Office of State Procurement
PROACT Contract Certification of Approval

This certificate serves as confirmation that the Office of State Procurement has reviewed and approved the contract referenced below.

Reference Number: 2000255086
Vendor: Mercer Health & Benefits, LLC
Description: Develop actuarially sound capitation rate ranges for Healthy Louisiana
Approved By: Pamela Rice
Approval Date: 6/20/2017

The above referenced number has been assigned by this office and will be used as identification for the approved contract. Please use this number when referring to the contract in any future correspondence or amendment(s).

The Internal Revenue Service (IRS) may find that this contract creates an employment relationship between your agency and the contractor. You should be advised that your agency is responsible for all taxes and penalties if such a finding is forthcoming. It is incumbent upon your agency to determine if an employee/employer relationship exists. Your agency must make the appropriate withholdings in accordance with law and IRS regulations, if applicable.

LDH - CF - 1
Revised: 2017-02

BHSF

CONTRACT BETWEEN STATE OF LOUISIANA
LOUISIANA DEPARTMENT OF HEALTH

Bureau of Health Services Financing

LAGOV: 2000255086
LDH: 061445
Agency # 305

AND

Mercer Health & Benefits, LLC

FOR

☐ Interagency ☐ Personal Services ☒ Professional Services ☐ Consulting Services ☐ Social Services

INCLUDE RFP NUMBER (if applicable):

1) **Contractor (Registered Legal Name)**
Mercer Health & Benefits, LLC

2) **Street Address**
3560 Lenox Road, Suite 2400

City Atlanta | **State** GA | **Zip Code** 30326

3) **Telephone Number**
(404) 442-3100

4) **Mailing Address (if different)**

City | **State** | **Zip Code**

5) **Federal Employer Tax ID# or Social Security #**
34201546302 **(Must be 11 Digits)**

6) **Parish(es) Served** Statewide
ST

7) **License or Certification #**

8) Contractor Status

Subrecipient:	☐ Yes	☒ No
Corporation:	☒ Yes	☐ No
For Profit:	☒ Yes	☐ No
Publicly Traded:	☐ Yes	☒ No

8a) **CFDA#**(Federal Grant #)

9) **Brief Description Of Services To Be Provided:**
The contractor will provide methods for the development and calculation of capitation rates for the Medicaid Managed Care Program and other support services that must be provided by an actuary and other similarly qualified staff employed by the contractor. Methods will be analytically sound, acceptable to the Centers for Medicare and Medicaid Services, and readily replicated.

10) **Effective Date** 05-16-2017

11) **Termination Date** 05-15-2020

12) **Maximum Contract Amount** $16,158,890.00

13) **Amounts by Fiscal Year** 17-$696,250 18-$5,448,580 19-$5,171,155 20-$4,842,905

14) **Terms of Payment**
If progress and/or completion of services are provided to the satisfaction of the initiating Office/Facility, payments are to be made as follows:
LDH shall pay such invoice within thirty (30) days of approval, which shall not be unreasonably withheld or delayed. LDH will promptly notify contractor of any good faith dispute and the parties shall work together to resolve such dispute expeditiously and the time for payment of such portion of the invoice shall be extended until a resolution is reached. If any invoice has not been paid within 90 days from date submitted by Contractor to LDH, Contractor may suspend the provision of services here until payment is received. Contractor will be paid based on the hourly rates listed in Attachment B upon the submission and approval of detailed invoices.

Contractor obligated to submit final invoices to Agency within fifteen (15) days after termination of contract.

PAYMENT WILL BE MADE ONLY UPON APPROVAL OF:

First Name	Last Name
Teresa	Bravo

Title	Phone Number
Medicaid Program Manager 2	225-342-0941

15) **Special or Additional Provisions which are incorporated herein, if any (IF NECESSARY, ATTACH SEPARATE SHEET AND REFERENCE):**

Attachment A: HIPAA Addendum
Attachment B: Statement of Work
Attachment C: Additional Provisions

Exhibit 1: Resume
Exhibit 2: Board Resolution
Exhibit 3: Out of State Justification and Multi-Year Request
Exhibit 4: Secretary of State Certificate
Exhibit 5: Emergency Preparedness Plan

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Attachment:HIPAA Addendum
Attachment:Standard Provisions
Attachment:Special Provisions
Attachment:Statement of Work
Attachment:Fee Schedule
Attachment:Budget
Attachment:
Exhibit:Board Resolution
Exhibit:Disclosure of Ownership
Exhibit:Multi Year Letter
Exhibit:Late Letter
Exhibit:Out of State Justification
Exhibit:Certificate of Authority
Exhibit:Resume
Exhibit:License
Exhibit:

During the performance of this contract, the Contractor hereby agrees to the following terms and conditions:

1. **Discrimination Clause:** Contractor hereby agrees to abide by the requirements of the following as applicable: Titles VI and VII of the Civil Rights Act of 1964, as amended by the Equal Employment Opportunity Act of 1972; the Vietnam Era Veterans' Readjustment Assistance Act of 1974; Americans with Disabilities Act of 1990; the Rehabilitation Act of 1973; Federal Executive Order 11246 as amended; Title IX of the Education Amendments of 1972; the Age Discrimination Act of 1975; the Fair Housing Act of 1968; and all applicable requirements imposed by or pursuant to the regulations of the U. S. Department of Health and Human Services.

   Contractor agrees not to discriminate in the rendering of services to and/or employment of individuals because of race, color, religion, sex, sexual orientation, age, national origin, disability, political affiliation, veteran status, or any other non-merit factor. Any act of discrimination committed by Contractor, or failure to comply with these statutory obligations when applicable, shall be grounds for termination of this contract.

2. **Confidentiality:** Contractor shall abide by the laws and regulations concerning confidentially which safeguard information and the patient/client confidentiality. Information obtained shall not be used in any manner except as necessary for the proper discharge of Contractor's obligations. (The Contractor shall establish, subject to review and approval of the Department, confidentiality rules and facility access procedures.)

3. **Auditors:** The State Legislative Auditor, Office of the Governor, Division of Administration, and Department Auditors or those designated by the Department shall have the option of auditing all accounts pertaining to this contract during the contract and for a five year period following final payment. Contractor grants to the State of Louisiana, through the Office of the Legislative Auditor, Louisiana Department of Health, and Inspector General's Office, Federal Government and/or other such officially designated body the right to inspect and review all books and records pertaining to services rendered under this contract, and further agrees to guidelines for fiscal administration as may be promulgated by the Department. Records will be made available during normal working hours.

   Contractor shall comply with federal and state laws and/or LDH Policy requiring an audit of the Contractor's operation as a whole or of specific program activities. Audit reports shall be sent within thirty (30) days after the completion of the audit, but no later than six (6) months after the end of the audit period. If an audit is performed within the contract period, for any period, four (4) copies of the audit report shall be sent to the Louisiana Department of Health, Attention: **Division of Fiscal Management, P.O. Box 91117, Baton Rouge, LA 70821-3797** and one (1) copy of the audit shall be sent to the **originating LDH Office**.

4. **Record Retention:** Contractor agrees to retain all books, records and other documents relevant to the contract and funds expended thereunder for at least four (4) years after final payment or as prescribed in 45 CFR 74:53 (b) whichever is longer. Contractor shall make available to the Department such records within thirty (30) days of the Department's written request and shall deliver such records to the Department's central office in Baton Rouge, Louisiana, all without expense to the Department. Contractor shall allow the Department to inspect, audit or copy records at the contractor's site, without expense to the Department.

5. **Record Ownership:** All records, reports, documents and other material delivered or transmitted to Contractor by the Department shall remain the property of the Department, and shall be returned by Contractor to the Department, at Contractor's expense, at termination or expiration of this contract. All records, reports, documents, or other material related to this contract and/or obtained or prepared by Contractor in connection with the performance of the services contracted for herein shall become the property of the Department, and shall, upon request, be returned by Contractor to the Department, at Contractor's expense, at termination or expiration of this contract.

6. **Nonassignability:** Contractor shall not assign any interest in this contract and shall not transfer any interest in the same (whether by assignment or novation), without written consent of the Department thereto, provided, however, that claims for money due or to become due to Contractor from the Department under this contract may be assigned to a bank, trust company or other financial institution without advanced approval. Notice of any such assignment or transfer shall be promptly furnished to the Department and the Division of Administration, Office of State Procurement.

7. **Taxes:** Contractor hereby agrees that the responsibility for payment of taxes from the funds received under this contract shall be Contractor's. The Contractor assumes responsibility for its personnel providing services hereunder and shall make all deductions for withholding taxes, and contributions for unemployment compensation funds.

8. **Insurance:** Contractor shall obtain and maintain during the contract term all necessary insurance including automobile insurance, workers' compensation insurance, and general liability insurance. The required insurances shall protect the Contractor, the Louisiana Department of Health, and the State of Louisiana from all claims related to Contractor's performance of this contract. Certificates of Insurance shall be filed with the Department for approval. Said policies shall not be canceled, permitted to expire, or be changed without thirty (30) days advance written notice to the Department. Commercial General Liability Insurance shall provide protection during the performance of work covered by the contract from claims or damages for personal injury, including accidental death, as well as claims for property damages, with combined single limits prescribed by the Department.

9. **Travel:** In cases where travel and related expenses are required to be identified separate from the fee for services, such costs shall be in accordance with State Travel Regulations. The contract contains a maximum compensation which shall be inclusive of all charges including fees and travel expenses.

10. **Political Activities:** No funds provided herein shall be used to urge any elector to vote for or against any candidate or proposition on an election ballot nor shall such funds be used to lobby for or against any proposition or matter having the effect of law being considered by the Legislature or any local governing authority. This provision shall not prevent the normal dissemination of factual information relative to a proposition or any election ballot or a proposition or matter having the effect of law being considered by the Legislature or any local governing authority. Contracts with individuals shall be exempt from this provision.

11. **State Employment:** Should Contractor become an employee of the classified or unclassified service of the State of Louisiana during the effective period of the contract, Contractor must notify his/her appointing authority of any existing contract with State of Louisiana and notify the contracting office of any additional state employment. This is applicable only to contracts with individuals.

12. **Ownership of Proprietary Data:** All non-third party software and source code, records, reports, documents and other material delivered or transmitted to Contractor by State shall remain the property of State, and shall be returned by Contractor to State, at Contractor's expense, at termination or expiration of this contract. All non-third party software and source code, records, reports, documents, or other material related to this contract and/or obtained or prepared by Contractor in connection with the performance of the services contracted for herein shall become the property of State, and shall be returned by Contractor to State, at Contractor's expense, at termination or expiration of this contract.

13. **Subcontracting:** Contractor shall not enter into any subcontract for work or services contemplated under this contract without obtaining prior written approval of the Department. Any subcontracts approved by the Department shall be subject to conditions and provisions as the Department may deem necessary; provided, however, that notwithstanding the foregoing, unless otherwise provided in this contract, such prior written approval shall not be required for the purchase by the contractor of and services which are incidental but necessary for the performance of the work required under this contract.

    No subcontract shall relieve the Contractor of the responsibility for the performance of contractual obligations described herein.

14. **Conflict of Interest:** Contractor warrants that no person and no entity providing services pursuant to this contract on behalf of Contractor or any subcontractor is prohibited from providing such services by the provisions of R.S. 42:1113.

15. **Unauthorized Services:** No claim for services furnished or requested for reimbursement by Contractor, not provided for in this contract, shall be allowed by the Department. In the event the Department determines that certain costs which have been reimbursed to Contractor pursuant to this or previous contracts are not allowable, the Department shall have the right to set off and withhold said amounts from any amount due the Contractor under this contract for costs that are allowable.

16. **Fiscal Funding:** This contract is subject to and conditioned upon the availability and appropriation of Federal and/or State funds; and no liability or obligation for payment will develop between the parties until the contract has been approved by required authorities of the Department; and, if contract exceeds $2,000, the Division of Administration, Office of State Procurement.

    The continuation of this contract is contingent upon the appropriation of funds from the legislature to fulfill the requirements of the contract. If the Legislature fails to appropriate sufficient monies to provide for the continuation of the contract, or if such appropriation is reduced by the veto of the Governor or by any means provided in the appropriations act to prevent the total appropriation for the year from exceeding revenues for that year, or for any other lawful purpose, and the effect of such reduction is to provide insufficient monies for the continuation of the contract, the contract shall terminate on the date of the beginning of the first fiscal year for which funds are not appropriated.

17. **State and Federal Funding Requirements:** Contractor shall comply with all applicable requirements of state or federal laws or regulations relating to Contractor's receipt of state or federal funds under this contract.

    If Contractor is a "subrecipient" of federal funds under this contract, as defined in 2 CFR Part 200 (Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards), Contractor shall comply with all applicable requirements of 2 CFR Part 200, including but not limited to the following:

    - Contractor must disclose any potential conflict of interest to the Department and the federal awarding agency as required by 2 CFR §200.112.
    - Contractor must disclose to the Department and the federal awarding agency, timely and in writing, all violations of federal criminal laws that may affect the federal award, as required by 2 CFR §200.113.
    - Contractor must safeguard protected personally identifiable information and other sensitive information, as required by 2 CFR §200.303.
    - Contractor must have and follow written procurement standards and procedures in compliance with federally approved methods of procurement, as required by 2 CFR §§200.317 - 200.326.
    - Contractor must comply with the audit requirements set forth in 2 CFR §§200.501 - 200.521, as applicable, including but not limited to:
        - Electronic submission of data and reports to the Federal Audit Clearinghouse (FAC) (2 CFR §200.512(d)).
        - Ensuring that reports do not include protected personally identifiable information (2 CFR §200.512(a)(2)).

    Notwithstanding the provisions of paragraph 3 (Auditors) of these Terms and Conditions, copies of audit reports for audits conducted pursuant to 2 CFR Part 200 shall not be required to be sent to the Department.

18. **Amendments:** Any alteration, variation, modification, or waiver of provisions of this contract shall be valid only when reduced to writing, as an amendment duly signed, and approved by required authorities of the Department; and, if the contract exceeds $2,000, by the Division of Administration, Office of State Procurement. Budget revisions approved by both parties in cost reimbursement contracts do not require an amendment if the revision only involves the realignment of monies between originally approved cost categories.

19. **Non-Infringement:** Contractor will warrant all materials, products and/or services produced hereunder will not infringe upon or violate any patent, copyright, trade secret, or other proprietary right of any third party. In the event of any such claim by any third party against LDH, the Department shall promptly notify Contractor in writing and Contractor shall defend such claim in LDH's name, but at Contractor's expense and shall indemnify and hold harmless LDH against any loss, expense or liability arising out of such claim, whether or not such claim is successful. This provision is not applicable to contracts with physicians, psychiatrists, psychologists or other allied health providers solely for medical services.

20. **Purchased Equipment:** Any equipment purchased under this contract remains the property of the Contractor for the period this contract and future continuing contracts for the provision of the same services. Contractor must submit vendor invoice with reimbursement request. For the purpose of this contract, equipment is defined as any tangible, durable property having a useful life of at least (1) year and acquisition cost of $1000.00 or more. The contractor has the responsibility to submit to the Contract Monitor an inventory list of LDH equipment items when acquired under the contract and any additions to the listing as they occur. Contractor will submit an updated, complete inventory list on a quarterly basis to the Contract Monitor. Contractor agrees that upon termination of contracted services, the equipment purchased under this contract reverts to the Department. Contractor agrees to deliver any such equipment to the Department within 30 days of termination of services.

