- Developed a Reporting Manual that detailed the instructions and reporting templates for the RCOs to use when submitting reports to AMA
- Created SOPs for AMA to use when reviewing RCO reports
- Developed monitoring manual for AMA to use to support effective oversight of RCOs
- Provided many training sessions to AMA staff to build monitoring skills and capacity

**Managed Care Procurements**

- Developed procurement materials for the managed-long term care procurement
- For an enrollment broker procurement, reviewed other states’ contracts to identify common requirements and services, drafted key program design considerations, and facilitated a work group charged with developing the design
- For an external quality review organization (EQRO) procurement, provided research on other state EQRO contracts and drafted scope of work for the RFP
- For a Health Home procurement, assisted in developing procurement materials, including a Health Home RFP

Example No. 3: State of Alabama	
	<ul style="list-style-type: none"> <li>For a dental managed care procurement, assisted in review of RFP, including providing subject matter expertise on compliance with federal regulations</li> </ul> <p><b>New Delivery or Payment Methodologies</b></p> <ul style="list-style-type: none"> <li>Assisted in transition from inpatient payment model (per diem payments) to All Patient Refined Diagnosis Related Group (APR-DRG) methodology</li> </ul> <p><b>Program Integrity</b></p> <ul style="list-style-type: none"> <li>Assisted drafting managed care contractual requirements for program integrity</li> <li>Assisted program integrity unit in preparing for transition from FFS oversight to managed care; developed RCO reporting requirements and initiated work with program integrity unit for collection and analyses of RCO reported data</li> </ul> <p><b>Quality Management</b></p> <ul style="list-style-type: none"> <li>Supported AMA's process to identify quality measures for both the RCO and ICN programs</li> <li>Assisted AMA to develop a methodology for distribution of incentive payments, based on satisfactory reporting and achievement of outcome and quality targets</li> <li>Assisted AMA in developing a managed care quality assessment and performance improvement strategy, which defined Alabama's goals and objectives for its managed care programs and described its approach to facilitate improvements in performance</li> </ul> <p><b>Readiness Reviews</b></p> <ul style="list-style-type: none"> <li>Developed readiness assessment reporting templates, governance structure, and timelines for AMA and RCOs</li> <li>Developed a readiness assessment tool, which identified the specific requirements that the RCOs must meet</li> <li>Conducted desk and on-site reviews</li> <li>Developed corrective action plans (CAPs) that were used to monitor the RCOs</li> </ul> <p><b>Special Populations</b></p> <ul style="list-style-type: none"> <li>Assisted AMA in developing a managed long-term care program for individuals in nursing facilities and individuals receiving HCBS, including dual eligibles</li> </ul>
<b>Beneficiaries</b>	The State of Alabama has approximately 900,000 Medicaid and CHIP enrollees.
<b>Contract Length</b>	2015 – 2018
<b>Contract Amount</b>	Approximately \$5 million per year
<b>Contact Information for Manager</b>	<p><b>Name and Title:</b> Jerri Jackson, Director of the Managed Care Division</p> <p><b>Organization:</b> Alabama Medicaid Agency</p> <p><b>Ph:</b>   <b>Em:</b> 334.242.5630   jerri.Jackson@medicaid.alabama.gov</p> <p><b>Address:</b> 501 Dexter Ave., Montgomery, Alabama 36130</p>

Example No. 4: Commonwealth of Kentucky	
<b>Services</b>	<p>Navigant has developed and certified managed care rates involving comprehensive covered services for the following programs: <b>TANF, CHIP, ABD non-dual eligible, Former foster care children, NEMT, Medicare-Medicaid dual eligible, and Mental and Behavioral health services.</b> Our current project team includes more than 20 individuals.</p> <p>From 2017-2018, Navigant conducted a comprehensive assessment of the Commonwealth's six 1915(c) home-and community-based waiver programs to identify opportunities to improve program design, operation and monitoring of the waivers and identify opportunities to optimize use of funding for programs.</p> <p>Following the conclusion of this assessment, Navigant has served as a strategic partner and subject matter expert as the Department undertakes redesign in several areas:</p> <ul style="list-style-type: none"> <li>• Re-writing of all 1915(c) waiver applications and waiver-related state regulations</li> <li>• Centralization of quality management</li> <li>• Redesign of the case management and person-centered service planning model</li> <li>• Redesign of participant directed services</li> <li>• Technological capture of functional assessment data and improved assessor training and contracts</li> <li>• Overhaul of stakeholder communications and legislative engagement strategy</li> <li>• Completion of a rate methodology study for all 1915(c) waiver funded services to develop a federally approved rate setting method</li> </ul>
<b>Beneficiaries</b>	The Commonwealth of Kentucky has approximately 1,219,000 Medicaid and CHIP enrollees.
<b>Contract Length</b>	Current contract: April 2017 – Present
<b>Contract Amount</b>	Current contract: \$3,793,424
<b>Contact Information for Manager</b>	<p><b>Name and Title:</b> Pam Smith, RN, Director of the Division of Community Alternatives</p> <p><b>Organization:</b> Kentucky Department of Medicaid Services</p> <p><b>Ph:   Em:</b> 502.604.7540   pam.smith@ky.gov</p> <p><b>Address:</b> 275 E Main St. Frankfort, KY 40601</p>

**B. Vendor References**

---

We are pleased that the following clients have agreed to serve as references to the type and quality of our work.

<p><b>Reference No. 1</b>  <i>Montana Hospital Association</i></p>	<p><b>Rich Rasmussen, President / CEO</b>          406.442.1911   rich@mtha.org          2625 Winne Avenue, Helena, Montana 59601</p>
<p><b>Reference No. 2</b>  <i>Kentucky Cabinet for Health and Family Services</i></p>	<p><b>Lead Reference</b></p> <p><b>Carol Steckel, Commissioner at Commonwealth of Kentucky Cabinet for Health and Family Services</b>          813.624.1549   carol.steckel@ky.gov</p> <p><b>For questions relative to our current contract:</b></p> <p><b>Pam Smith, RN, Director of the Division of Community Alternatives</b>          502.604.7540   pam.smith@ky.gov          275 E Main St. Frankfort, KY 40601</p>
<p><b>Reference No. 3</b>  <i>Alabama Medicaid Agency</i></p>	<p><b>Jerri Jackson, Director of the Managed Care Division</b>          334.242.5630   jerri.Jackson@medicaid.alabama.gov          501 Dexter Ave., Montgomery, Alabama 36130</p>
<p><b>Reference No. 4</b>  <i>Kansas Department of Health and Environment</i></p>	<p><b>Adam Proffitt, Medicaid Director</b>          785.296.3563   adam.proffitt@ks.gov          1000 SW Jackson, Suite 340, Topeka, KS 66601</p>

**C. Conflict of Interest / Independence**

---

Navigant affirms that we have read the Organizational / Personal Conflict of Interest Clause and that, without limitation or qualification, we have no actual, apparent, or potential conflicts of interest with, and are independent from all parties listed in the RFP.

**D. Sanctions, Corrective Actions, or Adverse Medicaid Program Occurrence**

---

As a public company, all material litigation and other proceedings are disclosed in our annual report on Form 10-K and quarterly reports on Form 10-Q filed with the SEC, copies of which can be found on Navigant's Investor Relations page or the SEC's website.

**E. Bondability**

---

Navigant has contacted our insurance provider, Lockton, with regard to our Certification of Bondability. Lockton has provided assurance that we will receive a Letter of Bondability prior to contract award. Their assurance is provided on the following page.





May 5<sup>th</sup>, 2019

State of Arkansas  
Department of Human Services  
Office of Procurement  
700 Main Street  
Little Rock, AR 72201

Re: Navigant Consulting, Inc.  
Obligee: State of Arkansas – Bid # 710-19-1020 Expanded Medicaid Evaluation  
Bid Security: Request for Surety Prequalification Letter of Commitment

To Whom It May Concern:

Great American Insurance Company a corporation under the laws of the State of Ohio, with an office and place of business (Surety Home Office), represents Navigant Consulting, Inc. for surety bonding needs. Great American Insurance Company has an AM Best Rating of "A+" (Superior) "XIV" (\$1.5 Billion to \$2 Billion). Great American is authorized to do business in the State of Arkansas.

Current, Great American Insurance Company is in a position to consider single projects up to \$2Mil within an aggregate limit of \$4Mil. The statement of these values is neither a commitment nor a limitation of the bonding capacity of Navigant Consulting, Inc. At the request of Navigant Consulting, Inc., Great American Insurance Company will give favorable consideration, to providing the required Performance bond.

Please note that the decision to issue the Performance bond is a matter between Navigant Consulting, Inc. and Great American Insurance Company, and will be subject to our standard underwriting at the time of the final bond request, which will include but not limited to the acceptability of the contract documents and acceptable annual bond forms; with annually renewable options. We assume no liability to Navigant Consulting, Inc. third parties or to you if for any reason we do not execute said bonds.

Sincerely,

*Debra Kohlman*

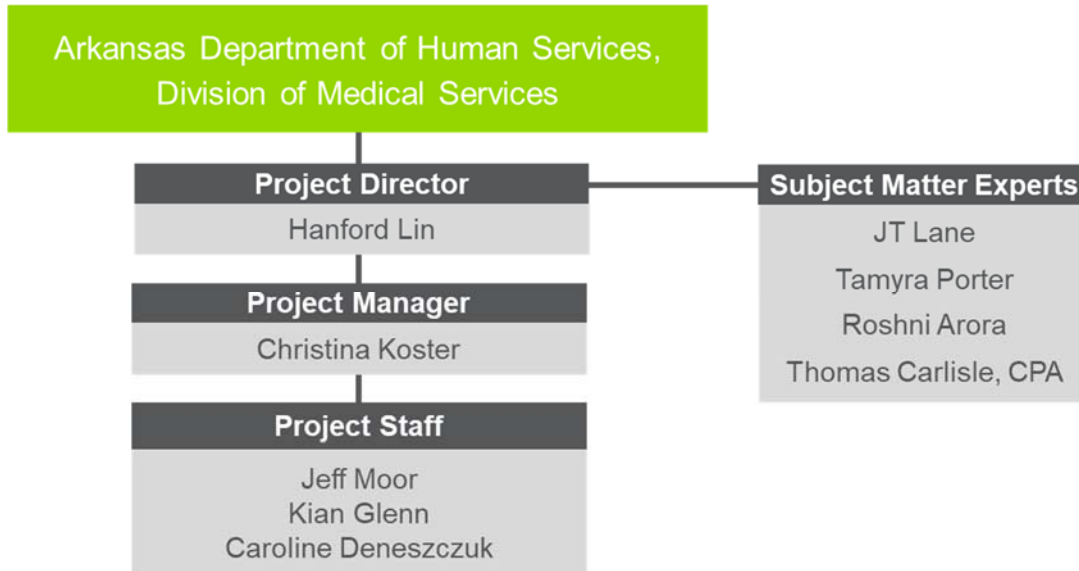
Debra Kohlman  
Attorney-In-Fact for Great American Insurance Company



**F. Organizational Chart and Staffing**

Navigant’s committed resources are healthcare professionals with numerous years of hands-on managerial and subject matter experience. We are confident Arkansas will find our collective complement of resources second to none.

We expect that the following professionals will lead Navigant’s efforts in respective functional areas:



Detailed information about these staff can be found in the following chart and in Appendix A.

