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Puerto Rico Department of Health

Puerto Rico Medicaid Program New Congress Requirements

Request for Quotation (RFQ)

March 8, 2020

Submitted By: Deloitte Consulting LLP

350 Carlos Chardon Avenue, Suite 700. San Juan, PR 00918

Puerto Rico Department of Health

Puerto Rico Medicaid Program New Congress Requirements

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March 8, 2020

Submitted by:

Deloitte Consulting LLP

350 Carlos Chardon Avenue, Suite 700

San Juan, PR 00918

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Submitted To:

Puerto Rico Medicaid Program
Ms. Luz Cruz-Romero
Puerto Rico Medicaid Executive Director

Deloitte.

Deloitte Consulting LLP
Torre Chardon
350 Chardon Avenue, Ste. 700
San Juan, PR 00918

March 8, 2020

Luz. E. Cruz-Romero
Executive Director
Puerto Rico Medicaid Program
Department of Health
P.O. Box 70184
San Juan, PR 00936-8184

RE: Request for Quotation (RFQ) Puerto Rico Medicaid Invitation of Special Requirements from Congress

Dear Ms. Cruz-Romero,

Deloitte Consulting LLP (Deloitte) is pleased to submit this response to the Puerto Rico Medicaid Program (PRMP) to provide consulting services to assist with the planning, assessment, and implementation of Special Requirements from Congress related to Program Integrity, Compliance, Reporting, and CMS leading practices. Additionally, PRMP is seeking a partner with proven capabilities working with Congress and the Centers for Medicare & Medicaid Services (CMS) to expedite Puerto Rico's compliance with the Special Requirements.

Our response highlights our extensive experience working with CMS and Medicaid clients on a myriad of different projects and initiatives, and demonstrates our capabilities in implementing the plans, strategies, policies, procedures, and technologies needed to address the requirement areas requested by Congress. We have assembled a team that brings unmatched Medicaid knowledge and leading practices, CMS and Washington DC relationships, experience with the requested services, and local PRMP understanding with a number of native speakers. Our proposed approach addresses each of the stated requirements using local Puerto Rico based and stateside subject matter specialists that work collaboratively with PRMP, the Department of Health (DOH) and the Puerto Rico Health Insurance Administration (ASES) in achieving compliance with Congress, CMS, and other entities of the Federal Government.

We appreciate this opportunity to continue our relationship with Puerto Rico and provide the Department with the level of professional services that you require for your important initiatives. Puerto Rico has been and continues to be an important and valued client to Deloitte. Please do not hesitate to call me at +1.732-586-4689 with any questions.

Very truly yours,

By: _____

Angel Quiñones Cardona
Principal
Deloitte Consulting LLP

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I. Deloitte is the Right Partner to Meet Your Needs

The Puerto Rico Department of Health (PRDOH) and its Medicaid Program (PRMP) is seeking a trusted advisor to support efforts related to the compliance requirements established by Congress for the enhancement of Program Integrity, Contract Reform/Oversight, Reporting, and Compliance of the program. Deloitte is prepared to collaborate with PRMP and support you with the requirements stated in the Request for Quotation (RFQ) published on February 24, 2020. As you embark in the planning, assessment, and implementation of the requirements established by Congress, we are ready to assist you to focus on effectively implementing the mandates established in H.R.1865.

In this response, we elaborate why Deloitte is the right partner to assist you on the journey from strategy through implementation for the requested changes, while balancing the need to manage the day-to-day operations of a Medicaid program that serves over 1.4 million beneficiaries in Puerto Rico.

We are invested in Puerto Rico's success and know your Medicaid program

Deloitte and Puerto Rico have a long history of collaboration spanning many years. We have had a local presence in Puerto Rico for the past 50 years with our office located at 350 Torre Chardon, Suite 700 in Hato Rey, San Juan. The Government of Puerto Rico has trusted us to deliver some of your toughest system, program, and operating model transformations. Some of the engagements where we have served Puerto Rico are highlighted in the following figure. **We are invested in your success.** What matters to you matters to us. We are invested in seeing your transformation become a reality because we are part of the community and have had the opportunity to understand your vision, programs, stakeholders, challenges, and desired outcomes.

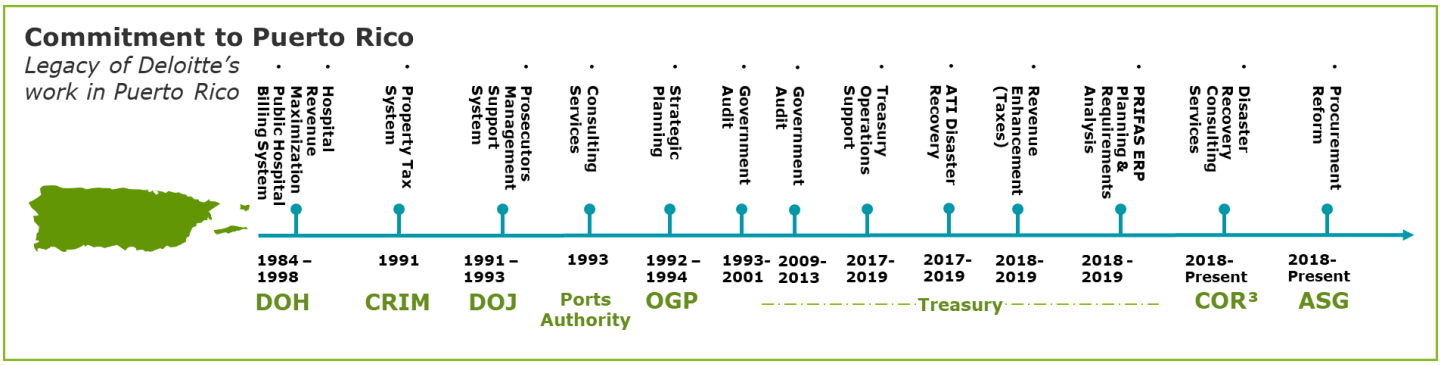

Figure 1- Legacy of Deloitte's work in Puerto Rico

Our proposed engagement team for PRMP understands your Medicaid Program, Managed Care environment, your State Plan, and most importantly how to be successful in implementing changes in Puerto Rico. Our proposed Engagement Executive, **Angel Quiñones Cardona** is from Puerto Rico and has been working on PR based engagements for the past 25 years; **Ramona Pereira-Chakka** and **Timothy Fitzpatrick** have over 15 years of experience serving Medicaid Programs and bring this background to PRMP. Our proposed Project Manager, **Gilberto (Tito) Torres** has more than 12 years of experience working with Puerto Rico in both Medicaid and the Puerto Rico Health Insurance Administration (ASES), serving as Strategic Operations Manager and Assistant to various Secretaries of Health. Two of our strategic partners from MJM Contigo LLC, **Michael Melendez** and **John Guhl** were leaders with the Centers for Medicare & Medicaid Services (CMS) Region II, managing the overall Medicaid Program for Puerto Rico from the federal regulatory side, have deep knowledge of the compliance and financial issues that PRMP needs to address to be able to comply with the Congressional requirements stated in your RFQ. Additionally, our teaming partner **Speire Healthcare Strategies**, which includes three former Medicaid directors, is currently working with the National Governor's Association (NGA) to provide technical assistance to state Medicaid programs, including Puerto Rico.

Nuestro equipo disponible para PRMP incluye un grupo de once (11) recursos locales y bilingües, muchos de los cuales residen y trabajan en Puerto Rico y estarán disponibles para trabajar con el equipo de trabajo del Programa de Asistencia Médica. Tenemos la experiencia, conocimiento de la reglamentación federal y del Programa de Medicaid necesario para apoyar los objetivos de Medicaid y ejecutar los requisitos federales de manera inmediata.

We bring experience responding to legislative oversight

Responding to legislative oversight is different than a traditional project initiative for a Medicaid agency. It requires frequent communication, detailed reporting, specific and tactical planning, extensive record keeping, and the need to respond to legislative inquiries rapidly and accurately. Deloitte has experience helping a variety of government agencies respond to legislative oversight, including oversight from the United States Congress. Bringing this experience, Puerto Rico has the benefit of a team of professionals who understand the unique nature of operating under legislative oversight and are experienced at navigating the complex interplay between local, state, territorial, and federal governments. The following two examples offer an overview of this experience:

Texas

As required by the 85th Legislature of the State of Texas, Deloitte led the comprehensive review and evaluation of the Texas Medicaid and CHIP Managed Care Program. The five-part study included: (1) studying prescription drug benefits, (2) reviewing the current delivery system, (3) assessing managed care contract oversight functions, (4) studying the rate-setting processes in other states, and (5) analyzing administrative costs. Studies included performing detailed analyses of the Medicaid payment models, interviewing Texas leaders and stakeholders, identifying opportunities for improvement, and presenting findings to legislative groups, the Governor's office, the general public, and stakeholders. More detailed information on this project, including contact information, is available in **Section II.**

- https://hhs.texas.gov/reports/2018/08/rider-60-prescription-drug-benefit-administration-medicaid-chip-other-health-related-services
- https://hhs.texas.gov/reports/2018/08/rider-61-evaluation-medicaid-chip-managed-care

Puerto Rico

Throughout our current engagement with the Puerto Rico Central Office for Recovery, Reconstruction, and Resilience (COR³), our team provided assistance responding to Congressional oversight through a specific workstream – DC Outreach. This team helped COR³ understand the operating environment and political currents in DC and advised COR³ leadership on politically feasible solutions to statutory and regulatory challenges faced with such a massive recovery effort. Additionally, the team provided assistance with Federal and Congressional Stakeholder visits, Puerto Rico leadership visits to DC, and helped COR³ leadership with responses to Congressional inquiries and hearings.

We bring you access to leading national Subject Matter Advisors

Deloitte provides PRMP access to leading national subject matter advisors, includes five (5) former Medicaid directors, former CMS officials, and former HHS leaders, who have addressed similar initiatives in their roles with CMS or running state Medicaid and CHIP programs.

- **Darin Gordon**, former **Tennessee Medicaid Director** and the current commissioner for the Medicaid and CHIP Payment and Access Commission (MACPAC)
- **Dianne Faup**, former Senior Advisor to then **US Department** of **Health and Human Services (HHS)** Deputy Secretary Alex Azar and former **Chief of Staff to the Washington DC** Medicaid program

- **Jim Hardy**, former **Pennsylvania Medicaid Director**
- **John Guhl**, former **New Jersey Medicaid Director** and former **Finance Director at CMS Region II**
- **John McCarthy**, former **Ohio and Washington DC Medicaid Director**
- **Tom Betlach**, former **Arizona Medicaid Director** as well as **President/Vice President of the National Association of Medicaid Directors (NAMD)**
- **Michael McMullan** who has served in a wide range of leadership positions at **CMS including Acting as the Administrator** during the transition between the Clinton and Bush Administrations
- **Michael Melendez**, former **Associate Regional Medicaid Administrator for CMS Region II**, which included Puerto Rico as part of its jurisdiction

These advisors bring their unique and deep-standing relationships across the Medicaid and healthcare landscape, including at HHS and CMS; along with years of experience in state Medicaid programs and are available to support PRMP in identifying leading practices in their specific specialties, details of individual experience are in **Section IV**.

We are a national leader in Medicaid that brings you deep experience from similar engagements

We have helped 47 states and the District of Columbia for more than 50 years to address their toughest Medicaid and health challenges. We support seven Federal Health clients including CMS. Below is a summary of recent projects that speak to the lasting impact we have made with these clients. More detailed information on these projects and contact information are available in **Section II.**

Centers for Medicare & Medicaid Services

Our team has worked with the Centers for Medicare & Medicaid Services (CMS) for the past decade in the areas of program management, program integrity, and organizational design. We are the Program Integrity Modeling and Analytics Support (PIMAS) contractor for the CMS Center for Program Integrity. Through this work, we develop models and edits for implementation into the Fraud Prevention System (FPS) and support identification of new vulnerabilities and risks for fraud, waste, and abuse in the Medicare and Medicaid programs. Through this work, we use multiple data sources to triangulate on provider aberrant behavior, including Medicare data and Medicaid T-MSIS data.

New York

Our team began working with the New York State Department of Health (NYDOH) in July 2017 to support Medicaid rate development, financial management, and technical assistance in support of the NYDOH's Medicaid programs. The services provided to NYDOH include: the certification of actuarially sound premium rates for programs, rate development and financial management of the individualized service programs, service-based payment rate methodology development and determination, fiscal impact analyses of legislative initiatives, state and federal healthcare reform fiscal impact analysis, 1915(c) waiver technical assistance, waiver budget neutrality calculations, and collaboratively working with the State on its Delivery System Reform Incentive Program (DSRIP).

Pennsylvania

Our team supports the Pennsylvania Office of Medical Assistance Programs (OMAP) from strategic planning to implementation services to improve the contract reform and oversight of Managed Care Organizations (MCOs) across contract monitoring, health care quality management, actuarial services, administrative cost analysis, and strategic and executive support for their Medicaid and CHIP programs.

Massachusetts

Our team supports the Massachusetts Executive Office of Health and Human Services (EOHHS), implementing an innovative payment and care delivery model that centers on transitioning more than one million Medicaid members to Accountable Care Organizations (ACOs) and community-based care coordination for behavioral health, long-term services and supports, and social services.

Georgia

Our team supports the State of Georgia in its transformational journey to increase access, improve quality, and decrease costs for the Medicaid and individual health insurance markets. Along with our teaming partner Speire Healthcare Strategies, we have collaborated with the State to assess the current health care environment, develop innovative concepts, and draft and submit both an 1115 and 1332 waiver to CMS to operate a unique healthcare market in the State. We are now working with the State and federal government through approval and implementation of these waivers.

Idaho

Our partner, Speire Health Care Strategies, is supporting the Idaho Medicaid leadership team in developing a strategic sustainability framework. This includes providing an environmental scan that reviewed the current Idaho reimbursement strategies for a number of different provider types. Speire provided a list of opportunities for the Idaho Medicaid leadership team on opportunities to improve payment structure to build on stronger alignment towards sustainability and value. Speire also provided opportunities on improving managed care oversight and program integrity.

National Governor's Association (NGA)

Our partner, Speire Healthcare Strategies, is currently engaged by the NGA to provide technical assistance to selected state Medicaid programs to develop and implement leading practices in Medicaid managed care programs to achieve health system goals. Current states Speire Healthcare Strategies is supporting include Wisconsin, Maryland, North Carolina, and **Puerto Rico**.

We bring PRMP our deep experience with federally funded health care programs

Deloitte brings deep experience across federally funded health care programs, providing advice, implementation support, and operations support across states and the federal government. The following figure highlights our broad experience across all aspects of federally funded healthcare programs.

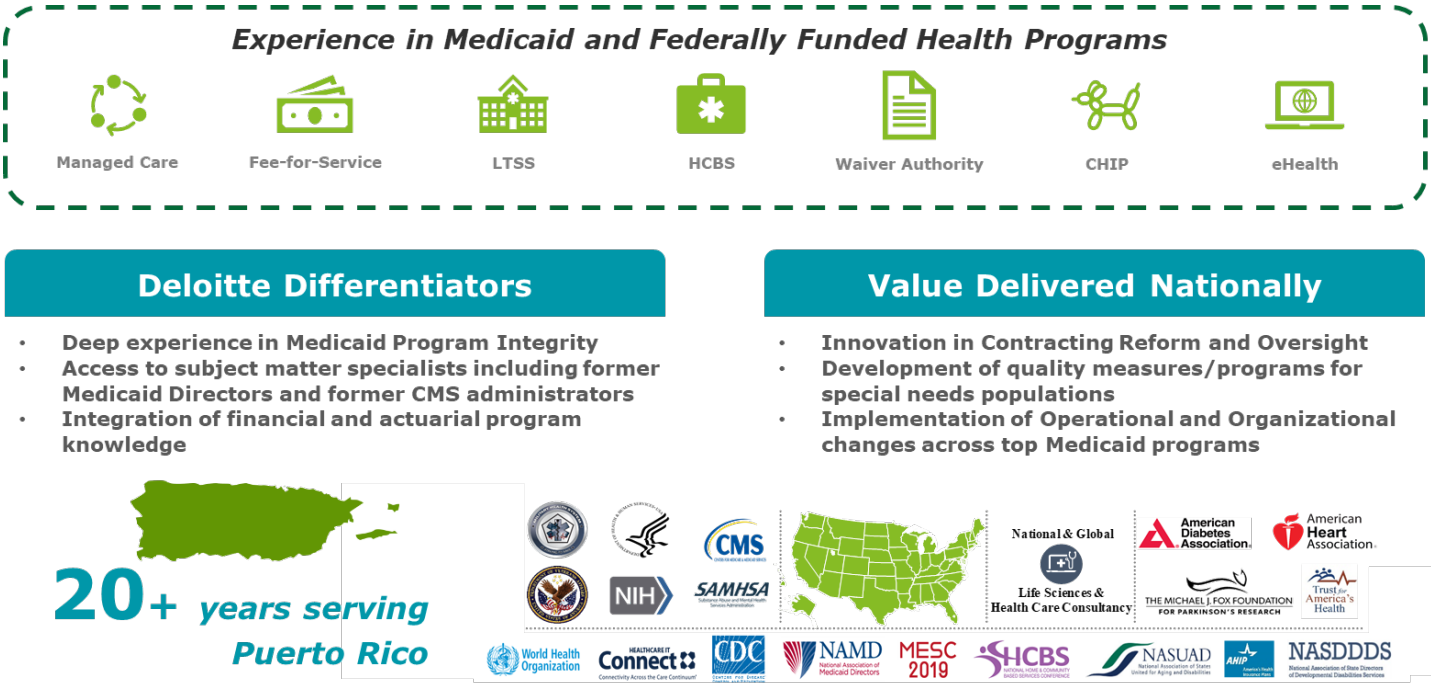

Figure 2- Our Experience with Federally Funded Health Care Programs

II. Our Client References

Our team has offered eight (8) unique client references that stand out among an array of Medicaid program support our experiences in working with federal and state health agencies. The Medicaid program experiences described below in Figure 3, demonstrate the depth and breadth of our engagements, our ability to exceed client expectations and demonstrates experience with services similar to what has been requested in the RFQ. We invite you to contact the listed reference contacts to obtain first-hand information of our team's Medicaid program knowledge and the results we delivered for clients.