21. **Indemnity:** Contractor agrees to protect, indemnify and hold harmless the State of Louisiana, LDH, from all claims for damages, costs, expenses and attorney fees arising in contract or tort from this contract or from any acts or omissions of Contractor's agents, employees, officers or clients, including premises liability and including any claim based on any theory of strict liability. This provision does not apply to actions or omissions for which R.S. 40:1237.1 et seq. provides malpractice coverage to the Contractor, nor claims related to treatment and performance of evaluations of persons when such persons cause harm to third parties (R.S. 13:5108.1(E)). Further, it does not apply to premises liability when the services are being performed on premises owned and operated by LDH.

22. **Severability**: Any provision of this contract is severable if that provision is in violation of the laws of the State of Louisiana or the United States, or becomes inoperative due to changes in State and Federal law, or applicable State or Federal regulations.

23. **Entire Agreement**: Contractor agrees that the current contract supersedes all previous contracts, negotiations, and all other communications between the parties with respect to the subject matter of the current contract.

24. **E-Verify**: Contractor acknowledges and agrees to comply with the provision of R.S. 38:2212.10 and federal law pertaining to E-Verify in the performance of services under this contract.

25. **Remedies for Default**: Any claim or controversy arising out of this contract shall be resolved by the provisions of R.S. 39:1672.2-1672.4.

26. **Governing Law**: This contract shall be governed by and interpreted in accordance with the laws of the State of Louisiana, including but not limited to R.S. 39:1551-1736; rules and regulations; executive orders; standard terms and conditions, and specifications listed in the RFP (if applicable); and this Contract.

27. **Contractor's Cooperation**: The Contractor has the duty to fully cooperate with the State and provide any and all requested information, documentation, etc. to the state when requested. This applies even if this Contract is terminated and/or a lawsuit is filed. Specifically, the Contractor shall not limit or impede the State's right to audit or shall not withhold State owned documents.

28. **Continuing Obligation**: Contractor has a continuing obligation to disclose any suspension or debarment by any government entity, including but not limited to the General Services Administration (GSA). Failure to disclose may constitute grounds for suspension and/or termination of the Contract and debarment from future contracts.

29. **Eligibility Status**: Contractor and each tier of Subcontractors, shall certify that it is not excluded, disqualified, disbarred, or suspended from contracting with or receiving federal funds or grants from the Federal Government. Contractor and each tier of Subcontractors shall certify that it is not on the List of Parties Excluded from Federal Procurement and Nonprocurement Programs promulgated in accordance with E.O.s 12549 and 12689, "Debarment and Suspension," as set forth at 24CFR Part 24, and "NonProcurement Debarment and Suspension" set forth at 2CFR Part 2424.

30. **Termination for Cause**: The Department may terminate this Contract for cause based upon the failure of the Contractor to comply with the terms and/or conditions of the Contract; provided that the Department shall give the Contractor written notice specifying the Contractor's failure. If within thirty (30) days after receipt of such notice, the Contractor shall not have either corrected such failure or, in the case of failure which cannot be corrected in thirty (30) days, begun in good faith to correct said failure and thereafter proceeded diligently to complete such correction, then the Department may, at its option, place the Contractor in default and the Contract shall terminate on the date specified in such notice. The Contractor may exercise any rights available to it under Louisiana law to terminate for cause upon the failure of the Department to comply with the terms and conditions of this contract; provided that the Contractor shall give the Department written notice specifying the Department's failure and a reasonable opportunity for the state to cure the defect.

31. **Termination for Convenience**: The Department may terminate this Contract at any time by giving thirty (30) days written notice to the Contractor. The Contractor shall be entitled to payment for deliverables in progress, to the extent work has been performed satisfactorily.

32. **Commissioner's Statements**: Statements, acts and omissions made by or on behalf of the Commissioner of Administration regarding the RFP or RFP process, this Contract, any Contractor and/or any subcontractor of the Contractor shall not be deemed a conflict of interest when the Commissioner is discharging his duties and responsibilities under law, including, but not limited, to the Commissioner of Administration's authority in procurement matters.

33. **Order of Precedence Clause**: In the event of any inconsistent or incompatible provisions in an agreement which resulted from an RFP, this signed agreement (excluding the RFP and Contractor's proposal) shall take precedence, followed by the provisions of the RFP, and then by the terms of the Contractor's proposal. *This Order of Precedence Clause applies only to contracts that resulted from an RFP.*

SIGNATURES TO FOLLOW ON THE NEXT PAGE

THIS CONTRACT CONTAINS OR HAS ATTACHED HERETO ALL THE TERMS AND CONDITIONS AGREED UPON BY THE CONTRACTING PARTIES. IN WITNESS THEREOF, THIS CONTRACT IS SIGNED ON THE DATE INDICATED BELOW.

Mercer Health & Benefits, LLC	**STATE OF LOUISIANA** **LOUISIANA DEPARTMENT OF HEALTH**
Robert C. Butler 4/24/17	
SIGNATURE **DATE**	**SIGNATURE** **DATE**
Robert C. Butler	
NAME	**NAME**
Principal	Secretary, Louisiana Department of Health or Designee
TITLE	**TITLE**
	Bureau of Health Services Financing
	 4/26/17
SIGNATURE **DATE**	**SIGNATURE** **DATE**
	Jen Steele
NAME	**NAME**
	Medicaid Director
TITLE	**TITLE**

Rev. 06/2016

HIPAA Business Associate Addendum

This HIPAA Business Associate Addendum is hereby made a part of this contract in its entirety as Attachment __A__ to the contract.

1. The Louisiana Department of Health ("LDH") is a Covered Entity, as that term is defined herein, because it functions as a health plan and as a health care provider that transmits health information in electronic form.
2. Contractor is a Business Associate of LDH, as that term is defined herein, because contractor either: (a) creates, receives, maintains, or transmits PHI for or on behalf of LDH; or (b) provides legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services for LDH involving the disclosure of PHI.
3. Definitions: As used in this addendum –
    a. The term "HIPAA Rules" refers to the federal regulations known as the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules, found at 45 C.F.R. Parts 160 and 164, which were originally promulgated by the U. S. Department of Health and Human Services (LDHS) pursuant to the Health Insurance Portability and Accountability Act ("HIPAA") of 1996 and were subsequently amended pursuant to the Health Information Technology for Economic and Clinical Health ("HITECH") Act of the American Recovery and Reinvestment Act of 2009.
    b. The terms "Business Associate", "Covered Entity", "disclosure", "electronic protected health information" ("electronic PHI"), "health care provider", "health information", "health plan", "protected health information" ("PHI"), "subcontractor", and "use" have the same meaning as set forth in 45 C.F.R. § 160.103.
    c. The term "security incident" has the same meaning as set forth in 45 C.F.R. § 164.304.
    d. The terms "breach" and "unsecured protected health information" ("unsecured PHI") have the same meaning as set forth in 45 C.F.R. § 164.402.
4. Contractor and its agents, employees and subcontractors shall comply with all applicable requirements of the HIPAA Rules and shall maintain the confidentiality of all PHI obtained by them pursuant to this contract and addendum as required by the HIPAA Rules and by this contract and addendum.
5. Contractor shall use or disclose PHI solely: (a) for meeting its obligations under the contract; or (b) as required by law, rule or regulation (including the HIPAA Rules) or as otherwise required or permitted by this contract and addendum.
6. Contractor shall implement and utilize all appropriate safeguards to prevent any use or disclosure of PHI not required or permitted by this contract and addendum, including administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of LDH.
7. In accordance with 45 C.F.R. § 164.502(e)(1)(ii) and (if applicable) § 164.308(b)(2), contractor shall ensure that any agents, employees, subcontractors or others that create, receive, maintain, or transmit PHI on behalf of contractor agree to the same restrictions, conditions and requirements that apply to contractor with respect to such information, and it shall ensure that they implement reasonable and appropriate safeguards to protect such information. Contractor shall take all reasonable steps to ensure that its agents', employees' or subcontractors' actions or omissions do not cause contractor to violate this contract and addendum.
8. Contractor shall, within three (3) days of becoming aware of any use or disclosure of PHI, other than as permitted by this contract and addendum, report such disclosure in writing to the person(s) named in section 14 (Terms of Payment), page 1 of the CF-1. Disclosures which must be reported by contractor include, but are not limited to, any successful security incident, any breach of unsecured PHI, and any "breach of the security system" as defined in the Louisiana Database Security Breach Notification Law, La.R.S. 51:3071 *et seq*. The parties acknowledge and agree that this section constitutes notice by Contractor to LDH of the ongoing existence and occurrence of attempted but Unsuccessful Security Incidents (as defined below) for which no additional notice to LDH shall be required. "Unsuccessful Security Incidents" shall include, but not be limited to, pings and other broadcast attacks on Contractor's firewall, port scans, unsuccessful log-on attempts, denials of service and any combination of the above, so long as no such incident results in unauthorized access, use or disclosure of PHI. At the option of LDH, any harm or damage resulting from any use or disclosure which violates this contract and addendum shall be mitigated, to the extent practicable, either: (a) by contractor at its own expense; or (b) by LDH, in which case contractor shall reimburse LDH for all expenses that LDH is required to incur in undertaking such mitigation activities.
9. To the extent that contractor is to carry out one or more of LDH's obligations under 45 C.F.R. Part 164, Subpart E, contractor shall comply with the requirements of Subpart E that apply to LDH in the performance of such obligation(s).
10. Contractor shall make available such information in its possession which is required for LDH to provide an accounting of disclosures in accordance with 45 CFR § 164.528. In the event that a request for accounting is made directly to contractor, contractor shall forward such request to LDH within two (2) days of such receipt. Contractor shall implement an appropriate record keeping process to enable it to comply with the requirements of this provision. Contractor shall maintain data on all disclosures of PHI for which accounting is required by 45 CFR § 164.528 for at least six (6) years after the date of the last such disclosure.
11. Contractor shall make PHI available to LDH upon request in accordance with 45 CFR § 164.524.
12. Contractor shall make PHI available to LDH upon request for amendment and shall incorporate any amendments to PHI in accordance with 45 CFR § 164.526.
13. Contractor shall make its internal practices, books, and records relating to the use and disclosure of PHI received from or created or received by contractor on behalf of LDH available to the Secretary of the U. S. LDHS for purposes of determining LDH's compliance with the HIPAA Rules.
14. Contractor shall indemnify and hold LDH harmless from and against any and all liabilities, claims for damages, costs, expenses and attorneys' fees resulting from any violation of this addendum by contractor or by its agents, employees or subcontractors, without regard to any limitation or exclusion of damages provision otherwise set forth in the contract.
15. The parties agree that the legal relationship between LDH and contractor is strictly an independent contractor relationship. Nothing in this contract and addendum shall be deemed to create a joint venture, agency, partnership, or employer-employee relationship between LDH and contractor.
16. Notwithstanding any other provision of the contract, LDH shall have the right to terminate the contract immediately if LDH determines that contractor has violated any provision of the HIPAA Rules or any material term of this addendum.
17. At the termination of the contract, or upon request of LDH, whichever occurs first, contractor shall return or destroy (at the option of LDH) all PHI received or created by contractor that contractor still maintains in any form and retain no copies of such information; or if such return or destruction is not feasible, contractor shall extend the confidentiality protections of the contract to the information and limit further uses and disclosure to those purposes that make the return or destruction of the information infeasible.

LaGOV PO# 2000255086
Attachment B
Statement of Work
Mercer Health & Benefits, LLC

Goal/Purpose

The purpose is to establish an actuarial services contract that will allow for rate development and other Louisiana Medicaid financial support activities by Mercer Health & Benefits, LLC (the Contractor). Contractor will provide methods for, and calculation of, capitation rates for the Medicaid managed care programs and other support services that must be provided by an actuary or other similarly qualified staff employed by the Contractor. Contractor's methods must be analytically sound, acceptable to the Centers for Medicare and Medicaid Services (CMS), and readily replicated.

The Louisiana Department of Health (LDH) manages approximately 1,600,000 Medicaid enrollees in its Healthy Louisiana and dental programs. Such management requires ongoing assistance with rate setting, risk adjustment, financial analysis, analysis of claims and encounters, evaluation of expenditures, budget projections, and financial and other reporting requirements as may be mandated by federal or state law.

Services that the Contractor shall perform to assist LDH in accomplishing its goals include:

1. Developing actuarially-sound rate ranges for capitated Managed Care Organizations (MCOs) and any additional Medicaid managed care models that may be developed by LDH.
2. Applying its broad base of knowledge of federal and state statutes and economic systems using mathematical models and techniques to ensure that capitated plans are paid actuarially sound rates.
3. Providing actuarial opinions and testimony on reimbursement methodology and managed care plans that have actuarial value in accordance with the principles and guidelines of the American Academy of Actuaries.
4. Applying its broad base of knowledge of federal and state policies, procedures and economic and payment systems for the support and implementation of Medicaid managed care models.
5. Assisting in the development and ongoing implementation of a risk adjustment methodology for the Medicaid managed care programs.
6. Preparing analyses and reports of cost effectiveness and related issues.
7. Other related assistance as requested by LDH.

Deliverables

1. **Actuarial Rate Development**

   Perform capitation rate setting according to generally accepted actuarial principles and practices that use a variety of parameters including recipients' age, gender, eligibility category, and geographic location for Medicaid managed care models. In addition, perform periodic adjustments due to changes in the eligibility category of aid. The development of capitation rates must be performed annually and as requested by LDH in accordance with 42 CFR §438.6.

   - Complete rate development and submit documents required by CMS to the Department on a date mutually agreed upon by LDH and the Contractor of each year.

- Provide LDH with a certification, at the conclusion of each specific Medicaid Managed Care program rate setting cycle which states that Federal regulations regarding rate setting were complied with (as necessary) and which includes a detailed description of the rate setting methodology, including all necessary assurances and explanations or other material specified by LDH including but not limited to:
    - The rates and time period for the rates;
    - A description of risk-sharing mechanisms;
    - A projection of expenditures;
    - An explanation of rate setting;
    - Provide documentation and assurance that all payment rates are:
        - Based only upon services covered under the Louisiana Medicaid State Plan or costs related to providing these services, such as health plan administration, and to Medicaid-eligible individuals.
    - Provided documentation of any adjustments to the base year data including detailing the policy assumptions, size, and effect of the adjustments. Adjustments may include services covered, administration, medical service cost, trend inflation and utilization;
    - Provide documentation identifying each rate cell by category for each rate setting period;
    - Provide documentation that the Contractor has examined base year data for distortions, such as special populations with catastrophic costs, and adjusted rates in a cost-neutral manner; and
    - Provide documentation of any use of state provided reinsurance and other risk-sharing mechanisms.
- Follow the parameters and priorities of Medicaid managed care rate development, as set by LDH, in each rate period and advise LDH if there appears to be any conflict with other requirements herein.
- Meet the work plan timeline, as agreed upon by LDH and the Contractor, of Medicaid managed care rate development in each rating period.
- Perform actuarial analyses to make recommendations on proposed rates for subsequent Medicaid managed care entity contract year(s).
- Review encounter data and financial performance of participating Medicaid managed care plans for use in determining rates and fees.
- Ensure that the methodology developed and rates calculated under all tasks meet all federal and state requirements. All reports and rate setting methodologies will be submitted to LDH for approval by CMS.
- Incorporate federal requirements, including those required by the Affordable Care Act (ACA), into managed care rates, and assist LDH in the reporting and reconciliation of such requirements as requested by LDH.
- Provide technical assistance concerning the rate setting methodology to LDH as needed. Technical assistance may include statistical data analysis and litigation support if litigation involves rates or rate setting as determined by LDH.
- Provide actuarial assistance in development of trends for Medicaid, LaCHIP and/or other populations.
- Assist LDH in budget projections pertaining to managed care rates.
- Assist in answering any and all rate related questions.