Name / Title	Relevant Experience
<b>Project Leadership</b>	
<p><b>Hanford Lin</b> Director</p>	<p>Hanford has 20 years of experience working with commercial, Medicaid, and Federal healthcare payers, providers, and life sciences companies. He helps clients with quality improvement, value-based purchasing models, fee-for-service and managed care program design and implementation, data analytics and performance management.</p> <p>As Acting Deputy Secretary for the Kansas Department of Health and Environment – Medicaid, worked closely with Medicaid leadership and frontline staff, Governor’s Office, and State Legislature to assess, design, and implement program initiatives. Led team to successfully develop and negotiate 1115 Demonstration Waiver renewal for Kansas’s Medicaid managed care program, including options assessment and design of community engagement requirements. He also previously conducted an independent study of the economic and healthcare access impact of Medicaid expansion in Montana. The study was used by the legislature and other stakeholders in their decision to reauthorize Medicaid expansion.</p> <p>Hanford leads engagements to develop, implement, and operate Medicaid managed care, primary care case management, and fee-for-service delivery systems, from</p>

Name / Title	Relevant Experience
	<p>procurement and contracting to development and implementation of operational processes, organizational structures, and tools. He supports clients to develop processes and strategies for monitoring and evaluating program performance and driving quality improvement and develops tools to facilitate program monitoring and operations.</p> <p>He also works extensively with quality and performance measure sets including Healthcare Effectiveness Data and Information Set (HEDIS®), Consumer Assessment of Healthcare Providers and Systems (CAHPS®), Agency for Healthcare Research and Quality (AHRQ), and other National Quality Forum (NQF)-endorsed measures for both physical health and behavioral health.</p>
<p><b>Christina Koster</b> Director</p>	<p>Christina has more than 10 years of experience working with public and private payers and providers, focusing on state Medicaid managed care programs. One of Christina’s areas of concentration is Medicaid waivers. Most recently, she assisted two states – Alabama and Kansas – with 1115 waivers. This included drafting the waiver application, managing the public input process, participating in and supporting CMS negotiations, and advising on strategy to support CMS waiver approval. In Alabama, Christina also managed the process to develop and receive CMS approval for operational protocols and other documents required by the waiver Terms and Conditions. Christina has also assisted states with 1915(b) waivers and 1915(c) waivers and provided guidance related to state directed payments and 438.6(c) preprint forms.</p> <p>Christina has assisted many states in determining strategy around Medicaid managed care initiatives, including those addressing behavioral health, long-term services and supports, and dental services. She is an experienced project manager, having led large multi-million, multi-year engagements with more than 20 staff.</p>
<b>Project Staff</b>	
<p><b>Caroline Deneszcuk</b> Managing Consultant</p>	<p>Caroline specializes in Medicaid waiver policy, stakeholder engagement, program management and operational assessments. Caroline has worked with Kentucky’s Cabinet for Health and Family Services on 1915(c) waiver redesign activities including conducting internal operational assessments, updating 1915(c) waiver applications, policies, regulations and operations.</p> <p>Caroline also led reviewing, drafting and negotiating efforts between Alabama and CMS for its 1915(b)/(c) concurrent waivers. She has also provided policy recommendations to CMS regarding 1115 waivers, including improving reporting requirements and adherence to Terms and Conditions.</p>
<p><b>Kian Glenn</b> Managing Consultant</p>	<p>Kian specializes in assisting states to achieve waiver, including 1115 waiver, approval by CMS. This work includes evaluating draft or historical waivers, conducting negotiations with CMS and other stakeholders, and drafting waiver Terms and Conditions and protocols. Kian has nine years of experience helping states and providers develop waiver funding strategies, integrate physical and behavioral health, identify evidence-based interventions and outcome measurements, implement advanced primary care models, and develop value-based payment methodologies.</p>

Name / Title	Relevant Experience
	<p>Kian uses research and analysis to help clients develop managed care strategy and policy. She is an expert at analyzing CMS approved models and developing innovative approaches to conform state goals into ones that fit within CMS' approval framework. This includes develop a state-specific Medicaid story, talking points, and project management approach to streamline CMS negotiations.</p> <p>Prior to joining Navigant, Kian worked as a principal planner for the Minnesota Department of Health. In this role she provided state planning, leadership, and clinical practice expertise for the Statewide Health Improvement Program, to reduce obesity and tobacco use rates, chronic disease morbidity and mortality and health care costs.</p>
<p><b>Jeffrey Moor</b> Director</p>	<p>Jeff has more than 18 years of experience in the healthcare industry and significant experience with Medicaid managed care programs, Medicaid waiver development and analysis, healthcare policy research, and data analysis. Jeff is an experienced engagement director, skilled at leading large and complex projects.</p> <p>Jeff is currently directing a large project at CMS where Navigant is responsible for reviewing and assessing the completeness, reasonableness and regulatory compliance of state 1915(c) waiver applications, renewals and amendments. Over the past 3.5 years of the contract, Jeff has overseen the review of approximately 130 different waivers across 30 different states. Jeff also oversees the development and delivery of HCBS training materials that CMS is using to educate states on best practices regarding 1915(c) waiver applications and program policies. Jeff's experience brings a unique perspective regarding CMS's approach to reviewing, negotiating and approving state waiver applications. Jeff also has experience with developing and evaluating waivers on behalf of states, including conducting independent assessments of 1915(b) waiver programs and designing and developing state 1915(c) waiver programs. Lastly, Jeff supported a project for a State Attorney General's office to review the state's 1115 waiver requirements and Medicaid managed care plan performance related to cost, quality, and access to services.</p>
<p><b>Subject Matter Expert Resource Pool</b></p>	
<p><b>Roshni Arora</b> Associate Director</p>	<p>Roshni has more than 12 years of experience in the healthcare industry working with government-sponsored programs. Roshni specializes in the design and implementation of Medicaid waiver programs including 1115 waiver demonstrations, 1915(b) waivers, and 1915(c) waivers. For example, she assisted the State of Kansas with drafting the Concept Paper and Section 1115 waiver demonstration renewal application, supported the public comment process (e.g., draft public notices, prepare public hearing meeting materials, prepare stakeholder engagement materials, respond to written public comments), and finalized the 1115 waiver renewal application for submission to CMS. She is also currently supporting the State in discussions and negotiations with CMS, including responding to CMS' questions.</p> <p>Roshni also has significant experience in supporting states to conduct procurement and contracting activities. Specifically, Roshni leads the development of procurement materials that incorporate best practices across all managed care program areas to develop a foundation for program implementation, monitoring, and evaluation.</p>

Name / Title	Relevant Experience
<p><b>Thomas Carlisle</b> Associate Director</p>	<p>Thomas offers a unique perspective to Navigant's Healthcare practice having previously served as Chief Financial Officer (CFO) for the Arkansas Division of Medical Services, which administers the State's Medicaid program. He has extensive leadership as a financial executive and for the past decade as a healthcare financial subject matter expert related to Medicaid, including 1115 waivers for initial applications and renewals. As Medicaid CFO in Arkansas, Thomas was part of the leadership team that obtained CMS approval for the first 1115 waiver to expand Medicaid under the Patient Protection and Affordable Care Act—known as the “Private Option.” He was responsible for all financial aspects of the approval process including working with the Arkansas Legislature, sister agencies, providers, other stakeholders and CMS.</p> <p>More recently, he supported Alabama with its CMS approval of an 1115 waiver to implement a new risk-based Medicaid managed care program. He assisted with financial program design, stakeholder meetings and education, public comment responses, and weekly negotiations with CMS, including development of financial protocols and Terms and Conditions. Thomas continues to work with Alabama on implementation of a long-term care program under a 1915(b)/(c) combo waiver.</p> <p>In addition to his 1115 waiver support in Alabama, Thomas recently served as the Interim Medicaid CFO for the Kansas Department of Health and Environment during Fall 2017/Winter 2018. During his tenure, he assisted Kansas with its renewal of their KanCare 1115 managed care program.</p>
<p><b>J.T. Lane</b> Director</p>	<p>J.T. has more than 15 years of experience in strategic planning and execution; budget and staff management; program and policy development, implementation and evaluation; and service delivery in the health, health care and human services sectors, including Medicaid managed care and legacy federal grant programs.</p> <p>J.T. has led innovative integration efforts to improve health and lower costs of Medicaid programs and health plans by leveraging other public sector health and human services programs. He has led public sector organizations through strategic planning, restructuring processes, implementation and change management activities to improve organizational performance and program impact. He has frequently presented on a variety of complex health and health care topics to governors, members of Congress, federal agency heads, state legislators and local elected officials. J.T. served as a Senior Advisor for Health and Human Services for A&amp;M's efficiency study for the State of Rhode Island. Prior to joining A&amp;M, J.T. worked as a Principal at Health Management Associates, Inc., where he advised and supported a variety of local, state, national, and global organizations on an array of Medicaid and population health topics. He led and performed strategic planning, research and analysis, internal and external meeting facilitation and engagement, community and public sector system assessment, technical assistance and organizational redesign planning.</p> <p>Previously, J.T. served as Louisiana's chief public health official on health system and payer transformation and health promotion to build safe, healthier communities in Louisiana. He co-led the development of Medicaid quality improvement initiatives with</p>

Name / Title	Relevant Experience
	<p>the state's Medicaid director. J.T. has also served as the Chief of Staff of the Louisiana Department of Health and Hospitals, where he actively guided the development and management of an \$8 billion annual budget and services that reached every corner of the state. He worked closely with health care providers, other stakeholder groups, and Louisiana Medicaid to develop and implement the Governor's Medicaid Reform Initiative, resulting in a "whole person" care coordination concept and addressing multidisciplinary wellness objectives for nearly one million Medicaid recipients and lower costs for taxpayers.</p>
<p><b>Tamyra Porter</b> Director</p>	<p>Tamyra has 19 years of experience working on the design, implementation, and oversight of Medicaid programs in over a dozen states. Her experience provides clients with subject matter expertise to interpret legislation, develop administrative codes, and conform to various other federal requirements. In Alabama, Tamyra provided support related to Alabama's 1115 waiver and implementation of waiver and protocol requirements. She was engaged in regular negotiations with CMS regarding the development of the waiver, financing, and Terms and Conditions. She directed changes to the risk-based contracts, in response to waiver negotiations.</p> <p>Tamyra has also worked closely with clients related to LTSS program design, including administering 1915(c) waivers and developing MLTSS program models. Tamyra has improved internal operations regarding oversight and quality improvement and assisted with CMS-issued corrective actions.</p>

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

Detailed professional resumes can be found in Appendix A.



## Section 3 Required Forms

Please see the following pages for Required Forms pursuant to the RFP:

- A. EO Disclosure Form (Attachment A)
- B. Equal Opportunity Policy
- C. Signed Addenda
- D. Agreement and Compliance Pages
- E. Proposed Subcontractors Form

[Balance of page intentionally left blank.]

**CONTRACT AND GRANT DISCLOSURE AND CERTIFICATION FORM**

Failure to complete all the following information may result in a delay in obtaining a contract, lease, purchase agreement, or grant award with any Arkansas State Agency.

**SUBCONTRACTOR:**  YES  NO **SUBCONTRACTOR NAME:** N/A

**Contractor for which this is a subcontractor:**  
Navigant Consulting, Inc.

**Estimated dollar amount of subcontract:** N/A

**TAXPAYER ID NAME:** Navigant Consulting, Inc. **IS THIS FOR:**  Goods?  Services  Both?

**YOUR LAST NAME:** N/A **FIRST NAME:** N/A **MI:** N/A

**ADDRESS:** 3325 Paddocks Parkway, Suite 425

**CITY:** Suwanee **STATE:** GA **ZIP CODE:** 30024 **COUNTRY:** UNITED STATES OF AMERICA

**AS A CONDITION OF OBTAINING, EXTENDING, AMENDING, OR RENEWING A CONTRACT, LEASE, PURCHASE AGREEMENT, OR GRANT AWARD WITH ANY ARKANSAS STATE AGENCY, THE FOLLOWING INFORMATION MUST BE DISCLOSED:**

**FOR INDIVIDUALS\***

Indicate below if: you, your spouse or the brother, sister, parent, or child of you or your spouse is a current or former: Member of the General Assembly, Constitutional Officer, State Board or Commission Member, or State Employee:

Position Held	Mark (✓)		Name of Position of Job Held [senator, representative, name of board/commission, data entry, etc.]	For How Long?		What is the person(s) name and how are they related to you? (i.e., Jane Q. Public, spouse, John Q. Public, Jr., child, etc.)	
	Current	Former		From MM/YY	To MM/YY	Person's name(s)	Relation
General Assembly	<input type="checkbox"/>	<input type="checkbox"/>					
Constitutional Officer	<input type="checkbox"/>	<input type="checkbox"/>					
State Board or Commission Member	<input type="checkbox"/>	<input type="checkbox"/>					
State Employee	<input type="checkbox"/>	<input type="checkbox"/>					

None of the above applies

**FOR A VENDOR (BUSINESS)\***

Indicate below if any of the following persons, current or former, hold any position of control or hold any ownership interest of 10% or greater in the entity: member of the General Assembly, Constitutional Officer, State Board or Commission Member, or State Employee, or the spouse, brother, sister, parent, or child of a member of the General Assembly, Constitutional Officer, State Board or commission Member, or State Employee. Position of control means the power to direct the purchasing policies or influence the management of the entity.