RFQ Requirement	PA	GA	NGA	NY	TX	MA	CMS	ID
1. Review Program Integrity Policies, Procedures, Staffing	✓		✓		✓		✓	
2. Develop Payment Error Rate Measurement (PERM) Plan							✓	
3. Develop Contracting Reform	✓		✓	✓	✓			✓
4. Review Medicaid Eligibility Quality Control (MEQC) Policy/Procedures/ Staffing	✓						✓	
5. Evaluate Dual Eligible Special Needs Plan	✓			✓	✓		✓	
6. Develop Annual Report	✓	✓		✓	✓			
7. Develop Report on Contract Oversight and Approval	✓		✓		✓	✓		✓
8. Evaluate Current Process of Managed Care Payments			✓	✓	✓		✓	✓
9. Define Scorecard Reporting Measures	✓	✓				✓	✓	
10.Develop Financial Executive Summary for CMS 64 and 37				✓			✓	
11. Evaluate Current Contract Requirements and CMS Reporting	✓		✓	✓	✓			✓
12. Implement Scorecard Reporting System	✓			✓		✓		
13. Develop Policies and Procedures for Penalties				✓	✓		✓	

Figure 3- Our Client References Exceed RFQ Requirements

Client Reference #1: Commonwealth of Pennsylvania

Office of Medical Assistance Programs (OMAP) Technical Assistance Contract

Contract Description and Services

The Pennsylvania Office of Medical Assistance Programs (OMAP) administers the Medicaid program that purchases health care for approximately 2.8 million Pennsylvania residents through its Health Choices Program. Pennsylvania delivers Medicaid services predominately through contracts with nine regional physical health MCOs, which provide services to over 2.3 million of the 2.8 million total Pennsylvania Medicaid recipients. On January 1, 2018, Pennsylvania's Office of Long-Term Living (OLTL) began the Community Health Choices (CHC) program, which will phase in Managed Care long-term services and supports. Additionally, approximately 500,000 recipients are served through a Fee for Service (FFS) model. OMAP is responsible for enrolling providers, processing provider claims, establishing rates and fees, contracting and monitoring of MCOs, and detecting and deterring provider recipient fraud and abuse.

Deloitte supports OMAP from strategic planning to implementation services to improve the oversight of MCOs. Deloitte is providing technical assistance and consulting support for all aspects of the Medicaid program including physical health MCO contract monitoring, MLTSS MCO contract monitoring, health care quality management, financing services, administrative cost analysis, and strategic and executive support.

Relevant Experience Related to Scope of Services

Much of the work completed under this contract involves complex work orders across multiple offices, MCOs, and vendors including:

- Helping the PA Medicaid and CHIP programs to collect and track deliverables and quality measures to address Managed Care contract requirements through the Medicaid Program Oversight Portal (MPOP), a cloud-based solution focusing on oversight of and reporting on Medicaid and CHIP programs. MPOP is used for Managed Care program oversight across 15 MCOs and 21 product lines delivering Managed Care services across Medicaid Physical Health, CHIP and MLTSS programs
- Assisting OMAP in improving their Managed Care contract monitoring in five distinct areas:
  - Ensuring compliance with all contract requirements by allowing contract monitoring staff to track progress on compliant and non-compliant monitoring items
  - Monitoring recipient and provider networks to track the adequacy of provider networks
  - Standardizing report templates and data reporting processes
  - Automating data integration for numerous contract monitoring reports
  - Improving monitoring of healthcare quality metrics by developing standardized and automated process for validating and analyzing quality reports
- Supporting PA Medicaid and CHIP programs in standardizing their Medicaid healthcare quality reporting to CMS. Through review of CMS reporting requirements and collaboration with office staff, External Quality Review Organizations (EQROs), and MCOs, Deloitte defined data sources, data structures, and reporting channels to enable accurate reporting of Medicaid quality metrics.
- Supporting the PA Office of Long-Term Living (OLTL), which is responsible for Medicaid programs for participants who are dually eligible for Medicare and Medicaid along with those with long term care needs, in defining the relevant CMS quality reporting guidelines. Our team met with OLTL stakeholders to review reporting guidelines, define cadences, and develop both data collection templates and scorecard formats used for both CMS reporting and internal Medicare MCO and Medicare Dual Eligible Special Need Plan (DSNP) oversight.
- Developing the Medicaid Program Oversight Portal (MPOP) which validates, and stores data used to produce automated reporting used for contract oversight and quality reporting for the PA Medicaid and CHIP programs. The agencies are able to analyze HEDIS, CAHPS, HCBS CAHPS, and other healthcare

quality datasets along with the results of contract monitoring such as Balance Budget Amendment compliance and produce reports used for CMS reporting on demand.

- Supporting PA OMAP in an operating model redesign effort which includes a review of existing operations by conducting interviews with Medicaid leadership, conducting leading practice research across peer states to help inform how other Medical Assistance programs were functioning and a workshop curated to review how peer Medicaid Agency operating models were structured to deliver services and how these could be applicable to Pennsylvania.
- Assisted OMAP to develop requests for proposal for their MMIS 2020 effort. This included:
  - Conducted requirement gathering sessions with other PA DHS Program offices to help OMAP create a Request for Information (RFI) to solicit information to be used with the development of Request for Proposals (RFPs) for the MMIS 2020 procurement
  - Drafted MES solutions requirements and CMS approvable MMIS RFPs for various modules including Managed Care and Financial, Provider Management, Third Party Liability, Fee-for-Service (FFS), Outpatient Drug Solution, the Electronic Data Interchange (EDI) module, the Prior Authorization Module, and the Outbound Mail Module for Pennsylvania's Medicaid enterprise
  - Developed a CMS approvable RFP, the Proposal Evaluation Plan, and preproposal conference materials to support replacement of the current MMIS for the Systems Integrator/Data Hub Module
  - Assisted OMAP in the validation of the requirements of the EDI and Prior Authorization and Outbound mail modules against the CMS MECT checklists

Contact Information and References

Nicole Risner, OMAP Technical Assistance Contract
nrisner@pa.gov (717) 409-3356

Team Members available to PRMP who Served on this Engagement

Ramona Pereira-Chakka

Lindsay Hough

Tim FitzPatrick

Jim Hardy

Matt Mardorff

Client Reference #2: State of Georgia

Governor's Office and Department of Community Health

Contract Description and Services

During the 2019-2020 Regular Session, the Georgia General Assembly passed Senate Bill 106, the Patients First Act. This legislation authorizes the Department to submit a Section 1115 Demonstration waiver to the Centers for Medicare & Medicaid Services (CMS) within the United States Department of Health and Human Services (HHS) which may include an increase in the income threshold up to a maximum of 100% of the federal poverty level (FPL). The legislation also allows the Governor to submit one or more applications to waive applicable provisions of the federal Patient Protection and Affordable Care Act (PPACA) under Section 1332 with respect to health insurance coverage or health insurance plans. Together, these two waivers represent the State's initiative to empower Georgians to increase their access to affordable healthcare coverage and improve their health and well-being.

The State engaged Deloitte and its teaming partner Speire Healthcare Strategies to develop both an 1115 waiver and 1332 waiver. This effort included conducting an environmental scan of the current healthcare landscape in the State, develop design options, evaluate and model those options, and then develop the waivers to authorize the agreed upon program design. Throughout waiver development, our team collaborated closely with the State and Federal government to develop innovative program designs, while complying with federal and state regulation. The State submitted both waivers on December 23, 2019. Our team is now supporting the State through waiver negotiation and approval with the federal government and operationalizing and implementing both waivers.

Relevant Experience Related to Scope of Services

As part of our team's efforts, we have helped the State to:

- Assess the strengths and challenges in the current healthcare environment
- Identify and develop creative first-in-the-nation solutions to address healthcare challenges in the State
- Collaborate with federal agencies, including CMS and the US Treasury, to develop solutions for the State that complied with federal requirements
- Model the financial and enrollment impact of the proposed program designs
- Develop operational program design
- Negotiate waiver approval with CMS

Contact Information and References

Ryan Loke, Special Projects and Health Policy Advisor for Governor Brian P. Kemp
ryan.loke@georgia.gov (404) 861-4919

Team Members available to PRMP Who Served on This Engagement


Jim Hardy


Jeff Burke


Tim FitzPatrick


John McCarthy


Dianne Faup


Darin Gordon


Tom Betlach

Client Reference #3: National Governor's Association

State Technical Assistance

Contract Description and Services

Our team, specifically Speire Health Strategies, is working with the National Governor's Association (NGA) to provide technical assistance to selected state Medicaid programs. Speire is providing subject matter expertise and technical support to states to develop and implement leading practices in Medicaid managed care programs to achieve health system goals. Currently, Speire is working with a number of Medicaid programs, including Wisconsin, Maryland, North Carolina and Puerto Rico.

Relevant Experience Related to Scope of Services

Technical Assistance varies by state. Currently, Speire is working with Puerto Rico to assess technical assistance opportunities to achieve the following goals:

- Increase accountability of plans to meet requirements for network adequacy and timely provider payments
- Increase internal capacity for compliance monitoring and oversight
- Strengthen the role of the Medicaid Fraud Control Unit (MFCU)
- Identify value-based purchasing (VBP) models to present to the Financial Oversight and Management Board (FOMB)
- Establish a process for stakeholders to inform managed care organization (MCO) contracts
- Strengthen transparency for program spending

Contact Information and References

Melinda Becker, Program Director,
Health Division, National Governor's Association
mbecker@nga.org (202)-624-5336

Team Members available to PRMP who Served on this Engagement

John McCarthy

Dianne Faup

Darin Gordon

Tom Betlach

Client Reference #4: New York State

New York State Department of Health

Contract Description and Services

Our team began working with the New York State Department of Health (NYDOH) in July 2017 to support Medicaid rate development, financial management, and technical assistance in support of the NYDOH's Medicaid programs. The services provided to NYDOH include: the certification of actuarially sound premium rates for programs, rate development and financial management of the individualized service programs, service based payment rate methodology development and determination, fiscal impact analyses of legislative initiatives, State and Federal healthcare reform fiscal impact analysis, 1915(c) waiver technical assistance, waiver budget neutrality calculations, and collaboratively working with the State on its Delivery System Reform Incentive Program (DSRIP).

Relevant Experience Related to Scope of Services

- Analyze benefit, population and program impacts for both fee for service and managed care programs to estimate fiscal and policy impacts on proposed changes to the state budget and aid the State in understanding the overall cost driver
- Advise on the State's annual pharmacy budget cap to identify and understand the progression of pharmacy costs and identify opportunities for savings by a variety of performance indicators, including generic dispending rate, therapeutic class breakdowns and preferred drug listings
- Support the State in evaluating its managed long-term care product strategy, assisting in the development of an approach to meet requirements in the development of a new product, identify pathways to reach program goals and lead successful interaction with CMS, MCOs, and advocacy groups
- Advise the State on preparing to incorporate social determinants of health into their risk adjustment program in order to refine estimation of future health care costs
- Provide advisory support on innovative payment models alternative payment arrangements for bundle payments, pharmaceutical value-based contracts, global capitated arrangements and other value-based care contracts to support the State on their mission in transforming from volume to value based care
- Review the State's processing of stop loss claims and identify potential improvements to streamline their processes, tools and staff model. Analyze potential incorporation of robotic process automation to stream line manual and repetitive tasks

Contact Information and References

Mike Ogborn, Medicaid Chief Financial Officer,
New York State Department of Health (NYSDOH)
Michael.ogborn@health.ny.gov (518)-473-3242

Team Members available to PRMP who Served on this Engagement

Tim FitzPatrick

Jim Hardy

Tom Betlach

Client Reference #5: State of Texas

Texas Health and Human Services Commission

Contract Description and Services

Our team has served the State of Texas government for more than 40 years. Recently, we provided consulting services to the Texas Health and Human Services Commission (HCSC) regarding two reports required by the Texas Legislature through two separate Riders (60 and 61) in the State of Texas Appropriations Act from the 85th Texas Legislature. These consulting services included a study and report on potential cost savings in the administration of prescription drug benefits (Rider 60) and a comprehensive review of, and evaluation of managed care in Texas Medicaid and CHIP (Rider 61).

Relevant Experience Related to Scope of Services

- Assessed Texas's Medicaid and CHIP managed care contract review and oversight function, including the effectiveness and frequency of audits; data necessary to evaluate existing contract requirements, enforcement, sanctions and operational reviews; trends and non-compliances; quarterly performance report and deliverables; and contract amendments and procurements processes.
- Surveyed other states about their contract amendments and procurement processes, providing benchmarks by which to compare Texas's processes and identified potential leading practices.
- Analyzed nationwide and state-specific HEDIS benchmarks and CAHPS benchmarks from the Nationwide Quality Comparison Data (NCQA)'s Quality Compass® Tool were used to evaluate managed care program's quality improvement outcomes.
- Evaluated HHSC's managed care contract review and oversight function for quality of care, including the use of the External Quality Review Organization (EQRO), the recently redesigned Pay for Quality (P4Q) Program, the Managed Care Quality Strategy undergoing CMS review, and the Value-Based Purchasing (VBP) Program, and the state's guidance on utilization management and medical necessity determinations.
- Analyzed trends, caseload growth, managed care programs, and summarized managed care program outcomes and initiatives other states have used to contain costs and improve program effectiveness.
- Evaluated the organizational and programmatic infrastructure (i.e., HHSC's sections and offices, other Texas government entities, and contracted vendors) involved in the oversight and management of the Medicaid and CHIP managed care contracts.
- Conducted interviews with HHSC leaders to understand the goals, objectives, and vision for the Medicaid and CHIP managed care contract review and oversight function and facilitated sessions with PRMP staff to access the maturity stages for the nine managed care contract review and oversight functional areas. The resulting evaluations were presented in the Ride 60 and 61 Evaluations reports for HHSC and the State of Texas Legislature.

Contact Information and References

Mariah Ramón, Senior Project Advisor,
Texas Health and Human Services Commission, Medicaid and CHIP Services
mariah.ramon@hhsc.state.tx.us

Team Members available to PRMP who Served on this Engagement

Ramona Pereira-Chakka

Lindsay Hough

Tim FitzPatrick

Jim Hardy

Matt Mardorff

Client Reference #6: Commonwealth of Massachusetts

Executive Office of Health and Human Services

Contract Description and Services

The Commonwealth of Massachusetts Executive Office of Health and Human Services (EOHHS) has designed and is implementing an innovative payment and care delivery model that centers on transitioning more than one million Medicaid members to Accountable Care Organizations (ACOs) and community-based care coordination for behavioral health, long-term services and supports, and social services.

Deloitte has been supporting the EOHHS Medicaid program (MassHealth) since September 2016 in its effort to transform how care is delivered and reimbursed through its Payment and Care Delivery Innovation (PCDI) project. EOHHS engaged Deloitte to stand up and manage a project management office (PMO) to lead the implementation and stabilization of this new and transformative program from a business and technology perspective. Deloitte continues to support the implementation of programs to provide community-based care coordination for behavioral health, long-term services and supports, and social services.

Relevant Experience Related to Scope of Services

- Deloitte has also supported MassHealth with several other aspects of its internal and external transformation efforts, including:
  - Developing and executing an implementation and operations strategy for the new Community Partners program, designed to increase care coordination among behavioral health and long-term services and supports with the ACOs
  - Developing and executing an implementation and operations strategy for the new Flexible Services program, designed to reimburse certain social services to help target social determinants of health
  - Conducting an assessment and roadmap for how MassHealth needs to operationally transition its organization to support the ACO program
  - Documenting operational processes and identifying opportunities for improvement
  - Identifying, designing, and leading development of operational reports MassHealth now uses for management of its program
  - Designing a process and tools for MassHealth to manage and maintain provider to ACO relationships
  - Establishing new processes and reporting standards for managing MMIS change orders and defects across the program
  - Developing an implementation approach and leading the execution of that approach for new cost-sharing standards for the Medicaid program
  - Assessing member and provider escalations to offer improvements to the member and provider experience
  - Developing a business solution to support better identification and tracking of member to primary care provider attribution

Contact Information and References

Renee Washington, Director of Business & Systems Integration
renee.washington@massmail.state.ma.us
(617) 847-3132

Team Members available to PRMP who Served on This Engagement

Jim Hardy

Jeff Burke

Client Reference #7: Center for Medicare & Medicaid Services (CMS)

Center for Medicare & Medicaid Services

Contract Description and Services

Deloitte serves the Centers for Medicare & Medicaid Services (CMS) as the Lead Analytical Contractor (LAC) for Medicare Advantage (MA) Risk Adjustment Data Validation (RADV) Activities.

CMS conducts two types of RADV activities:

- National payment error estimates to comply with reporting requirements mandated by the Improper Payment and Information Act (IPIA) of 2002, amended by the Improper Payments Elimination and Recovery Acts (IPERA) of 2010 and 2012
- MA contract-level RADV audits for payment recovery purposes

Relevant Experience Related to Scope of Services

- Deloitte has extensive experience supporting CMS Part C program, policy, and plan ecosystem
- Deloitte has a deep understanding of CMS' systems, processes, and applicable laws and regulations
- Deloitte has supported CMS with a number of key activities, including:
  - Developing and implementing statistically sound sampling frames, analysis plans, data analyses, and findings reports. These include:
    - Producing data sets required to calculate payment error for IPIA/IPERA reporting to the Office of Management and Budget (OMB) and consult on annual payment error estimate calculation methods
    - Using insights derived from data analytics to drive the discussion on policy effectiveness
    - Developing complex programming to respond to changes in CMS policy
  - Leading knowledge transfer sessions with CMS. Deloitte provided an overview and demonstration of the BI reports and dashboards for the Central Data Abstraction Tool (CDAT) redesign effort
  - Consulting with CMS as needed to support CMS' payment recovery efforts and Part C and Part D payment error determination issues. Incorporate analysis of trending over time and predictive analytic capabilities
- Deloitte produced over 50 reports for the CMS' Part C Medicare Advantage division and for its review contractors over a three-year period
- Deloitte was instrumental in helping CMS to reduce the MA payment error rate in from 11.4 percent down to 9.5 percent. This resulted in a cost savings of $10.3M for pilot and $3.4M for targeted audits, approximately $10M-15M in total coast savings.
- Deloitte continues to enhance their analytical abilities that focuses on CMS' priorities

Contact Information and References

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Team Members available to PRMP who Served on this Engagement

Kelly Bowman

Client Reference #8: State of Idaho

State of Idaho, Strategic Planning and Technical Assistance

Contract Description and Services

Idaho Medicaid administers comprehensive healthcare coverage for eligible Idahoans. Medicaid contracts with individual healthcare providers, agencies, institutions, and managed care entities to provide healthcare services for low-income people and families, including children, pregnant women, the elderly, and people with disabilities.