2. Data Quality

- Perform reasonable reliability and validity checks not requiring an audit on all Medicaid managed care capitation rate development data provided by Medicaid managed care entities and LDH. Work directly with Medicaid managed care entities and LDH to collect financial and encounter data from Medicaid managed care entities and provide guidance to assist health plans in resolving reliability and validity problems with their data.
- Provide an actuarial analysis of the encounter data collected from capitated Medicaid managed care entities.
- Provide supporting documentation to LDH and offer mechanisms to verify the accuracy of analysis completed and base data.
- Evaluate and validate encounter data completeness for risk adjustment purposes.

3. Risk Adjustments

The Department pays risk bearing Medicaid managed care entities a risk based per member per month (PMPM) payment utilizing the Adjusted Clinical Group (ACG) Case-Mix System by Johns Hopkins University or another risk adjustment method specified by the Department consistent with Medicaid managed care plan contracts. Plan specific scores are a function of its ACG distribution of enrollees multiplied by the relative weight.

The contractor will be responsible for:

- Developing initial individual risk scores based on the health of recipients using the diagnostic data captured within the relevant claims and encounter data.
- Developing plan risk scores based on the individual risk scores and enrollment data to assign members to the appropriate plan.
- Adjust the plan risk scores (as appropriate) to maintain budget neutrality and avoid double counting the risk already addressed through existing age/sex universal rates.
- Applying adjusted plan risk scores to develop risk-adjusted per member per month (PMPM) capitation rates for Medicaid managed care entities.
- Providing periodic updates of risk adjustments over time.
- Evaluating and validating encounter data completeness for risk adjustment purposes.
- Providing ongoing assistance in relation to risk adjustment, including agreed upon reports between LDH and Mercer.

4. Pay for Performance Plan

Assistance with evaluation and/or validation of the actuarial value of enhanced payments to providers and expanded benefits to members that may be proposed by prospective Medicaid managed care entities in response to the Request for Proposals for Medicaid managed care plans.

5. Fee Development

Develop fees as requested by LDH, engage stakeholders regarding the development of such fees, and assist LDH in the implementation, budgeting, and monitoring or such fees as requested by LDH. Fees may include, but not be limited to, development of Diagnostic Resource Groups (DRGs) for hospital inpatient fees.

6. Waivers and Federal Reporting

Assist LDH in the development, submission, renewal and financial projections related to federal waivers for new and existing programs as requested by LDH. Such work may include support for the capitated dental program and managed care/utilization management/prior authorization for other services such as Medicaid radiology, laboratory and durable medical equipment services.

7. Procurement

Assist LDH in the development of Requests for Proposals (RFPs), data books, contracts, fees, capitation rates and budget projections for new programs and re-procurement of existing programs.

8. Alternative Payment Models, Value Based Purchasing, Accountable Care Organizations and Delivery System Models

Assist LDH in the design, development, implementation and monitoring of alternative payment arrangements and service delivery systems as requested. Such activities may include data analysis, data monitoring, rate development and other tasks associated with such initiatives.

9. Reports

- Provide LDH with reports, data sets, analysis, and documents relevant to the rate setting process and calculations in the format(s) specified by LDH. The Contractor shall provide all documents and data in the electronic media format(s) designated by LDH, and the Contractor shall be required to accept and be able to process electronic documents and files in the electronic media format(s) by LDH.
- Provide complete explanations of all calculations as requested by LDH and provide all formulas to LDH as requested.
- Provide reports outlining how rate development complies with the CMS Medicaid Managed Care Rate Setting Checklist and that reflect the necessary costs associated with meeting requirements in technical and general areas.
- Provide personnel and documentation of formulas and methodologies to document and explain challenges by CMS or other parties relative to the matters herein contracted.
- Provide rate certification letters and benchmark letters and related documents as prescribed by LDH to be submitted to CMS for approval.
- Provide risk adjustment scores and related documents as prescribed by LDH to be used to adjust capitation rates.
- Respond timely to *ad hoc* data requests.
- Provide all data, program and regulatory analysis requested by LDH.
- Prepare quarterly and annual Medicaid managed care plan financial reports for review by LDH as requested.
- All reports should be submitted within timeframes agreed upon by LDH and the Contractor.

10. Participation in Meetings and Work Groups

- Participate in periodic meetings with LDH staff throughout each capitation rate cycle to discuss the parameters, priorities, methodology, and ongoing results of capitation

rate development in each rate cycle. Provide documents and data, as directed by LDH to discuss at these meetings.

- Participate in meetings with LDH, legislative committees and CMS representatives as requested. Meetings may be scheduled on very short notice.
- Participate in meetings with Medicaid managed care entities, provider groups and other concerned parties as requested by LDH.

11. Technical, Clinical and Policy Assistance

Perform technical, clinical and policy assistance and ongoing support of Medicaid managed care initiatives and the Louisiana Medicaid fee-for-service program. This may include but is not limited to assistance with *ad hoc* requests, interpretation of new federal regulations, preparation of waiver and state plan amendments in accordance with CMS and federal policy requirements, and other assistance as requested by LDH.

12. Turnover

At the end of the contract period, work cooperatively with LDH and any of their contracting organizations to develop and successfully implement a plan to turn over all non-proprietary data, methodologies, documentation, and ongoing projects to the succeeding contracting organization, vendor, or firm. The turnover plan must be delivered to LDH 90 days prior to the scheduled termination date of the contract unless LDH advises otherwise.

13. Actuarial Personnel

The Contractor must have available at least two actuaries and a data analyst on staff that are able to provide the following services:

- The principle actuary must be a Fellow in the Society of Actuaries (FSA) and a Member of the American Academy of Actuaries (MAAA) with proven experience with a Medicaid and/or CHIP program.
- One actuary must be either an ASA or FSA and MAAA and have proven experience with a Medicaid/or CHIP program.
- Non-actuaries must work under the supervision of the principle actuary to perform actuarial work.
- At least one actuary must be available either in person or by phone within four hours every Monday through Friday between the hours of 7:30 AM and 5:00 PM CT to discuss actuarial matters and work on pressing issues.
- At least one actuary must be available in person, within 72 hours, seven days a week during any State Legislative Session to discuss and testify on actuarial matters and work on pressing issues.
- As requested by LDH, provide resumes for all key personnel, including the project manager, who will be involved in providing the services of this contract. The resumes must include: name, education, and years of experience and employment history.
- Provide the name and qualifications of any subcontractor who will be involved with this contract. Describe the work and estimate the percentage of total work the subcontractor will be performing.

Performance Measure

The contractor will submit detailed monthly invoices due on the 25th of each month documenting the activities performed and the status of outstanding deliverables.

Monitoring Plan

The LDH contract monitor will:

1. Be available for consultation by phone, e-mail, and face-to-face meetings to discuss priorities and provide direction;
2. Meet with the contractor on a weekly basis, if needed, by telephone to ensure that work toward the completion of deliverables is being accomplished; and
3. Review and approve monthly detailed invoices.

Actuarial Errors, Corrective Action Plans, & Monetary Penalties

In the event of an actuarial error in a final deliverable, the Contractor shall provide written notice of the error to LDH. The notice shall include a detailed description of the error, including its scope and severity.

The Contractor agrees to correct actuarial errors at its own expense and without significant delay to the schedule for Contract deliverables. The Contractor shall not bill nor will LDH pay for the cost of correcting actuarial errors.

In the event of an actuarial error significant enough to require revision of a major deliverable, such as capitated rate certification or risk adjustment, LDH may require submission of a corrective action plan and may assess monetary penalties as defined below.

The purpose of establishing and imposing monetary penalties is to provide a means for LDH to obtain the services and level of performance required for successful operation of the Contract.

The decision to impose monetary penalties may include consideration of some or all of the following factors:

- The duration of the violation;
- Whether the error (or one that is substantially similar) has previously occurred;
- The Contractor's history of errors;
- The severity of the error;
- The "good faith" exercised by the Contractor in attempting to avoid errors.

If assessed, the penalties will be used to reduce LDH's payments to the Contractor or if the penalties exceed amounts due from LDH, the Contractor will be required to make cash payments to LDH for the amount in excess.

For each occurrence of a significant actuarial error, the Contractor may be liable to LDH for monetary penalties in an amount as specified in the table below. Monetary penalties escalate by occurrence over the term of this Contract.

Occurrence	Penalty Per Occurrence
1-2	$25,000
3-4	$50,000
5 and beyond	$75,000

Excessive actuarial errors may result in termination of the contract.

Terms of Payment

This is a fixed price contract to be paid in accordance with the following rates:

Position	Year 1	Year 2	Year 3
Principal/Partner	$ 450	$ 459	$ 468
Senior Consultant/Actuary/Project Manager/Project Coordinator	$ 395	$ 403	$ 411
Clinician	$ 375	$ 383	$ 391
Senior Associate	$ 335	$ 342	$ 349
Associate	$ 300	$ 306	$ 312
Analyst	$ 235	$ 240	$ 245
Program/Payment Analysis Subcontractor - Lead	$ 300	$ 306	$ 312

Program/Payment Analysis Subcontractor - Analyst	$ 275	$ 281	$ 287
Policy/Program Design Subcontractor - Lead	$ 300	$ 306	$ 312
Policy/Program Design Subcontractor - Analyst	$ 200	$ 204	$ 208
Administrative Support	$ 90	$ 92	$ 94

Itemized invoices containing the tasks, deliverables completed, hours worked, and the personnel that performed the work shall be submitted to LDH by the 25th of the month following the month in which the work was performed. LDH will notify contractor in advance when invoices are required prior to the 25th.

The term of this contract is for a period of 3 years. With all proper approvals and concurrence with the successful contractor, agency may also exercise an option to extend for up to twenty-four (24) additional months at the same rates, terms and conditions of the initial contract term. Subsequent to the extension of the contract beyond the initial 36 month term, prior approval by the Joint Legislative Committee on the Budget (JLCB) or other approval authorized by law shall be obtained. Such written evidence of JLCB approval shall be submitted, along with the contract amendment to the Office of State Procurement (OSP) to extend contract terms beyond the initial 3 year term. No contract/amendment shall be valid, nor shall the state be bound by the contract/amendment, until it has first been executed by the head of the using agency, or his designee, the contractor and has been approved in writing by the director of the Office of State Procurement. Total contract term, with extensions, shall not exceed five (5) years.

The continuation of this contract is contingent upon the appropriation of funds by the legislature to fulfill the requirements of the contract.

Additional Provisions

The following terms and conditions replace the struck-through text on pages 2-4 of the CF-1.

2. **Confidentiality:** Contractor shall abide by the laws and regulations concerning confidentially which safeguard information and the patient/client confidentiality. Information obtained shall not be used in any manner except as necessary for the proper discharge of Contractor's obligations. The Department hereby approves the confidentiality rules and facility access procedures of the Contractor.

3. **Auditors:** The State Legislative Auditor, Office of the Governor, Division of Administration, and Department Auditors or those designated by the Department shall have the option of auditing during normal working hours all books and records directly pertaining to the services rendered under this contract during the contract and for a five year period following final payment upon reasonable prior written notice to the Contractor. Contractor grants to the State of Louisiana, through the Office of the Legislative Auditor.

Louisiana Department of Health, and Inspector General's Office, Federal Government and/or other such officially designated body the right to inspect and review all books and records directly pertaining to services rendered under this contract, and further agrees to guidelines for fiscal administration as may be promulgated by the Department. Records will be made available during normal working hours.

Contractor shall comply with federal and state laws and/or LDH Policy requiring an audit of the Contractor's operation as a whole or of specific program activities. Audit reports shall be sent within thirty (30) days after the completion of the audit, but no later than six (6) months after the end of the audit period. If an audit is performed within the contract period, for any period, four (4) copies of the audit report shall be sent to the Louisiana Department of Health, Attention: **Division of Fiscal Management, P.O. Box 91117, Baton Rouge, LA 70821-3797** and one (1) copy of the audit shall be sent to the **originating LDH Office**.

4. **Record Retention:** Contractor agrees to retain all books, records and other documents relevant to the contract and funds expended thereunder for at least four (4) years after final payment or as prescribed in 45 CFR 74:53 (b) whichever is longer. Contractor shall make available to the Department such records within thirty (30) days of the Department's written request and shall deliver such records or copies thereof to the Department's central office in Baton Rouge, Louisiana, all without expense to the Department. Contractor shall allow the Department to inspect, audit or copy records at the contractor's site, without expense to the Department upon reasonable prior written notice to the Contractor.

5. **Record Ownership:** All records, reports, documents and other material delivered or transmitted to Contractor by the Department shall remain the property of the Department, and shall be returned by Contractor to the Department, at Contractor's expense, at termination or expiration of this contract. All records, reports, documents, or other material related to this contract obtained or prepared specifically and exclusively for the Department by Contractor in connection with the performance of the services contracted for herein shall become the property of the Department, and shall, upon request, be returned by Contractor to the Department, at Contractor's expense, at termination or expiration of this contract. Notwithstanding anything to the contrary in this contract, but subject to confidentiality obligations herein, Contractor may (i) retain copies of the Department's materials that is required to be retained by law or regulation, (ii) retain copies of its work product that contain the Department's materials for archival purposes or to defend its work product and (iii) in accordance with legal, disaster recovery and records retention requirements, store such copies and derivative works in an archival format (e.g. tape backups), which may not be returned or destroyed upon the Department's request and/or at termination or expiration of this contract.

8. **Insurance:** Contractor shall obtain and maintain during the contract term all necessary insurance including automobile insurance, workers' compensation insurance, and general liability insurance. The required insurances shall protect the Contractor, the Louisiana Department of Health, and the State of Louisiana from claims related to Contractor's performance of this contract. Certificates of Insurance shall be filed with the Department for approval. Said policies shall not be canceled, permitted to expire, or be changed without thirty (30) days advance written notice to the Department. Commercial General Liability Insurance shall provide protection during the performance of work covered by the contract from claims or damages for personal injury, including accidental death, as well as claims for property damages, with combined single limits prescribed by the Department in this attachment.

12. **Ownership of Proprietary Data:** All non-third party software and source code, records, reports, documents and other material delivered or transmitted to Contractor by State shall remain the property of State, and shall be returned by Contractor to State, at Contractor's expense, at termination or expiration of this contract. All non-third party software and source code, records, reports, documents, or other material related to this contract and/or obtained or prepared specifically and exclusively for the Department by Contractor in connection with the performance of the services contracted for herein shall become the property of State, and shall be returned by Contractor to State, at Contractor's expense, at termination or expiration of this contract.

15. **Unauthorized Services:** No claim for services furnished or requested for reimbursement by Contractor, not provided for in this contract, shall be allowed by the Department. In the event the Department reasonably determines that certain costs which have been reimbursed to Contractor pursuant to this or previous contracts are not allowable, the Department shall have the right to set off and withhold said amounts from any amount due the Contractor under this contract for costs that are allowable.