Position Held	Mark (✓)		Name of Position of Job Held (senator, representative, name of board/commission, data entry, etc.)	For How Long?		What is the person(s) name and what is his/her % of ownership interest and/or what is his/her position of control?		
	Current	Former		From MM/YY	To MM/YY	Person's name(s)	Ownership Interest (%)	Position of Control
General Assembly	<input type="checkbox"/>	<input type="checkbox"/>						
Constitutional Officer	<input type="checkbox"/>	<input type="checkbox"/>						
State Board or Commission Member	<input type="checkbox"/>	<input type="checkbox"/>						
State Employee	<input type="checkbox"/>	<input type="checkbox"/>						

None of the above applies

\* NOTE: PLEASE LIST ADDITIONAL DISCLOSURES ON SEPARATE SHEET OF PAPER IF MORE SPACE IS NEEDED


CONTRACT AND GRANT DISCLOSURE AND CERTIFICATION FORM F-2

**Failure to make any disclosure required by Governor's Executive Order 98-04, or any violation of any rule, regulation, or policy adopted pursuant to that Order, shall be a material breach of the terms of this contract. Any contractor, whether an individual or entity, who fails to make the required disclosure or who violates any rule, regulation, or policy shall be subject to all legal remedies available to the agency.**

**As an additional condition of obtaining, extending, amending, or renewing a contract with a state agency I agree as follows:**

1. Prior to entering into any agreement with any subcontractor, prior or subsequent to the contract date, I will require the subcontractor to complete a **CONTRACT AND GRANT DISCLOSURE AND CERTIFICATION FORM**. Subcontractor shall mean any person or entity with whom I enter an agreement whereby I assign or otherwise delegate to the person or entity, for consideration, all, or any part, of the performance required of me under the terms of my contract with the state agency.
2. I will include the following language as a part of any agreement with a subcontractor:  
***Failure to make any disclosure required by Governor's Executive Order 98-04, or any violation of any rule, regulation, or policy adopted pursuant to that Order, shall be a material breach of the terms of this subcontract. The party who fails to make the required disclosure or who violates any rule, regulation, or policy shall be subject to all legal remedies available to the contractor.***
3. No later than ten (10) days after entering into any agreement with a subcontractor, whether prior or subsequent to the contract date, I will mail a copy of the **CONTRACT AND GRANT DISCLOSURE AND CERTIFICATION FORM** completed by the subcontractor and a statement containing the dollar amount of the subcontract to the state agency.

**I certify under penalty of perjury, to the best of my knowledge and belief, all of the above information is true and correct and that I agree to the subcontractor disclosure conditions stated herein.**

Signature  Title Managing Director Date May 08, 2019  
Vendor Contact Person Dave Mosley Title Managing Director Phone No. 678.845.7644

**AGENCY USE ONLY**

Agency Number 0710 Agency Name Department of Human Services Agency Contact Person \_\_\_\_\_ Contact Phone No. \_\_\_\_\_ Contract or Grant No. \_\_\_\_\_



## Equal Employment Policy

---

Navigant is committed to equal employment opportunity and affirmative action, both in principle and as a matter of corporate policy. Navigant maintains a strict policy prohibiting discrimination because of race, color, national origin, ancestry, citizenship status, military status, protected veteran status, religion, creed, physical or mental disability, medical condition, marital status, sex, sexual orientation, gender, gender identity or expression, age, genetic information or any other basis protected by law, ordinance, or regulation. Navigant's commitment to equal employment opportunity, affirmative action, and non-discrimination is outlined in detail in the Equal Employment Opportunity and Affirmative Action Statement of Policy posted on Navigant's internal intranet, the Employee Handbook, and in each office location.

### **Standard:**

1. Navigant will recruit, hire, train, and promote applicants and employees in all job classifications without discrimination.
2. Navigant will ensure that promotion decisions are in accordance with principles of equal employment opportunity by imposing only valid requirements for promotional opportunities.
3. Navigant will ensure that all other personnel actions, such as compensation, benefits, transfers, layoffs, returns from layoffs, tuition assistance, company-sponsored training, education, and social and recreational programs will be administered without discrimination.
4. Furthermore, Navigant ensures equal employment opportunities to qualified individuals with a disability and, upon request, will make reasonable accommodations to qualified employees or applicants provided such accommodation will not place an undue hardship on the conduct of the company's business.
5. Navigant will not discharge or in any other manner discriminate against employees or applicants because they have inquired about, discussed, or disclosed their own pay or the pay of another employee or applicant. However, employees who have access to the compensation information of other employees or applicants as a part of their essential job functions cannot disclose the pay of other employees or applicants to individuals who do not otherwise have access to compensation information, unless the disclosure is (a) in response to a formal complaint or charge, (b) in furtherance of an investigation, proceeding, hearing, or action, including an investigation conducted by Navigant, or (c) consistent with the Navigant's legal duty to furnish information.
6. Navigant will not retaliate against any person who files a complaint concerning EEO and shall ensure that no one harasses, intimidates, threatens, coerces, or discriminates against any individual exercising rights under this policy.

State of Arkansas  
DEPARTMENT OF HUMAN SERVICES  
700 South Main Street  
P.O. Box 1437 / Slot W345  
Little Rock, AR 72203  
501-320-6511

**ADDENDUM 1**

**DATE:** March 28, 2019

**SUBJECT:** 710-19-1020 Expanded Medicaid Evaluation

The following change(s) to the above referenced Invitation for Bid for DHS has been made as designated below:

**Change of specification(s)**


- Additional specification(s)
- Change of bid opening date and time
- Cancellation of bid
- Other

See Attachment.

---

BIDS WILL BE ACCEPTED UNTIL THE TIME AND DATE SPECIFIED. THE BID ENVELOPE MUST BE SEALED AND SHOULD BE PROPERLY MARKED WITH THE BID NUMBER, DATE AND HOUR OF BID OPENING AND BIDDER'S RETURN ADDRESS. IT IS NOT NECESSARY TO RETURN "NO BIDS" TO THE DEPARTMENT OF HUMAN SERVICES.

If you have questions please contact the buyer at [nawania.williams@dhs.arkansas.gov](mailto:nawania.williams@dhs.arkansas.gov) or 501-320-6511

  
\_\_\_\_\_  
Vendor Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Company

State of Arkansas  
DEPARTMENT OF HUMAN SERVICES  
700 South Main Street  
P.O. Box 1437 / Slot W345  
Little Rock, AR 72203  
501-320-6511

**ADDENDUM 2**

**DATE:** April 24, 2019

**SUBJECT:** 710-19-1020 Medicaid Expansion Evaluation

The following change(s) to the above referenced Invitation for Bid for DHS has been made as designated below:

**Change of specification(s)**

Additional specification(s)  
 Change of bid opening date and time  
 Cancellation of bid  
 Other

Attachment B Written Question(s) - Updated to include all questions and answers

**BID OPENING DATE AND TIME**

Bid opening time will not change.

---

BIDS WILL BE ACCEPTED UNTIL THE TIME AND DATE SPECIFIED. THE BID ENVELOPE MUST BE SEALED AND SHOULD BE PROPERLY MARKED WITH THE BID NUMBER, DATE AND HOUR OF BID OPENING AND BIDDER'S RETURN ADDRESS. IT IS NOT NECESSARY TO RETURN "NO BIDS" TO THE DEPARTMENT OF HUMAN SERVICES.

If you have questions, please contact the buyer at [nawania.williams@dhs.arkansas.gov](mailto:nawania.williams@dhs.arkansas.gov) or 501-320-6511

  
\_\_\_\_\_  
Vendor Signature

May 08, 2019  
\_\_\_\_\_  
Date

Navigant Consulting, Inc.  
\_\_\_\_\_  
Company



State of Arkansas  
DEPARTMENT OF HUMAN SERVICES  
700 South Main Street  
P.O. Box 1437 / Slot W345  
Little Rock, AR 72203  
501-320-6511

**ADDENDUM 3**

**DATE:** April 25, 2019

**SUBJECT:** 710-19-1020 Medicaid Expansion Evaluation

The following change(s) to the above referenced Invitation for Bid for DHS has been made as designated below:

**Change of specification(s)**

Additional specification(s)  
 Change of bid opening date and time  
 Cancellation of bid  
 Other

**FINAL - Bid Response Packet**

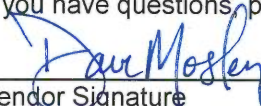
**BID OPENING DATE AND TIME**

Bid opening time will not change.

---

BIDS WILL BE ACCEPTED UNTIL THE TIME AND DATE SPECIFIED. THE BID ENVELOPE MUST BE SEALED AND SHOULD BE PROPERLY MARKED WITH THE BID NUMBER, DATE AND HOUR OF BID OPENING AND BIDDER'S RETURN ADDRESS. IT IS NOT NECESSARY TO RETURN "NO BIDS" TO THE DEPARTMENT OF HUMAN SERVICES.

If you have questions, please contact the buyer at [nawania.williams@dhs.arkansas.gov](mailto:nawania.williams@dhs.arkansas.gov) or 501-320-6511

  
\_\_\_\_\_  
Vendor Signature

\_\_\_\_\_  
May 08, 2019

\_\_\_\_\_  
Date

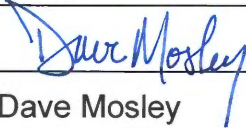
\_\_\_\_\_  
Navigant Consulting, Inc.

\_\_\_\_\_  
Company

## SECTION 1 - VENDOR AGREEMENT AND COMPLIANCE

- Any requested exceptions to items in this section which are NON-mandatory **must** be declared below or as an attachment to this page. Vendor **must** clearly explain the requested exception, and should label the request to reference the specific solicitation item number to which the exception applies.
- Exceptions to Requirements **shall** cause the vendor's proposal to be disqualified.

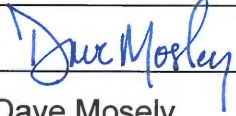
By signature below, vendor agrees to and **shall** fully comply with all Requirements as shown in this section of the bid solicitation.

<b>Vendor Name:</b>	Navigant Consulting, Inc.	<b>Date:</b>	May 08, 2019
<b>Signature:</b>		<b>Title:</b>	Managing Director
<b>Printed Name:</b>	Dave Mosley		

## SECTION 2 - VENDOR AGREEMENT AND COMPLIANCE

- Any requested exceptions to items in this section which are NON-mandatory **must** be declared below or as an attachment to this page. Vendor **must** clearly explain the requested exception, and should label the request to reference the specific solicitation item number to which the exception applies.
- Exceptions to Requirements **shall** cause the vendor's proposal to be disqualified.

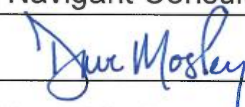
By signature below, vendor agrees to and **shall** fully comply with all Requirements as shown in this section of the bid solicitation.

<b>Vendor Name:</b>	Navigant Consulting, Inc.	<b>Date:</b>	May 08, 2019
<b>Signature:</b>		<b>Title:</b>	Managing Director
<b>Printed Name:</b>	Dave Mosely		

## SECTION 3 - VENDOR AGREEMENT AND COMPLIANCE

- *Exceptions to Requirements shall cause the vendor's proposal to be disqualified.*

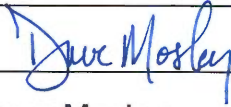
By signature below, vendor agrees to and **shall** fully comply with all Requirements as shown in this section of the bid solicitation.

<b>Vendor Name:</b>	Navigant Consulting, Inc.	<b>Date:</b>	May 08, 2019
<b>Signature:</b>		<b>Title:</b>	Managing Director
<b>Printed Name:</b>	Dave Mosley		

## SECTION 4 - VENDOR AGREEMENT AND COMPLIANCE

- *Exceptions to Requirements shall cause the vendor's proposal to be disqualified.*

By signature below, vendor agrees to and **shall** fully comply with all Requirements as shown in this section of the bid solicitation.

<b>Vendor Name:</b>	Navigant Consulting, Inc.	<b>Date:</b>	May 08, 2019
<b>Signature:</b>		<b>Title:</b>	Managing Director
<b>Printed Name:</b>	Dave Mosley		

# PROPOSED SUBCONTRACTORS FORM

- *Do not include additional information relating to subcontractors on this form or as an attachment to this form.*

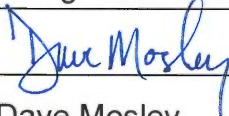
**PROSPECTIVE CONTRACTOR PROPOSES TO USE THE FOLLOWING SUBCONTRACTOR(S) TO PROVIDE SERVICES.**

*Type or Print the following information*

Subcontractor's Company Name	Street Address	City, State, ZIP
N/A		

**PROSPECTIVE CONTRACTOR DOES NOT PROPOSE TO USE SUBCONTRACTORS TO PERFORM SERVICES.**

By signature below, vendor agrees to and **shall** fully comply with all Requirements related to subcontractors as shown in the bid solicitation.