Speire Healthcare Strategies provided strategic support for the Idaho Medicaid leadership team. Speire is supporting the Idaho Medicaid leadership team in developing a strategic sustainability framework. Speire provided a list of opportunities for the Idaho Medicaid leadership team on opportunities to improve payment structure to build on stronger alignment towards sustainability and value. Speire also provided opportunities on improving managed care oversight and program integrity.

Relevant Experience Related to Scope of Services

Facilitated sessions on strategic development of upcoming managed care procurements. This included leading the team through a multi-day planning effort that solidified how to address a number of initiatives that the state was looking to incorporate into the procurements. It also involved addressing a number of timeline and operational issues associated with the procurement.

Provided a strategic review and analysis of the State's payment system. This included developing a report that identified some of the current weaknesses and opportunities. The state is moving forward with legislation to implement some of the opportunities. They also provided strategic support for the Medicaid finance team on how to track and trend overall spend as part of targeting sustainability efforts.

Contact Information and References

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Team Members available to PRMP who Served on this Engagement

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III. Our Experience Exceeds PRMP's RFQ Requirements

The following section provides our response for each of the requirements stated in the RFQ. For each requirement, our response is structured in the following format to facilitate your review:

1. **Requirement Title**
2. **Our compliance with the requirement**
3. **Requirement Description** – this information was obtained for each requirement from the first column of the table provided in the RFQ, starting from Page 1 through Page 7.
4. **Responsibilities of the Vendor** - this information was obtained for each requirement from the second column of the table provided in the RFQ, starting from Page 1 through Page 7.
5. **Our Relevant Experience and Qualifications** – we provide our response highlighting how our team's capabilities and experiences meet the requested services from PRMP.

1. Review Program Integrity Office Policies/ Procedures/ Staffing

Requirement by Congress	✓ ***EXCEEDS REQUIREMENT***
Requirement Description	• Not later than 6 months after the date of the enactment of this paragraph, the agency responsible for the Administration of Puerto Rico´s Medicaid Program under Title XIX shall designate an officer (other than the Director of Such Agency) to serve as the Program Integrity Lead for the such Program.
Responsibilities of the vendor	• PRMP currently has a Program Integrity Office. The selected vendor should advise and recommend changes to policies and procedures and scope of work to ensure compliance with Congress Requirement. • Recommend if additional Human Resources are needed to strengthen the Medicaid Integrity Office. • The selected vendor should develop and prepare a quarterly report draft to ensure compliance of the requirements and avoid penalties as stated in the law.

Our Relevant Experience & Qualifications to Exceed this Requirement

Our team understands the critical role that Program Integrity has within a Medicaid organization and how it permeates the full Medicaid program, not just your Program Integrity Division. As the payer of last resort, Medicaid programs must have the infrastructure in place to perform its fiduciary responsibility from the top down.

We bring experience improving Program Integrity (PI) Operations across the healthcare industry. We know that the role and scope of PI has grown to be even more prominent over the past six years as more programs and services transitioned into managed care. PRMP has a responsibility to protect against fraud, waste, and abuse throughout the organization through mature processes and well-trained resources.

From our perspective an effective Program Integrity function has the following main elements:

1) An accountable entity with the authority to implement and operate integrity activities.
2) An ongoing risk assessment to make sure that activities are risk-based and aligned to the highest priority concerns.
3) A set of activities to detect, prevent, and respond to the identified PI risks that includes a focus on data analytics.
4) A method for evaluating the success of the program through process and outcome measures to use as feedback to adapt the overall program.

During this phase of the project, our team assesses existing PRMP PI policies, processes, procedures, and staffing to identify gaps, vulnerabilities, and areas where efficiencies can be gained. Our evaluation is focused on process improvement and PI maturity.

- **Process improvement** focuses on whether improvements could make the existing activities more efficient.
- **PI maturity** focuses on whether activities should be revised or changed to have a greater impact on preventing, detecting, and responding to fraud, waste, abuse, and improper payments.

Deloitte drafts quarterly reports to Congress to demonstrate compliance with requirements outlined in the law documenting the process improvement and maturity activities with the PRMP PI office. We work with PRMP to develop a report template that meets Congress' expectations and then draft the quarterly report with ample time for PRMP's review.

Our PI related experience includes:
Our team currently supports PI for the Centers for Medicare & Medicaid Services (CMS), the Drug Enforcement Agency (DEA), the Department of Justice (DOJ), commercial Medicare Advantage plans and Medicaid managed care organizations (MCOs), and state Medicaid agencies. Our Core Team members and subject matter experts (SMEs) led state Medicaid programs, large state Medicaid Program Integrity Divisions, Surveillance Utilization Review (SUR) divisions, and the CMS Fraud Prevention System.

- We have experience working with state Medicaid agencies to develop an action plan to improve PI along the maturity model. For example, our team provided technical assistance to state Medicaid agencies for CMS to facilitate a current state, future state, and action plan for improving PI specific to provider enrollment.
- Through our experience supporting PI efforts across healthcare payers, we understand the characteristics of mature PI that aligns with rules and guidance and incorporates leading practices in operations.

Figure 4- Requirement 1. Review of the Program Integrity Policy & Procedures

2. Develop Payment Error Rate Measurement (PERM) Plan

Requirement by Congress	✓ ***EXCEEDS REQUIREMENT***
Requirement Description	• PERM Requirement- Not later than 18 months after the date of the enactment of this paragraph, Puerto Rico shall publish a plan developed by Puerto Rico in coordination with the Administrator of CMS, and approved by the Administrator, for how Puerto Rico will develop measures to satisfy the payment error rate measurement (PERM) requirements under subpart of part 431 of Title 42 CFR or any successor regulation)
Responsibilities of the vendor	• Advise how the Plan to comply with the PERM should be developed. • The selected vendor should design a plan to implement the PERM in Puerto Rico. This is a new requirement and currently Puerto Rico does not have the scorecard measures. • The selected vendor should develop and prepare a draft of the quarterly report to ensure compliance of the requirements and avoid penalties as stated in the law.

Deloitte Relevant Experience & Qualifications to Exceed this Requirement

Our experience and capabilities **conducting Payment Error Rate Measurement (PERM) reviews** helps PRMP establish a plan within the 18-month deadline to satisfy the PERM requirements and allow CMS to continue their compliance efforts with Federal requirements and Office of Management and Budget (OMB) guidance.

Our experience assisting state agency programs in their PERM audits over multiple years prepares us to assist PRMP in defining the approach that complies with CMS's PERM requirements as stated in subpart 431 of Title 42 of the CFR. CMS's PERM requirements are derived from the Improper Payment Information Act of 2002 (IPIA), which was recently replaced with the Payment Integrity Information Act of 2019 (PIIA) on March 2, 2020. Having worked with many State Medicaid programs through multiple PERM cycles, we understand the most common errors and findings and helps PRMP in developing processes to minimize these findings.

Our team works closely with PRMP in the development of the plan and the capture of PERM requirements in the quarterly report. The plan includes processes to select samples of Medicaid and CHIP encounters, the evaluation of the encounter universe and reconciliation to the quarterly CMS-64 reports, the development of metrics to identify and mitigate potential compliance issues, and the capture of all information in a PERM scorecard to share with PRMP.

Our PERM related experience includes:

- **States of Arizona, New Jersey, Ohio, and Tennessee, Commonwealth of Pennsylvania, District of Columbia** – Our team comprises former Medicaid directors who have worked with CMS auditors, responding to auditor requests, and developing any needed corrective action plans.
- **National Association of Medicaid Directors** – Speire Healthcare Strategies team members have worked with CMS on the development of PERM through their leadership roles on the National Association of Medicaid Directors.
- **State of Nebraska** – We have implemented an analytics solution for identification of the PERM population and generation of full PERM data set for the review process.
- **State of Maine** - Our team provided support to the Office of MaineCare Services (state's Medicaid program) during its PERM review. Specifically, we helped them to prepare for the review and assisted them to respond to questions posed during the review, including providing supporting documentation.
- **CMS**: We serve the Centers for Medicare & Medicaid Services (CMS) as the Lead Analytical Contractor (LAC) for Medicare Advantage (MA) Risk Adjustment Data Validation (RADV) Activities. CMS conducts two types of RADV activities:

- National payment error estimates to comply with reporting requirements mandated by the Improper Payment and Information Act (IPIA) of 2002, amended by the Improper Payments Elimination and Recovery Acts (IPERA) of 2010 and 2012
- MA contract-level RADV audits for payment recovery purposes

More detailed information on this project, including contact information, is available in **Section II.**

Figure 5- Requirement 2. Plan to Implement Payment Error Rate Measurement (PERM)

3. Develop Contracting Reform Plan

Requirement by Congress	✓ ***EXCEEDS REQUIREMENT***
Requirement Description	• Contracting Reform – Not later than 12 months after the date of the enactment of this paragraph, Puerto Rico shall publish a contract reform plan to combat fraudulent, wasteful or abusive contracts under Puerto Rico's Medicaid Program under Title XIX.
Responsibilities of the vendor	• Advice regarding the development of the Plan to comply with the Contract reform as required by Federal and Puerto Rico Law, rules, regulations and federal policy established by CMS and Government Agencies best practices. • The plan should include metrics for evaluating the success of the plan. • Document recommended new contract business processes. • If needed, should recommend new or amendments to existing local laws and Regulations. • The selected vendor should develop and prepare a draft of the quarterly report to ensure compliance of the requirements and avoid penalties as stated in the law.

Deloitte Relevant Experience & Qualifications to Exceed this Requirement

Implementing a model of oversight for a Managed Care program is a complex task that demands a unique understanding of MCO processes at the local level, and nationwide. In this task, our brings diverse experience supporting other states, expertise in cutting-edge oversight practices, an intimate knowledge of PRMP's Managed Care program, and opportunities for how contractual business processes can be improved. With 100% of a population in Managed Care, operations must continuously evolve to allow for emergent regulations, including more comprehensive reporting and monitoring requirements, such as the CMS Medicaid and CHIP Managed Care Final Rule, which requires states to: implement a Comprehensive Quality Strategy; ensure enrollees have adequate access to all services; monitor and track all aspects of a managed care program; and guarantee beneficiaries can efficiently access providers.

Our approach to this area includes developing metrics for evaluating PMRP contract business processes against eight functional areas that align with the Medicaid and CHIP Managed Care Final Rule.

- State Monitoring Standards
- Quality of Care
- Network Adequacy and Access to Care
- Program Integrity
- Grievances and Appeals
- Marketing and Communication Activities
- Enrollments and Disenrollments
- Rate Development Standards

Our contracting reform plan related experience includes:

- **Texas Health and Human Services Commission (HHSC):** As required by the 85th Legislature of the State of Texas, Deloitte led the comprehensive review and evaluation of the Texas Medicaid and CHIP Managed Care Program. The five-part study included: (1) studying prescription drug benefits, (2) reviewing the current delivery system, (3) assessing managed care contract oversight functions, (4) studying the rate-setting processes in other states, and (5) analyzing administrative costs. Studies included performing detailed analyses of the Medicaid payment models, interviewing Texas leaders and stakeholders, identifying opportunities for improvement, and presenting findings to legislative groups, the Governor's office, the general public, and stakeholders. Below are the publicly

available links to these reports. More detailed information on this project, including contact information, is available in **Section II.**
https://hhs.texas.gov/reports/2018/08/rider-60-prescription-drug-benefit-administration-medicaid-chip-other-health-related-services
https://hhs.texas.gov/reports/2018/08/rider-61-evaluation-medicaid-chip-managed-care

- **National Governor's Association (NGA):** Our partner, Speire Healthcare Strategies, is currently engaged by the NGA to provide technical assistance to selected state Medicaid programs to develop and implement leading practices in Medicaid managed care programs to achieve health system goals. Current states Speire Healthcare Strategies is supporting include Wisconsin, Maryland, North Carolina, and **Puerto Rico.** More detailed information on this project, including contact information, is available in **Section II.**
- **Pennsylvania Office of Medical Assistance Programs (OMAP)**: Assisting OMAP in improving their Managed Care contract monitoring in five distinct areas below. More detailed information on this project, including contact information, is available in **Section II.**
    - Ensuring compliance with all contract requirements by allowing contract monitoring staff to track progress on compliant and non-compliant monitoring items
    - Monitoring recipient and provider networks to track the adequacy of provider networks
    - Standardizing report templates and data reporting processes
    - Automating data integration for numerous contract monitoring reports
    - Improving monitoring of healthcare quality metrics by developing standardized and automated process for validating and analyzing quality reports
- **Government of Puerto Rico:** Since 2017, Deloitte Consulting has been a strategic partner supporting the Government of Puerto Rico's effort to reform all aspects of its central government procurement operations. Procurement reform was identified by the Government as a critical component of overall fiscal reform because of its potential to generate significant positive financial impact.
    - Deloitte helped the Government identify more than $400 million in savings achievable over a five-year period by reforming its procurement operating procedures, executing the strategic sourcing process, and implementing procurement technology that makes it possible for agencies of the central government to make purchases using government-wide contracts negotiated with significant volume discounts. Deloitte helped the Government designed new procurement operating procedures and is currently supporting the government's effort to implement these new procedures while also executing the strategic sourcing process to begin realizing savings.
    - Deloitte's support also includes the design of Federally-compliant procurement operating procedures for procuring goods and services with Federal funds related to the disaster recovery effort.

Figure 6- Requirement 3. Contracting Reform to combat Fraud, Waste and Abuse

4. Review Medicaid Eligibility Quality Control (MEQC) Policy/Procedures/ Staffing

Requirement by Congress	✓ ***EXCEEDS REQUIREMENT***
Requirement Description	• MEQC – Not later than 18 months after the date of the enactment of this paragraph, Puerto Rico shall publish a plan, developed by Puerto Rico in coordination with the Administrator of CMS, and approved by the Administrator, for how Puerto Rico will comply with the Medicaid Eligibility Quality Control (MEQC) requirements of Subpart P of Part 431 of Title 42 CFR or any Successor regulation.
Responsibilities of the vendor	• PRMP currently has a MEQC Office. The selected vendor should advise and recommend changes to policies and procedures and scope of work to ensure compliance of the Congress Requirements. • Make recommendations on how to fully comply with CMS MEQC requirements. • Recommend additional staff if needed to perform MEQC duties.

Deloitte Relevant Experience & Qualifications to Exceed this Requirement

Our experience provides the capability and understanding to assist PRMP with establishing a Medicaid Eligibility Quality Control (MEQC) unit. We have worked with over **31 Medicaid State agencies** in developing and maintaining their Medicaid eligibility and enrollment programs. This includes performing ongoing quality control checks on the eligible population and providing our clients the ability to support PERM reviews as needed. Our experience coupled with our understanding of the PRMP enables us to assist PRMP to develop an execution plan within the 18-month deadline to comply with CMS MEQC requirements.

During this phase of the project, our team assesses existing Puerto Rico MEQC office policies, processes, procedures, and staffing to identify gaps, vulnerabilities, and areas where efficiencies can be gained. Additionally, our team reviews and evaluates existing contracts and develop the framework for the new business processes. Our evaluation is focused on quality check enhancement processes, and work towards identification of higher risk recipients for review. Our process improvement approach focuses on whether improvements could make the existing activities more efficient with the current resources available to MEQC, and where applicable recommend additional staff to perform eligibility quality reviews.

As part of the MEQC compliance plan and maturity model, out team has the capability to support PR in deploying Medicaid eligibility check analytics to identify high-risk factors within a recipient population. This approach for review of the Medicaid eligible population provides PRMP with trends in behavior patterns to flag errors, inform the eligibility rules and conditions, and when necessary revise the program eligibility checks to eliminate future errors. Our approach can assist PR in detecting and preventing intentional program violations by both members and case workers, and flag unintentional agency errors.

We work with PRMP to develop a report template that meets Congress' expectations and then draft the quarterly report to Congress to demonstrate compliance with requirements outlined in **42CFR431.810**.

Our MEQC related experience includes:

- Our team supported a State Medicaid agency serving 1.7 Million recipients by performing quality checks on eligibility for five of their high-risk and error-prone populations: Adult Expansion, Provisional Medicaid, Children, Pregnant Women, and HCBS Waivers. To perform this quality review, we leveraged analytics and developed rules and models to cluster each population type into meaningful segments. Our models identified anomalous behavior within the segments and combined outliers with additional risk factors to identify individuals most at-risk of ineligibility. The result of this information enabled our team to review individual case files to address errors, improve the State's eligibility determination process, and enabled the state to prevent future similar errors in advance of PERM

- Our team supported Pennsylvania Department of Human Services to develop staffing projections for a consolidation effort across program offices including Bureau of Autism Services, Office of Long-Term Living, Office of Mental Health and Substance Abuse Services, Office of Development Programs, and Office of Children Development and Early Learning.

Figure 7- Requirement 4. Medicaid Eligibility Quality Control

5. Evaluate Dual Eligible Special Needs Plan

Requirement by Congress	✓ ***EXCEEDS REQUIREMENT***
Requirement Description	• Treatment of Funding Under Enhanced Allotment Program – Section 1935 (e) of the Social Security Act (42 USc1396 u -5e as amended.
Responsibilities of the vendor	• Evaluate the current Puerto Rico special needs plan for dual eligible and recommend changes needed. • Evaluate the requirement established by Congress. • Determine steps to be taken to fully comply with this requirement. • Develop a step by step plan needed to comply with Congress.