19. **Non-Infringement:** Contractor will warrant all materials, products and/or services produced hereunder will not infringe upon or violate any patent, copyright, trade secret, or other proprietary right of any third party. In the event of any such claim by any third party against LDH, the Department shall promptly notify Contractor in writing and Contractor shall defend such claim in LDH's name, but at Contractor's expense and shall indemnify and hold harmless LDH against any loss, expense or liability arising out of such claim, whether or not such claim is successful. This provision is not applicable to contracts with physicians, psychiatrists, psychologists or other allied health providers solely for medical services. This provision is subject to the additional provisions contained in this attachment.
20. Deleted.

21. **Indemnity:** Contractor agrees to protect, indemnify and hold harmless the State of Louisiana, LDH, from all claims for damages, costs, expenses and reasonable attorney fees arising in breach of contract or tort from this contract or arising from any negligent acts or omissions of Contractor's agents, employees, officers or subcontractors, if any, in its performance of services hereunder. This provision does not apply to actions or omissions for which R.S. 40:1237.1 et seq. provides malpractice coverage to the Contractor, nor claims related to treatment and performance of evaluations of persons when such persons cause harm to third parties (R.S. 13:5108.1(E)). Further, it does not apply to premises liability when the services are being performed on premises owned and operated by LDH.

The Contractor’s indemnity obligations shall not apply to any claim for infringement or misappropriation of intellectual property rights to the extent that any such infringement or misappropriation is caused by: (i) information or materials provided by the Department, (ii) modifications made by the Department or a third party other than Contractor or Contractor’s subcontractors to services, work product or other materials provided to the Department in connection with the services or any parts thereof, or (iii) Department’s use of the services, work product or such other materials or any parts thereof, in a manner inconsistent with terms of the contract.

22. **Severability**: Any provision of this contract is severable if that provision is in violation of the laws of the State of Louisiana or the United States, or becomes inoperative due to changes in State and Federal law, or applicable State or Federal regulations.

It is the intent of the parties hereto that the provisions of this contract shall be enforced to the fullest extent permitted by applicable law. To the extent that the terms set forth herein are found to be illegal or unenforceable by a court of law for any reason, such term shall be modified, deleted or interpreted in such a manner so as to afford the party for whose benefit it was intended the fullest benefit commensurate with making this contract, as modified, enforceable and the other terms of this contact shall not be affected thereby. The parties agree to enter into an amendment of the contract as necessary to effect the ruling of the court.

27. **Contractor's Cooperation**: The Contractor has the duty to reasonably cooperate with the State and provide any and all requested information, documentation, etc. directly pertaining to the services provided under this contract to the state when requested provided Contractor still maintains such information and is not legally restricted or subject to confidentiality obligations. This applies even if this Contract is terminated and/or a lawsuit is filed. Specifically, the Contractor shall not limit or impede the State's right to audit or shall not withhold State owned documents.

31. **Termination for Convenience**: The Department may terminate this Contract at any time by giving thirty (30) days written notice to the Contractor. The Contractor shall be entitled to payment for deliverables in progress, to the extent work has been performed in accordance with the terms of the contract.

33. Deleted.

The following terms and conditions are in addition to the provisions ending on page 4 of the CF-1.

34. **Ownership and Use of Work; Intellectual Property:**

A. Only materials prepared by Contractor specifically and exclusively for the State pursuant to this contract (the "Work") shall be owned exclusively by the State. Notwithstanding anything to the contrary set forth in this contract, Contractor will retain all copyright, patent and other intellectual property rights in the methodologies, methods of analysis, ideas, concepts, know-how, models, tools, techniques, skills, knowledge and experience owned or possessed by Contractor before the commencement of, or developed or acquired by Contractor after, the performance of the services, including without limitation, all such systems, software, specifications, documentation and other materials created, owned or licensed and used by Contractor or its affiliates or subcontractors in the course of providing the services (the "Intellectual Property"). To the extent any Work incorporates any Intellectual Property, Contractor hereby grants the State a non-exclusive, royalty-free, non-transferable right to use such Intellectual Property in accordance with the terms of this contract.

B. The State shall be responsible for, and Contractor shall have no liability with respect to, (a) modifications made by any person other than Contractor (or third parties under the control of Contractor) to the Work, Intellectual Property or other work product provided to the State by Contractor or (b) any use of any Work or Intellectual Property or other material supplied by Contractor under this contract in a manner other than as mutually contemplated when Contractor was first retained to perform the applicable services.

35. **Limitation of Liability:**

A. The aggregate liability of Contractor, its affiliates and any officer, director or employee of Contractor and its affiliates ("Contractor Parties") to the State, the Department, its affiliates, its officers or employees or those of its affiliates for any and all Losses arising out of or relating to the provision of any services at any time by any of the Contractor Parties shall not exceed, the greater of, three times the compensation for the services giving rise to such Loss, or five million dollars. Contractor shall have no liability for the acts or omissions of any third party other than its affiliates or subcontractors.

B. In no event shall either party or its affiliates be liable in connection with this contract or the services to the other party, its affiliates or any third party for any loss of profit or incidental, consequential, special, indirect, unitive or similar damages.

C. For purposes of this contract "Loss" means damages, claims, liabilities, losses, awards, judgments, penalties, third party claims, interest, costs and expenses, including reasonable attorneys' fees, whether arising under any legal theory including, but not limited to claims sounding in tort (such as for negligence, misrepresentation or otherwise), contract (whether express or implied), by statute, or otherwise, claims seeking any kind of damages and claims seeking to apply any standard of liability such as negligence, statutory violation or otherwise

36. **Third Party Beneficiaries:**

Neither the contract nor the provision of the services is intended to confer any right or benefit on any third party.

37. **The Department's Information:**

In performing the services, Contractor will use all information supplied by the Department without having independently verified the same, and the Contractor assumes no responsibility for the accuracy or completeness of such information.

38. **Involvement in Third Party Disputes:**

In a dispute between the Department and a third party, for which the Contractor's potential fault is not an issue, the Department may request services of the Contractor at the hourly rates set forth in the Contract for such additional services.

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LaGOV PO# 2000255086
Exhibit 1

Patty Anderson, MBA

QUALIFICATIONS

Patty combines her organizational, communication and leadership skills to help effectively manage multiple projects for Mercer Medicaid clients. She has worked on several state clients including Connecticut, Louisiana, Massachusetts, and New York.

EXPERIENCE

Prior to joining Mercer, Patty worked for Blue Cross Blue Shield of Arizona for five years as an actuarial analyst.

In her role as Government Consultant, Patty's accomplishments include:

- Managing the Massachusetts Primary Care Payment reform project, including client and provider communications, quarterly rate setting, risk adjustment, shared savings calculations, care management and policy.
- Managing, coordinating and facilitating client and internal communication for several client teams, including Massachusetts Behavioral Health Program (MBHP), Massachusetts Primary Care Payment reform (PCPR), Massachusetts Senior Care Options and One Care programs, as well as Louisiana risk adjustment.
- Coordinating and writing final reports of findings and recommendations for several projects, including the Massachusetts PCPR, SCO and One Care projects.
- Presenting final findings and recommendations to State Agencies, Health Plans, providers and other state vendors for several clients, including Massachusetts and Louisiana.
- Providing high level consultant review of the rate setting process for several clients, including Massachusetts.
- Reviewing risk adjustment results and final risk adjusted rates for Louisiana.
- Analyzing claims, utilization and other health care data to inform the rate-setting process on several clients, including SCO, OneCare, MBHP and PCPR.
- Managing internal project activities and deadlines for several clients.

Patty Anderson, MBA
Government Consultant

EDUCATION
Master's Degree, Business Administration
Arizona State University

Bachelor's Degree, Mathematics
Arizona State University

EXPERIENCE
12 years
professional experience

CORE COMPETENCIES
Alternative payment methodologies
Long term care policy and rate setting
Behavioral health rate setting
Project management
Risk adjustment
Data analysis

MERCER

Andy Rulis

Role: Associate

Overview

Andy is an Associate in Mercer's Government Human Services Consulting group, a part of Mercer Health & Benefits LLC (Mercer) in the Atlanta office. He has been a team member for the client states of Louisiana, Massachusetts, North Carolina, Delaware, Oklahoma, and Alabama. His current responsibilities include, but are not limited to, assisting the actuarial team in claims analysis, data book preparation, IBNR modeling, and rate setting.

Experience/Accomplishments

At Mercer, Andy's present duties include, but are not limited to:

- Collection, analysis and interpretation of health care data including fee-for-service (FFS), financial, and encounter data in the states of Louisiana and Massachusetts.
- Developing physical health, specialized behavioral health, and NEMT service capitation rates.
- Estimating future plan costs and developing budget models. Specifically, Andy has worked on budget models in the states of Louisiana and North Carolina.
- Calculating claims completion factors and trends for Medicaid rate setting projects in Louisiana and Massachusetts.
- Building data books and rate setting models to meet individual Medicaid program needs in Louisiana and Massachusetts.
- Setting financial benchmarks for Medicaid services and determining savings under a Shared Savings program.
- Comparing, re-pricing, and estimating the impact of services on the Medicare or Medicaid fee schedules. Specifically, Andy has worked on the implementation of the Affordable Care Act (ACA) Section 1202 Primary Care Physician (PCP) fee increase in the state of Louisiana.
- Calculating the enhanced Federal match for Family Planning services in Louisiana and Massachusetts.

Education

- Bachelor's degree in Business Administration in Risk Management and Insurance, University of Georgia.
- Successfully completed five of the Preliminary Actuarial Exams in the pursuit of a Fellow of the Society of Actuaries designation.

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Duane Angulo, PharmD, JD

QUALIFICATIONS

Duane utilizes his numerous years' experience in Medicaid to assist Medicaid clients in evaluating drug expenditures, program efficiencies and benefit design. The combination of his Medicaid Managed Care Organization and pharmacy benefit management experience allows him to provide clients perspectives from a MCO point-of-view. He and the pharmacy team work closely with their state clients, growing the relationship to that of a trusted advisor, forming a true partnership to complement their current staff.

EXPERIENCE

Prior to joining Mercer, Duane was the Director of Pharmacy for an Arizona Medicaid Managed Care Organization for over five years. His responsibilities included operations and budget for the pharmacy benefit, preferred drug list management, prior authorization review, analytics and data management. He represented the company as a member of the State's Pharmacy and Therapeutics Committee.

Prior to his role as Director of Pharmacy, Duane served as Director of Pharmacy for five years for a company that provides home respiratory services and certain medical equipment, including oxygen therapy, nebulized inhalation therapies, and sleep apnea treatment. His duties included management of the mail order pharmacy, customer service, and billing departments.

Duane's extensive experience includes:

- Working with various state Medicaid programs in the development of pharmacy trend including a thorough review of traditional and specialty therapeutic classes.
- Ongoing monitoring of new drug therapies, new generic products to market and new indications for medication already in market.
- Pharmacy benefit design development and cost and utilization management.
- Extensive knowledge of Medicare Part B & D medication guidelines, Part B & D coordination of pharmacy benefits billing, and Special Needs Pharmacy Plan (D-SNP).
- Analyzing pharmacy carve in/out considerations for Medicaid agencies.
- Long Term Care Medicaid Managed Care Organization.
- Managed care oversight.

Duane Angulo, PharmD, JD
Principal

EDUCATION

Doctor of Pharmacy
University of Arizona

Juris Doctor degree
Sandra Day O'Connor College of Law

EXPERIENCE

23 years
professional experience

CORE COMPETENCIES

Data analysis plans
Program evaluation
Project management
Vulnerable populations
Evaluation, plan development and implementation
Policy implementation analysis
Pharmacy trend
PBM and MCO extensive knowledge

AFFILIATIONS

Licensed Pharmacist, Arizona

Member, Academy of Managed Care Pharmacy

- Evaluating policy considerations.
- Pharmacy Benefit Management (PBM) experience.
- Sales and Account Management.
- Development of pharmacy efficiency analyses.
- Prescription Drug List (PDL) development.
- Prior authorization process development and review.
- Pharmacy and Therapeutics (P&T) Committee oversight
- Acute Care Medicaid Managed Care Organization.

Accomplishments:

- Full compliance with Medicaid Agency during his five plus year tenure as Director of Pharmacy for an Arizona Medicaid Managed Care Organization.
- Assisting with development of statewide Minimum Required Prescription Drug List (MRPDL) for all Medicaid Managed Care Organization's to incorporate as part of their (PDL).
- Developing adherence program which increased the overall compliance percentage to over 85% for members taking nebulized respiratory.
- Developing electronic prior authorization program for the largest client of a pharmacy benefit management company which reduced review process from seven to 10 business days to two to three business days which improved member and provider satisfaction.

MERCER
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Scott Banken, CPA

QUALIFICATIONS

Scott's experience is in managing finance teams in both national and regional Managed Care Organizations (MCOs), with both Medicare and Medicaid experience. This experience allows him to understand different strategies for financial management of capitation rate plans, risk-sharing and risk corridor negotiation, benefit management, and interventions to maximize efficiency and minimize costs.

He has experience working with clients on innovation design and testing plans to improve the quality, customer satisfaction, and efficiency of their Medicaid programs. In addition, Scott brings expertise in oversight plan design and financial systems development to create efficient, auditable reporting solutions for financial, regulatory and operational reporting. He also has experience developing and administering templates for cost-based rates such as prospective payment system (PPS) rates and pharmacy cost-of-dispensing (COD) rates.

EXPERIENCE

Prior to joining Mercer, Scott managed finance departments for national and regional managed-care organizations for over ten years where he was responsible for oversight of Medicare and Medicaid financial operations.

Scott Banken, CPA
Senior Associate

EDUCATION

Master's degree, Business Administration
Informational Technology
University of Minnesota
Carlson School of Management

Bachelor's degree, Accounting
University of St. Thomas

EXPERIENCE

23 years of professional experience

CORE COMPETENCIES

Accounting
Financial reporting
Value-based payments
Program integrity
Prospective payment system rates
Pharmacy cost-of-dispensing surveys

AFFILIATIONS

Certified Public Accountant (CPA)
Member, Minnesota Society of CPAs
Associate member, Association of Certified Fraud Examiners

Scott's experience includes:

- Developing cost report templates, instructions, and technical assistance webinars for prospective payment system rate development for Certified Community Behavioral Health Centers.
- Developing and administering pharmacy COD surveys to help states implement Actual Acquisition Cost (AAC) pricing for Medicaid reimbursement.
- Working in conjunction with Actuarial teams to develop models for Medicaid rates and Medicare bids for special needs populations, including seniors and disabled.
- Participating in annual reviews of finance and program integrity operations for physical and behavioral health managed care organizations to identify deficiencies and best practices related to financial management, internal controls, organizational structure, and reporting.
- Participated with pricing teams for Medicare products to ensure viability, including 1915(c) waiver products for elderly waiver and waiver for disabled individuals.
- Managing CMS audits for Medicare Advantage with Part D (MAPD) contracts. Working with Actuarial teams to ensure compliance in the Medicare bid process.