<b>Vendor Name:</b>	Navigant Consulting, Inc.	<b>Date:</b>	May 08, 2019
<b>Signature:</b>		<b>Title:</b>	Managing Director
<b>Printed Name:</b>	Dave Mosley		



## Appendix A Navigant Staff Resumes

Please see the following pages for detailed resumes for our professional staff.

[Balance of page intentionally left blank.]

## Hanford Lin

### Director

hlin@navigant.com

New York, New York

Direct: 646.227.4344

### Professional Summary

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

### Areas of Expertise

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

### Professional Experience

#### Medicaid

- Served as Acting Deputy Secretary for the Kansas Department of Health and Environment – Medicaid (February 2017 through June 2018).
  - Developed one-year extension of KanCare (managed care) 1115 demonstration waiver that CMS approved. Led team to develop KanCare five-year waiver renewal that CMS approved in December 2018. Supported CMS discussions and negotiations for special terms and conditions.

## Hanford Lin

### Director

- Advised Medicaid and sister agency (Kansas Department of Aging and Disability Services) leadership, Governor's Office, and legislators on key Medicaid program considerations, national best practices on managed care monitoring and performance improvement, policy analysis, and other initiatives.
- Participated in high-visibility, high-priority Medicaid initiatives, including managed care pay-for-performance, health plan transition, implementation of the Kansas Modular Medicaid management information system (MMIS) and decision support system, and eligibility and enrollment process improvement.
- Supported all aspects of managed care program monitoring, including provider network development for both general and long-term services and supports populations, performance improvement projects, and dashboard and operational reporting.
- Leads team to support Tennessee's Patient-Centered Medical Home (PCMH) and Tennessee Health Link (THL) practices. Team provides one-on-one coaching for practices to achieve National Committee for Quality Assurance (NCQA) PCMH recognition. Develops statewide and regional conferences, educational sessions, and webinars for practices to learn about TennCare priority topics and share best practices and lessons learned. As of November 2018, the team has helped 37 practice sites achieve NCQA PCMH recognition.
- Leads team to conduct an assessment of Montana's Medicaid expansion. The assessment evaluated the impact of Medicaid expansion on Montana's economy, hospital performance, and quality and access to care. We also compared Montana's performance against peer states that have and have not expanded Medicaid.
- Leads engagements to design, implement, and operate Medicaid managed care programs in states such as Alabama, California, Illinois, Iowa, Mississippi, and Pennsylvania. Project work has involved:
  - Working with senior leadership to develop pay-for-performance and value-based payment programs that incentivize value over volume.
  - Developing reporting templates, dashboards, and other reports to collect and disseminate performance data (quality, operational, and financial) to internal and external stakeholders.
  - Assessing and developing organizational structures, processes, and policies and procedures to promote effective program monitoring and continuous performance improvement.
  - Conducting data analysis to identify performance opportunities and successes and evaluate program effectiveness.

## Hanford Lin

### Director

- Facilitating stakeholder workgroups consisting of agency staff, clinicians, hospital, and health plan executives, consumers, and legislators to identify health plan and program performance measures.
- Conducting readiness reviews to assess contractor readiness prior to program go-live.
- Developing and providing feedback on procurement materials, including Requests for Proposals, responses to bidder questions, and proposal scoring tools.
- Training agency staff on subject matter, such as Medicaid and managed care, and skills, such as data analysis and program monitoring.
- Worked with Wyoming Department of Health to evaluate and refine its quality-based incentive program for WYHealth, a primary care case management program. Led a HEDIS® and Quality Measure rate validation study for performance measures calculated by the WYHealth contractor for utilization and care management services.
- Worked with the California Health Care Foundation and California Department of Health Care Services Medi-Cal Managed Care Division to examine the performance of Medi-Cal managed care plans and the factors that may impact performance.
- Assisted a Medicaid health plan with reviewing its HEDIS® data collection and reporting processes for selected HEDIS® measures. Conducted onsite interviews with operational and decision support staff to identify potential risk areas and opportunities for improvement. Developed a process map to illustrate the health plan's systems and processes involved in the rate development process.
- Assisted the Illinois Governor's Office with implementation of its State Innovation Model. Facilitated Quality Measure workgroup sessions to identify and select quality measures used to assess physical health and behavioral health integration.

### Federal Initiatives

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

## Hanford Lin

### Director

- Managed a project to assist the Veterans Health Administration (VHA) with developing a Quality Measurement Plan and implementation strategies for two of the VHA's Purchased Care programs, the Fee Program and the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). Conducted interviews, literature review, and additional research to identify current best practices and emerging trends in quality measurement used by commercial healthcare payers, state Medicaid agencies, and other Federal payers.
- Assisted the Department of Defense in assessing the feasibility of HEDIS® accreditation for TRICARE Prime and TRICARE Senior Prime and assisted the Department of Defense with the extraction, analysis, and compilation of healthcare data for use in Joint Commission accreditation of military treatment facilities.

### Litigation Services

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

### Health Information Technology

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

### Developmental Disabilities

- Assisted a State Medicaid agency with assessing access to dental services for managed care members with special needs. Compiled and analyzed telephone survey data to evaluate whether health plans could identify and refer members with special needs to appropriate dental services.
- Assisted the Pennsylvania OMAP Division of Quality and Special Needs Coordination with developing a special needs access and availability database to assess and track the accessibility of provider offices to members with special needs. Updated special needs reports to support Commonwealth staff with monitoring each Medicaid health plan's Special Needs Unit performance.

## Hanford Lin

Director

### Long-Term Care

- Assisted the Ohio Department of Job and Family Services with identifying and evaluating long-term care rebalancing strategies. Researched unified long-term care budgets, care planning and case management, “single point of entry” and “no wrong door initiatives, and nursing home diversion programs. Surveyed states to identify long-term care best practices and lessons learned.
- Assisted the Pennsylvania Office of Social Programs to clarify and evaluate the current reimbursement system for each of the Bureau of Home- and Community-Based Services’ Medicaid waiver programs. Assisted with the potential development of new reimbursement methodologies.

### Other Relevant Experience

- Leading engagement to support the New York State Podiatric Medical Association (NYSPMA) with developing and implementing a public and population health strategy that aligns with the New York Department of Health, CMS, commercial payers, and health systems.
- Assisted states such as Alabama and Pennsylvania with strategic planning for their Non-Emergency Medical Transportation (NEMT) programs. Assessed current NEMT model and identified alternative service delivery models. For Pennsylvania, developed a consumer survey to evaluate current transportation services and program performance.
- Assisted a life sciences company with developing an enhanced methodology and forecast model for estimating Medicaid drug rebates. Conducted internal stakeholder workgroup sessions to understand current methodology, historical rebate submissions, and roles and responsibilities. Researched factors that impact Medicaid rebate submissions, such as state Medicaid enrollment, impact of ACA Medicaid expansion, managed care penetration, and 340B changes.
- Assisted a life sciences company with assessing potential opportunities for partnering with quality improvement organizations to improve health outcomes for selected diseases. Determined areas of alignment between the company’s product portfolio and quality improvement priorities.
- Conducted a managed care assessment for a national health system. Led team to conduct reimbursement benchmarking analyses to support negotiations with commercial payers. Developed workflows for contract negotiations, revenue reconciliation, and other managed care processes. Worked with corporate and market-level executives to identify appropriate governance structures for collaborative decision-making processes.
- Assisted a national dental benefits provider with developing a pay-for-performance program for its dental providers. Developed options for measuring quality dental performance and scoring and payment distribution methodologies to reward high-performing dentists.





## Hanford Lin

Director

### Work History

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

### Education

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

### Selected Recent Presentations and Publications

- Hanford Lin, Jeff Moor, and Dustin Schmidt, “How State Medicaid Agencies Can Prepare for Administration Changes.” Navigant Insights, December 2018.
- Roshni Arora, Christina Koster, and Hanford Lin, “Evolving Medicaid Managed Care Regulations: What Do These Changes Mean For You?” Navigant Insights, November 2018.
- Roshni Arora, Randy Whiteman, and Hanford Lin, “Upcoming Medicaid Managed Care Regulations – How Do You Stack Up?” Navigant Insights, May 2018.
- Hanford Lin, Randy Whiteman, and Roshni Arora, “Provider Network Adequacy Changes in Medicaid Managed Care Final Rule Leave States with Much to Address.” Navigant Whitepaper, July 2016.
- California HealthCare Foundation Briefing, “Monitoring Performance: A Dashboard of Medi-Cal Managed Care.” Presented at California HealthCare Foundation, December 2013.

## Christina Koster

### Director

christina.koster@navigant.com

Chicago, Illinois

Direct: 312.583.3758

### Professional Summary

Christina Koster is a Director with Navigant's Value Transformation practice. Christina has more than 12 years of experience working with public and private payers and providers, focusing on state Medicaid programs. She has supported states to design, implement, and operate managed care programs.

### Areas of Expertise

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

### Professional Experience

#### Medicaid Reform

- Assisting TennCare with its Patient Centered Medical Home and Health Link (behavioral health home) programs, to assist Tennessee in achieving primary care transformation goals, including reducing total cost of care, improving quality measure performance, and integrating physical health and behavioral health services. Providing technical assistance and training to TennCare Medicaid practices to support them in achieving Patient Centered Medical Home recognition from the National Committee for Quality Assurance.
- Assisted a healthcare provider consortium in a complex strategic planning process to determine organizational goals and strategic options to respond to changes in the Federal healthcare environment; used the Kepner-Tregoe decision-making methodology to work with healthcare executives to identify priorities.

## Christina Koster

### Director

- Supported the Kansas Department of Health and Environment in the development of an extension for the KanCare Section 1115 demonstration. Drafted the extension application to meet the Federal transparency and public notice requirements, compiled documentation of compliance with the KanCare Special Terms and Conditions, supported meetings with CMS, and provided guidance regarding public notice and public hearing requirements.
- Facilitated the development and submission of the Alabama Medicaid Agency's (AMA's) Section 1115 demonstration proposal to implement a provider-led managed delivery model. Drafted content, managed the Federally required public comment process, negotiated with CMS, and assisted the State in reviewing and operationalizing the demonstration's Special Terms and Conditions as required by CMS. The approved demonstration includes Designated State Health Program (DSHP) funding and over \$300 million in Transition Pool funding to assist in the State's Medicaid transformation. Transition Pool funding is similar to a DSRIP program.
- Assisted AMA in developing amendments for its Section 1115 demonstration. Developed the amendment in accordance with the Special Terms and Conditions and supported AMA to respond to CMS questions regarding the proposed amendment.
- Managed an engagement to support Illinois with its State Innovation Model design process, which was focused on strategies to improve the delivery of behavioral health services provided through the Department of Healthcare and Family Services, the Division of Mental Health, and the Division of Alcoholism and Substance Abuse. Assisted the State with the evaluation of health transformation strategies, stakeholder engagement, and workgroup facilitation and development of a State Health Innovation Plan (SHIP). Regularly provided guidance to leadership from the Governor's Office and the Department of Public Health.
- Conducted a meta-analysis and qualitative reviews to evaluate the impact that initiatives to implement patient-centered medical homes (PCMHs) have had on access, quality, and cost as well as to better understand the barriers to achieving PCMH.