Our Relevant Experience & Qualifications to Exceed this Requirement

The Enhanced Allotment Plan (EAP) was provided by Congress in 2005 to allow Puerto Rico to establish a Medicare/Medicaid Dual Eligible program for Medicare Advantage (MA) given that Puerto Rico was not included in the Low-Income Subsidy program of MA. When this occurred in 2005, Puerto Rico was looking to transfer all dual-eligible beneficiaries onto MA plans as was the case in the Continental US. Because PR was not included in the Low-Income Subsidy program, PR determined to establish a Wraparound Benefit for Dual Eligible whereby the beneficiaries could enroll in a MA plan and the Puerto Rico Health Insurance Administration (ASES) would procure from the MA plans coverage to wrap the Medicaid benefit in Medicare. This meant that if a dual elected to enroll in MA, the MA plans would add benefits to their coverage in order to equate their benefit to Medicaid.

The EAP funds were earmarked to be used to pay for the cost of equating these benefits. The first year ASES paid $30 per-member, per-member (PMPM) for the wraparound benefit Since then this benefit has cost around $10 PMPM. There are approximately 300,000 dual eligible beneficiaries in the Medicaid program. Currently this cost is estimated at $36,000,000. Puerto Rico currently receives $58,000,000 under the cap for the EAP.

Puerto Rico must submit a plan to Congress that indicates the changes the government implements to the Dual Eligible Program to maximize the use of funding of the EAP. Our team can help Puerto Rico to evaluate the current SNP programs for Dual Eligible and the benefits provided. We can help Puerto Rico determine how to define the benefit to emulate a Low-Income Subsidy program to increase the level of funding for the EAP and provide data to Congress that includes that funding within the Medicaid funding cap.

Our Dual Eligible Special Needs plan evaluation related experience includes:
As has been done in other states, our team supports the **State of New York** to operate three unique managed long-term care (MLT)C programs (MLTCP, Primary Fully Integrated Dual Advantage (FIDA), Medicaid Advantage Plus (MAP), and Program of All-Inclusive Care for the Elderly (PACE)) that provide long term services and supports (LTSS) and limited acute care benefits to 280,000 elderly and/or disabled members. Members who are dually-eligible for Medicare and Medicaid benefits ("dual-eligible") are eligible to enroll in all three programs and comprise the vast majority of enrollees in the MLTCP and PACE programs and the entirety of the MAP program. As the State's actuary, we set annual capitation rates for each MLTC program as well as supplemental rate updates through the fiscal year as needed due to program or policy changes made by the State. We apply a detailed rate setting methodology based on analyzing financial experience reported by the 30+ MCOs that participate in the program, developing program change adjustments and trend assumptions to account for changes expected between the base experience period and the rate period, developing administrative and care management assumptions based on MCO experience and program requirements, and plan-specific risk-adjustment factors.

Requirement by Congress	✓ ***EXCEEDS REQUIREMENT***

In setting base data for the capitation rates, we analyze cost and utilization experience from MCO-submitted annual financial reports by category of service. Many LTSS services are covered primarily by Medicaid, however we understand the data is not well reported for dual-eligibles for categories of service where there is coordination with Medicare. For those categories of service, we analyze the data and adjust for data issues appropriately as well as analyze other sources of data such as Medicaid fee-for-service data for the State's larger non-dual populations and encounter data. For the PACE program, rate is set separately for dual and non-dual populations, therefore base data is separated by population. Similarly, due to the large number of MCOs in the State, additional analysis and adjustments are conducted to ensure consistency in the data by MCO used for rate setting. Further adjustments are made for things such as estimates of claims incurred but not reported. Program changes are often necessary to account for program and policy changes effective between the base period and the rate period. We analyze available data and policy documents from the State to develop assumptions for the impact of these program changes. Similarly, we analyze historical experience reported by the plans as well as industry data to determine appropriate trend assumptions to apply to the adjusted base data. The rate development also accounts for administrative and care management expenses incurred by the MCOs based on analysis of experience reported by the plans and plan-specific risk scores using the State's long-term care risk adjustment model. More detailed information on this project, including contact information, is available in **Section II.**

Our team can employ similar tools and techniques as those employed in New York State to help Puerto Rico analyze the EAP, evaluate the SNP plans and present Congress a plan on how to the treatment of the EAP should be legislated, enhanced and improved.

In addition to developing Medicaid dual-eligible rates, we bring significant experience at the **Centers for Medicare & Medicaid Services (CMS)** in pricing related to Medicare Advantage (MA) and Part D (PDP). For over 15 years, members of our team have conducted reviews of CMS' MA and PDP Actuarial Bids and Resubmissions for the contract years since inception in 2006. CMS was confident in our abilities because of our in-depth knowledge of the health industry, our experience in financial audits related to health insurance, and our success within their own bid review programs. During this time, we reviewed 1,400 to 3,200 bid submissions from plan sponsors across the United States and Puerto Rico.

The CMS MA-PD project demonstrates Deloitte's in-depth knowledge of MA and PDP Actuarial Bids and Resubmissions. As representatives of the Office of the Chief Actuary (OACT), Deloitte has reviewed more than 20,000 bids during our support for CMS.

Our in-depth knowledge pricing related to Medicaid, Medicare, and dual-eligible populations allow us to provide PRMP with detailed steps and insight on funding considerations and what is needed to comply with the EAP requirement.

Figure 8- Requirement 5. Evaluate the Puerto Rico Special Needs Plan for Dual Eligible

6. Develop Annual Report

Requirement by Congress	✓ ***EXCEEDS REQUIREMENT***
Requirement Description	• Annual Report- In general not later than the date that is 30 days after the end of each fiscal year (beginning with fiscal year 2020 and ending with fiscal year 2021), in the case that a specified territory receives a Medicaid cap increase, or an increase in the federal medical assistance percentage for such territory under section 1905 (ff),for such fiscal year, such territory shall submit to the Chair and Ranking Member of the Committee on Energy and Commerce of the House of Representatives and the Chair and Ranking Member of the Committee of Finance of the Senate a report, employing the most up-to-date information available, that describes how such territory has used such Medicaid cap increase, or such applicable, to increase access to health care under the State Medicaid plan of such territory under title XIX (or a waiver of such plan). Such report may include-"(i) the extent to which such territory has, with respect to such plan (or waiver)-"(I) increased payments to health care providers; "(II) increased covered benefits; "(III) expanded health care provider networks; or "(IV) improved in any other manner the carrying out of such plan (or waiver); and "(ii) any other information as determined necessary by such territory.

Responsibilities of the vendor	• Evaluate the requirement established by Congress.
	• Determine steps to be taken to fully comply with this annual report.
	• Develop a document with the information needed to ensure compliance with this report.
	• This plan should at least: Provide counseling and support to develop and implement, at least, the following strategies:
	  ○ How Puerto Rico has used the Medicaid Cap increase or Federal Medical Assistance Percentage (FMAP) increase
	  ○ Increase access to health care
	  ○ Increased payments to health care providers;
	  ○ Increased covered benefits;
	  ○ Expanded health care provider networks; or
	  ○ Improved in any other manner the carrying out of such plan; and
	  ○ Any other information as determined necessary
	• The Puerto Rico Medicaid Program Annual Report to the Congress shall consider the following 3 elements:
	  ○ Employing the most up-to-date information available
	  ○ Description of how Puerto Rico has used the Medicaid Cap increase or such increase in the Federal Medical Assistance Percentage (FMAP)
	  ○ Increase access to health care
	• Puerto Rico REPORT may include:
	  ○ The extent to which Puerto Rico is involved with creating such plan.
	  ○ Increased payments to health care providers;
	  ○ Increased covered benefits;
	  ○ Expanded health care provider networks; or
	  ○ Improved in any other manner the carrying out of such plan; and
	  ○ Any other information as determined necessary by Puerto Rico.

Deloitte Relevant Experience & Qualifications to Exceed this Requirement	
The annual report to Congress is critical in demonstrating how Puerto Rico's efforts are increasing payments to healthcare providers, increasing covered benefits, expanding provider networks, and making	

Requirement by Congress	✓ EXCEEDS REQUIREMENT

other improvements. This provides PRMP with an opportunity to tell its story of success through both narrative information and factual data.
Our team works closely with PRMP to develop an outline and format of the annual report that meets Congress' requirements and outlines the efforts and results of PRMP. Following the outline, we work with PRMP to identify and compile data and information needed as inputs to the report, and then analyze the data and transform it into visuals that help to illustrate the impact of the PRMP reforms. Using the compiled data and information we draft the annual report and work through review cycles with PRMP.

Based upon our experience, developing the final product is not the most important task. Instead, we believe that the final product is only as good as the regimented process that leads up to production. Our steps to develop a quality deliverable include understanding the audience, drafting the materials, obtaining feedback and input, and finally developing the final product. This overall process is key to an effective final product that tells PRMP's story.

Our annual report related experience includes:
Deloitte has significant experience reviewing data and assessing the impact of program reforms on Medicaid programs, including evaluating the impact on provider payments, benefits, and provider networks. Moreover, we know what is required for public-facing reports, especially those that are intended for legislative oversight. The following are examples of reports our team has developed for state Medicaid programs that document the results of programmatic and operational changes.

- **Kentucky Medicaid Expansion Report**: Following the completion of the first year of Medicaid expansion under the Affordable Care Act (ACA), Deloitte was engaged to refresh an initial impact analysis that was developed prior to the policy change. This report documented the impact of the first year of expansion and provided updated budget and economic projections of the program.
- **Texas Rider Report:** Recently our proposed team served HHSC in a comprehensive review of, and evaluation of managed care in Texas Medicaid and CHIP. This included (1) study the potential savings from implementing certain changes to the current method of administering prescription drug benefits, (2) review of the current Medicaid and CHIP managed care delivery system and an assessment of the performance of managed care, (3) assessment of managed care contract review and oversight function, (4) study of Medicaid Managed Care rate setting processes and methodologies in other states, and (5) analysis of MCO administrative costs. Through this review and evaluation of managed Medicaid in Texas, our team has gained a deep understanding of all aspects of the Texas Medicaid program. More detailed information on this project, including contact information, is available in **Section II.**
- **Georgia Department of Community Health Project – National Environmental Scan Report & Waiver Concept Paper:** Like many other states, Georgia faces challenges with the rising cost of healthcare, high uninsured rates, closure of rural hospitals, and poor health outcomes. On March 27, 2019 Governor Kemp signed the "Patients First Act" into law to help address many of these issues. The bill authorized an 1115/1332 Waiver Request. As part of the waiver design efforts, Deloitte and Speire supported Georgia in a number of public-facing reports, including a National Environmental Scan Report which analyzes the landscape of 1115/1332 waivers. Deloitte and Speire also prepared a public concept document for the waivers as well as various other reports and communications for public review. More detailed information on this project, including contact information, is available in **Section II.**

Figure 9- Requirement 6. Develop Annual Report

7. Develop Report on Contracting Oversight and Approval

Requirement by Congress	✓ ***EXCEEDS REQUIREMENT***
Requirement Description	• Report on Contracting Oversight and Approval- Not later than 1 year after the date of enactment of this Act, the Comptroller General of the United States shall issue, and submit to the Chair and Ranking Member of the Committee on Energy and Commerce of the House of Representatives and the Chair and Ranking Member of the Committee on Finance of the Senate, a report on contracting oversight and approval with respect to Puerto Rico's State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) (or a waiver such plan). Such report shall- (A) examine- (i) the process used by Puerto Rico To evaluate bids and award contracts under such plan (or waiver); (II) which contracts are not subject to competitive bidding or requests for proposals under such plan (or waiver); and (iii) oversight by the Centers for Medicare & Medicaid Services of contracts awarded under such plan (or waiver); and (b) include any recommendations for Congress, the Secretary of Health and Human Services, or Puerto Rico relating to changes that the Comptroller General determines necessary to improve the program integrity of such plan (or waiver).
Responsibilities of the vendor	• Evaluate current process used by Puerto Rico to evaluate bids and award contracts under State Plan. • Recommend which contracts are not subject to competitive bidding or requests for proposals under current State Plan. • Along with PRMP Management, prepare responses to possible findings and recommendations made by the Comptroller General.

Deloitte Relevant Experience & Qualifications to Exceed this Requirement

We understand that evaluation of contracts and awarding bids is more than building a scoring evaluation sheet; it includes developing the elements that PRMP wants to measure/score and then prioritizing the scoring elements that matter the most and can help with the selection of the right MCO partners. Our Medicaid and CHIP Managed Care Procurements Framework, provided in Figure 10 on next page, provides states with a holistic approach to the contract bidding and evaluation process. This framework has been developed and modified not only with our projects' managed care procurement experiences but also with the experiences of our team members that have successfully run state Medicaid procurements in their Medicaid Director roles. We work with PMRP leverage this Managed Care Procurements Framework to evaluate the process PRMP uses to evaluate bids/award contracts or evaluate contracts are not subject to competitive bidding or requests for proposals.

One of the key lessons learned from these experiences is that earlier components of the framework – Program Goals Setting, RFP Strategy Development, and Requirements Development, RFP Development are critical and have to been done right so that the later stages of Evaluation, Scoring, and Selection focuses on alignment with achieving PRMP's goals and selects the MCOs most likely to meet those goals.

Figure 10- Deloitte's Managed Care Procurement Framework

As described in requirement #7 above in the development of the contract reform plan we leverage CMS' Medicaid and CHIP Managed Care Final Rule to evaluate CMS' oversight of the awarded contracts.

Our contract evaluation related experience includes:

In addition to our deep experience in Medicaid and CHIP programs, our key differentiator is that our broad experiences in managed care procurements, ranging from strategy design to implementation, provides us with a unique 360-degree view into Managed Care Procurements. Our experiences do not simply stop at the designing of procurements or awarding of contracts or MCO readiness. We are on the ground helping some of the Top Medicaid Programs in the country manage the day -to-day of implementation and monitoring the effectiveness of their MCO contracts.

- **Texas Health and Human Services Commission (HHSC) Rider Reports:** Recently our proposed team served Texas HHSC in a comprehensive review and evaluation of their managed care contract amendments and procurement processes. We surveyed other states about their contract amendments and procurement processes, providing benchmarks by which to compare Texas' processes and identified potential leading practices. More detailed information on this project, including contact information, is available in **Section II.**
- **State of Idaho Managed Care Procurements:** Speire Healthcare Strategies facilitated sessions with Idaho on strategic development of upcoming managed care procurements. This included leading the team through a multi-day planning effort that solidified how to address a number of initiatives that the state was looking to incorporate into the procurements. It also involved addressing a number of timeline and operational issues associated with the procurement.
- **State of New Hampshire Manage Care Design and Procurement:** The New Hampshire Department of Health and Human Services (DHHS) was faced with meeting a legislative mandate to transition the majority of its Medicaid population from a Medicaid fee-for-service (FFS) program to a capitated managed care program within one year after the passage of the legislation. DHHS was legislatively required to move all populations and services into the

Requirement by Congress	✓ EXCEEDS REQUIREMENT

managed care program and create a statewide care management model that integrated physical health, behavioral health, waivered long-term support services and nursing home services. DHHS was given strict timelines for the procurement and program start within the legislation that significantly accelerated a typical program design, procurement, and implementation. Deloitte has supported the program design and procurement efforts as well as implementation of the program. Efforts included:

  - Deloitte collaborated with the client's senior leadership to create a managed care strategy, develop a program design, draft an RFP, draft a model managed care contract, and conduct staff training tools for RFP evaluations.
  - Deloitte assisted DHHS through the implementation of the care management program with three selected MCOs. We established a joint DHHS/Deloitte implementation team, strategy, and timeline that balanced the concerns of the members, the effort of the MCOs, and the time constraints placed on DHHS. We then worked closely with the State through all aspects of implementation.

- **Pennsylvania Office of Medical Assistance Programs (OMAP) Medicaid Management Information Systems (MMIS) 2020 Procurement support:** Deloitte assisted OMAP to develop requests for proposal for their MMIS 2020 effort. This included:
  - Conducted requirement gathering sessions with other PA DHS Program offices to help OMAP create a Request for Information (RFI) to solicit information to be used with the development of Request for Proposals (RFPs) for the MMIS 2020 procurement
  - Drafted MES solutions requirements and CMS approvable MMIS RFPs for various modules including Managed Care and Financial, Provider Management, Third Party Liability, Fee-for-Service (FFS), Outpatient Drug Solution, the Electronic Data Interchange (EDI) module, the Prior Authorization Module, and the Outbound Mail Module for Pennsylvania's Medicaid enterprise
  - Developed a CMS approvable RFP, the Proposal Evaluation Plan, and preproposal conference materials to support replacement of the current MMIS for the Systems Integrator/Data Hub Module
  - Assisted OMAP in the validation of the requirements of the EDI and Prior Authorization and Outbound mail modules against the CMS MECT checklists

  More detailed information on this project, including contact information, is available in **Section II.**

Figure 11- Requirement 7. Develop Report on Contracting Oversight and Approval

8. Evaluate Current Process of Managed Care Payments

Requirement by Congress	✓ ***EXCEEDS REQUIREMENT***
Requirement Description	• Audits of Managed Care Payments. – Not later than the date that is 1 year after the date of enactment of this Act, the Inspector General shall develop and submit to Congress- (A) A report identifying payments made under Puerto Rico's Medicaid program to managed care organizations that the Inspector General determines to be at high risk for waste, fraud, or abuse; and (B) a plan for auditing and investigating such payments.
Responsibilities of the vendor	• Evaluate current process used by Puerto Rico to make payments to the Managed Care organizations. • Recommend if current process represent risks of fraud waste or abuse. • Along with PRMP Management, prepare responses to possible findings made by the Office of Inspector general.