- Managing the Medicare and Medicaid financial operations of a non-profit MCO, including regulatory reporting for National Association of Insurance Commissioners (NAIC) filings, Medicaid program financial results and Department of Commerce filings.
- Developing financial models to measure impact of risk adjustment from diagnosis level to risk adjustment score and resulting risk adjustment payment improvement.
- Negotiating value-based contracts with providers around Medicaid and Dual-Eligible member programs to improve levels of care and manage risk.
- Reviewing encounter data submission systems and processes to increase accuracy and completeness.
- Establishing criteria for, administering, and reporting on health plan readiness for Medicaid managed care.
- Facilitating multi-payer workgroups to build consensus and develop alternatives to fee-for-service that incent outcomes rather than volume for state innovation model grant recipients.
- Developing actionable reports for care coordinators and nurse practitioners to reduce improper or ineligible services and identify revenue opportunities for eligible members.

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Denise Blank

QUALIFICATIONS

Denise specializes in the design and application of risk adjustment concepts to capitation rate development and clinical support activities. Denise has worked directly with the stakeholders to successfully implement and apply risk adjustment concepts including the evaluation of available risk adjustment models, risk adjustment application design/review, development of cost weights, and sufficiency determination of the encounter data. Risk adjustment has been growing in the marketplace over the last decade, and Mercer has implemented about half of these programs within Medicaid. Denise's work in the risk adjustment field covers fifteen Medicaid programs. Currently Denise supports the risk adjustment programs in Delaware, Louisiana, New York and Pennsylvania.

Denise Blank
Principal

EDUCATION
Bachelor's degree, Actuarial Science and Economics
Eastern Michigan University

EXPERIENCE
21 *years professional experience*

CORE COMPETENCIES
Risk adjustment modeling
Project management
Statistical methods and analysis
Encounter data evaluation
Capitation rate development

In addition to her risk adjustment consulting, Denise manages numerous complex engagements with state Medicaid clients. In this role, she works closely with Mercer's client relationship manager, the state's contract management, and all internal and external resources to ensure that the project is on time and on budget to reach the clients' end goal. Her strength is her ability to see the big picture of the project and how all of the pieces fold together. Denise's work in this area was primarily focused in Delaware, Ohio, and New York.

EXPERIENCE

Denise's specific experience includes:

- Consulting on uses of risk assessment models including capitation rate adjustment, bid evaluation, provider profiling, and targeting recipients for intervention activities for Arizona, California, Delaware, District of Columbia, Florida, Louisiana, Massachusetts, New Jersey, New Mexico, New York, Ohio, Oklahoma, and Pennsylvania.
- Evaluating of eligibility, encounter, and fee-for-service claims data to support various financial initiatives including risk assessment, rate development, quality measurements, and other management activities Delaware, Florida, Louisiana, New York, Ohio, Oklahoma, and Pennsylvania.
- Leading project teams that support various Medicaid initiatives, including capitation rate development, cost effectiveness evaluations, cost driver analyses, risk assessments and reviews of health plan encounter operations.
- Creating a risk adjusted rates implementation strategy for Delaware, Florida, Louisiana, New Jersey, New York, Missouri, Ohio, Oklahoma, and Pennsylvania.

- Providing independent evaluation of risk-adjustment methodologies used in Colorado, Massachusetts, and Oregon along with Minnesota's encounter data to support future risk-adjustment model updates.
- Assessing health plan operations from management oversight, provider relations, claims systems, and encounter report to determine areas of potential data loss that could adversely impact risk adjustment and other encounter-based analyses. This work for Pennsylvania has been leveraged to create surveys and provide technical assistance for multiple clients.
- Developing a long term care risk-adjustment model in conjunction with the State of New York Department of Health.
- Consulting on Medicaid managed care initiatives including numerous health areas for consideration to legislative and political challenges from strategic and technical perspectives in Delaware, Ohio, and New York.
- Providing technical assistance to state staff, health plans, and other stakeholders, including on-site presentations and answering submitted questions on a variety of topics including data issues, risk-adjustment and rate setting methods for Arizona, Delaware, District of Columbia, Florida, Louisiana, New Jersey, New York, Ohio, Oklahoma, and Pennsylvania.
- Developing actuarially-sound capitation rates and evaluating impact of waiver programs for various models, benefits, and populations for Delaware, Ohio, Maine, New Jersey, and New York.
- Developing capitation rates for Medicaid expansion programs, leveraging available experience, surveys and census data for Delaware, Ohio, and Louisiana.
- Collecting detail-level encounters directly from health plans to support risk adjustment, rate-setting and other management activities for Pennsylvania and New York.
- Developing and updating financial reporting guidelines to collect the necessary information to support future rate development and plan monitoring for Delaware and Ohio.
- Creating a series of financial dashboard reports for Ohio leadership to monitor plan performance and encounter dashboard reports for New York leadership to monitor the quality and quantity of data submissions.
- Evaluating reimbursement strategies to address the unique aspects of individuals at risk of institutionalization, including condition-specific rates and risk-adjustment techniques for County of San Diego, Contra Costa Health Plan, and Ohio.
- Leading overall activities for the actuarial contract for Delaware and Ohio, which includes rate development, financial reporting, encounter/claim data summarization and other analyses.
- Participating on Mercer's bid review team for the Medicare Advantage (Part C and Part D) bid submissions.
- Evaluating the cost savings achieved for a pediatric Accountable Care Organization using available Medicaid data that the Medicaid Director authorized for the study.

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PUBLICATIONS AND PUBLIC FORUM PRESENTATIONS

- Society of Actuaries 2015 Annual Meeting; Risk Adjusters in Medicaid; Making Your Data Work for You Turning Risk Assessment Results into Meaningful Information; October 13, 2015

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Robert Butler

QUALIFICATIONS

Robert is a long-term care (LTC) specialist. His experience encompasses both Medicaid and the private sector, with an emphasis on nursing facilities. Robert has been involved in LTC services his entire Medicaid career and can help clients in all aspects of LTC.

Robert often leads client engagements in addition to providing specialized consulting in LTC. In this capacity, he is responsible for bringing all of Mercer's resources together for the most comprehensive and effective outcome. He is a team leader for Louisiana, and has worked with the Mercer team to help the state design and implement its Medicaid managed care program, to integrate behavioral health services into its main managed care program, and to assist the state in evaluating a managed long-term services and support program (MLTSS). He has work on the Pennsylvania team in the development of home and community based services (HCBS) fee-for-service (FFS) rate development. As leader of a specific Ohio project, he helped the state with the development of a new level of care (LOC) assessment tool for children and adults.

Robert Butler
Principal

EDUCATION
Bachelor's degree, Accounting
Florida State University

EXPERIENCE
22 years
professional experience

CORE COMPETENCIES
Understanding client needs
Designing and implementing managed care programs, including MLTSS
Determining FFS rates and service definitions
Determining nursing facility rates and payment methodologies
Managing projects

EXPERIENCE

Prior to joining Mercer, Robert served the State of Florida by managing fiscal projections for the state Medicaid program, institutional rate development and managed care rate development. His consulting career began with consulting for preparation of nursing home Medicaid cost reports. He also has operational experience through his experience working for a managed care plan and a nursing facility operator.

His experience and accomplishments include:

- Helping Ohio update its Nursing Facility Level of Care Assessment tools, including the creation of a tool specifically for children.
- Assisting in the development and design of a managed long-term services and supports program for Louisiana.
- Helping Louisiana design and implement its first Medicaid managed care program for physical health, and recently assisting the state in integrating behavioral health.
- Assisting in rate development for home and community based services in Pennsylvania.
- Guiding stakeholder discussions for Connecticut nursing home right-sizing strategic planning.
- Completing desk reviews of CMS Medicare Advantage bids.

- Developing and planning transformation of the Louisiana Medicaid program through managed care, including policies, rates and MMIS systems.
- Developing fees and rates for multiple Medicaid programs, including federally qualified health clinics and psychiatric residential treatment facilities for children in Washington and Nebraska.
- Lead Medicaid stakeholder and provider meetings in Pennsylvania, and training on reporting requirements.
- Developing and negotiating the Florida Medicaid Reform 1115 Waiver.
- Managing the preparation of Florida Medicaid rates for hospitals, nursing homes, facilities for the developmentally disabled and other institutional providers.
- Managing and implementation of Florida managed care rates for Medicaid MCOs, Nursing Home Diversion Programs and Prepaid Mental Health Plans.
- Reviewing and managing financial projections for multiple federal waivers, including those related to home and community based services and managed care programs.
- Managing Florida's program auditing institutional provider cost reports.
- Reviewing and managing Medicaid caseload and program expenditure projections for the Florida Medicaid state budget.
- Assisting with the development and management of Florida's Medicaid Disproportionate Share Program and Low Income Pool.
- Consulting and preparing nursing home costs reports for Florida facilities.
- Preparing financial projections for Florida regulatory filings for long-term care facilities, including certificates of need.
- Reviewing and analyzing managed care rates and related methodologies.
- Promoting integration of Medicaid and Medicare services through coordinated rate development for Medicare Special Needs Plans (SNPs).

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Lisa deVries, RPh

QUALIFICATIONS

Lisa combines her experience in Medicaid and retail pharmacy to evaluate and assist Mercer Medicaid clients on management of the pharmacy benefit. As a licensed pharmacist, her work experience includes pharmacy benefit management positions serving both government and commercial insurance claims processing.

EXPERIENCE

Prior to joining Mercer, Lisa worked for the State of Nebraska Department of Health and Human Services. During this time she had several roles beginning with oversight of the operational aspects of the pharmacy program which included liaising between the PBM and MMIS. Eventually, as the Pharmacy program administrator her responsibilities encompassed contract management, drug rebate and policy development. Prior to that, Lisa worked for ACS/Xerox as the Clinical Account Manager for Nebraska. In her role as Director of Benefit Design at Prime Therapeutics she was responsible for new client implementation as well as ongoing maintenance of benefit design operations.

Examples of Lisa's experience and accomplishments include:

- Serving as pharmacy subject matter expert within the Department for technical initiatives related to pharmacy claims.
- Designing, implementing and evaluating next generation in- house drug rebate system.
- Designing and implementing physician administered drug rebate activities.
- Performing data analysis, clinical and financial evaluation, coupled with policy evaluation to develop management recommendations needed for compliance.
- Analyzing pharmacy expenses to identify inefficiency and operationalize changes for positive budget impact while minimizing provider and patient disruption.
- Analyzing physician administered drug billing inaccuracies and implementing changes to improve claims processing and rebate administration.
- Coordinate, document and implement benefit design changes for the Nebraska Medicaid pharmacy program on ACS/Xerox claim system.

Lisa deVries, RPh
Senior Associate

EDUCATION
Bachelor's degree, Pharmacy
University of Iowa

EXPERIENCE
31 years
professional experience

Former state Medicaid pharmacy program administrator

CORE COMPETENCIES
Pharmacy benefit management
Pharmacy claims processing
Medicaid drug rebates

AFFILIATIONS
Licensed pharmacist in Iowa and Nebraska

Nebraska Pharmacists Association (NPA)

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Joseph Dobberke, MBA

QUALIFICATIONS

Joe joined Mercer Health & Benefits LLC in the Minneapolis office as a senior associate in 2016. Joe has 10 years of experience working on teams in regional Managed Care Organizations (MCOs), with both Medicare and Medicaid experience, and managing teams in large retail pharmacy organizations.

EXPERIENCE

Joe's experience allows him to understand different strategies for financial management of capitation rate plans, risk-sharing and risk corridor negotiation, benefit management, and interventions to maximize efficiency and minimize costs.

Joe enjoys working with clients to improve the quality and efficiency of their Medicaid programs, specifically in the pharmacy and mental health arenas. Joe brings expertise in pharmacy acquisition and supply chain and creating efficient, auditable financial, regulatory and operational reporting.

Joe joined Mercer in April 2016. Current experience on Mercer projects includes:

- Desk review of cost reports, financial statements and other requested documents/analyses for Certified Community Behavioral Health Centers.
- Cost based rate setting through cost of dispensing surveys.
- Instruction creation for cost of dispensing surveys as well as review and edits of actual cost of dispensing surveys.
- State MCO regulatory reporting financial statement and modeling review.

Joe's experience prior to Mercer includes a three year stint with Target Corporation working on Target's pharmacy drug acquisition and distribution team as finance manager as well as six and a half years holding various positions with regional MCO's. Relevant experience from these positions includes:

- Pharmaceutical supply chain and drug acquisition financial analysis and reporting, including annual generic drug RFPs.
- Medicaid and Medicare plan financial reporting and analysis including dual eligible products, FFS products and Medicare cost plan.
- Management of the financial aspect (reporting, monitoring and analysis) of a large corporate acquisition (Target/CVS deal) and associated transition planning.
- Access database creation and modeling to enhance efficiency and accuracy around items like Medicare Plan-to-Plan pharmacy payment process and various financial reporting packages.
- Leading cross functional teams on various projects such as reimagining and implementing a new financial forecasting process.

Joseph Dobberke, MBA
Senior Consultant

EDUCATION

Bachelor's degree in Finance and Economics
University of Minnesota – Carlson School of Management

Master's degree of Business Administration (emphasis in Strategic Management)
University of Minnesota – Carlson School of Management

EXPERIENCE

10 years professional experience

CORE COMPETENCIES

PBM extensive knowledge
Pharmaceutical supply chain and drug acquisition
Financial analysis
Reporting
Project management
Evaluation, plan development and implementation

- Budgeting and forecasting of government health plans for MCOs as well as the pharmacy department at Target. This includes analysis, project management and presentation to upper management.

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ERIK AXELSEN, ASA, MAAA

Role: Supporting Actuary

Overview

Erik is a Senior Associate within the Government Human Services Consulting department, a part of Mercer Health & Benefits LLC (Mercer). Erik has been a supporting actuary working on Louisiana's programs covering physical health, pharmacy, dental, and behavioral health services. Erik has signed all the Bayou Health (including Expansion) and Dental rate certifications for the last two years. *He also has over 10 years of commercial experience supporting a large variety of actuarial functions. He was the signing actuary for multiple states for both 2014 and 2015 ACA rates in the Individual and Small Group markets. He also has expertise in rate reviews, reserving (IBNR), forecasting, etc. He has extensive experience working directly with underwriting, finance, sales, and corporate leadership. Erik joined Mercer in May 2015.*

Experience/Accomplishments

Some of Erik's accomplishments include:

- Developed Medicaid managed care capitation rates for acute care services, pharmacy, dental, and behavior health
- Prepared and signed ACA filings for Individual on/off-exchange and Small Group off-exchange for multiple states and legal entities for effective dates 2014 and 2015
- Responsible for strategy, pricing, IBNR, and forecasting (including budget) for multiple markets
- Managed teams of up to 6 actuaries to support markets owned
- Prepared and signed Actuarial Certifications, Opinions, and Filings
- Developed enhancements to Aetna tools during migration with Coventry

Education

- Bachelor's degree in Actuarial Science , University of Nebraska-Lincoln
- Associate of the Society of Actuaries, 2008
- Member of the American Academy of Actuaries, 2012

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Dianne Heffron, MBA

QUALIFICATIONS

Dianne has extensive experience in the development of Medicaid financing strategies and related program design. Of particular focus are state reimbursement strategies, emerging purchasing models, delivery system design and the development of section 1115 demonstrations. Most recently, Dianne is working with Arizona on an 1115 transformational incentive program and worked with California and the Teaching Hospitals of Texas on the renewal of the CA and TX 1115 demonstrations renewals. Dianne also worked with the National Governors Association supporting the Medicaid Transformation Policy Academy. The Policy Academy supports three states seeking 1115 demonstration approval. She has also worked with Louisiana, Missouri, New Jersey, New York, Oregon and Delaware on reimbursement and funding design in both fee-for-service and managed care environments. She has also worked on the primary care payment bump, disproportionate share hospital payment policy and emerging value based purchasing arrangement in Arkansas and Minnesota.