### Medicaid Managed Care

- For the Wisconsin Department of Health Services, conducted a feasibility study for implementing state-directed payment options to expand the State's fee-for-service physician Upper Payment Limit program to its managed care program. Identified the steps for designing, implementing, and obtaining CMS approval for a state-directed payment program.
- Supported AMA to design and implement a managed care under which AMA would pay risk bearing, provider-based regional care organizations (RCOs) on a capitated basis to provide the full scope of Medicaid benefits, including primary, acute, behavioral, maternal, and post-acute services.
  - Assisted the State to develop the protocols for providers to receive Transition Pool funding, educate stakeholders, develop application materials and instructions, and comply with Federal

## Christina Koster

### Director

- requirements. Helped the State to develop the process for evaluating performance milestones and metrics and link Transition Pool payments to process and outcome achievements.
- Assisted with the development and implementation of AMA's statewide Health Home program, authorized under Section 2703 of the Affordable Care Act, to provide case management and care coordination services to approximately 300,000 individuals with chronic conditions in Alabama. Developed and refined Health Home procurement materials and readiness assessment materials.
  - Assisted AMA to develop managed care contract requirements related to enrollment and enrollee services, provider network and services, covered services, and care coordination. Developed contract language in accordance with State laws, administrative rules, and Federal regulations.
  - Led the development of a Federally required managed care quality strategy for AMA, including quality goals and objectives, program effectiveness and quality measures, monitoring approach, and major quality initiatives.
- Led a project to assist the Nevada Division of Health Care Financing and Policy to evaluate options for modifying its Medicaid managed care delivery system. Considered options such as expanding the current managed care program to new geographic areas and populations (e.g., individuals who are aged, blind, or disabled). Evaluation considered the impact of managed care models on the State's supplemental payment programs and the impact of managed care on special populations including those with behavioral health issues, children receiving foster care, and children involved in the juvenile justice system. Conducted over 30 focus groups and town hall meetings regarding the proposed delivery system recommendations.
  - Assisted Georgia's Department of Community Health with design, implementation, and ongoing operations of Medicaid managed care programs. Led the development of monitoring materials and readiness review tools for the implementation of managed care for children in foster care and adoption assistance and youth in juvenile justice. Co-led the development of the operational design of a value-based purchasing program and the development of a value-based purchasing manual to guide State and managed care organization (MCO) operations.
  - Supported the Pennsylvania Department of Public Welfare with various activities to support its Medicaid managed care program. Developed a learning institute for the Department to train approximately 400 staff and contractors on Medicaid, health reform topics, leadership, and operations. Assisted with development of a value-based purchasing program to encourage performance improvement on program goals.
  - Served as the key point of contact for a multi-year project with West Virginia's Bureau for Medical Services for the design and administration of a mandatory managed care program. Managed daily contact with the client, contracted MCOs and other vendors, conducted ongoing evaluation of MCO performance, developed provider network standards, evaluated provider networks, prepared annual MCO contract updates, created 1915(b) waiver renewal applications, and coordinated with CMS to obtain approval of the applications.

## Christina Koster

### Director

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

### Behavioral Health

- Assisting TennCare with its Patient Centered Medical Home and Health Link (behavioral health home) programs. Developing content for conferences, collaboratives, and webinars to promote practice transformation. Responsible for a team of five coaches who provide one-on-one coaching to practices to support practice transformation.
- Assisted Illinois to develop strategies to improve physical health and behavioral health integration, including behavioral health homes, data sharing options for behavioral health providers, behavioral health self-management programs, and supportive housing services for individuals with behavioral health needs. Prepared for and facilitated dozens of stakeholder workgroups to develop recommendations for enhancements to the behavioral health delivery system.
- Supported interagency efforts between AMA and the Alabama Department of Mental Health to develop policies around behavioral health care coordination for RCOs. Facilitated meetings with the Alabama Department of Mental Health to answer questions about how the Section 1115 demonstration will impact the Department.

### Long-Term Care

- Assisting AMA with the design and implementation of an Integrated Care Network program, authorized by State legislation, to cover individuals in need of long-term care services in a nursing facility or home- and community-based setting. Provided guidance to AMA leadership regarding Medicaid long-term care program design options and supported stakeholder meetings. Developed a concept paper to summarize program design decisions and seek input from stakeholders. Created an administrative rule on network adequacy standards for the program.
- Assisted Georgia's Department of Community Health with the development of a Request for Proposals for a Medical Coordination Program to provide medical coordination services to Medicaid members who are aged, blind, or disabled.
- Worked with the Illinois' Bureau of Managed Care to develop and implement a new monitoring approach for the Integrated Care Program, a Medicaid managed care program for seniors and persons with disabilities. Led the development of business processes, databases, and standard operating procedures to support contract monitoring. Trained staff on managed care and use of monitoring tools.

## Christina Koster

Director

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

### Other Relevant Experience

- Conducted an operational assessment of a Medicaid and Dual Special Needs Plan health plan to assess performance in the areas of quality, risk adjustment, medical management, network contracting, call center, grievances and appeals, and pharmacy. Developed a comprehensive and actionable implementation plan for improving performance in each of the functional areas of focus.
- Led an analysis of the Medicare Part D benefit for the Pharmaceutical Research and Manufacturers of America. Estimated the number of Medicare beneficiaries with comprehensive drug coverage by various factors. Analyzed year-to-year changes in Part D plan premiums, deductibles, and benefit designs. Researched the Department of Veterans Affairs' experience in negotiating prices and analyzed the coverage of the Department's national formulary as compared Part D plan formularies.
- Wrote an assessment for a commercial insurer on the needs of consumers in its service. The final report contained state-level profiles outlining major socio-economic, health status, and healthcare delivery strengths and weaknesses.

### Work History

Navigant Consulting, Inc.	2013 – Present
Project Manager, University HealthSystem Consortium	2011 – 2013
Consultant, The Lewin Group	2005 – 2009

### Education

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

### Selected Recent Presentations and Publications

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



## Jeffrey Moor

### Director

jmoor@navigant.com  
Philadelphia, Pennsylvania  
Direct: 215.832.4422

### Professional Summary

Jeffrey Moor is a Director with Navigant's Government Healthcare Solutions practice. He has more than 17 years of experience in the health care industry, working with state Medicaid programs, the Federal government and health plans. He has expertise with operational and performance reviews, organizational assessments, health care billing and compliance reviews and litigation support.

### Areas of Expertise

- Has deep project management and leadership experience. Directs projects for Federal, state and commercial clients focused on assessing and enhancing organizational capabilities and performance.
- Supports state Medicaid agencies in analyzing and evaluating delivery and reimbursement systems, Medicaid managed care programs and programs for disabled populations; Medicaid waiver development and analysis; and Medicaid policy, research and data analysis.
- Works with state and commercial clients on healthcare billing and compliance-related matters and litigation support.

### Professional Experience

#### Federal Initiatives

- Serving as the engagement manager for a contract with the Centers of Medicaid and Medicare (CMS) Center for Medicaid and CHIP Services (CMCS) to improve CMS oversight of rate setting and financial reporting for Medicaid managed care and Home- and Community-Based (HCBS) Waiver programs. Provided oversight to the development of detailed review tools to assess completeness, reasonableness and regulatory compliance of state managed care contracts and HCBS Waiver applications, renewals and amendments. Managing the ongoing reviews of managed care contracts and HCBS waiver submissions. Also overseeing the development of HCBS training materials that CMS is using to educate states on HCBS rate setting approaches.
- Managing a multi-year engagement with the CMS Center for Consumer Information and Insurance Oversight (CCIIO) to provide full-service technical assistance support to Consumer Operated and Oriented Plan (CO-OP) program. Project work has involved:

## Jeffrey Moor

### Director

- Identifying and accessing internal and external subject matter experts to address a broad array of technical assistance needs and ad hoc requests
  - Developing and implementing a technical assistance strategy
  - Working with CMS to prepare technical assistance resources. Managed development of training sessions with senior leadership and workgroups on reform, legislative and exchange, and payer related topics (e.g., care management, member relations, provider contracting, broker/distribution)
  - Assisting with the development of tools and conducting site visits to facilitate CMS' monitoring and assessment of the CO-OPs' operational readiness during the overall programs' start-up phase
  - Coordinating site visits to CO-OPs to develop an understanding of the current state of the CO-OPs' organization, operations, financial management, viability and market competitiveness
- Directed a project with the U.S. Department of Veterans Affairs National Payer Relations Office to conduct reviews of Veteran's Health Administration contracts with third-party insurance companies. Analyzed claims data, rate data and contract provisions to determine whether third-party payers are in compliance with federal reimbursement regulations.

### Medicaid Reform

- Directed a project for the Massachusetts Executive Office for Administration to provide consulting services to the Massachusetts Medicaid Delivery Model Advisory Committee. Supported the Committee with a study of the comparative costs and benefits of varied care delivery models for the Medicaid program and to compare the current and projected impact of the Managed Care Organization (MCO) program and the Primary Care Clinician (PCC) plan in the context of proposed reforms in paying for medical services and promoting integrated care delivery systems such as accountable care organizations and patient-centered medical homes. Conducted research and interviews to gather information on similar initiatives in other states. Coordinated stakeholder meetings throughout the Commonwealth to solicit feedback and input on the current MCO and PCC programs and potential design changes. Developed a model to determine the potential financial impact of various delivery system options being considered by the Committee.
- Assisted in the development of an 1115(a) demonstration proposal to implement Medicaid Medical Savings Accounts for Montana. Conducted research to develop program design features and eligibility criteria and assisted with writing the demonstration proposal and a Request for Proposals to procure an administrator for the program.

## Jeffrey Moor

Director

### Medicaid Managed Care

- Managed a project with the Massachusetts Commonwealth Connector Authority to conduct an operational audit of Medicaid managed care plans participating in the Commonwealth Care program. Analyzed claims payment accuracy, provider contracting strategies and utilization and disease management functions for each of the managed care plans and compared them to industry best practices. Coordinated the collection of information from each of the health plans to inform the audit process. Conducted interviews with health plan staff responsible for provider contracting, claims adjudication and care management functions. Developed a final report summarizing the key findings from the operational audit. The executive leadership of the Connector Authority used the report to inform policy-making decisions for the Commonwealth Care program.
- Conducted an operational review of a Medicaid health plan which had recently been sanctioned by a state Medicaid agency for allegedly failing to meet its contractual obligations. Conducted interviews with health plan staff and reviewed compliance plans, activities and policies and procedures to assess whether corrective actions being undertaken by the health plan were likely to address the sanctions. Developed a report of findings and recommendations that was presented to the health plan's board of directors.
- Assisted in the development of quarterly reports for Indiana's Office of Medicaid Policy and Planning (OMPP) to monitor the performance of its contracted MCOs. Collected and analyzed financial and non-financial performance data submitted by the contracting MCOs to develop quarterly reports that summarize and trend plan performance for each MCO and OMPP. The client used these reports to assist with their monitoring of MCO contracts, including monitoring member access to services.
- Assisted in the development of the annual external quality review report for Indiana's Hoosier Healthwise Medicaid managed care program. Analyzed performance data submitted by the contracting MCOs. Developed charts that trend member-to-primary medical provider ratios and member inquiry and grievance and appeals data to assess member access to services.

### Government Payment Transformation

- Managed a project with the Massachusetts Executive Office of Health and Human Services to conduct a legislatively-mandated study of selected providers and MCOs providing services to the Commonwealth's Medicaid population to assess the value these organizations provide to the Commonwealth in their use of state funds and why some providers and MCOs may perform better than others. Analyzed financial, operational and quality data for MCOs and hospitals contracting with the Commonwealth and conducted interviews with key provider and MCO representatives to assess the entities' performance in comparison to industry benchmarks.

## Jeffrey Moor

### Director

- Assisted the Texas Health and Human Services Commission to evaluate the current model-based rate development methodology for intermediate care facilities for people with intellectual disabilities HCBS Local Authority waiver program. Conducted an analysis of the components of the current rate development methodologies to identify issues to address during the rebasing project. Developed cost reports and related instructions and training to collect cost data from providers.
- Assisted the Illinois Department of Human Services and Department of Health Care and Families with conducting a cost analysis related to the State's conversion from a grant-based to a fee-for-service-based reimbursement system for its mental health program. Drafted a final report submitted by the Departments to the State Legislature detailing the project methodology, findings and recommendations.

### Medicaid Performance Management

- Managed organizational assessments for state Medicaid agencies and Program Integrity units in states such as Alabama, North Carolina and Texas. The goals of these projects were to evaluate and conduct in-depth reviews of the organization and operations of these agencies and departments to help maximize the efficiency and effectiveness of their operations. Project work has involved:
  - Developing interview guides interviewing executive leadership and department staff to document their knowledge, skill levels, day-to-day activities and responsibilities
  - Assessing the appropriateness of staffing resources and use, including identifying gaps in knowledge and expertise
  - Documenting and assessing workflows and processes
  - Reviewing and assessing program policies and procedures for accuracy, compliance with state and Federal regulations and relevance to organization functions
  - Assessing systems and supports, such as information technology systems
  - Identifying compliance issues, risk areas and major challenges
  - Researching and documenting best practices
  - Providing recommendations for changing organizational structures, job functions and workflows and processes, and assessing the impact of these changes on existing staffing levels and roles and responsibilities
- Assisted California, Florida, Mississippi and Texas with conducting payment accuracy studies, for publicly-funded programs such as Workers' Compensation, State employees' health benefits, Medicaid and SCHIP.
  - Assisted with the design and review of sampling plans

## Jeffrey Moor

### Director

- Coordinated the collection of recipient identification, billing, eligibility and medical record documentation from providers
- Conducted claims and recipient eligibility reviews
- Developed models to estimate payment error rates and financial liabilities
- Provided support to multiple states for CMS-required Medicaid Payment Error Rate Measurement (PERM) studies
- Supported engagements with provider organizations, such as those under Corporate Integrity Agreements, to quantify potential overpayments to government payers. Developed sampling protocols for claims review processes, conducted claims reviews and developed models to estimate error rates and quantify potential overpayments. Assisted with responding to inquiries from government agencies related to review findings.