Deloitte Relevant Experience & Qualifications to Exceed this Requirement

Deloitte's experience analyzing managed care payments for State Medicaid and federal agencies, and commercial carriers positions us to assist PRMR with a review of their MCO payment business process to identify areas of gaps, risks, vulnerabilities and provide detailed process improvement opportunities. To do this, Deloitte can:

1. Evaluate the current status and effectiveness of PRMP's control environment
2. Evaluate PRMP's existing fraud risk management framework to detect potential gaps in controls in the processes
3. Recommend enhancements of existing controls or mitigating controls for implementation, based on gaps detected
4. Enable continuous monitoring of controls using technology and/or perform forensic data analytics of transactions at the process level
5. Develop a fraud response plan to address cases of alleged or confirmed fraud
6. Incorporate identified fraud risks and schemes into fraud risk management framework based on findings

This review process allows us to provide PRMP with opportunities in a report that identifies areas of risk, areas to support the PRMP team in negotiating lower capitation rates, obtaining insights into proactive program integrity, and providing data quality insights.

Additionally, this detailed process insight and evaluation enables PRMP and our team to work together to draft a detailed response to include a corrective action plan to possible findings made the Office of the Inspector General.

Our related experience includes:
Our team has worked with several states and with CMS on and around the managed care payment process. This includes identifying vulnerabilities and risks for fraud, waste, and abuse; improving the data quality reported by MCOs to allow for more insights to program cost drivers and potential risks; and evaluating over and under payments to MCOs and calculating the corrected amounts. The following examples highlight our team's experience:

- **CMS Center for Program Integrity**: Our experience includes working as a Program Integrity Modeling and Analytics Support (PIMAS) contractor for the CMS Center for Program Integrity (CPI). Through this work, we develop models and edits for implementation into the Fraud Prevention System (FPS) and support identification of new vulnerabilities and risks for fraud, waste, and abuse (FWA) in

Requirement by Congress	✓ EXCEEDS REQUIREMENT

the Medicare and Medicaid programs. Through this work, we use multiple data sources to triangulate on provider aberrant behavior, including Medicare data and Medicaid T-MSIS data.

- **Minnesota Medicaid MCO Data Quality**: As one of the largest payers of health care in Minnesota, the Department of Health Services (DHS) strives to provide high quality data that serve a wide variety of analyses, including Medicaid rate setting. Deloitte was brought on to assist in the development of the quality assurance protocols (QAPs). The purpose of this initiative is to improve the timeliness, accuracy, and completeness of encounter data submitted to DHS. After the implementation, Deloitte performed an assessment to evaluate the effectiveness of the QAPs implementation that was put in place.
- **New York Medicaid MCO Reimbursement Adjustment:** The New York State Department of Health (NYDOH or State) and the Office of the Medicaid Inspector General (OMIG) have identified through audits duplicate or overlapping Medicaid capitation payments made on behalf of managed care enrollees. OMIG has identified and recovered additional capitation payments that were made inappropriately. Medicaid Managed Care Organizations (MCOs) were responsible for paying encounters while receiving a capitation payment. Since capitation payments were subsequently recovered by OMIG, the MCOs wouldn't be responsible for encounters incurred during the recovered payment time period. In partnership with the State, Deloitte identified the reimbursement amounts for eligible encounters paid for by MCOs. The MCOs are to be reimbursed for the costs of the submitted eligible encounters applicable to members for which the capitation payment was recovered by OMIG. As part of the process, MCOs were not reimbursed for encounters that shouldn't have been covered, such as when an enrollee is deceased or incarcerated, when there is third party coverage from same plan's commercial product, and the enrollee moved out of state. More detailed information on this project, including contact information, is available in **Section II.**

- **New York Medicaid MCO Data Quality:** New York encounter data, depending on the managed care program, is 5-20% below audited financial data. This gap is even larger at a category of service level with variances of +/- 50%. The State and CMS have a goal to be able to rely on encounter data for rate setting and developing premiums for managed care plans. Deloitte has worked with the State to improve their encounter data from multiple avenues. First, we have developed dashboards that we provide on a semi-annual basis to the health plans comparing the encounter and financial data by category of service. We work with the plans to resubmit data and explain the variances through developing detailed action plans to correct the data gaps. Plans are held financially liable if they are not within 10% of the financial data by category of service. We also reviewed the State's systems and data marts and identified data loss due to State processing and rejection issues. Deloitte is working with the State to provide opportunities for how to mitigate this data loss and to resolve the issues. We are supporting the organization of the data governance structure who will be managing the whole data submission and monitoring processes. We are working with the State to create a sub group that will generally make data governance decisions, provide guidance to the health plans, manage the coding updates needed for the State's internal warehousing, and create frequent reporting to manage data quality submissions. Deloitte is working with the State to define the work groups activities, goals, and governance in order to manage the data processes long term. More detailed information on this project, including contact information, is available in **Section II.**

Figure 12- Requirement 8. Evaluate Current Process of Managed Care Payments

9. Develop Scorecard Reporting Measures

Requirement by Congress	✓ ***EXCEEDS REQUIREMENT***
Requirement Description	• System for tracking Federal Funding Provided to Puerto Rico; Medicaid and Chip scorecard reporting. -Section 1902 of the Social Security Act (42 U.SC.1396a), as amended by subsection (e), is further amended by adding at the end the following new subsection:" (rr) Program Integrity requirements for Puerto Rico.- "(1) System for tracking federal Medicaid Funding Provided to Puerto Rico.-
Responsibilities of the vendor	• The selected vendor should advise and recommend policies and procedures and scope of work to ensure compliance of the Congress Requirement. This is a new requirement and currently Puerto Rico does not have the scorecard measures. • Evaluate requirement established by Congress. • If needed, design and prepare if a template for the report.

Our Relevant Experience & Qualifications to Exceed this Requirement

Our team has extensive experience supporting Medicaid measure reporting, data analytics, technical assistance, and quality improvement for state and federal Medicaid agencies that helps us in defining how Puerto Rico can meet Puerto Rico's new CMS reporting requirements. Our past performance includes numerous active and recent projects that span the three new reporting areas required be Congress, and our team brings extensive experience successfully working with Medicaid measures, states, and delivering impactful projects within CMS.

There are a number of items which must be considered to help PRMP develop accurate scorecard measures to report to CMS. We work with PRMP to first determine the needs of their population and business, what data is available, and corresponding congressional policy requirements that should be considered for accurate and timely reporting. We use our extensive experience analyzing Congressional and other federal guidelines, including CMS, to review, develop, and report concise summaries of relevant requirements to agency stakeholders, so agencies do not have to comb through volumes of data to understand appropriate reporting measures. After appropriate measures are agreed upon, standardized templates and cadences for reporting are established. We use our extensive network of federal and state practitioners to establish open communication across all levels of Medicaid and Medicare agencies, allowing quick resolution of any questions that may arise.

Our Scorecard development related experience includes:
Our summary of Relevant Project Experience highlights our project management and technical assistance work related to federal reporting, Medicaid measures, and quality improvement.

- **CMS Data Feedback & Analysis for the Comprehensive Primary Care Plus Model:** The Data Feedback contract demonstrates our ability to successfully provide dashboard support to present healthcare measures in an approachable and understandable format to drive quality improvements. On the Comprehensive Primary Care Plus (CPC+) Data Analysis and Feedback contract, our team developed and continues to maintain and enhance a Data Feedback Dashboard that allows practices to view their claims data through an interactive web portal and receive aggregated feedback data, as well as beneficiary-level and practice-level data.
- **Centers for Medicare & Medicaid Services (CMS) Medicaid Innovation Accelerator Program (IAP) Performance Improvement:** Deloitte worked with Center for Medicare & Medicaid Innovation (CMMI) and Center for Medicaid and CHIP Services (CMCS) to drive the use of performance improvement tools and methodology in all work with state Medicaid agencies and specifically in the Medicaid Innovation Accelerator Program. In order to do this, the Deloitte team develops driver diagrams, supporting performance improvement tools, delivers performance improvement training to

Requirement by Congress	✓ EXCEEDS REQUIREMENT

CMS staff and Medicaid agencies, and provides performance improvement technical support to IAP participants.

- **Pennsylvania Office of Medical Assistance Programs:** As part of the OMAP Technical Assistance Contract, Deloitte has worked with the PA Physical Health Medicaid Managed Care Program in defining approaches on reporting of key program measures across the domains of population, financial, provider oversight, agreement oversight, and quality oversight. This support included the defining of metrics used to measure program and MCO performance across these areas that is used for both CMS reporting and internal program oversight. Specific metrics where reporting processes have been supported include MCO recipient enrollment, market share, and churn; Medicaid cost can be by key areas such as medical, pharmacy, and administrative; provider network metrics including both composition by MCO and the adequacy of each MCOs network based on their enrolled population; and quality measures such as HEDIS and CAHPS as well as PA defined measures. More detailed information on this project, including contact information, is available in **Section II.**

Figure 13- Requirement 9. Development of Scope, Policies, and Procedures for Scorecard Reporting

10. Develop Financial Executive Summary for CMS 37/64 Reporting

Requirement by Congress	✓ ***EXCEEDS REQUIREMENT***
Requirement Description	• "(A) In general- Puerto Rico shall establish and maintain a system, which may include the use of a quarterly Form CMS-64, for tracking any amounts paid by the Federal Government to Puerto Rico with respect to the State plan of Puerto Rico (or a waiver of such plan). Under such system, Puerto Rico shall ensure that information is available, with respect to each quarter in a fiscal year (beginning with the first quarter beginning on or after the date that is 1 year after the date of the enactment of this bisection), on the following: "(I) In the case of a quarter other than the first quarter of such fiscal year-" (I) the total amount expended by Puerto Rico during any previous quarter of such fiscal year under the State plan of Puerto Rico (or a waiver of such plan); and "(II) a description of how such amount was so expended. "(ii) The total amount that Puerto Rico expects to expend during the quarter under the Sate plan of Puerto Rico (or a waiver of such plan) and a description of how Puerto Rico expects to expend such amount. "(B) Report To CMS.- For each quarter with respect to which Puerto Rico under subparagraph (A) to ensure that information described in such subparagraph is available, Puerto Rico shall submit to the Administrator of the Centers for Medicare & Medicaid Services a report on such information for such quarter, which may include the submission of a quarterly Form CMS-37.
Responsibilities of the vendor	• PRMP Staff currently completes and submits the CMS 37 and CMS 64 on a timely manner. However, we require the selected vendor to propose an executive summary draft to send with the CMS 37 and the CMS 64. • Recommend what should be included in the narrative section on the CMS-37 and CMS-64. • If needed, design and prepare a fact sheet that includes all the needed requirements.

Deloitte Relevant Experience & Qualifications to Exceed this Requirement

The executive summary for the CMS 64 should include administrative expenditures and program expenditures for the quarter. It should indicate how it compared to the CMS 37 forecast of expenditures and include the same expenditures to date for the federal fiscal year. The quarterly expenditures should highlight any anomalies in expenditures for the quarter, either increases or decreases, and state the cause. Finally, the executive summary should show the available balance of federal funds and state how the expenditures compare to federal funding available, i.e., is there sufficient federal funds for the balance of the federal fiscal year to support the state expenditures or does Puerto Rico have to use local funding only to finish the federal fiscal year.

The executive summary for the CMS 37 should show anticipated expenditures for the next quarter and for the fiscal year for both administration and program. All expenditures for all costs involved in the administration of the Medicaid program are to be included in the report, even if the costs exceed the federal funding available. It should explain any anomalies for the next quarter, either increases or decreases and state the cause. It should also show the balance of federal funding available and say if the federal funding is sufficient to support the expenditure levels.

The CMS 64 narrative should include any anomalies that presented during the quarter. It should reflect the number of Medicaid and CHIP beneficiaries served by eligibility category. Finally, the narrative should show the federal funding expended to date and reflect the balance available.

Our team works with PRMP to develop the report and fact sheets as requested in the RFQ.

Requirement by Congress	✓ ***EXCEEDS REQUIREMENT***

Our CMS 37/64 financial summary related experience includes:
Our team includes Michael Melendez and John Guhl both Sr. Subject Matter Specialists from subcontractor MJM Contigo LLC. Mr. Melendez is the former CMS Region II Associate Regional Administrator who was responsible for overseeing Puerto Rico and the US Virgin Islands in all aspects of Medicaid and CHIP. Mr. Guhl is the former CMS Region II Financial Branch Manager. Before joining CMS, Mr. Guhl was the State of New Jersey Medicaid Director. He personally **trained Puerto Rico staff on how to complete the CMS 64 and CMS 37 on multiple occasions.** Michael and John supported Puerto Rico for many years, providing technical assistance, ongoing advice, monitoring and oversight and when needed, working with Puerto Rico to prepare and submit or re-submit financial and program reports accurately. The outcome of this effort brought over $200 million in additional federal funds to Puerto Rico.

Figure 14- Requirement 10. Financial Executive Summary for CMS 37/64 Reporting

11. Evaluate Current Contract Requirements and CMS Reporting

Requirement by Congress	✓ ***EXCEEDS REQUIREMENT***
Requirement Description	• Request – Puerto Rico shall, upon request, submit to the Administrator of the Center for Medicare & Medicaid Services all documentation requested with respect to contracts awarded under the State plan of Puerto Rico (or waiver of such plan).
Responsibilities of the vendor	• Evaluate all documentation that is required in current contracts. • Recommend a process on how to report to CMS PRMP's current contracts.

Deloitte Relevant Experience & Qualifications to Exceed this Requirement

We understand that effective and proactive program monitoring is critical for the Government of PR to achieve the simultaneous goals of ensuring access to high-quality care for citizens receiving medical assistance, promoting MCO compliance with contractual requirements, and safeguarding taxpayer dollars by promoting programs that improve health outcomes at lower cost; all while meeting legislative and Federal regulatory requirements. The typical MCO contract in the PR is 300 pages and it has a number of contractual requirements. It is critical to assess the required documentation to assess MCO compliance against these requirements.

Our approach starts by reviewing and understanding the program monitoring goals of the department. We then review the current contracts and documentation submitted by the MCOs and conduct a gap analysis to understand where revisions or improvements may be needed. Next, we analyze our findings and develop opportunities to improve monitoring guidelines, assessment tools, or reporting systems can be changed to better align to the PRMP's vision.

Our evaluating current contract documentation related experience includes:
Our team has worked with the Commonwealth of Pennsylvania Office of Medical Assistance Program (OMAP) and Office of Long-Term Living (OLTL) to develop and implement business and technology changes to support MCO compliance against contractual requirements. Contract managers have access to a central repository for reviews of MCO adherence to each contractual standard. They are able to record notes on issues; upload documentation received from MCO and identify and track MCO remediation activities. This enables them to easily identify areas of non-compliance and remediation options, as well as monitoring guidelines that need to be updated.

This integrated view of program oversight continues to advance OMAP and OLTL's ability to have a deeper multifaceted understanding of program performance, not just from a perspective of meeting contractual obligations but the impact the programs have on the populations they serve. More detailed information on this project, including contact information, is available in **Section II.**

Figure 15- Requirement 11. Evaluate Current Contract Requirements and CMS Reporting

12. Implement Scorecard Reporting System

Requirement by Congress	✓ ***EXCEEDS REQUIREMENT***
Requirement Description	• "(3) Reporting on Medicaid and Chip scorecard measures-Beginning 12 months after the date of enactment of this subsection, Puerto Rico shall begin to report to the Administrator of the Center for Medicare & Medicaid Services on selected measures included in the Medicaid and Chip Scorecard developed by the Center for Medicare & Medicaid Services".
Responsibilities of the vendor	• Evaluate Congress requirements. • Design a plan to be presented to CMS to determine what information should be included in the Scorecard Measures report. This is a new requirement and Puerto Rico does not have the scorecard measures in place. • Develop a draft of the Scorecard Measures report. • This reporting should include two phases, the cost of the scorecard measures and the reporting of the scorecard measures.

Deloitte Relevant Experience & Qualifications to Exceed this Requirement

Our experience provides the capability and understanding to assist PRMP in developing their scorecard. There are several steps the PRMP should consider when developing an effective program scorecard for CMS reporting of Medicaid and Medicare data. We work with PRMP to create a scorecard development plan for submission to CMS, determining the information to be included in the scorecard information report. First, we work with PRMP to review and evaluate all relevant Congressional and CMS policy requirements pertaining to the scorecard report. We work with PRMP to define and categorize the business needs (requirements) of their Medicaid program, as well as the needs of the populations served. Next, these requirements should be mapped to the appropriate measures within Medicaid datasets available to Puerto Rico. These include basic program measures such as enrollments, overall spending, success of submitting data to CMS, etc. along with specific quality measures such as HEDIS, CAHPS, and Core Set. Once the plan is developed, we work with PRMP to draft a scorecard report design that not only includes all relevant measures but displays metrics in a format acceptable to CMS.

Our measures system development related experience includes:

- **Centers for Disease Control and Prevention Patient Safety Dashboard Portal:** Deloitte worked with CDC's Division of Healthcare Quality Promotion to build a Patient Safety Dashboard Portal for a set of measures related to antibiotic resistance. This portal will provide enhanced methods to study and share how hospital-associated infections and antimicrobial resistance, use, and stewardship vary in risk across the nation, providing data throughout spatially driven mediums to drive intuitive decision-making. The online dashboard includes various data-driven pages, ranging from narratives, or data "stories", to advanced analytical surveillance dashboards, all maintaining dynamic qualities for high levels of user interaction.
- **Pennsylvania Office of Long-Term Living (OLTL):** As part of the OMAP Technical Assistance Contract, Deloitte has worked with OLTL to define and expand reporting requirements surrounding the CMS's HCBS CAHPS survey. Our team conducted initial reviews HCBS CAHPS reporting policies and survey data structure to develop measure rates that would accurately exhibit program performance to CMS. We worked with OLTL to create data collection templates and instructions for circulation to the program's MCOs and third-party survey vendors. Our team designed, built, and implemented an application that allows OLTL to store HCBS CAHPS data and generate reports for submission to CMS. We also assisted OLTL with the analysis of HCBS CAHPS data to assure that accurate and reliable results were being submitted to CMS and other external stakeholders.
- **Pennsylvania Office of Medical Assistance Programs (OMAP) Medicaid Program Oversight Portal (MPOP):** Deloitte worked collaboratively with OMAP to develop a cross-program portal, which will allow the office to comprehensively compare the performance of all its Medicaid and Medicare

programs. Our team leveraged its previous experience with the Commonwealth's Medicaid and Medicare programs and corresponding policies, in coordination with OMAP staff, to define the requirements for cross program reporting. We performed a comprehensive review of quality datasets to determine the metrics that would meet reporting requirements. We then collectively worked with OMAP to create a scorecard design which displayed these quality measures in a clear, accurate, and concise manner. More detailed information on this project, including contact information, is available in **Section II.**

- Below are some sample screenshots for s**imilar scorecard measures tracking** applications that we have built for other Medicaid agencies. Depending on the scorecard measures that PRMP decides to use for CMS Reporting, we can develop similar applications for PRMP.