Dianne Heffron, MBA
Principal

EDUCATION
Master's degree, Business Administration
George Washington University

Bachelor's degree, Economics
University of Maryland

EXPERIENCE
25 years
professional experience

CORE COMPETENCIES
Federal Medicaid finance strategies
Reimbursement design
Medicaid transformational waivers

EXPERIENCE

Prior to joining Mercer, Dianne worked with the Centers for Medicare & Medicaid Services (CMS) serving as the director of the Financial Management Group since 2009 and the acting director of the Children and Adult Health Program Group in 2008. Dianne was responsible for the oversight of all Medicaid grants, DSH payment policy, reimbursement and funding policy from a national perspective. Prior to that she worked on reimbursement and delivery system strategies with the National Association of Community Health Centers (NACHC). Prior to joining NACHC, Dianne worked on integrated delivery system strategies and strategic marketing with Johns Hopkins Medical Institutions.

Dianne has worked with virtually every state regarding Medicaid reimbursement policy, Medicaid financial operations, state Medicaid financing strategies including the development and review of provider taxes. She has worked extensively in developing financial models for section 1115 demonstrations including budget neutrality models and innovative programs directed at the uninsured and delivery system reform.

Dianne's accomplishments include:

- Developing transformational investment and incentive programs under section 1115 authorities while at CMS. Dianne has worked directly with California, Texas, Massachusetts, New York, Arizona to develop and/or renew their waiver programs.
- Supported the National Governors Association policy academy focused on state transformation waivers. In particular, this policy academy provided support to Alabama, Washington and Nevada in the submission or approval of 1115 waivers as well as developing a road map to assist other states in developing similar programs.

- Creating a Medicaid state plan option to reimburse for care coordination activities using existing statutory and regulatory models that allowed states to implement value based purchasing strategies. States taking early advantage of the model were Missouri, Oregon, and Minnesota.
- Assisting New York in tackling operational issues associated with instituting payment incentives, value based strategies and financing issues within managed care.
- Creating a Medicaid state plan option to reimburse for care coordination activities using existing statutory and regulatory models that allowed states to implement value based purchasing strategies. States taking early advantage of the model were Missouri, Oregon, and Minnesota.
- Worked with Oregon to develop options to institute alternate payment models to effectively implement a global budget model consistent with Medicaid managed care rules.
- Work with multiple states that are moving from FFS to managed care to develop capitated models to address provider concerns regarding the UPL programs and potential reduced revenues.
- Worked with multiple states on the development and use of provider taxes as funding sources in conjunction with section 1115 expenditure authorities and managed care models.

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Christian Jensrud

QUALIFICATIONS

Christian is the Atlanta business office leader for Mercer Government Human Services Consulting with expertise in Medicaid, executive leadership, strategy, budgeting, managed care rate setting, and healthcare economics. Clients can rely on his years of hospital, integrated health system, and Medicaid managed care experience to manage ongoing projects, new initiatives, or strategy related to changes to current Medicaid programs.

EXPERIENCE

Prior to joining Mercer, Christian was the Vice President with Amerigroup/WellPoint's national Medicaid health plan for eight years and worked with major integrated health systems and hospitals in New Mexico and Georgia before that. He provided executive management, healthcare economics analysis, medical finance, new business Medicaid underwriting, business development, program development and strategy related to managed care growth.

Christian Jensrud
Principal

EDUCATION
Bachelor's degree, Business Administration
Georgia Southern University
Statesboro, GA
Graduated 1986

EXPERIENCE
25 years professional experience

2 years at Mercer

CORE COMPETENCIES
Medicaid Managed Care
Healthcare Economics
Healthcare Executive Management

Highlights of his work include the following:

- Broad role in financial evaluation, underwriting, and submission of winning managed care bids that helped the company grow revenues by more than 10 billion and that ultimately created several billion in tax payer savings over a 15 year period.
- Participated in program development and rate negotiation during the launch of New Mexico's coordinated long term care program.
- Provided cost savings analysis, financial impact analysis, and funding strategies for proposed changes to numerous Medicaid programs.
- Advised state financial leadership, Medicaid leadership, and governor budget offices on alternative approaches and impact to improving and reforming state Medicaid programs.
- Built detailed models to project impact of proposed changes to long term care support and service programs in several states.
- Provided strategic and tactical support in response to health care reform and Medicaid expansion.
- Testified before several state legislatures and published numerous white papers to provide advice and analysis to support decision making related to proposed changes to Medicaid programs.
- Developed Medicaid data warehouse to produce periodic and ad hoc reporting to states.
- Strategic and technical support of Medicaid health plan administrative cost efficiency improvements.
- Advisor to state officials related to innovation, improvements, and emerging issues related to the Medicaid population nationwide.

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PUBLICATIONS AND PUBLIC FORUM PRESENTATIONS

- National Association of State Human Services Finance Officers 2014 and 2015 Annual Meeting presentation on trends in Medicaid
- 4th Annual World Congress Medicaid Summit, 2014 Speaking Faculty
- 21st Annual Medicaid Managed Care Congress presentation, 2013

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Marta Kalleberg, MS, CEBS

QUALIFICATIONS

Marta leads the Pennsylvania rate setting project for Informatics. Before joining the Informatics team in August 2012, Marta was a project manager with Mercer Seattle's Health and Benefits (H&B) practice, focusing on Mercer's largest H&B client.

EXPERIENCE

Prior to joining Mercer, Marta was a health care data analyst at the nation's largest External Quality Review Organization (EQRO). In her role as a data analyst, she had day-to-day oversight responsibility for all analytic survey-related EQRO activities. Additionally, she performed data analysis on a national survey-related project by the Centers for Medicare & Medicaid Services (CMS).

Marta's experience includes:

- Providing expertise related to data needs and issues.
- Analyzing data for Capitation rate setting.
- Applying Risk Adjustment for Medicaid capitation payments.
- Developing cost weights using Medicaid managed care encounter data.
- Developing and executing project work plans and timelines.
- Training junior staff.
- Documenting process flows.
- Reporting project status.

Marta Kalleberg, MS, CEBS
Senior Analyst, Informatics

EDUCATION

Master's degree, Economics
Purdue University

Bachelor's degree, Economics,
Mary Baldwin College

EXPERIENCE

12 years
professional experien

CORE COMPETENCIES

Data validation

Training

Documentation

Project Management

AFFILIATION

Certified Employee Benefit Specialist

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Nicole Kaufman, JD, LL.M

QUALIFICATIONS

As a former Technical Director for Medicaid Managed Care Policy and Health Insurance Specialist for section 1115 demonstration programs for the Centers or Medicare & Medicaid Services (CMS), she has a unique understanding of the federal legal and policy framework for Medicaid managed care and delivery system reform design.

EXPERIENCE

Nicole is a Senior Associate in Mercer's Government Human Services Consulting Policy and Operations Sector.

Before joining Mercer in 2016, Nicole held a senior position in the CMS Baltimore Central Office's Division of Managed Care Plans. Nicole was the subject matter expert for Medicaid managed care policy, which involved providing technical assistance and support to CMS staff nationally and states in the development and implementation of Medicaid managed care programs across federal authorities and drafting subregulatory guidance documents on several topics. Nicole also specialized in the negotiation of complex section 1115 demonstration projects that involved delivery system integration and DSRIP initiatives.

Nicole's experience includes:

- Serving as the primary author and project manager for CMS' Medicaid Managed Care Final Rule (April 2016) and Proposed Rule (June 2015).
- Crafting and delivering presentations on regulatory matters to national audiences, which included state officials and staff, managed care plan and provider associations, and beneficiary stakeholder groups.
- Overseeing national implementation of the Affordable Care Act's payment increase to primary care physicians under Medicaid managed care programs.
- Negotiating, from the federal perspective, new section 1115 demonstration projects or amendments to such programs in Texas, Tennessee, New Mexico, Utah, Maryland, Kansas, among others.
- Assisting states in evaluating and modifying managed care contracts, rate certifications, and policies for compliance with the Medicaid Managed Care Final Rule.

Nicole Kaufman, JD, LL.M
Senior Associate

EDUCATION

Master of Laws (LL.M), Health Law, Saint Louis University School of Law

Juris Doctor (JD), Southern Illinois University School of Law (May 2007)

Bachelor of Arts, History and Political Science, University of Illinois

EXPERIENCE

8 years professional experience

CORE COMPETENCIES

Medicaid laws and regulations

Medicaid managed care rate setting and payment policies

Medicaid state plan and waiver authorities

AFFILIATIONS

District of Columbia, Inactive Bar Member, Admitted June 2009

Missouri, Inactive Bar Member, Admitted September 2007

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Kodzo Dekpe, ASA, MAAA

QUALIFICATIONS

Kodzo is an Associate in Mercer's Atlanta office. He is one of actuaries working on Louisiana's programs covering physical health, pharmacy, dental, and behavioral health services. He works with North Carolina ADAP projecting future program costs and has analyzed the cost implications of a number of program design changes. Kodzo has also overseen Texas Medicaid Wellness Program's projects including cost effectiveness analysis of 1915(b) waiver and evaluation of vendor's performance related to cost savings, humanistic outcomes and clinical quality measures.

EXPERIENCE

Kodzo's experience includes:

- Developing Medicaid managed care capitation rates.
- Providing technical review and assistance in adjusting Medicaid capitation rates for health risk.
- Providing technical review and assistance in developing the Affordable Care Act (ACA) Section 1202 physician fee increase adjustments.
- Analyzing and recommending strategies to achieve cost savings for program design changes.
- Reviewing rates proposed by managed care organizations for government-sponsored program.
- Evaluating cost effectiveness of Medicaid program and financial performance of Medicaid program's contractor.

Kodzo Dekpe, ASA, MAAA
Associate Actuary

EDUCATION
Master of Actuarial Science
Georgia State University

Bachelor of Science, Mathematics
Pittsburg State University

EXPERIENCE
4 years
professional experience

CORE COMPETENCIES
Medicaid managed care rate setting
Design of quantitative studies
Fiscal forecasting
Actuarially sound practices

AFFILIATIONS
Associate Society of Actuaries
Member American Academy of Actuaries

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Meredith Mayeri

QUALIFICATIONS

As a former Technical Director and Policy Advisor for the Centers for Medicare & Medicaid Services (CMS), she has experience in the planning, design and implementation of Medicaid waivers, state plan amendments, managed care programs and delivery system innovations since 1998. Meredith specializes in health program strategy and program development, including federal program requirements.

Meredith Mayeri
Principal
Policy and Operations Sector Co-lead

EDUCATION
Bachelor's Degree, Economics
LaSalle University

EXPERIENCE
18 years
professional experience

CORE COMPETENCIES
Medicaid laws and regulations

Medicaid state plan and waiver authorities

Medicaid managed care rate setting and payment policies

EXPERIENCE

Meredith is a Principal with Mercer and co-leader of Mercer's Government Human Services Consulting Policy and Operations Sector. Meredith is one of Mercer's senior policy consultants specializing in health program strategy and program development, including federal Medicaid and CHIP policy.

Before joining Mercer in March 2010, Meredith held senior positions in the CMS San Francisco Regional Office's Division of Medicaid and Children's Health. Meredith specialized in Medicaid managed care, waivers and demonstrations and provided technical assistance and support to CMS staff nationally and states in the development and implementation of these programs.

Meredith's experience includes:

- Development and implementation of successful new waiver programs (section 1115, 1915(b) and 1915(c) waivers), including benefit and payment model design, authority options, support with CMS negotiations.
- Advising clients on changes in federal laws, regulations and policy in the areas of the Affordable Care Act (ACA), Medicaid managed care, state funding mechanisms, waiver renewals, fee-for-service and managed care rate setting, LTSS and dual-eligibles.
- Developing Medicaid alternative benefit plan state plan amendments, including review of essential health benefits, actuarial equivalency, and mental health parity.
- Designing, implementing and renewing a section 1115 waiver to increase access to primary and behavioral health care within a patient-centered medical home model and support provider financial sustainability through diverse financing (Medicaid, commercial, grant funding).
- Researching and analyzing emerging value-based payment models in Medicaid.
- Developing policy, contracting and payment strategies for a statewide Medicaid enhanced primary care case management model that included provider shared savings in alignment with CMS Integrated Care Model guidance.
- Providing assistance in CMS negotiations to resolve payment policy and regulatory issues around accountable care organizations (ACOs) within Medicaid managed care.

- Assessing the policy, operational and financial viability of an ACA Section 2703 Health Home model for individuals with chronic conditions within Medicaid managed care to align with state SIM goals for multi-payer engagement in health homes.
- Conducting a comprehensive assessment and operational plan, including waiver, contract and operational requirements, for the implementation of a Medicaid managed long-term care expansion program.

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George Nyakairu

QUALIFICATIONS

George combines his experience in data science and analytics to effectively manage and evaluate health care data for Mercer Medicaid clients. He is a team member and Informatics lead for client states of Louisiana, Texas, Virginia, and District of Columbia. George helps the Informatics and actuarial teams verify claims and eligibility data accuracy and completeness, analyze health care trends and costs, and report results to clients.

EXPERIENCE

Prior to joining Mercer, George was employed with Alere as a senior SAS (Statistical Analysis Software) programmer. Prior to that, George worked for Ingenix as a senior healthcare analyst and before that with Harvard Pilgrim Healthcare as an actuarial analyst.

George's experience includes:

- Providing technical expertise to actuarial, pharmacy, and clinical teams related to claims and eligibility data needs and issues.
- Working with Informatics statistics team to develop predictive models and provide statistical expertise on projects.
- Providing disease management and Hedis expertise on various clinical projects.
- Developing and executing project work plans and timelines as relates to our client teams.
- Finding patterns and trends in the claims data to provide meaningful insights for decision making.
- Coding, documenting and peer reviewing of SAS processes.
- Processing ad-hoc client data requests from actuarial teams.
- Training and technical support for the Informatics group in general.

George Nyakairu
Senior Informatics Consultant

EDUCATION

Masters of Science, Predictive Analytics
Northwestern University

Bachelors of Science, Statistics and Economics
Makerere University (Uganda)

EXPERIENCE

15 years
Of professional experience

CORE COMPETENCIES

Data analytics using SAS and R programming techniques

Risk adjustment modeling

Machine-learning techniques and predictive analytics

Medicaid claims and eligibility data loading, validation and analysis

AFFILIATIONS

Certifications in SAS programming (I,II,III), Macro SAS programming, SAS programming using Pro SQL, Advanced SAS programming
SAS Institute, Boston MA

Member, Business Intelligence and Analytics Group

Member, Global Analytics Network

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Laura Pavlecic, RN, BSN, MBA

QUALIFICATIONS

Laura has extensive experience in the healthcare delivery system of managed Medicaid and Medicare services within a variety of states. Utilization management (UM), care and case management, care coordination, integration of physical health, behavioral health and pharmacy are areas of expertise. Laura has worked on the National Committee for Quality Assurance (NCQA) accreditation for health plans in a variety of states, resulting in consistent passing or exceeding expectations. Laura has worked with a variety of populations, i.e., Aged, Blind and Disabled (ABD), Temporary Assistance for Needy Families (TANF), Dual eligible and Special Needs Plan (SNP), Children's Health Insurance Program (CHIP). She has conduct oversight of readiness reviews for the clinical staff.