### Litigation Services

- Assisted in developing expert reports for a personal injury protection insurer in response to several lawsuits filed by providers regarding the insurer's payment rates for certain procedures. Analyzed industry payment and charge benchmarks and other data to determine the market rates for the procedure at issue and compared those rates to those offered by the insurer.
- Provided litigation support services to multiple state Attorney General Offices in claims brought against state Medicaid programs related to the adequacy of reimbursement levels to support access to services. Project activities and involved analyzing Medicaid claims data to measure the provision and utilization of services, researching and analyzing reimbursement rates paid by other states for similar services and analyzing and mapping provider locations.
- Assisted in developing an expert report for a national health insurance company in response to a patient lawsuit regarding the insurers' methodology for calculating secondary payments when it is coordinating benefits with Medicare. Developed detailed claims analyses to compare the secondary-plan benefits that would result in different methods for coordinating with Medicare in cases where there is not actual Medicare payment because member failed to enroll or was treated by a provider who opted out of Medicare. The analysis included an examination and comparison of two methods used by the insurer and a third method proposed by plaintiffs.
- Assisted in developing an expert report for a health insurance company in response to a physician lawsuit regarding the processing of healthcare claims. Conducted research on how physicians report services to insurers, health plans, government and other payers. Described the concepts of Current Procedural Terminology (CPT) and other coding systems and how they are part of the reporting process. Explained how errors can occur in the reporting of services and the results of those errors. Described how payers use software editing tools to identify incorrectly reported claims.

## Jeffrey Moor

### Director

- Assisted in developing an expert report as part of expert witness testimony in a class action managed care litigation matter involving managed care companies. Researched issues related to claims processing, editing and bundling software, coding and billing accuracy, provider payment methodologies, among others.

### Behavioral Health

- Assisted the Texas Health and Human Services Commission to develop a 1915(c) waiver program for children with severe emotional disturbances. Assisted with the drafting of service definitions and developing a cost-neutrality analysis as part of the State's waiver application. The State received approval from CMS for the waiver.
- Managed the Year Two and assisted with the Year One Independent Assessment of North Carolina's 1915(b) behavioral health waiver program, Piedmont Behavioral Health. Developed evaluation criteria, conducted interviews of Division of Medical Assistance and Piedmont staff and reviewed documentation to assess how quality, access and cost have changed since the implementation of the program.
- Assisted the Wyoming Mental Health Division to implement a pilot program to expand the continuum of care and access for acute psychiatric services in an underserved region of the State with the goal of reducing State hospital admissions. Assisted with program design and procurement of a contractor to operate the pilot program. Developed a Request for Proposals and responded to bidder questions.

### Other Relevant Experience

- Managed a financial and contractual review conducted as part of an overall performance audit of an Administrative Services Organization responsible for administering a large publicly-funded health benefit program. Conducted interviews with the Organization's staff to gather information and understand the Organization's policies and procedures. Reviewed financial and other performance data to assess the Organization's compliance with various financial and contractual requirements. Provided recommendations for improving project budgeting and internal financial reporting.
- Assisted on an engagement in which Navigant served as the Independent Review Organization for a provider in the final year of a three-year Corporate Integrity Agreement. Developed the sampling protocol for the claims review process and assisted with drafting the final report that the client submitted to the Federal Government as part of its obligations under the Agreement.



## Jeffrey Moor

Director

### Work History

Director, Navigant	2012 – Present
Managing Consulting / Associate Director, Navigant	2004 – 2012
Manager, Tucker Alan Inc.	1999 – 2004

### Education

Master of Public Policy and a Graduate Certificate in Health Administration and Policy	University of Chicago, Irving B. Harris School of Public Policy
Bachelor of Arts	University of Rochester



## Kian Glenn

### Managing Consultant

#### Professional Summary

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

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

#### Professional Experience

##### Medicaid Managed Care

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

##### Other Relevant Experience

- Assisted the State of Nebraska, Division of Developmental Disabilities with rate development as it redesigned its home- and community-based services (HCBS) waivers. Reviewed proposed service definitions based on unbundling of current services, led in-person discussions with State staff to define waiver service assumptions for rate setting, including the use of payment tiers, staffing ratios, wages and other model assumptions. Developed rate model and fiscal impact analyses, and presented findings to State staff and stakeholders during webinars and in-person meetings. Reviewed

## Kian Glenn

### Managing Consultant

waiver application submission and correspondence from CMS, and assisted with responses to CMS requests.

- Supported the State of Illinois' State Innovation Model (SIM) strategy with a focus on integrating physical and behavioral health through advanced primary care models. Responsibilities included: identifying federal funding opportunities for the State to pursue, researching and drafting whitepapers on integration models and funding strategies, interviewing staff and identifying current processes, gap analysis, project management of work plan and associated tasks, stakeholder engagement strategy, drafting of State Health System Innovation model sections. Also: developed managed care organization (MCO) performance reports and dashboards for the State of Illinois Department of Healthcare and Family Services.
- Collaborated with New York's largest primary care based Preferred Provider System (PPS). Assisted in completing the PPS and project DSRIP applications and still performs quarterly reporting tasks. Other support included evaluation of state application requirements, with subsequent gap analysis to identify critical strategic, cultural, market, organizational, clinical, operational, and financial capabilities, and positioning to continue the PPS' development as a Patient Centered Medical Home (PCMH). The application writing and submission included collection, integration and revision of work products across teams, development of an integrated point of view (including stewardship and management), and content management and application process control across work teams. The PPS was among the top five DSRIP applicants and published in international news.
- At the Minnesota Department of Health, developed a strategic plan for a state health department to implement the clinical portion of the Community Transformation Grant from the Centers for Disease Control and Prevention (CDC). As a result, the health department assisted primary care clinics across the State to improve preventive health practices to reduce chronic disease.
- Assisted a large health services company with the integration strategy of various newly acquired physician practices across the country. Led cross-functional teams to develop actuarial, clinical, network and operational models to support risk-sharing agreements to assist new acquisitions to better manage the care of patients. Created market-level reports to identify strategic opportunities for new acquisitions.
- Developed strategy and initial implementation of an onsite health and wellness strategy for a Fortune 20 company to address high needs employees. Strategy included an onsite clinic at the flagship office featuring a mid-level provider, dietitian, and health coach and benefits concierge. Based on claims data, employees with high risk were targeted and provided with a personalized and integrated experience. Onsite clinic created savings and employee retention so valuable that it has been replicated at more than 15 sites within three years.



## Kian Glenn

Managing Consultant

### Work History

Managing Consultant, Navigant

Consultant, Optum (UnitedHealth Group)

Healthcare Coordinator / Principal Planner, Minnesota Department of Health

Analyst, Optum (UnitedHealth Group)

Associate Consultant, Carlson Consulting Enterprise

### Certifications, Memberships, and Awards

Corporate Citizenship Award Recipient, Navigant Consulting, Inc.

NAVI Award Recipient, Navigant Consulting, Inc.

Super Hero Award Recipient, Optum

Emerging Leaders Program Participant, Optum

Heroh! Award Recipient, Optum

### Education

Bachelor of Science – Finance and International Business

University of Minnesota Carlson  
School of Management

## Caroline Deneszczuk, MPH

### Managing Consultant

caroline.deneszczuk@navigant.com

Washington, D.C.

Direct: 202.973.3277

### Professional Summary

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

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

### Areas of Expertise

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

### Professional Experience

#### Federal Initiatives

- Provided subject matter expertise to the Centers for Medicare and Medicaid Services (CMS) regarding Medicare and the Dual Eligible population. Assisted CMS in implementing healthcare

## Caroline Cay Deneszczuk

### Managing Consultant

demonstrations for this population through the Financial Alignment Initiative. Aided in the readiness review of contracted health plans and the ensuing implementation and monitoring of the demonstration in Washington, Colorado, Texas, New York, and California.

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

### Medicaid Reform

- Aided Wyoming to identify gaps and provide recommendations to improve the State's Adult Protective Services system and improve communication and collaboration across agencies, advocates, the judicial system, and business leaders that serve vulnerable adults.
- Aided in the development of the State Innovation Model (SIM) Plan in Washington, D.C. Led stakeholder engagement efforts through conduct of consumer interviews and focus groups, provider surveys, and assisting in advisory committee and workgroup activities. Led research and drafting efforts of several sections of the State Healthcare Innovation Plan (SHIP) including the environmental scan, stakeholder engagement, and building connections between social and medical services.
- Served as the assistant project manager for a Federal 1115 waiver demonstration management and evaluation project. Provided policy and evaluation recommendations to CMS regarding Medicaid 1115 waivers throughout the United States. Aided CMS and states in improving reporting requirements and adherence to Standard Terms and Conditions (STC). Reviewed quarterly and annual reports of providers participating in the Delivery System Reform Incentive Payment (DSRIP) program. Determined providers' achievement of milestones necessary for performance payment in the DSRIP program.

### Medicaid Managed Care

- Managed teams in conduct of readiness reviews of Medicaid managed care organizations in Texas, New York and California, and well over 30 plans. Led staff through the readiness review process by providing training, guidance, and expertise. Planned, staffed, and conducted desk reviews and site visits to all three states and led discussions on care coordination, appeals and grievances, and staffing.

## Caroline Cay Deneszczuk

### Managing Consultant

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

### Medicaid Performance Management

- In collaboration with subject matter experts within Navigant and Alabama Medicaid Agency, develop standard operating procedures regarding program governance, key staffing roles, monitoring of subcontractor agreements, and provider certification to collaborate with the State.
- Led efforts to monitor and evaluate the performance of managed fee-for-service demonstrations in Washington State and Colorado. Developed all annual reports to CMS regarding process and outcomes measures reported by the states. Selected the questions and administered a demonstration-specific CAHPS survey during each year of the monitoring and evaluation effort.

### Long-term Care

- Assisting the Alabama Medicaid Agency with its planned transition to managed LTSS delivery system (expected implementation October 2018). Responsibilities include leading the development of the Section 1915(b) and 1915(c) Medicaid waiver applications, developing a concept paper for public comment, and analyzing results of a survey of LTSS consumers, caregivers, providers, and advocates.
- Assisting Colorado with streamlining case management service delivery and redesigning reimbursement methodology for the State's ten 1915(c) home- and community-based services waivers. Researching and interviewing case management experts to determine best practices that offer choice in case management providers, eliminate conflicts of interest, establish a framework for fair reimbursement, and increase provider capacity.

### Other Relevant Experience

- Assisted Navigant's Healthcare Revenue Cycle practice to support healthcare systems implement and refine coding and billing procedures using Epic Software®. Worked with the University of Texas Medical Branch (UTMB) to conduct research and devise strategies and procedures to prevent claim denials and avoidable write-offs. Provided weekly training to coding and billing staff at UTMB and produced policy and procedure documents for long-term software management.
- Developed and conducted training of survey staff on how to approach, conduct and record responses from Medicaid enrollees regarding their experiences in the healthcare system. Analyzed and interpreted the data collected by survey staff to develop healthcare reforms for the District of Columbia's State Healthcare Innovation Plan.

## Caroline Cay Deneszczuk

### Managing Consultant

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

### Work History

Managing Consultant, Navigant	2018 – Present
Senior Consultant, Navigant	2015 – 2018
NORC at the University of Chicago	2013 – 2015
Office of Congressman Jim McDermott	2012– 2013
American Association for Retired Persons	2011 – 2012

### Education

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

### Selected Recent Presentations and Publications

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



## J.T. Lane, MPH

### Director

jt.lane@navigant.com  
Washington, D.C.  
Direct: 202.481.7506

### Professional Summary

As a seasoned health leader, J.T. leads innovative transformation efforts to improve population health outcomes, financial and organizational strength, and programmatic quality and performance outcomes of Public Health and Medicaid programs, health plans, healthcare providers, and multi-sector private and public partners. He often leads public and private sector organizations through strategic planning, restructuring, implementation, and change management activities to transform the impact they have on their stakeholders.