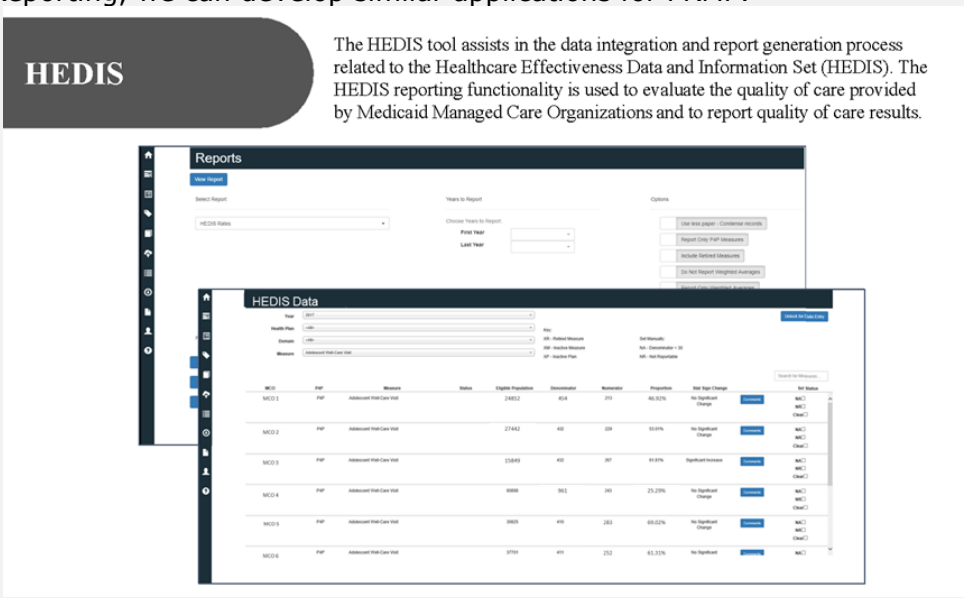

Figure 16- Quality Applications: HEDIS tool

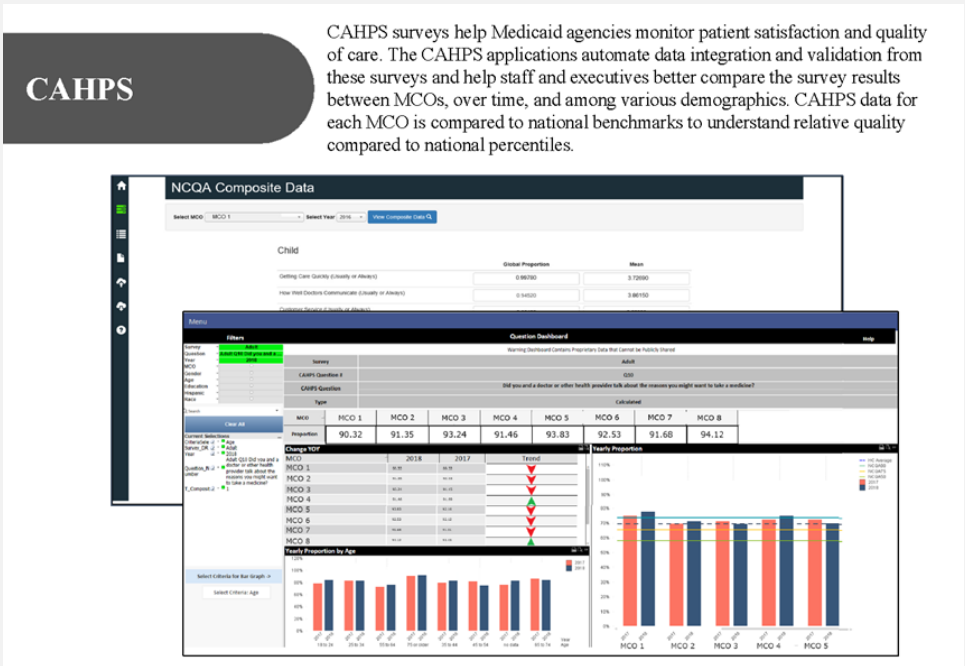

Figure 17- Quality Applications: CAHPS

Comprehensive Care Management

The Comprehensive Care Management tools help Medicaid agency staff and executives to monitor the numerous traditional and community- based care management programs of each MCO on a quarterly basis and to analyze the effectiveness of each initiative and MCO program overall.

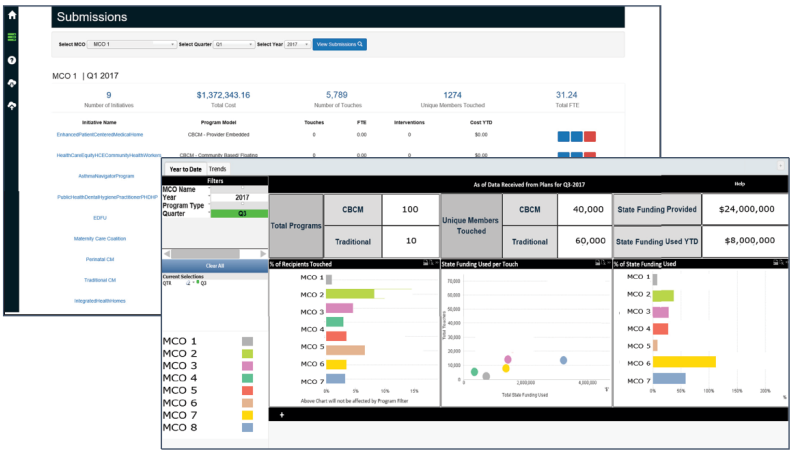

Figure 18- Quality Applications: Comprehensive Care Management

Member Level Data

Member Level Data is demographic data for key HEDIS measures collected to better understand discrepancies in healthcare effectiveness for these measures for different racial and ethnic groups. Maps and graphs allow users to visualize disparity in quality of care from multiple perspectives, to identify areas for questions with MCOs, and to help direct initiatives to improve quality of care.

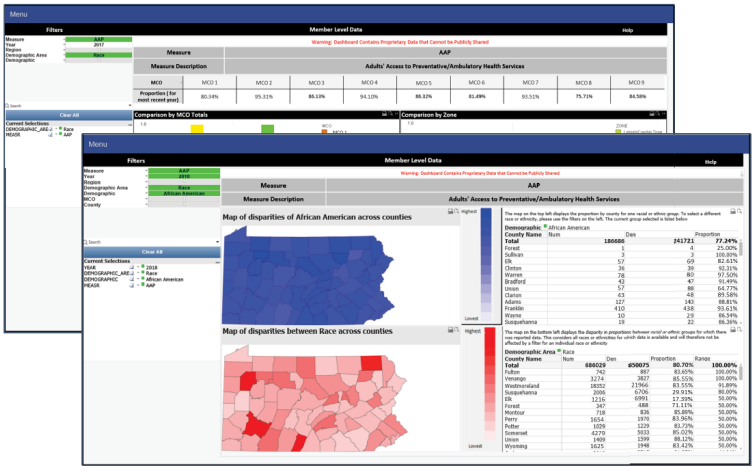

Figure 19- Quality Applications: Member Level Data

Figure 20- Requirement 12. Scorecard Reporting

13. Develop Policies and Procedures for Penalties

Requirement by Congress	✓ ***EXCEEDS REQUIREMENT***
Requirement Description	• In general- for each fiscal quarter during the period beginning on January 1, 2020 and ending on September 30, 2021: (I) for every clause under sub paragraph (A) with respect on which Puerto Rico does not fully satisfy the requirements described in the clause (including requirement imposed under the terms of a plan described in the clause) in the fiscal quarter, the Federal medical assistance percentage applicable to Puerto Rico under section 1905 (ff) shall be reduced by the number of percentage points determined for the clause and fiscal quarter under subclause (II). • (II) The number of percentage points determined under for this subclause with respect to a clause under subparagraph (A) and a fiscal quarter shall be the number of percentage points (not to exceed 2.5 percentage points equal to: (aa) 0.25 percentage points; multiplied by (bb) the total number of consecutive fiscal quarters for which Puerto Rico has not fully satisfied the requirements described in such clause.
Responsibilities of the vendor	• Recommend policies and procedures in order to avoid penalties. • Develop a calendar based on requirements of important dates and milestones needed.

Deloitte Relevant Experience & Qualifications to Exceed this Requirement

Our team includes **Michael Melendez** and **John Guhl** both Sr. Subject Matter Specialists from subcontractor MJM Contigo LLC. They conducted a full programmatic review of PRMP in 2011. There were several findings that needed to be addressed and they met with PRMP several times to have the corrections implemented. Throughout their tenure at CMS, Mr. Melendez and Mr. Guhl provided technical support to PRMP and advised them on how to operate their program and how to take advantage of federal funding opportunities. They advocated for Puerto Rico and the other territories and were recognized and sought out by senior CMS and HHS leadership, over several administrations as the Medicaid experts related to US territories. They are intimately familiar with each additional federal requirement. They know what needs to be done to assist state and territorial governments to bring their Medicaid programs into and maintain compliance with federal requirements.

When New York implemented Medicaid redesign with over 200 amendments to its Medicaid program, Mr. Guhl was assigned the lead from CMS' side. He developed an interactive tracking system that was used by NY staff, CMS Region II and CMS Central office. NY completed the redesign ahead of schedule.

Our team works with PRMP to assess their existing policies and efforts to comply with the current and all additional federal requirements. We present any necessary modifications to the oversight efforts to make sure PRMP is on track to meet each one. The review examines PRMP's policies, standard operating procedures, manuals and training provided to staff, staffing levels and qualifications of existing staff. Where needed and appropriate, our team suggest opportunities for improvement.

Our team meets with PRMP and presents to Puerto Rico leadership the status of meeting the additional federal requirements as necessary. We develop a tracking system for each additional requirement that is shared with Puerto Rico. This tracking system is the subject of weekly conference calls to address the status of each requirement. Any slippage in any of the timelines must be addressed immediately. Our team provides the support necessary to assist PRMP to get back on track. Our team prepares quarterly draft reports for each requirement.

Figure 21- Requirement 13. Develop policies and procedures for penalties

Additional and General Requirements in RFQ

Requirement	Compliance with the Additional and General Requirements
Develop a budget of funding needed for PRMP, in order to fully comply with requirements	We have provided an estimated budget of funding by Federal Fiscal Year 2020 and Federal Fiscal Year 2021 in **Section V, Cost Proposal.**
If applicable, develop the draft to amend the State Plan Amendment (SPA)	Our team has extensive experience working on the development of SPA's for our Medicaid clients. If applicable, we can work with PRMP to finalize scope related to any SPA amendments that may be required as a result of our work in in this engagement.
Recommend if additional personnel are necessary in order to maintain and continue the effort needed to comply with all requirements in subsequent periods.	As requested in Requirement 1, and 4, we are prepared to support PRMP in identifying any additional personnel required for the Program Integrity and MEQC office. Should the need arise to identify additional personnel for any other group, we can work with PRMP to identify the priorities and readjust scope accordingly.
Currently, Puerto Rico has no waiver granted by CMS, so vendor should assume this when preparing quote.	Our team acknowledges that PRMP is under no waiver authority and has taken this fact into consideration throughout the development of our response.
Some members of the proposed staff to work with PRMP should be fully bilingual (Spanish and English, both verbal and written).	Nuestro equipo disponible para trabajar con PRMP tiene 11 miembros que son totalmente bilingües que residen y trabajan en Puerto Rico.
Some members of the staff should be available and willing to work on site at PRMP offices located in San Juan, Puerto Rico and to attend meetings or hearings in CMS offices and other government offices including Congress in Washington DC.	Deloitte and Puerto Rico have a long history of collaboration spanning many years. We have had local presence in Puerto Rico for the past 50 years with our office located at 350 Torre Chardon, Suite 700 in Hato Rey, San Juan. Our staffing plan and estimated budget has been drafted with an understanding PRMP's requested need to have a local, bilingual team available to work on site in San Juan, Puerto Rico. Additionally, we have also incorporated into our estimated budget the assumptions related to travel expenses to support PRMP in meetings, hearings and other activities in Washington DC. If selected, we will work with PRMP to confirm resource onsite/travel assumptions and finalize the need for/frequency of travel during this effort.
Please include a list of references with contact information of prior work performed with other states on CMS, HHS or Congress related work.	Our team has offered eight (8) unique client references in **Section II – Client References** that stand out among an array of Medicaid program support Deloitte experiences in working with federal and state health agencies. We invite you to contact the listed reference contacts to obtain first-hand information of the Deloitte team's Medicaid program knowledge and the results we delivered for clients.
This work requires extreme urgency, so immediate availability of the professional staff offered in the proposal is required.	Our team highlighted in **Section IV** has been assembled taking in consideration your request for immediate availability.

Requirement	Compliance with the Additional and General Requirements
The selected vendor will be responsible for the Tax requirements of Puerto Rico and the State of origin.	Our experience in Puerto Rico enables us to acknowledge that we understand the Tax requirements of working with PRMP and we will abide our tax responsibilities in Puerto Rico and Stateside.
The contract will be administered and in compliance with all applicable federal and Puerto Rico laws, rules and regulations.	We acknowledge that our contract abides with all applicable Federal and Puerto Rico laws, rules and regulations.
All intellectual property and documentation produced in this contract by the selected vendor will be property of the Government of Puerto Rico.	We acknowledge that the intellectual property and documentation generated as part of this engagement will be the property of the Government of Puerto Rico.

Figure 22- Additional and General Requirements in RFQ

IV. Our Team Available to PRMP

PRMP benefits from a project team that brings experience in program integrity, Medicaid/CHIP managed care oversight and financial reporting, in addition to future-oriented thinking on the direction of health and human services for Puerto Rico. Our team not only brings national Medicaid experience, but also has direct knowledge of the Medicaid program in Puerto Rico. We have assembled an extremely qualified team to address PRMP' needs across the RFQ tasks. Among the team available to you we have five (5) former Medicaid Directors from the States of **Tennessee, Ohio, Pennsylvania, Arizona, and New Jersey, as well as the District of Columbia**.

We also bring the ability to scale to meet increased demand and need for specialized knowledge. The Deloitte team strikes the right balance for PRMP bringing knowledge of the intricacies and differences of the Puerto Rico Medicaid environment, with the inclusion of Gilberto (Tito) Torres who worked with ASES and Medicaid for 12 years in multiple roles and Mr. Michael Melendez of MJM Contigo LLC who was the former CMS Associate Regional Administrator for Medicaid in Region 2 – New York, together with national experience in health and human services.

We understand that assembling the right team members with the appropriate blend of skills and experience is essential to planning for the future of health and human service delivery across the island. Our team has been assembled to provide PRMP with access to talented individuals with strategic planning and program transformation experience, health care policy and research expertise and deep analytics capabilities.

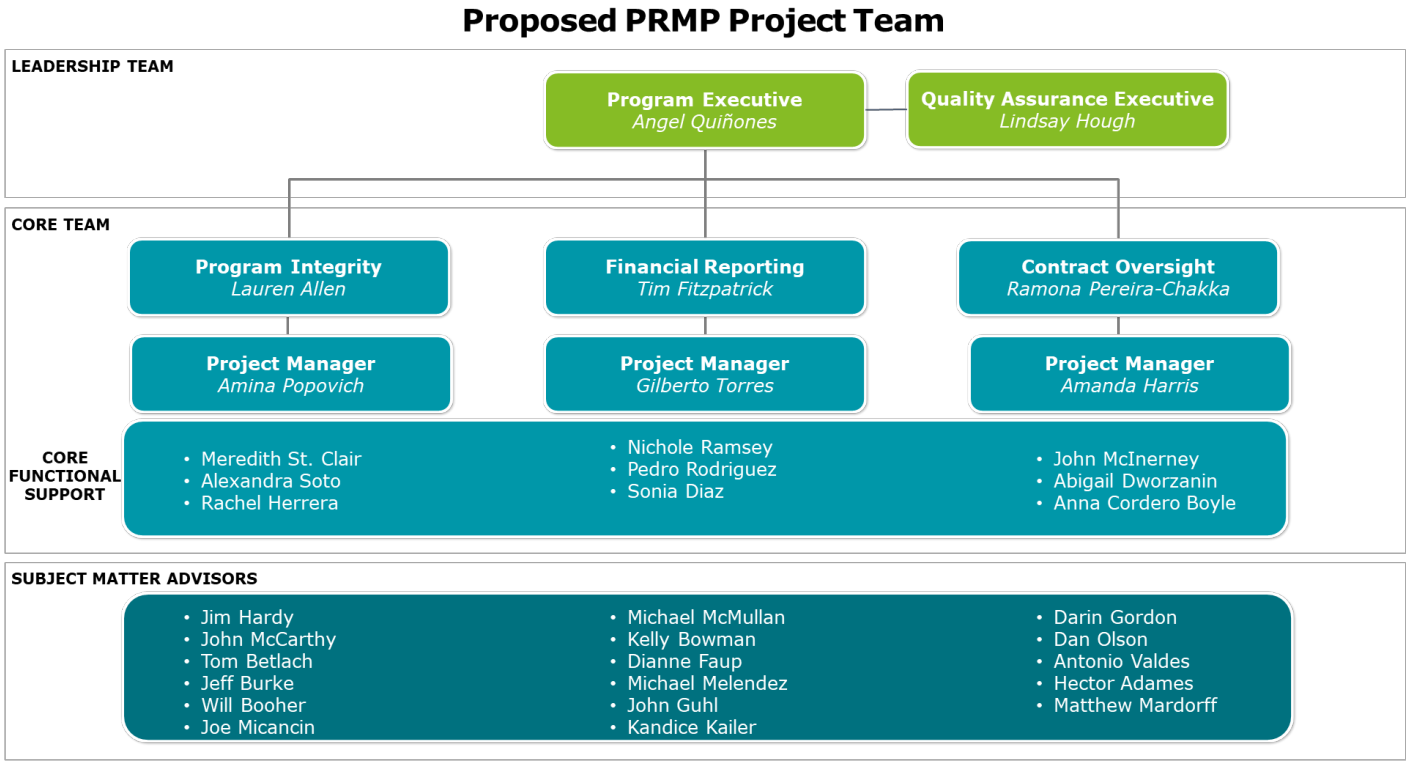

Figure 23- Our Project Team Org Chart

Our Core Deloitte Team Available to PRMP

We have provided below a summary of our Core Team's experiences followed by bios of these team members.