Laura Pavlecic, RN, BSN, MBA
Principal

EDUCATION
Master Business Administration (MBA)
Chatham University, Pennsylvania

Bachelor Science in Nursing (BSN)
University of Pittsburgh, Pennsylvania

EXPERIENCE
29 years
professional experience

CORE COMPETENCIES
Managed Care Clinical Operations
Utilization Management Analytics
Field and Office Based Care and Case Management Models
Quality Base Analytics
Budget design for care and administrative costs

AFFILIATIONS
Licensed Registered Nurse, Pennsylvania

EXPERIENCE

Before joining Mercer, Laura has worked within managed care clinical operations for 21 years. She had clinical oversight of a local unit that managed several states. She later worked as a vice president of clinical operations for the public sector, having the behavioral health clinical directors and their clinical teams report to her. Prior to working in managed care, Laura worked as a registered nurse on a psychiatric adolescent unit and then in the psychiatric emergency room which worked in conjunction with the medical emergency room.

Examples of Laura's experience and accomplishments include:

- Laura began in managed care as a care manager and was promoted throughout her career to leadership positions, last one being a corporate level vice president.
- Retained clients through open direct access for the client, meeting and exceeding expectations set by the contract.
- Involved in acquiring new business through participation of answering Request for Proposal (RFP) questions, on the ground meetings with the state agencies and certain provider groups, participation in the RFP interview process by the states.
- Oversight of developing staffing models and hiring the needed staff, collaborating with the finance team on the development of the administrative budget.
- Developing medical action plans that guide the interventions for care costs. This process involved working with many different departments, including provider and network development, customer services, quality and finance.
- Collaboration with other departments, for example, network development on evaluating and intervening where there are identified gaps of services available.

- As a consultant, assessed the feasibility and the return on investment on integrating a behavioral health unit within a health plan from a vendor arrangement.
- Oversight of integrating the behavioral health unit within an existing physical health UM and CM program. The success of this project relied on learning the current operations and then evaluating the needs to include behavioral health (BH):
  - Contracting and credentialing required adaptation to the current provider contracts that included NCQA and State or the Center for Medicare & Medicaid Services (CMS) requirements.
  - Providing identification for claims classifications.
  - Incorporating BH UM and quality initiatives within the UM and quality program descriptions and committee meetings.
  - Writing description of services and directives for the member and provider handbooks.
  - Hiring and training of licensed clinical staff and non-licensed staff.
  - Continuing supervision and assessment of BH team.
  - Developing stand-alone BH and integrated BH and PH clinical rounds
- Development of clinical operations departmental goals, as well as the oversight of the individual goals set by managers and supervisors for the clinical staff.

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Jaredd Simons, ASA, MAAA

QUALIFICATIONS

Jaredd is a Principal in Mercer's Atlanta office. He is the senior actuary overseeing Mercer's work on Louisiana's programs covering physical health, pharmacy, dental, and behavioral health services. He works with North Carolina ADAP projecting future program costs and has advised on the cost implications of a number of program design changes. Jaredd also oversees rate development for Oklahoma NEMT services and is currently working with the VA Legislature to review their managed care program.

Jaredd Simons, ASA, MAAA
Senior Actuary

EDUCATION
Bachelor degree, Finance
University of North Carolina at Charlotte

EXPERIENCE
10 years
professional experience

CORE COMPETENCIES
Medicaid managed care rate setting
Design of quantitative studies
Fiscal forecasting
Actuarially sound practices

AFFILIATIONS
Associate Society of Actuaries
Member American Academy of Actuaries

EXPERIENCE

Before joining Mercer, he spent six years working for Coventry Health Care on both commercial products and Medicaid managed care. During that time, Jaredd was also involved in the early implementation of ACA requirements corporate wide and helped with coordination across business units.

Jaredd's experience includes:

- Developing Medicaid managed care capitation rates for acute care services, pharmacy, dental, and behavioral health.
- Projecting AIDS Drug Assistance Program costs
- Developing Managed Long term care capitation rates.
- Developing NEMT service capitation rates
- Implementing ACA 1202 fee schedules and supplemental capitation rate development.
- Reserving and forecasting for Medicaid managed care plans in Virginia and Pennsylvania.
- Pricing, reserving, and forecasting for commercial products in Georgia, Louisiana, Virginia, and West Virginia.
- Developing traditional and non-traditional benefit designs.

EXPERIENCE

Reference #1

Name:	Jen Steele
Title:	Interim Medicaid Director
Address:	Louisiana Medicaid, Department of Health 628 North 4th Street Baton Rouge, LA 70802
Phone Number:	+1 225 342 3032
E-mail:	jen.steele@la.gov

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Reference #2

Name:	Kevin Rupe
Title:	Director of Member Services
Address:	Oklahoma Health Care Authority 4345 Lincoln Boulevard Oklahoma City, OK 73105
Phone Number:	+1 405 522 7498
E-mail:	kevin.rupe@okhca.org

Reference #3

Name:	John S. Furnari, MA
Title:	AIDS Care Program Administrator
Address:	Division of Public Health, Communicable Disease Branch North Carolina Department of Health and Human Services 1902 Mail Service Center Raleigh, NC 27699-1900
Phone Number:	+1 919 733 9576
E-mail:	john.furnari@dhhs.nc.gov

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Michele Puccinelli Walker, MSG, MPA

QUALIFICATIONS

Michele specializes in policy and program development for Medicaid and Children's Health Insurance programs (CHIP) with a focus on delivery system innovation, behavioral health, dual eligibles and long-term care (LTC). She serves as project manager for the states of Ohio and South Carolina coordinating a multi-faceted team and team member for other states such as Delaware, New York, and North Carolina.

EXPERIENCE

Prior to joining Mercer, Michele held senior positions for over 17 years within the U.S. Department of Health and Human Services (DHHS), including the Administration on Aging, the Centers for Medicare & Medicaid Services (CMS) and the Office of the Secretary's Regional Director for Region IX. During her 12 years at CMS, Michele served in senior positions within the Office of Legislation, the Division of Medicaid and Children's Health Operations and the Division of Medicare Health Plan Operations. Michele served as the Regional Executive Officer for the Office of the Regional Director, focusing on the implementation of health care reform. Highlights of her projects included:

- Managing the collaboration of a federal-private partnership with a foundation focusing on the impact of health care reform on the aging population.
- Directing the Federal Regional Council, which was comprised of 19 federal agencies in Region IX, including initiatives on health care reform, homelessness, Native Americans and sustainable communities.
- Designing, implementing and coordinating oversight of the Programs for All-Inclusive Care for the Elderly (PACE), including coordinating and tracking Medicare, Medicaid and Part D policy issues between PACE organizations, states and CMS; managing the PACE application review process; and directing the review and approval of PACE Medicaid capitation rates and program compliance/monitoring.
- Coordinating the oversight of Medicaid managed care and waiver programs, including 1915(b) and 1115 waivers and state plan amendments and review of actuarial sound rates.

While at Mercer, Michele has worked with the states of Arizona, California, Connecticut, Delaware, Florida, Kansas, Louisiana, Massachusetts, New Jersey, New Mexico, New York, North Carolina Ohio, Pennsylvania and South Carolina, as well as the District of Columbia.

Michele's experience includes:

Michele Puccinelli Walker, MSG, MPA
Senior Associate

EDUCATION

Master's Degree, Gerontology
Master's Degree, Public Administration
University of Southern California

Bachelor's Degree, Human Development
University of California, Davis

EXPERIENCE

23 *years*
professional experience

CORE COMPETENCIES

Program design and implementation
Policy and regulatory analysis
Behavioral health program design

AFFILIATIONS

Member, American Society on Aging

- Advising clients and designing behavioral health coordinated systems of care for children at risk for out of home placement for the states of Louisiana and South Carolina.
- Working on the design and implementation of behavioral health system redesigns, including the Autism benefit for the states of Louisiana, North Carolina, Ohio, and South Carolina.
- Working on the design and implementation of statewide Medicaid managed LTC programs for the states of Delaware, Kansas, New Jersey, and New Mexico.
- Advising clients on changes in federal laws, regulations and policy in the area of health care reform, managed care, state funding mechanisms, managed care rate-setting, PACE, long-term care and dual-eligibles for the states of California, Delaware, Massachusetts, North Carolina, Ohio, and Pennsylvania.
- Participating in a workgroup with the National PACE Association on Medicaid ratesetting for PACE programs.
- Designing health insurance exchanges and evaluating alternative (benchmark) benefit package options for Connecticut and Ohio.
- Preparing and negotiating 1915(b), 1915(c) and 1115 waivers and 1932(a) State Plan Amendments for the states of Delaware, Kansas, Louisiana, New Mexico, New York, Ohio, Pennsylvania, and the District of Columbia.

PUBLICATIONS AND PUBLIC FORUM PRESENTATIONS

- Publication: Torres-Gil, Fernando M. and Michele A. Puccinelli. "Aging Policy in the Clinton Administration." *Journal of Aging and Social Policy*, Vol. 7(2) (1995): 13-18.
- Torres-Gil, Fernando M. and Michele A. Puccinelli. "Mainstreaming Gerontology in the Policy Arena." *The Gerontologist*, 34 (1994): 749-752
- Torres-Gil, Fernando M. and Michele A. Puccinelli. "Aging: Public Policy Issues and Trends." *Encyclopedia of Social Work*, 19th Edition (1) (1993): 159-164.
- Presentation: The SCAN Foundation's 2013 LTSS Summit. *ARDC Business Plan Development.* November 13, 2013.
- Presentation: Mercer's Webinar for Clients. *Informational Review for Mercer Clients: Medicaid Home and Community-Based Services New Rule.* June 27, 2014.
- Presentation: Ohio's HCBS Public Stakeholder Meeting. *Medicaid Home and Community-Based Services Basics and New Rules.* July 30, 2014.

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Cindy Ward, RN, MBA, LHRM

QUALIFICATIONS

Cindy's brings extensive Medicaid healthcare quality experience to the Mercer team. She is a registered nurse with clinical proficiency in both physical and behavioral health settings, experience supporting Medicaid rate setting and in the development of clinical efficiency data analyses. Her experience and understanding of physical health and behavioral health service provision as well as managed care, provides a unique and invaluable level of expertise. In addition, she holds a MBA and is licensed as a healthcare risk manager, which ensures focus and sensitivity to fiscal and risk issues for her clients.

EXPERIENCE

Prior to joining Mercer, Cindy served in quality and clinical compliance roles with nationally recognized Medicaid and Medicare Managed Care health plans.

Cindy's areas of expertise are as follows:

- Innovative and integrated (physical health and behavioral health) care coordination models.
- Clinical and quality analysis of claims data.
- Value based purchasing strategies for managed care and health providers.
- Medicaid Managed Care Operations.
- Population health innovations that drive health outcome improvements.
- Medicaid program design and program evaluation.
- Healthcare quality and outcome measures development.

As a registered nurse, Cindy has worked in both behavioral and physical health clinical settings and programs. In addition she has held leadership positions within managed care organizations where she has served in both quality and clinical compliance roles. She has a passion for quality and process improvement that ensures members are receiving the highest possible quality services, built on evidence based practices that maximize financial and quality outcomes for all stakeholders.

Cindy Ward, RN, MBA, LHRM
Principal

EDUCATION

Master Business Administration (MBA)
Kennesaw State University, Georgia

Bachelor Science in Nursing (BSN)
Georgia Southern University, Georgia

Associate of Science in Nursing (ASN),
Armstrong Atlantic State University
Georgia

Six Sigma Green Belt Certification

EXPERIENCE

21 years
professional experience

CORE COMPETENCIES

Clinical and Quality Analytics
Innovative Care Coordination Models
Value Based Purchasing
Managed Care Operational Oversight
Population Health Solutions
Integrated care models
Quality Measure Development

AFFILIATIONS

Licensed Registered Nurse
Georgia and Florida

Licensed Healthcare Risk
Manager, Florida

Member of National Association
for Healthcare Quality

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Cindy's experience includes:

- Designing and implementing quality improvement programs including innovative care coordination models that integrate physical and behavioral health.
- Drafting managed care contractual requirements for integrated and field based care coordination programs.
- External Quality Reviews and Managed Care Readiness and Compliance Reviews.
- Independent Waiver Assessments.
- Targeted Medicaid programmatic evaluations to improve state oversight and program management.
- Clinical data analysis to identify population health and program cost drivers.
- Developing value based purchasing models in managed care and fee for service Medicaid models.
- Designing clinical efficiency analyses that quantify avoidable healthcare costs.
- Providing technical assistance to managed care programs on integrated physical and behavioral health program design.
- Evaluating long term care programs, including managed long term care and PACE programs.

LaGOV PO# 2000255086
Exhibit 2

MERCER

CERTIFICATE

OF THE

ASSISTANT SECRETARY

OF

MERCER HEALTH & BENEFITS LLC

I, Margaret M. O'Brien, Assistant Secretary of Mercer Health & Benefits LLC, a Delaware limited liability company (the "LLC") certify that at a duly authorized meeting of the Board of Directors of the LLC, dated February 11, 2010, the Board adopted procedures authorizing any Principal, Partner or Senior Partner of the LLC, including the list of individuals attached hereto, to execute contracts, agreements, applications and other instruments on behalf of the LLC. This resolution has neither been amended nor rescinded and is in full force and effect as of the date hereof.

IN WITNESS WHEREOF, I have set my hand and the seal of the LLC on this 28th day of March 2017.

Margaret M. O'Brien
Assistant Secretary

State of New York)

County of New York)

On this 28th day of March 2017, before me personally came Margaret M. O'Brien to me known, who acknowledged to me that she executed the foregoing instrument.

Notary Public

Sandra Davenport
Notary Public - State of New York
No. 01DA6139698
Qualified in Nassau County
Certified in New York County
Commission Expires February 20, 2018

MERCER
MAKE TOMORROW, TODAY

AUTHORIZED SIGNATORIES

Name	Title
Angela WasDyke	Senior Partner
Ann Marie Janusek	Principal
Anna Theisen-Olson	Principal
Anthony Asciutto	Principal
Bill Lasowski	Principal
Branch McNeal	Senior Partner
Candace Jacobs	Principal
Christian Jensrud	Principal
Deidra Abbott	Principal
Denise Podeschi	Partner
Dianne Heffron	Principal
Frederick Gibison	Partner
Jared Nason	Partner
Jessica Osborne	Principal
Joel Schuenke	Principal
Jon Marsden	Partner
Katie Falls	Principal
Katie Olecik	Principal
Laura Nelson	Principal
Leena Hiilivirta	Principal
Meredith Mayeri	Principal
Mike Nordstrom	Partner
Mike Priniski	Principal
Misti Beckman	Partner
Robert Butler	Principal
Ron Ogborne	Principal
Ryan Johnson	Principal
Sam Espinosa	Partner
Shawna Kittridge	Principal

MERCER HEALTH & BENEFITS LLC

(Delaware)

(the "LLC")

CONSENT TO ACTION WITHOUT A MEETING OF THE BOARD OF DIRECTORS

The undersigned, being all the members of the Board of Directors of this LLC, hereby consent to the following action being taken without a meeting:

RESOLVED: any employee of this LLC who has achieved a grade level "E" is automatically elected to serve in the office of Associate of this LLC until his or her termination, removal or resignation from office or such other date as specified in this LLC's by-laws, whichever first occurs and further,

RESOLVED: any employee of this LLC who has achieved a grade level "F" is automatically elected to serve in the office of Senior Associate of this LLC until his or her termination, removal or resignation from office or such other date as specified in this LLC's by-laws, whichever first occurs and further,

RESOLVED: any employee of this LLC who has achieved a grade level "G" or a grade level "H" is automatically elected to serve in the office of Principal of this LLC until his or her termination, removal or resignation from office or such other date as specified in this LLC's by-laws, whichever first occurs and further,

RESOLVED: any employee of this LLC who has achieved a grade level "I" or a grade level "J" is automatically elected to serve in the office of Partner of this LLC until his or her termination, removal or resignation from office or such other date as specified in this LLC's by-laws, whichever first occurs and further,

RESOLVED: the President of this LLC may appoint employees to serve in the office of Senior Partner of this LLC and each such Senior Partner shall serve in such office until his or her termination, removal or resignation from office or such other date as specified in this LLC's by-laws, whichever first occurs and further,

RESOLVED: that any elected Principal, Partner or Senior Partner of this LLC is authorized and empowered, in accordance with the guidelines set forth in the then in-effect Mercer Approval Procedures, to execute contracts, agreements, applications and other documents on behalf of the LLC.