J.T. frequently presents on a variety of complex health and healthcare topics to governors, members of Congress, federal agency heads, state legislators, decision makers, and influencers. He advises organizations on the integration of healthcare, business, philanthropic and community-based efforts to improve community health by leveraging not only traditional health-based constituencies, but also transportation, housing, economic development, workforce, and other sectors representing the social determinants of health.

He has previously led inter-agency, multi-sector efforts among Medicaid, managed care, public health and healthcare provider groups to develop quality improvement initiatives for adolescent health, chronic disease, HIV, and birth outcomes. J.T. has co-chaired or chaired national steering or advisory committees focused on leveraging public payer, healthcare and public health systems to improve quality, performance and financial efficiency, and advised groups on modernizing the nation's public health infrastructure and financing.

As a former state health official, he has supported efforts for the successful implementation of the Louisiana Governor's Medicaid reform initiative, public-private partnerships for indigent care and a statewide wellness initiative. He also guided the development of complex state health care budgets exceeding \$8 billion for 8 years that included revenues from seven federal agencies, state general funds, private foundations, and local tax funds.

### Areas of Expertise

- Policy innovation and development
- Organizational transformation
- Strategic planning
- Multi-sector stakeholder engagement

## J.T. Lane, MPH

### Director

- Financial planning
- Healthcare and human services, including Medicaid, managed care, and population health

### Professional Experience

- Leverages diverse, multi-sector management and leadership experience to advise, guide and support local, state, national and global public and private sector organizations, primarily in health, Medicaid, managed care and human services, to identify, develop and execute new ways to overcome complex challenges and implement sustainable change.
- Works on-site, embedded with leaders, managers and staff of a multitude of organizations to provide greater value in developing and implementing innovative solutions together each step of the way.
- Assists local, state and federal health, human services, education, technology and economic development agencies and their private sector partners in creating and executing tailored approaches for high-performing policy, program, financial and quality improvement initiatives that lead to better results and outcomes for citizens, customers, and stakeholders.
- Advised and supported clients on an array of local, state, national and global population health topics, including Medicaid, managed care, child and family health, infectious disease, health care coverage and benefits policy, stakeholder engagement and collaboration, health data and informatics, community health assessment and health improvement planning, chronic disease prevention and health system transformation.
- Established and led HMA's population health transformation practice area, and actively pursued new public and private sector organizations leading to \$3 million in revenue.
- Provide guidance and intelligence to city- and county-based, state, national and global organizations, including government and private corporate, non-profit and philanthropic entities in the public health, healthcare and human services sectors.
- Perform strategic planning, research and analysis, internal and external meeting facilitation and engagement, community and system assessment, technical assistance and organizational redesign planning.
- Appointed by Governor and confirmed by Louisiana State Senate, one of the state's leads on health system transformation and public health promotion to build safe, healthier communities in Louisiana.
- Launched the first-ever merger of public health and Medicaid programs and expertise to create new quality improvement and payment reform initiatives for Medicaid managed care plans.
- Launched the first-ever Center for Population Health Informatics to provide best possible health data and business intelligence to health care providers, researchers, community organizations and businesses.

## J.T. Lane, MPH

### Director

- Launched the agency's national accreditation efforts beginning with the organization's first strategic plan, and culminating in a statewide community health assessment and improvement plan, which contains the collective input and effort of nearly 3,000 individuals from more than 500 organizations across the state.
- Using Lean Six Sigma methodology, overhauled environmental health inspection operations for more transparency and accountability, improved evaluation and 60 percent productivity increase.
- Successfully advocated for a 40 percent increase in state general funds over three years and unanimous legislative passage of health fee increase in 2013 with 100 percent of new funds going to health improvement.
- Actively balanced fiscal and health policy agendas through oversight and management of a \$330 million budget, 1,200 employees, headquarters operations, three laboratories, a pharmacy and 69 health clinics.
- Implemented complex regulatory frameworks, interfaced with federal agencies and regulators and adhered to voluminous federal reporting requirements, while simultaneously discerning and reporting on costs attributable to statutorily required health services.
- Actively engaged stakeholders, including decision makers, influencers, elected officials, beneficiaries, healthcare providers, payers and community-based organizations for solutions to health challenges.
- Led and oversaw efforts to decrease the state's burden of chronic and infectious disease and risk factors, including HIV, diabetes, obesity, poor nutrition and tobacco use.
- Responsible for the administration of emergency medical services and preventive health services in immunizations, sexually transmitted diseases, family planning, children's special health services and nutrition.
- Worked closely with healthcare providers, other stakeholder groups and Louisiana Medicaid to develop and implement the Governor's health care reform initiative aimed at providing "whole person" care coordination and lower costs through risk-based managed care.
- Guided the development of the business plan for a new state-of-the-art academic medical training and research center.
- Served as senior advisor to the Secretary and as an advisor to the Governor on health care policy and provision of healthcare services in Louisiana, as well as the impact of policy changes on stakeholders, healthcare providers and consumers.
- Led departmental business planning efforts to increase productivity and performance in health care programs and services, as well as internal administrative functions.
- While balancing myriad demands and spontaneous internal and external matters, directly oversaw management functions of business and strategic planning, communications, legal, legislative and

## J.T. Lane, MPH

### Director

intergovernmental affairs, emergency preparedness and stakeholder affairs.

- Provided oversight of budget, programmatic, policy and administrative functions of the Department, and directly managed the Office of the Secretary with more than 300 staff.
- Coordinated healthcare services in response to the Gulf of Mexico oil spill, as well as strategic planning and pre-implementation of the Patient Protection and Affordable Care Act of 2010.
- Represented the Secretary in official capacities, served as spokesperson for the Department, and oversaw human resources, communications, legislative affairs and other strategic functions.
- Prepared the Secretary for major policy addresses, Congressional and legislative testimony, high-profile news interviews and speaking engagements.
- In the aftermath of hurricanes Katrina and Rita, directed all statewide and national education and outreach efforts of a disaster recovery organization with a \$70 million budget.
- Led and managed education and outreach staff and half-million dollar budget; served as one of five members of organization's management team.
- Oversaw board relations and other organizational strategic functions and facilitated strategic planning efforts.
- Prepared the chief executive officer and board members for high-level presentations and speeches before national organizations and agencies, including the U.S. Congress, New York Regional Association of Grantmakers and policy groups.
- Assisted in the development and execution of faculty research grant programs to stimulate more competitive faculty research proposals to federal agencies, including the National Institutes of Health, National Science Foundation, Department of Defense, Environmental Protection Agency, NASA, Department of Commerce and many others.
- Directed all public education, communications and outreach efforts of LSU's research and economic development arm (with significant focus on health, medical and biological sciences).
- Developed content for a variety of materials for the Web, social media, printed collateral and the press.

### Work History

Director, Navigant	2019 – Present
Senior Director, Alvarez & Marsal, Public Sector Services, LLC	2017 – 2018
Principal, Health Management Associates, Inc.	2016 – 2017
Assistant Secretary for Public Health, Louisiana Department of Health and Hospitals	2011 – 2016

## J.T. Lane, MPH

### Director

Chief of Staff, Louisiana Department of Health and Hospitals	2010 – 2011
Deputy Chief of Staff, Louisiana Department of Health and Hospitals	2008 – 2010
Director of Operations and Communications, Louisiana Family Recovery Corps	2007 – 2008
Development and Outreach Manager, Louisiana State University Office of Research and Economic Development	2002 – 2007
External Affairs Consultant, ExxonMobil Corporation	2002
Assistant Account Executive, Pennino and Partners	2000 – 2001
Associate, Cranch-Hardy & Associates	2000 – 2001
Public Affairs, Louisiana Department of Insurance	1999 – 2000

### Certifications, Memberships, and Awards

- Milbank Memorial Fund Emerging Leaders Program, Mentor, 2016 – 2018
- University of California Berkeley Public Health Mentorship Program, Mentor, 2016 – Present
- American College of Healthcare Executives, Member, 2015 – 2017
- Aspen Institute Justice & Society Program, Team Work: Leadership for Health States, Advisory Board Member, 2015 – 2017
- Robert Wood Johnson Foundation State Health Leadership Initiative Faculty Member & Advisory Committee Member, 2016 – 2017
- National Public Health Community Platform Executive Committee Co-Chair, 2014 – 2016
- American Public Health Association, Member, 2014 – Present
- Association for State and Territorial Health Officials (ASTHO), 2011 – Present
  - Alumni Society, Member-At-Large & Executive Committee Member, 2016 – Present
  - Informatics Policy Committee, Member, 2016 – present
  - Board of Directors, Member, 2012 – 2016
  - Informatics Policy Committee, Chair, 2015 – 2016
  - Performance Policy Committee, Co-Chair, 2013 – 2015
  - Government Relations Committee, Member, 2013 – 2016
- National Public Health Community Platform Steering Committee Member, 2013 – 2014

## J.T. Lane, MPH

Director

- Louisiana Public Health Institute, Board of Directors, 2011 – 2016
- Louisiana Obesity Prevention and Management Commission, 2014
- Louisiana Animal Welfare Commission (by Gubernatorial appointment), 2009 – 2012

### Education

Master of Public Health

University of California Berkeley

Leadership for State Health Officials Executive  
Education

Harvard University John F. Kennedy School of  
Government

Bachelor of Arts, Mass Communication

Louisiana State University

## Tamyra Porter

### Director

tporter@navigant.com  
Washington, DC  
Direct: 202.973.3138

### Professional Summary

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

### Areas of Expertise

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



## Tamyra Porter

Director

### Professional Experience

#### Medicaid Managed Care

- Supported and directed various aspects of program design and implementation. Roles in this area have included concept paper development, internal stakeholder facilitation, development and drafting of waiver applications (1915 b and c, as well as 1115), updating and drafting state plans and developing and reviewing budget neutrality calculations. Tamyra has also assisted states in coordination and meeting with CMS to usher through the waiver approval process. Supported New Hampshire, Kentucky, Pennsylvania and Alabama in these aspects of program design implementation.
- Directed and supported the development of procurement and reprocurement tools, including state administrative code development, RFPs, proposal evaluation resources, and contracts. Provided support with an eye towards ongoing operations and oversight incorporating principles of value-based purchasing. Provided such support for Pennsylvania, Mississippi, Georgia and Alabama for full-risk managed care programs, provider-sponsored managed care programs, EPCCM programs, Enrollment Broker contracts, EQRO contracting, Pharmacy Benefits Managers, Specialty Pharmacy contracting, ADA compliance audits, and public outreach campaigns.
- Directed and supported the development of various readiness review tools for a variety of state Medicaid managed care programs including Indiana, Pennsylvania, Mississippi, Alabama, and Iowa. Has assisted in training state and contracted staff in the use of designed tools and providing ongoing support and dashboarding of readiness tools throughout the readiness process. Served as a subject matter expert with emphasis on systems readiness, network adequacy, reporting, long-term care, and special needs populations. As a subject matter expert, she participates and leads desk reviews and participates in site visits related to the readiness process. Worked with states to leverage the readiness efforts as a seamless transition to ongoing monitoring, including evaluation and assessment of national and local Medicaid health plans such as Centene, Amerigroup, United, AmeriHealth Mercy, Molina, and also provider-sponsored entities who have partnered with groups such as Blue Cross Blue Shield, Sentara, Viva, and others.
- Works with a variety of states to evaluate and support their monitoring and oversight of state programs. Worked on targeted efforts to evaluate provider network access and availability, ADA accessibility, care management evaluations, compliance with grievances and appeals, and maternity care programs. Worked with state clients in multi-year engagements and one-time GAP analyses to develop Monitoring Boot Camp trainings, provide automated tools to facilitate monitoring, provide oversight documentation, and develop reporting requirements and tools to read and aggregate vendor reporting for state dashboarding and oversight. Her approach to monitoring includes the use of existing resources and development of automated tools to more efficiently document and complete

## Tamyra Porter

### Director

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

- Directed an engagement for Texas Health and Human Services Commission to support compliance with Corrective Action Orders specific to the Consent Decree in *Frew v. Hawkins* and mandate to provide adequate supply of healthcare providers. Conducting robust series of provider network adequacy tests which she has leveraged in assisting other states in the development of network adequacy requirements and related reporting and analytics to monitor ongoing compliance with access standards.
- Assisted states in the development or renewal of their state quality strategy. Worked with Pennsylvania, Mississippi, and Alabama in crafting the quality strategy as a foundational component of their overarching approach to value-based monitoring and oversight and as a means of aligning state program goals and objectives with the national quality strategy. Led efforts to engage stakeholders in identifying and adopting quality measures for their state programs and in turn assisting the state in the operational reporting, data collection and analyses of these measures.