Core Team	Related Experience
Angel Quiñones Cardona, Project Engagement Executive	
Lindsay Hough, Quality Assurance Engagement Executive	
Ramona Pereira-Chakka, Contract Oversight Engagement Executive	
Tim FitzPatrick, Financial Reporting Engagement Executive	
Lauren Allen, Program Integrity Engagement Executive	
Amina Popowich, Project Manager	
Tito Torres, Project Manager	
Amanda Harris, Project Manager	
Meredith St. Clair, Functional Task Lead 1	
Nichole Ramsey, Functional Task Lead 1	
John McInerney, Functional Task Lead 1	

Figure 24- Core Team Experience Chart

Local Puerto Rico Team available to PRMP

In addition to Angel Quiñones and Tito Torres, we have a strong team of local and bilingual team members that are available work on site at PRMP offices located in San Juan, Puerto Rico, including Alexandra Soto, Anna Cordero, Pedro Rodriguez, Hector Adames, Sonia Diaz and Rachel Herrera.

Angel Quiñones Cardona, Project Engagement Executive ES

Angel is a Principal with over 24 years of consulting experience serving the Government and Public Services (GPS) Industry at Deloitte Consulting. He has led large-scale engagements for the entire system development life cycle, quality assurance, strategic information systems planning, and operations assessment engagements. His industry experience has included the delivery of projects for Health and Human Services, Homeland Security & Emergency Preparedness, Justice & Public Safety, Finance & Administration, Transportation, Labor & Human Resources, and Education clients.

Angel has led the Electronic Health Records market for the GPS Industry and served as the Lead Consulting Partner for the State of New York. He is currently delivering projects critical projects in the Commonwealth of Puerto Rico.

Lindsay Hough, Quality Assurance Engagement Executive

Lindsay is a national leader in our health and human services practice, where her focus is on implementing health and human services business transformations, developing new operating models to align to customer service demands, and working with stakeholder groups at the local, county, state and Federal levels. Lindsay has directly served Secretaries of Health and/or Human Services in 10 states in the last 5 years. Recent clients nationally include agencies such as the Texas Health and Human Services Commission (HHSC), Virginia Secretariat for Health and Human Resources, West Virginia Department for Health and Human Resources, New York City Department of Health, Ohio Department of Medicaid, the New Hampshire Department of Health and Human Services, the Rhode Island Executive Office of Health and Human Services, and Kentucky Cabinet for Health and Family Services. Lindsay is a Certified Government Financial Manager (CGFM) and a Project Management Professional (PMP).

Ramona Pereira-Chakka, Contract Oversight Engagement Executive

Ramona has over a decade of experience helping health and human services agencies, including some of the nation's largest Medicaid managed care programs, transform their operations and ensure quality health outcomes for millions of recipients. She recently supported Texas Health and Human Services Commission (HHSC) in an evaluation of their Medicaid and CHIP Managed Care program to address legislative requirements and is currently leading an effort to help HHSC implement the improvement initiatives identified by the reports. She also leads project management activities across 15-18 task orders per year to help Pennsylvania Office of Medical Assistance Programs improve managed care contract oversight of their MCOs.

Ramona's experience includes health and human service agencies across the country, including Virginia Secretariat for Health and Human Resources, West Virginia Department for Health and Human Resources, New York Department of Health, New York Justice Center for Persons with Special Needs, New York City Department of Health, and Michigan Wayne County Department of Health and Human Services.

Tim FitzPatrick, ASA, Financial Reporting Engagement Executive

Tim has more than 17 years of health care experience and leads Deloitte's State Health Transformation Services practice. Tim has worked with three of the nation's largest Medicaid programs including New York, Texas and Pennsylvania, other state government agencies, employers, plans and provider groups on public health care initiatives such as program transformation, value-based purchasing, program monitoring, financial analysis, project management, underwriting, benefit design, reimbursement strategy, waiver support, and pricing/rate setting. Tim has demonstrated ability leading teams in program assessments, options development and analysis, vision and strategy development, and implementation planning. Tim's project experience includes assisting health care transformation efforts across several state Medicaid programs including Georgia, Iowa, Kentucky, Maine, Massachusetts, Minnesota, Missouri, New York, North Dakota, Ohio, Pennsylvania, Rhode Island, Texas, Virginia, and Wisconsin. He is an Associate of the American Academy of Actuaries (ASA) and a member of the American Academy of Actuaries (MAAA).

Lauren Allen, Program Integrity Engagement Executive

Lauren leads the Deloitte Government & Public Services Program Integrity practice. She specializes in working with government organizations to take an integrated strategic, actionable, and measurable approach to payment management to help drive program efficiency and effectiveness. She leads the program integrity team which has a goal of supporting agencies in transitioning from pay and chase recovery to avoidance of improper payments. Lauren has extensive experience in data management practices in the litigation and investigation realms.

Christopher Young, Engagement Executive (ES)

Christopher (Chris) is our lead consulting partner for Puerto Rico and supports all the engagement teams by aligning all the necessary Deloitte resources to the projects.

Gilberto (Tito) Torres, Project Manager (ES)

Tito is a Specialist Leader with over 30 years of experience in Public Sector consulting in Puerto Rico and the United States. Tito focuses on strategic planning, project management, operations management, process reengineering and technology integration. Tito applied these skills when he worked as a consultant to various Executive Directors of the Puerto Rico Health Insurance Administration supporting the operations and contracting of the Managed Care Organizations for the PRMP. He also worked as a consultant for the Secretary of Health serving as Program Manager for the initiation of the first MMIS for Puerto Rico within the Medicaid Program and as liaison for the Secretary with CMS. Tito understands Puerto Rico's Medicaid program from practical experience and brings to bear this knowledge and background as he manages the engagement for Deloitte.

Amanda Harris, Project Manager

Amanda is a Senior Manager in Deloitte's State Health practice with 14 years of public sector experience in areas of project management, strategic planning, data analytics for business operations, business process improvement, Medicaid and HCBS operations transformation, provider enrollment, and HHS policy. Amanda's experience includes leading projects in multiple state HHS agencies and with the Centers for Medicare and Medicaid Services (CMS). She has spent over six years leading extensive research, data and policy analysis for Pennsylvania's Department of Human Services across Medicaid and various HCBS programs to improve service delivery. For two years, Amanda led the CMS Center for Program Integrity technical assistance team for provider enrollment where she conducted site visits, operational and compliance assessments, and built strategic roadmaps for eighteen state Medicaid programs to enhance their provider enrollment and program integrity operations. Additionally, Amanda is a former senior policy advisor for the Wyoming Department of Health.

Amina Popowich, Project Manager

Amina Popowich has over 16 years of experience in assisting Government agencies with business process improvement, conducting risk assessments, performing compliance reviews, and providing support to address Inspector General and other governing entity inquiries. This experience also includes process evaluation and redesign, financial system and internal control related training development and deployment, operations research, and policy and procedure development. Amina is a leader in Deloitte's Forensic Program Integrity offering. She is focused on bringing innovative Program Integrity solutions to State and Local agencies. She specializes in working with State agencies to enhance their ability to take a strategic, actionable, and measurable approach to program execution with a focus on program impact and outcomes.

Meredith St. Clair, Functional Task Lead 1

Meredith is an Analytics Manager with experience working for both Government and Private sector clients, specializing in Health Analytics. Ms. St Clair is PMP, CDMP, and SAS certified, and has significant analytics experience serving the State of Wyoming, Navy Bureau of Medicine and Surgery, the Center for Medicaid and Medicare Services, and the Veterans Health Administration. She has expertise in healthcare claims analysis and reporting along with programming experience including writing code and performing data analyses and quality control for the "Payment Error Rate Measurement" (PERM) project for the Center for Medicaid and Medicare Services. For this effort she used SAS to manipulate and evaluate large Medicaid and Medicare claims data from all 50 states and the District of Columbia to conduct outlier analysis, trend analysis, and created a threshold model to compare all data to CMS 64 reports. Ms. St Clair currently serves the Wyoming Department of Health in overseeing the Fraud Waste and Abuse analytics platform development and implementation.

Nichole Ramsey, Functional Task Lead 1

Nichole is a health actuary with more than 10 years of experience delivering actuarial and financial solutions to state and government clients, health plans, employers, provider groups, and integrated health systems. She is a subject matter advisor on quality-based and value-based payment structures, and health claims opportunity analysis modeling. She also supported the State of Texas HHSC in providing consulting services including a study and report on a comprehensive review of, and evaluation of managed care in Texas Medicaid and Children's Health Insurance Program (CHIP) (Rider 61). Specifically, Nichole led several sections of the report including analyzing trends, caseload growth, managed care programs, and summarized managed care program outcomes and initiatives other states have used to contain costs and improve program effectiveness and reviewing capitation rate development process across Texas and other

states comparing core rate setting elements. Nichole is an Associate of the American Academy of Actuaries (ASA) and a member of the American Academy of Actuaries (MAAA).

John McInerney, Functional Task Lead 1

John has over 15 years of Medicaid, CHIP and health financing experience at both the state and Federal levels. Previously, he has worked with state CHIP directors as Program Manager with the National Academy for State Health Policy (NASHP), as a health policy analyst for the Congressional Joint Economic Committee, and as health policy director for a policy research non-profit. John is currently supporting Texas Health and Human Services Commission in implementing initiatives to help improve oversight of their managed care program that were highlighted in the legislative Riders 60/61 reports highlighted in our references.

Alexandra Soto Jimenez, Functional Task Lead 2 ES

Alexandra is a Senior Consultant with experience working for both Government and Private sector clients, specializing in Strategy Technology. Alexandra has 6 years of experience in IT strategy definition and enablement, process re-engineering and software procurement and implementation. She is originally from Puerto Rico and has been supporting the Government of Puerto Rico engagements since 2018, within her role Alexandra frequently engages with key stakeholders and has helped develop key client relationships. Alexandra holds a bachelor's degree of Science in Business Management from Babson College, focused on Entrepreneurship and Economics.

Anna Cordero Boyle, Business Analyst 1 ES

Anna is a Health Technology Consultant with experience in Organizational Change Management. Anna joined Deloitte in February 2019. Prior to Deloitte, Anna's professional experience included Project Management and Organizational Change Management. Anna has a Bachelor of Science in Business Administration from Duquesne University with a concentration in Marketing and Supply Chain Management. Anna's first engagement at Deloitte was supporting project management in the Department of Treasury in the Government of Puerto Rico. As a Spanish native speaker, within her role Anna frequently engaged with key stakeholders and developed key client relationships. In her latest role, Anna is responsible for leading organizational change management activities for a Massachusetts state agency within the Executive Office of Health and Human Services.

Pedro Rodriguez, Business Analyst 1 ES

Pedro is a Consultant with experience in Strategic Planning, Crisis Management, Process Improvement, Sourcing to Pay (S2P), Project Management, and System Engineering. Pedro recently supported the State-wide Puerto Rico Procurement Centralization by designing the requirements for a Technological Implementation, by designing the Space Plan of the new building of the agency, by implementing Project Management leading practices on the execution of the Strategic Sourcing plan, and by assessing and providing process improvement solutions to the centralized Requisitioning and Purchase Order processes. He brings to bear this experience as we evaluate Contracts and Contracting Reform for PRMP.

Abigail Dworzanin, Business Analyst 1

Abigail (Abby) is a Consultant at Deloitte, for over 2 years she has been specializing in health actuarial consulting. She has primarily worked with public sector clients on projects including medical plan design modeling, Medicaid rate setting evaluation, Foster Care rate methodology analysis and benchmark assessments. Most recently, Abby worked on the design, development, and launch of dashboard modules for financial monitoring and enhancement of business processes of a Medicaid program.

Rachel Herrera, Business Analyst 2 ES

Rachel is a Business Analyst who joined Deloitte in August 2018 after graduating from Princeton University in 2017 with a bachelor's degree in Mechanical and Aerospace Engineering and spending a postgraduate year completing a Fulbright Fellowship in Mexico. At the firm, Rachel's project experience includes supporting a client in the Federal Health sector in the implementation of a new Performance Improvement office. For this engagement, Rachel contributed to the identification and reporting of over $600M in HIT savings through the modification of a new cost savings tracking process and the implementation of new business rules. Since February of 2018 Rachel has supported the Government of Puerto Rico across various workstreams for a disaster recovery engagement. In this role, Rachel has used her Spanish language ability to facilitate client and stakeholder meetings and develop formal communications.

Other Deloitte Subject Matter Specialists and Functional Staff Available to PRMP

Will Booher, Functional Task Lead 1 ES

Will is a Manager in our Advisory practice that has over 10 years of experience in the outreach and communications at the federal, state and private sector levels. As the former Director of Public Affairs for the Federal Emergency Management Agency, he has experience leading and supporting communications, programmatic and policy initiatives and successful outreach efforts across Congress and Washington DC.

Michael McMullan, Sr. Subject Matter Specialist

Michael served in a wide range of leadership positions at CMS including Acting as the Administrator during the transition between the Clinton and Bush Administrations. At CMS, Michael lead the development of new programs ranging from medical information systems and clinical quality improvement programs to the Medicare Prescription Drug program. Michael has directed and managed significant national program operations including the health care quality improvement program, Medicare fee-for-service and health plan contractor operations, the National Medicare Education Program and customer service operations. Michael provides expert advice developing strategies and operational approaches to health care innovation, health plan performance measurement and management, and organizational development in implementing Medicare and Medicaid program requirements. Michael was awarded the Presidential Distinguished Executive Rank Award from both President George W. Bush and President Bill Clinton.

Jim Hardy, Sr. Subject Matter Specialist

Jim is a Specialist Executive with over 30 years of Medicaid and health care experience, including serving as Pennsylvania's Medicaid Director. He helps states improve the performance of their managed care programs and develops new payment and delivery models that increase value, improve quality and control costs for Medicaid's most complex populations. Jim also works with states to improve the organizational efficiency of their Medicaid programs and develops new approaches to consumer directed care and long-term services and supports.

Kelly Bowman, Sr. Subject Matter Specialist

Kelly Bowman is a Specialist Leader with significant expertise in leading fraud, waste, and abuse prevention and detection for Medicaid, Medicare, and the Exchanges (ACA). Kelly has specific experience and expertise in maturing program integrity operations, leading strategy development, conducting fraud risk assessments, implementing enterprise governance structures, measuring performance and savings, implementing predictive analytics systems and methodologies, and leading organizational change. Kelly spent over a decade in public service in senior roles in state and federal government agencies with a focus on healthcare, program integrity, and strategy.

Dan Olson, CFE, Sr. Subject Matter Specialist

Dan is a Chief Fraud Examiner (CFE) who has worked for 25 years in healthcare fraud examination following five years in auditing and compliance. Dan has applied his background to provide leading practices and implement analytics in state Medicaid agencies, Medicare and commercial payer plans. Dan's experience includes working twelve years leading the analytics division for the Office of Inspector General for a large state Medicaid agency. Upon leaving state government, Mr. Olson spent the past thirteen years as the healthcare fraud, waste, and abuse subject matter specialist in the design of predictive analytics and a fully integrated case management system for federal, state, and commercial clients. This work included leading program integrity teams in seven states to implement advanced analytics and case management solutions. Additionally, Mr. Olson commits himself to researching trends and developments in the areas of healthcare fraud and abuse and educating other members of the program integrity community, as well as, external stakeholders. As part of this commitment, Dan wrote a national monthly healthcare fraud newsletter, has been a keynote speaker and speaker at numerous institutes, conferences, and program integrity annual meetings, authored twelve healthcare white papers, testified before Congress, and served as a healthcare fraud resource to senior Congressional leaders.

Matthew Mardorff, Sr. Subject Matter Specialist

Matthew is a certified Project Management Professional (PMP) and has over 18 years of experience working with State Medicaid programs in the areas of reporting, analytics, and information management focusing specifically on how state Medicaid programs can leverage data to improve program oversight, outcomes for recipients, and federal reporting requirements. Recently he has worked with multiple states including Texas, Pennsylvania, and New Hampshire to help each improve reporting on their Medicaid programs and support their ability to oversee both Fee for Service and managed Care programs. In Texas. he assisted in a review of their current Medicaid Managed Care oversight data and reporting processes including how current and future reporting is used to meet CMS requirements. In Pennsylvania he led the implementation of a next generation MCO oversight and reporting solution that collects, validates, and produced both reports and dashboards used for program oversight and CMS reporting. In New Hampshire he led a project to develop reporting and dashboards used to track the performance of the state Medicaid program.

Jeff Burke, Sr. Subject Matter Specialist

Jeff is a leader in Deloitte's public sector practice, focusing on strategic planning, business transformation, project management, organizational design and improvement, operations improvement, and process reengineering for public and private sector health care organizations. He has experience helping these organizations respond to the transforming health care environment, including topics such as value-based care, Medicaid Managed Care, Health Care Reform, technology strategy, and organizational transformation. Jeff's project experience includes assisting the Commonwealth's of Kentucky, Massachusetts, and Pennsylvania, and the states of Georgia, Louisiana, Maine, New Hampshire, and New York and the with health care transformation efforts.

Hector F. Adames, CFE, Functional Task Lead 1 ES

Hector is a Manager in the San Juan Risk Management practice, he has over 6 years of experience in forensics and audit and is a Certified Fraud Examiner (CFE). He is currently focused on risk-based monitoring & on-going monitoring services support to state crisis recovery. Hector also has extensive experience providing financial investigations support to State and Federal law enforcement. His state law enforcement and executive leadership experience provides critical support for monitoring and financial investigations across the government of a U.S. commonwealth.

Kandice Kailer, Functional Task Lead 1

Kandice has more than a decade of experience consulting with state and local governments, providers, and health plans to manage, finance and operate their Medicaid programs and services. Kandice is a Manager in Deloitte's State Health Transformation practice with experience in operations, finance, and business model transformations. She supports agencies as they transitioned to Managed Care and Managed Long-Term Supports and Services (MLTSS). She also has hands-on experience with provider reimbursement and cost analysis of community-based Medicaid services delivered by county, tribal and other local agencies. For a state Medicaid agency, she coordinated and drafted their Section 1115 Demonstration waiver initial application establishing a new Delivery System Reform Incentive Program (DSRIP). In Wisconsin, Kandice consulted on Medicaid hospital payment reform and the transition toward value-based payments with the implementation of a new outpatient payment classification system (i.e. Enhanced Ambulatory Patient Groups).

Antonio Valdes, Functional Task Lead 2 ES

Antonio is a Senior Consultant for Deloitte's Risk and Financial Advisory Practice and an expert in healthcare fraud prevention, investigation and data analytics with ten years of experience investigating healthcare fraud, waste and abuse. Antonio has managed projects involving complex investigative strategies, worked with predictive analytic models used by federal agencies and identified health program vulnerabilities. Furthermore, Antonio is recognized for his knowledge of fraud prevention in the health care industry, federal contract selection knowledge and in the oversight/ daily guidance of a Medicare fraud prevention contractor. He has used his knowledge in the continued development of the federal government's Medicare and Medicaid fraud, waste and abuse investigative strategies.

Joe Micancin, Functional Task Lead 2 ES

Joe came to Deloitte with over six years of experience solving complex change management problems in a variety of organizations. In 2019, he worked in Puerto Rico to help the government to stand up COR3. Most recently prior to joining the firm he worked with New York City's Department of Social Services' Office of Business Process Innovation – a small office in a large agency, focused on using technology and policy to improve delivery of social services. Prior to this he worked in economic development for the State of New York. A native English speaker, Joe speaks Russian and conversational Spanish.

Our Strategic Partners Available to PRMP

MGM CONTIGO, LLC.

MJM CONTIGO, LLC is a consulting firm that specializes in government health insurance programs under the leadership of Michael J. Melendez, LMSW. MJM CONTIGO, LLC, offers guidance specific to Medicaid, CHIP and Medicare programs for governments, health care providers, health Insurance companies, and entities interested in expanding and improving the health care market in the US Territories. MJM CONTIGO, LLC is committed to addressing funding, and service inequities resulting from differences in Medicare, Medicaid and CHIP program regulation that uniquely apply to US Territories of Puerto Rico, the US Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

Michael Melendez, Sr. Subject Matter Specialist ES

To further assure we bring the right resources to bear for this critical engagement for Puerto Rico, we have decided to partner with Mr. Michael Melendez from MJM CONTIGO LLC. Michael has more than 30 years of experience working in the Not-For-Profit and government sectors. Michael has significant expertise in the Medicaid, CHIP and Medicare programs, given two decades of experience in the administration and operation of both programs. Michael brings his expertise in Medicaid from his experience within CMS, as Regional Medicaid Administrator for Puerto Rico within Region 2.

John Guhl, Sr. Subject Matter Specialist

John has been a consultant with MJM Contigo, LLC since January 2019. Prior to consulting, John was the Financial Branch Manager for CMS Region II overseeing federal funding for Puerto Rico, U.S. Virgin Islands, New York and New Jersey. Among his numerous other duties, he was responsible for the review and approval of the quarterly financial reports (CMS-64, CMS-37, CMS-21 and CMS-21B); review of all state plan and waiver amendments; and issuing deferring unsupported federal funds / disallowing unallowable federal funds. Mr. Guhl was recruited by CMS Region II, while serving as the NJ Medicaid Director. John worked for the NJ Medicaid program for over 25 years, serving as Medicaid Director the final four years. He was responsible for all aspects of the Medicaid and CHIP programs in New Jersey.

Speire Healthcare Strategies

speire HEALTHCARE STRATEGIES

The Speire team brings a wealth of experience and deep relationships across the industry. Its four partners have served as government and private sector executives, holding leadership roles in Medicaid agencies, the U.S. Department of Health and Human Services, and within top tier management consulting firms.

Speire helps organizations make sense of the emerging federal and state policy environment and understand the associated business implications. The team of experienced former state and federal government executives have the knowledge and relationships to navigate the complexities of Medicaid, CHIP, and the evolving health policy reforms. Speire has worked with a wide range of clients tackling some of the most complicated Medicaid issues.

Darin Gordon, Sr. Subject Matter Specialist

Darin is a founding partner at Speire Healthcare Strategies. Darin is a seasoned executive with over 22 years of experience in public healthcare finance, policy and operations. Darin is a nationally recognized expert in state health insurance programs. He currently works with C-level clients throughout the healthcare ecosystem and across the country providing solutions to complex healthcare issues. In 2017, Darin was selected to be a commissioner for the Medicaid and CHIP Payment and Access Commission (MACPAC), a non-partisan agency that provides advice to Congress, the Secretary of the U.S. Department of Health and Human Services and states, he is serving a three-year term. Previously, Darin served as the Director of Tennessee's Medicaid program – TennCare, an $12 billion healthcare enterprise that provides services to over 1.5 million Tennesseans. Darin also served first as Vice-President and then President of the National Association of Medicaid Directors.

Dianne Faup, Sr. Subject Matter Specialist

Dianne is a founding partner at Speire Healthcare Strategies. Dianne has over 30 years of experience working in the healthcare industry as an attorney, a management consultant and a government executive. Her private, federal and state healthcare background includes working with White House, Congressional and U.S. Department of Health & Human Services (HHS) executive leaders. In more than 20 years of consulting she has advised over 100 organizations, including U.S. and foreign government agencies, payers, technology companies, providers, and non-profits, helping to solve complex business problems. Dianne served as a senior advisor within HHS, first at CMS and then in the Immediate Office of the Secretary as a Senior Advisor to Deputy Secretary Alex Azar. While at HHS, she advised on HIPAA, health technology, CMS issues and fraud waste and abuse policy. Dianne also served as chief of staff for the District of Columbia Department of Health Care Finance, a $2 billion Medicaid agency that serves more than one-third of District residents. Dianne currently provides policy advice and subject matter expertise to CMS on 1332 state relief and empowerment waivers, including advising on how to effectively provide technical assistance to states. Led multiple MMA and ACA implementation projects for CMS, including state technical assistance, eligibility and enrollment and appeals strategy and process design, and navigator strategy and training.

Tom Betlach, Sr. Subject Matter Specialist

Tom is a partner of Speire Healthcare Strategies. He is a nationally recognized thought leader on Medicaid and healthcare policy, known for his expertise in serving complex populations, delivery system transformation, value-based purchasing, 1115 waivers, managed care, and cost containment. Prior to joining Speire, Tom completed 27 years of state service in Arizona, working for five different Governors in three different cabinet positions. As Arizona's Medicaid Director or Deputy Director for 17 years, Tom led five 1115 waivers from concept through operations across a range of topics from increasing healthcare access to establishing premiums and cost sharing. Tom also led the development of the State's approved 1115 waiver for community engagement. As a consultant, Tom worked with the State of Utah to develop a per capita cap 1115 waiver that seeks to expand coverage up to 100% FPL with enhanced FMAP and include community engagement. The work also includes complex budget neutrality modeling. He is currently providing technical assistance to a number of state Medicaid agencies on improved alignment for dual eligible beneficiaries, managed care contracting, value-based care, and other high priority issues.

John McCarthy, Sr. Subject Matter Specialist

John has more than 20 years of healthcare consulting and government leadership experience. He served as Medicaid Director in Ohio and the District of Columbia. John provides strategy and advisory services to clients to help them navigate the rapidly changing healthcare markets in the public and private sectors at both the federal and state levels. He is a nationally recognized expert in Medicaid reforms, value-based purchasing, delivery system design, system implementation, and reimbursement policy. John served as the Director of the Ohio Department of Medicaid (ODM), Ohio's first cabinet-level Medicaid agency. He also served as Policy Director and ultimately Medicaid Director for the District of Columbia. John also served as a board member and later Vice President of the National Association of Medicaid Directors.

V. Our Cost Proposal

We are pleased to provide our cost proposal which includes a summary of the estimated budget broken down by Federal Fiscal Year 2020 and Federal Fiscal Year 2021 in Figure 25. This is followed by a table, in Figure 26, highlighting the detailed estimated budget per requirement area based on the number of hours need to deliver the work by the assigned staff job titles and the hourly billing rates for each title. We have based these estimates on our understanding of the complexity involved in similar efforts as a result of our experience helping other states respond to congressional mandated reports. If selected for the effort, we can work with PRMP to confirm the timing, scope, and hours needed for the requirements areas.

We have a strong local presence in Puerto Rico with several of our proposed staff, fully bilingual (Spanish and English, both verbal and written), residing in Puerto Rico and available to work onsite alongside PRMP in San Juan, Puerto Rico. The local team is supplemented with team members with national Medicaid expertise in other states as well as CMS, as requested by the RFQ. Some of these proposed national resources might have the need to travel to Puerto Rico to meet with PRMP team during the kick- off, data gathering, evaluation, report review/validation phases as well as to attend meetings in CMS offices and other government offices including Congress in Washington DC based on PRMP direction. As such we anticipate additional travel expenses which we assume are billed separately. Based on similar efforts, we estimate total travel expenses to be $500,000 for the duration of the project. For our expense budget, consistent with our prior and current contracts with the Government of Puerto Rico (GPR) and at your direction, we can abide by Federal Per Diem and GPR travel policies. If selected for this effort, we can work with PRMP to confirm resource onsite/travel assumptions and finalize the need for/frequency of travel during this effort.

Requirement	Estimated Hours	Total Estimated Cost	Estimated Cost April 1. 2020- September 30, 2020	Estimated Cost October 1, 2020- June 30, 2021
1. Review Program Integrity Office Policies, Procedures, Staffing	2,388	$662,900	$662,900	
2. Develop Payment Error Rate Measurement (PERM) Plan	1,736	$488,850		$488,850
3. Develop Contracting Reform Plan	2,435	$695,560	$695,560	
4. Review Medicaid Eligibility Quality Control (MEQC) Policy/Procedures/ Staffing	2,038	$568,150		$568,150
5. Evaluate Dual Eligible Special Needs Plan	1,361	$375,975		$375,975
6. Develop Annual Report	4,568	$1,267,345	$1,267,345	
7. Develop Report on Contract Oversight and Approval	2,162	$603,130		$603,130
8. Evaluate Current Process of Managed Care Payments	1,361	$375,975		$375,975
9. Define Scorecard Reporting Measures	2,479	$704,945		$704,945
10.Develop Financial Executive Summary for CMS 64 and 37	1,361	$375,975		$375,975
11. Evaluate Current Contract Requirements and CMS Reporting	2,178	$607,350		$607,350

Requirement	Estimated Hours	Total Estimated Cost	Estimated Cost April 1. 2020- September 30, 2020	Estimated Cost October 1, 2020- June 30, 2021
12. Implement Scorecard Reporting System	8,353	$2,196,835		$2,196,835
13. Develop Policies and Procedures for Penalties	1,366	$377,150		$377,150
Total Fees based on hourly rates	33,786	$9,300,140	$2,625,805	$6,674,335
Estimated Travel Expenses	N/A	$500,000	$300,000	$200,000
Total Estimated Budget	**33,786**	**$9,800,140**	**$2,925,805**	**$6,874,335**

Figure 25- Summary Estimated Costs broken down by Federal Fiscal Years

Assigned staff roles by Requirement Area	Proposed Hourly Billing Rate	Estimated Hours	Estimated Cost
1. Review Program Integrity Office Policies, Procedures, Staffing			
Engagement Executive	$345	80	$27,600
Sr. Subject Matter Specialist	$345	88	$30,360
Project Manager	$305	292	$89,060
Functional Task Lead 1	$290	400	$116,000
Functional Task Lead 2	$275	1,020	$280,500
Business Analyst 1	$235	508	$119,380
Total		**2,388**	**$662,900**
2. Develop Payment Error Rate Measurement (PERM) Plan			
Engagement Executive	$345	155	$53,475
Sr. Subject Matter Specialist	$345	88	$30,360
Project Manager	$305	242	$73,810
Functional Task Lead 1	$290	500	$145,000
Functional Task Lead 2	$275	243	$66,825
Business Analyst 1	$235	508	$119,380
Total		**1,736**	**$488,850**
3. Develop Contracting Reform Plan			
Engagement Executive	$345	158	$54,510
Sr. Subject Matter Specialist	$345	288	$99,360
Project Manager	$305	342	$104,310
Functional Task Lead 1	$290	300	$87,000
Functional Task Lead 2	$275	840	$231,000
Business Analyst 1	$235	508	$119,380
Total		**2,435**	**$695,560**
4. Review Medicaid Eligibility Quality Control (MEQC) Policy, Procedures, Staffing			
Engagement Executive	$345	80	$27,600
Sr. Subject Matter Specialist	$345	88	$30,360
Project Manager	$305	292	$89,060

Assigned staff roles by Requirement Area	Proposed Hourly Billing Rate	Estimated Hours	Estimated Cost
Functional Task Lead 1	$290	500	$145,000
Functional Task Lead 2	$275	570	$156,750
Business Analyst 1	$235	508	$119,380
Total		**2,038**	**$568,150**
5. Evaluate Dual Eligible Special Needs Plan			
Engagement Executive	$345	80	$27,600
Sr. Subject Matter Specialist	$345	88	$30,360
Project Manager	$305	242	$73,810
Functional Task Lead 1	$290	200	$58,000
Functional Task Lead 2	$275	243	$66,825
Business Analyst 1	$235	508	$119,380
Total		**1,361**	**$375,975**
6. Develop Annual Report			
Engagement Executive	$345	160	$55,200
Sr. Subject Matter Specialist	$345	289	$99,705
Project Manager	$305	442	$134,810
Functional Task Lead 1	$290	300	$87,000
Functional Task Lead 2	$275	2,420	$665,500
Business Analyst 1	$235	958	$225,130
Total		**4,568**	**$1,267,345**
7. Develop Report on Contract Oversight and Approval			
Engagement Executive	$345	94	$32,430
Sr. Subject Matter Specialist	$345	138	$47,610
Project Manager	$305	272	$82,960
Functional Task Lead 1	$290	300	$87,000
Functional Task Lead 2	$275	850	$233,750
Business Analyst 1	$235	508	$119,380
Total		**2,162**	**$603,130**
8. Evaluate Current Process of Managed Care Payments			
Engagement Executive	$345	80	$27,600
Sr. Subject Matter Specialist	$345	88	$30,360
Project Manager	$305	242	$73,810
Functional Task Lead 1	$290	200	$58,000
Functional Task Lead 2	$275	243	$66,825
Business Analyst 1	$235	508	$119,380
Total		**1,361**	**$375,975**
9. Develop Scorecard Reporting Measures			
Engagement Executive	$345	141	$48,645
Sr. Subject Matter Specialist	$345	268	$92,460
Project Manager	$305	272	$82,960
Functional Task Lead 1	$290	450	$130,500
Functional Task Lead 2	$275	840	$231,000
Business Analyst 1	$235	508	$119,380

Assigned staff roles by Requirement Area	Proposed Hourly Billing Rate	Estimated Hours	Estimated Cost
Total		**2,479**	**$704,945**
10. Develop Financial Executive Summary for CMS 64 and 37			
Engagement Executive	$345	80	$27,600
Sr. Subject Matter Specialist	$345	88	$30,360
Project Manager	$305	242	$73,810
Functional Task Lead 1	$290	200	$58,000
Functional Task Lead 2	$275	243	$66,825
Business Analyst 1	$235	508	$119,380
Total		**1,361**	**$375,975**
11. Evaluate Current Contract Requirements and CMS Reporting			
Engagement Executive	$345	80	$27,600
Sr. Subject Matter Specialist	$345	188	$64,860
Project Manager	$305	382	$116,510
Functional Task Lead 1	$290	300	$87,000
Functional Task Lead 2	$275	570	$156,750
Business Analyst 1	$235	658	$154,630
Total		**2,178**	**$607,350**
12. Implement Scorecard Reporting System			
Engagement Executive	$345	235	$81,075
Sr. Subject Matter Specialist	$345	388	$133,860
Project Manager	$305	642	$195,810
Functional Task Lead 1	$290	1,000	$290,000
Functional Task Lead 2	$275	1,530	$420,750
Technical Task Lead 2	$250	1,350	$337,500
Technical Analyst 1	$230	3,208	$737,840
Total		**8,353**	**$2,196,835**
13. Develop Policies and Procedures for Penalties			
Engagement Executive	$345	80	$27,600
Sr. Subject Matter Specialist	$345	88	$30,360
Project Manager	$305	242	$73,810
Functional Task Lead 1	$290	200	$58,000
Functional Task Lead 2	$275	243	$66,825
Business Analyst 1	$235	513	$120,555
Total		**1,366**	**$377,150**
Total Fees based on Hourly Rates		33,783	$9,300,140
Estimated Travel Expenses		N/A	$500,000
Total Estimated Costs		**33,783**	**$9,800,140**

Figure 26- Estimated Hours and Cost by Requirement Area