### Medicaid Performance Management

- Conducted various reviews of internal state oversight functions and provided technical assistance and recommendations for performance improvements in several states including Indiana, Pennsylvania, Texas, Alabama, Mississippi, Louisiana, and North Carolina. Provided clients with various technical, customized database solutions to better track and document monitoring activities, report on these functions and improve oversight. Recommended monitoring review steps, sources for obtaining required data and guides for measuring and evaluating performance. Developed detailed standard operating procedures to support the ongoing monitoring efforts and transitioned these tools to the assigned staff for ongoing use. Provided detailed training manuals and conducted classroom trainings to support staff in these efforts. The monitoring tool also connects compliance decisions to contractor performance reporting.
- Designed and directed the development of a state training institute to assist clients in program transitions from fee-for-service to managed care and to provide ongoing staff development resources. Directed the development of various e-learning solutions to be packaged and hosted on state platforms or hosted for our state clients.

## Tamyra Porter

Director

### Long Term Care

- Assisting states in their design and development of program reforms for their long-term care programs. Working with state clients to develop concept papers, stakeholder engagement efforts, waivers and state plan modifications. Coordinating efforts with legislative mandates and affiliated workgroups. Assurances also includes payment transformation and leveraging managed care designs to transition to alternative payment models. Recent efforts have focused on provider-led initiatives where provider groups would gradually assume risk for the long-term care population. Serves as a subject matter expert on LTSS issues on projects for Iowa readiness reviews, Kentucky program design, Kansas and others while directing program design projects for Alabama and New Hampshire.
- Assisted Pennsylvania's Bureau of Home and Community Based Services (HCBS) with ongoing analysis of its current Individual Service Planning and service plan approval process. Assisted the Commonwealth in evaluating process for automating the service planning and approval process. Conducted research and support for the evaluation of uniform needs assessment tools to aid in the development of individualized budgets for HCBS waiver services. Expanded this research to include a full spectrum of public welfare services including the critical services for dual eligibles and those who may qualify for long-term care and support.
- Researched and developed a bed-needs study for Ohio. Compared the number of nursing facilities available across the state to occupancy rates and unused beds for each area of the State. Compared findings with trends in nursing home usage in other states, as well as nationally, in context to recent Federal requirements related to rebalancing and nursing home transitions. Prepared summary reports and presented findings to Ohio's Office of Jobs and Family Services.
- Developed and conducted a training institute for HCBS waiver providers and service planners to fulfill training requirements for enrollment as a qualified provider with the Commonwealth of Pennsylvania.
- Provided initial support for an automated audit tool to assist state clients in their quality improvement and audit functions of HCBS providers.

### Government Payment Transformation

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

## Tamyra Porter

### Director

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

### Medicaid Reform

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

### Health Information Technology

- Assisted the States of Pennsylvania, Kansas, Maryland, and the District of Columbia in the design and planning for the Medicaid HIT provider incentive payment program. Assisted in the development of various planning sessions and the drafting of the SMHP for CMS review and approval. For the District of Columbia, assisted in the drafting of a statement of work the District would use to procure support for the ongoing operations of its incentive program.
- Directed engagements related to encounter data requirements and validation. Projects have included development of contract requirements, evaluation of readiness, assistance with encounter data production testing. Developed various encounter data studies to look at timeliness and completeness and determine opportunities for efficiencies and other studies comparing HEDIS scores for administrative measures comparing results from encounter data calculations to audited HEDIS reports.
- Developed MCO contract requirements related to promoting use of HIT by providers requiring adoption and use for inclusion in provider networks for certain high-volume provider types.

## Tamyra Porter

Director

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

### Healthcare Compliance

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

### Work History

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

### Education

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

### Selected Recent Presentations and Publications

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

## Roshni Shah Arora

### Associate Director

roshni.arora@navigant.com

Washington, DC

Direct: 713.646.5021

### Professional Summary

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

### Areas of Expertise

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

### Professional Experience

#### Federal Initiatives

- Led an engagement for a large national health plan (Part C, Part D, Medicare-Medicaid) to overhaul existing policy infrastructure to develop a comprehensive set of policies addressing Medicare and Medicare-Medicaid products. Tasks included policy life cycle management design, development of a policy template, policy research and development, and procedure review. The policy research and development component incorporated a review of all relevant regulatory frameworks, including

## Roshni Shah Arora

### Associate Director

federal and state regulations, federal and state guidance, and contracts with government purchasers. At the conclusion of the project, led the review and update of over 400 policies.

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

### Medicaid Reform

- Assisted the District of Columbia to engage public and private sector stakeholders in developing the District’s proposal for innovative payment and service delivery models. Tasks include data collection and research, stakeholder engagement, meeting facilitation, development of policy recommendations, financial modeling, and communications activities. Developing the District’s State Health System Innovation Plan (SHIP) that the District will submit to CMS.
- Conducted a study for the Association of Community-Affiliated Health Plans (ACAP) to identify the benefits and challenges associated with leveraging Medicaid safety net health plans for health reform.



## Roshni Shah Arora

### Associate Director

#### Medicaid Managed Care

- Supported engagements to design, implement, and operate Medicaid managed care programs in states such as Alabama, Kansas, Illinois, Mississippi, Pennsylvania, and West Virginia. Project work has involved:
  - Supported the evaluation of program design considerations through research, analysis, and stakeholder engagement.
  - Supported the management and oversight of Medicaid managed care for long-term services and supports (LTSS).
  - Supported the development of 1115 waiver demonstration, including preparation of application materials and participating in CMS discussions and negotiations.
  - Developed reporting templates, dashboards, and other reports to collect and disseminate performance data (quality, operational, and financial) to internal and external stakeholders.
  - Supported quality improvement and performance monitoring, including development and update of the federally-required Quality Strategy and establishing performance through metrics such as Healthcare Effectiveness Data and Information Set (HEDIS®), Consumer Assessment of Healthcare Providers and Systems (CAHPS®), and other state-generated measures.
  - Assessed and developed organizational structures, processes, and policies and procedures to promote effective program monitoring and continuous performance improvement.
  - Conducted data analysis to identify performance opportunities and successes and evaluate program effectiveness.
  - Facilitated stakeholder workgroups consisting of agency staff, providers, and health plan executives, and consumers to identify health plan and program performance measures.
  - Conducted reviews of state agency and health plan to assess readiness prior to program go-live.
  - Developed and provided feedback on procurement materials, including Medicaid managed care organization contracts, Requests for Proposals, responses to bidder questions, and proposal scoring tools.
  - Trained agency staff on subject matter, such as Medicaid and managed care, and skills, such as data analysis and program monitoring.
- Supported strategic planning for senior leadership from the Florida Agency for Health Care Administration's Division of Medicaid to prioritize activities in 2017-2020. Led interviews with senior leaders to understand their role, activities and approach for oversight, monitoring, and performance management, and ongoing challenges. Facilitated strategic planning session using a decision-making framework to prioritize agency activities and establish goals for 2017-2020 to achieve short- and long-term program goals.

## Roshni Shah Arora

### Associate Director

- Managed daily project operations for a technical assistance contract with West Virginia's Bureau for Medical Services, which included serving as the primary point of contact with the client, contracted MCOs, CMS, and other vendors. Supported the State with expansion of managed care to include SSI beneficiaries and new services (e.g., behavioral health, dental, and pharmacy services). Prepared the 1915(b), quality strategy, and other supporting documentation to obtain federal authority for program changes. Provided strategic support for implementation activities such as phased-expansion schedule, stakeholder communications, and supported readiness reviews.
- Provided assistance to the Georgia Department of Community Health to develop and implement a value-based purchasing model for select Georgia Medicaid managed care programs. Designed a collaborative process with vendors, identified key priority areas, developed an incentive payment model, and prepared performance measurement specifications.
- Provided recommendations for combining New York's Medicaid managed care contract for the special needs plan (SNP) program for Medicaid-eligible individuals with HIV/AIDS into the mainstream Medicaid managed care program contract. As a result, the State adopted a single managed care contract for these programs, facilitating contract oversight and vendor monitoring.
- Assisted multiple Medicaid MCOs in responding to state Requests for Proposals to participate in mandatory Medicaid managed care programs. Reviewed health plan policies and procedures, interviewed health plan staff and executives and drafted responses to RFP questions.

### Medicaid Performance Management

- Performed an assessment of Mississippi's Medicaid managed care program to improve operational and program performance. The assessment focused on the areas such as monitoring and oversight, data analytics, enrollment, quality management, and care management.
- Supporting engagements to assess and improve program integrity functions in Alabama, Mississippi, Texas, and West Virginia. Project work has involved:
  - Assessing organizational structure and processes to improve critical processes, especially in the context of increased managed care enrollment.
  - Building agency program integrity capacity through the development of policies and procedures and staff trainings.
  - Developing strategic work plans to prioritize agency activities.
  - Developing reporting templates to collect contractor data for program integrity activities.
- Provided consultation on organizational structure and development to the Illinois Bureau of Managed Care to identify operational and structural efficiencies. Facilitated strategic planning to determine



## Roshni Shah Arora

### Associate Director

priorities to enhance the Bureau's oversight of current and new programs. Proposed recommendations for organizational realignment to increase functional efficiency.

- Conducted an analysis for Arizona to identify potential cost savings that would minimize adverse impacts on the health status of Arizona Health Care Cost Containment System (AHCCCS) beneficiaries. For each proposed area, identified and estimated the projected cost savings and identified advantages and the potential for adverse effects on the target population, exacerbation of related chronic conditions, cost shifting to other covered services, and delayed access to care.
- Provided technical assistance to West Virginia on overall quality improvement, program monitoring, and oversight. Reviewed all MCO deliverables and prepared a quality dashboard to highlight key issues. Coordinated with the State's EQRO to identify interventions to improve performance.
- Led the collection and analysis of information of Medicaid primary care case management (PCCM) programs, including beneficiary access, cost-sharing, and associated disease management and care management components, for New York to use in considering a future PCCM program as an alternative to full-risk managed care in rural areas. Evaluated beneficiary access to primary care and specialist providers in New York's Medicaid managed care program through conduct of focus groups.
- Assessed the performance of Connecticut's HUSKY Program, a capitated Medicaid managed care to compare the policy alternatives of retaining HUSKY versus adopting a "managed fee-for-service" model of coverage for the Connecticut Association of Health Plans.
- Developed an independent assessment of New Mexico's managed care program, Salud!, and behavioral health managed care programs, assessing access, quality, and cost-effectiveness.

### Other Relevant Experience

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

### Work History

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



## Roshni Shah Arora

Associate Director

### Certifications, Memberships, and Awards

Navigant Most Outstanding Leadership Collaboration 2015-2016

Client Focus Award, OptumInsight Consulting

### Education

Master of Public Health, Health Policy and Management	Columbia University, Mailman School of Public Health
---	--

Bachelor of Arts, Health and Societies and Political Science	University of Pennsylvania
--	----------------------------

### Selected Recent Presentations and Publications

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

## Thomas Carlisle, CPA

### Associate Director

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

### Professional Summary

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

### Areas of Expertise

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

## Thomas Carlisle

Associate Director

### Professional Experience

#### Medicaid Managed Care

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

#### Other Relevant Experience

- Served as Chief Financial Officer at the Arkansas Department of Human Services – Division of Medical Services. Managed \$6 billion+ Medicaid program, Arkansas' largest agency. Responsible for accounting and budgeting, human resources, reimbursement, and administrative units of division.
- Oversaw all Finance and Reimbursement function within State Medicaid Agency in Arkansas. Developed annual operating budget for executive and legislative approval, which included forecasting of existing and new programs based on historical, geographic, demographic, and other trends. Responsible for monthly budget analysis to identify variances within programs that could indicate under-utilization or access to care issues, as well as over-utilizations or consumption. Responsible for reporting Medicaid program finance results to Legislative Oversight Committees.

### Work History

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

## Thomas Carlisle

Associate Director

### Certifications, Memberships, and Awards

Alabama and Arkansas Society of CPAs

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

President and Board of Directors, Executive Networking Organization

President and Board of Directors, Downtown Civitan Club

Beta Alpha Psi, National Accounting Honors Fraternity

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

### Education

Bachelor of Science – Business Administration in Accounting      Auburn University