Effective: February 11, 2010

Thomas L. Elliott

Roy A. Gonella

Diane O'Neill

LaGOV PO# 2000255086

Exhibit 3

John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Louisiana Department of Health
Bureau of Health Services Financing

April 10, 2017

Ms. Pamela Bartfay Rice, Esq.
Interim Director, Professional Contracts
Office of State Procurement
P. O. Box 94095
Baton Rouge, Louisiana 70804-9095

RE: Justification for Out-of-State Contract and Request for Multi-Year Contract

Dear Ms. Rice:

Please consider this justification for the Louisiana Department of Health (LDH) to enter into an out-of-state and multi-year contract with Mercer Heath and Benefits, LLC (hereafter "Mercer"), to function as the department's actuary for the Medicaid managed care programs.

Mercer will be required to provide methods for, and calculation of, capitation rates, which must be actuarially sound and readily replicated according to federal law and regulations. Mercer has been providing excellent actuarial services to LDH for the past nine years and has similar contracts to establish Medicaid rates for a number of other states. The expertise required for this type of work simply does not exist within Louisiana. The contractor will not be in the state more than 30 days.

The proposed contract is for a three-year term. These actuarial services are required for the managed care contracts that are currently in place for almost all Medicaid recipients. The managed care contracts will be competitively reprocured in 2018 and are anticipated to be in place for a minimum of three years. Funds for the first fiscal year of the proposed actuarial contract are available and payment and performance for subsequent fiscal years shall be subject to the availability of funds.

The estimated requirements covering the period of the contract are reasonably firm and continuing and such a contract will serve the best interests of the State. We appreciate your assistance in this matter and we hope that you will give this contract your favorable consideration and approval. Should you need further information, please contact me via telephone at (225) 342-3426 or via e-mail at pam.diez@la.gov.

Sincerely,

Pam Diez
Medicaid Deputy Director

Tom Schedler
Secretary of State

State of Louisiana Secretary of State

COMMERCIAL DIVISION
225.925.4704

Fax Numbers
225.932.5317 (Admin. Services)
225.932.5314 (Corporations)
225.932.5318 (UCC)

Name	Type	City	Status
MERCER HEALTH & BENEFITS LLC	Limited Liability Company (Non-Louisiana)	WILMINGTON	Active

Previous Names

Business: MERCER HEALTH & BENEFITS LLC
Charter Number: 35787878Q
Registration Date: 9/30/2004

Domicile Address
1209 ORANGE STREET
WILMINGTON, DE 19801

Mailing Address
121 RIVER ST., 8TH FL.
TAX DEPT.
HOBOKEN, NJ 07030

Principal Business Office
1166 AVENUE OF THE AMERICAS
NEW YORK, NY 10036

Registered Office in Louisiana
3867 PLAZA TOWER DR.
BATON ROUGE, LA 70816

Principal Business Establishment in Louisiana
5615 CORPORATE BLVD., STE. 400B
BATON ROUGE, LA 70808

Status

Status: **Active**
Annual Report Status: **In Good Standing**
Qualified: 9/30/2004
Last Report Filed: 10/3/2016
Type: Limited Liability Company (Non-Louisiana)

Registered Agent(s)

Agent: C T CORPORATION SYSTEM
Address 1: 3867 PLAZA TOWER DR.
City, State, Zip: BATON ROUGE, LA 70816
Appointment Date: 9/30/2004

Officer(s)

Additional Officers: No

Officer: MERCER (US), INC.

Title:	Member
Address 1:	1166 AVENUE OF THE AMERICAS
City, State, Zip:	NEW YORK, NY 10036

Officer:	SHERYL P. MULRAINE-HAZELL
Title:	Manager
Address 1:	121 RIVER ST
City, State, Zip:	HOBOKEN, NJ 07030

Amendments on File (4)

Description	Date
Foreign LLC Statement of Change	1/29/2008
Revoked	12/18/2012
Reinstatement	1/22/2013
Foreign LLC Statement of Change	10/18/2015

Print

Summary of Marsh & McLennan Companies Business Resiliency Program as of April, 2016

A cornerstone of Marsh & McLennan Companies client relationships is our commitment to the protection of client information and to our continuation of services, even in the event of a disaster. To support that commitment, we maintain a robust business resiliency program which includes conducting Business Impact Analyses; establishing and maintaining business resiliency, disaster recovery, crisis management and incident response plans; and testing of recovery capabilities, in order to ensure our ability to continue to serve and support our clients in the event of a business disruption.

Business Resiliency Management (BRM)

The Marsh & McLennan Companies Business Resiliency Management (BRM) Group provides business continuity guidance and overall program management to all of our operating companies (Marsh, Mercer, Guy Carpenter and Oliver Wyman). BRM also coordinates communications and other shared response resources, including emergency communication systems, business resiliency planning systems and external vendor contracts for items such as space in recovery locations and computer equipment for use in a recovery.

Business Resiliency/Disaster Recovery Plans

Marsh & McLennan Companies mandates that every one of our offices maintain Business Resiliency/Disaster Recovery plans with specific provisions for staff mobilization, alternate work spaces, recovery of network and telecommunications systems, restoration of data and communication with clients. These plans were created based on a Business Impact Analysis that identifies every location's recovery requirements and priorities.

The Business Resiliency/Disaster Recovery plans address loss of:

- Office facilities and personnel;
- Data, operating systems or application software; and
- Network services or mission-critical components

Our offices are required to maintain copies of their current Business Resiliency/Disaster Recovery plans in three separate locations: onsite, at an offsite storage facility, and on the Business Resiliency Management internet portal. Additionally, so that staff can effectively respond to any incident at any time, key employees keep a copy of the plan in their offices and at home.

Business Resiliency/Disaster Recovery plans include:

- Daily differential and weekly full backup cycles
- Daily and weekly onsite and offsite storage of backup files and documentation
- Ongoing cross-site replication of critical or high-volume data
- Staff and client notification of communications procedures and details

- Disaster impact assessment, timetables, and action plans
- Coordination of national assistance, if needed
- Plans for implementing long and short-term alternate operations
- Contingency plans to replace lost equipment
- Contingency plans to use other corporate or operating company offices, data centers and resources in the event of facility loss
- Contracts with external parties for data center and work-area equipment and facilities

Alternate Work Sites

Marsh & McLennan Companies uses a multi-layered matrix approach to providing alternate work sites in the event that an office is unable to provide service for any reason. This approach is aligned closely with each of our businesses and functions, and it recognizes important support requirements of all phases of our operations. In this matrix approach, our staff may work from any of the following places:

- Home, using high-speed internet connections and VPN to access internal data networks
- An alternate space, where prior arrangements for recovery support has been made
- Commercial fixed and mobile work sites
- Other corporate or operating company offices, either directly or where critical client support activity has been transferred

Local Office Technology

Local area networks in all Marsh & McLennan Companies offices use a fault-tolerant approach to system designs. That is, we have implemented technologies that limit our vulnerabilities in case of a systems failure, office location failure or natural disaster. Each office's computing environment is established using global standards that facilitate remote support.

All workstations are secured against use by unauthorized persons. Employees are required to enter a user ID and password to gain access to our systems and can enter only appropriate areas on the network.

Marsh & McLennan Companies uses a full range of commercial and custom software applications, all of which are centrally maintained and installed. Also, all employees use the same core suite of industry standard applications.

Data Backup

We back up data nightly (differential backup) and weekly (full backup). Backups are stored both at offsite storage facilities and in secured onsite data-storage facilities. We also perform cross-site replication of critical or high-volume data. The standardization of backup systems and storage procedures across our offices enables recovery efforts at alternate sites.

Operations at an Alternate Facility

Should there be a complete facility disaster, critical operations of an affected office can be up and running at another corporate or operating company facility within 72 hours for locations, processes and applications designated as Tier One. Alternate local equipment and facilities can be available within one week after the disaster.

Marsh & McLennan Companies maintains two strategic data centers in each of three global regions. Recovery plans for critical systems are aligned to the requirements specified by Business Impact Analyses and include:

- Recovery from a local data center to a strategic data center
- Recovery from one strategic center to another
- Recovery at a recovery services vendor site

Critical system recovery plans are tested and updated annually, with results reported to senior management and assessed by internal and external auditors.

Successful Plan Execution

Marsh & McLennan Companies has successfully supported critical business activities during disruptions of normal business processes resulting from both natural and man-made disasters. On each occasion where the Plan has been invoked, it has been executed successfully. Some examples include:

- Power Blackouts: Northeast US, Memphis (11 days)
- Potential Mass Transit Outages: New York, Los Angeles, Toronto
- Terrorist Activities: Spain Train Bombings, London Bombings; India Attacks
- Hurricanes: Bermuda, Cayman Islands, Florida, regions bordering the Gulf of Mexico
- Typhoons: Japan, China, Taiwan, India, and Philippines
- Pacific Tsunamis
- Flooding: Thailand, Major Data Center
- Pandemic: Sudden Acute Respiratory Syndrome (SARS), Influenza H1N1 (Swine Flu)
- WTO and G20 Global Summit Meetings (Pittsburgh, Toronto)
- Earthquakes: Chile, Japan, New Zealand (Christchurch)

Pandemic Preparedness

The Marsh & McLennan Companies Business Resiliency Management Group, in concert with our Health and Life Safety Committee, identifies and assesses the potential issues relating to communicable diseases and develops and helps implement protocols to mitigate the effect they may have on our operations, our colleagues, and our ability to serve clients.

The Marsh & McLennan Companies Business Resiliency Management Group and our Health and Life Safety Committee monitors and develops responses to communicable disease issues, including pandemics such as avian (H5N1) and swine (H1N1) flu, supported by third-party advisors such as International SOS, iJET Intelligent Risk Systems, and by risk and pandemic preparedness experts at our operating companies, including Marsh and Mercer.

Ongoing Commitment

At Marsh & McLennan Companies, planning for the continuity of business and service to our clients is part of the way we do business. We are committed to ensuring that our Business Resiliency, Disaster Recovery, Crisis Management and Incident Response plans are reviewed, updated and tested regularly.

John Bel Edwards
GOVERNOR

Rebekah E. Gee MD, MPH
SECRETARY

State of Louisiana

Louisiana Department of Health
Bureau of Health Services Financing

April 28, 2017

Ms. Pamela Bartfay Rice, Esq.
Assistant Director, Professional Contracts
Office of State Procurement
P. O. Box 94095
Baton Rouge, Louisiana 70804-9095

Dear Ms. Rice:

The following contract is being submitted to your office this date for review and approval in accordance with Louisiana Revised Statutes 39:1481, et seq. and the rules and regulations adopted pursuant thereto:

Submitting Agency – Louisiana Department of Health

Contractor – Mercer Health & Benefits, LLC

Amount – $16,158,890.00

Your consideration in this regard is greatly appreciated. If additional information is needed, please contact me at (225) 342-0941.

Sincerely,

Teresa Bravo

Teresa Bravo
Medicaid Program Manager 2

Louisiana SCS State Civil Service

Contract Review – Agency Request Form

Form Revision Date: 03/16

FOR CIVIL SERVICE USE ONLY		
Effective Date of Contract	**Approval Date**	
	SCS Commission Approval (if required)	***SCS Approval (Initial and Date)***
		MCM 05/01/17
Comments		

COMPLETE THE FOLLOWING INFORMATION FOR REQUESTS DEALING WITH THE CONTRACTING OF STATE SERVICES AND/OR STATE PERSONNEL

Agency Name	Personnel Area Number	Agency Number
Bureau of Health Services Financing	7201	305

CONTRACT INFORMATION

Contract #	Name of Contractor
2000255086	Mercer Health & Benefits, LLC

Is this an amendment to an existing contract?		If yes, OCR # (if applicable)
Yes ☐	**No** ☒	

Start Date of Contract	End Date of Contract/Amendment	Dollar Amount of Contract (Including Amendment)
5/16/2017	**5/15/2020**	~~**$16,223,150.00**~~ **$16,158,890.00** (Rev 6/13/2017)

CONTRACT DETAILS PROVIDED BY AGENCY TO SCS

Provide a brief overview of services to be performed to include the following:

Services to be replaced/provided by a contractor:

The contractor will provide methods for the development and calculation of capitation rates for the Medicaid Managed Care Program and other support services that must be provided by an actuary and other similarly qualified staff employed by the contractor. Methods will be analytically sound, acceptable to the Centers for Medicare and Medicaid Services, and readily replicated.

Advantages of contracting out services:

The Department of Health has no staff with the required qualifications to perform these services.

Justification for contracting out services:

The Department of Health has no staff with the required qualifications to perform these services.

POTENTIAL IMPACTS ON CLASSIFIED STATE EMPLOYEES

Will this contract result in the removal of responsibilities from one or more classified state employees?

Yes	No
Yes ☐	**No** ☒

Will this contract establish a relationship wherein an employee or official of the state takes the following actions:

Determines the work hours of the person performing the contractual services	**Yes** ☐	**No** ☒
Determines the day to day duties of that person	**Yes** ☐	**No** ☒
Approves the absences from the work place of that person	**Yes** ☐	**No** ☒

If the answer to all of the previous four questions is "NO," please email this completed form to DSCScontractreview@la.gov or send it in PROACT for SCS approval. If the answer to any of the questions is "YES," please complete the "Notification of SCS Commission's Authority on Contracts" portion of the form and then submit two copies of the proposed contract with this form to the Department of State Civil Service, Employee Relations Division, P.O. Box 94111, Baton Rouge, LA 70804-9111.

NOTIFICATION OF SCS COMMISSION'S AUTHORITY ON CONTRACTS

An agency requesting approval of an outsourcing contract which will result in the involuntary displacement of a classified employee must have the State Civil Service Commission's approval as provided in Civil Service Rule 2.9(h). The Commission will review all request for contract approval under the following guidelines:

1. The Commission will review all contracts that directly affect civil service employees within in a reasonable period of time to the contract's implementation.
2. The Commission will ensure that classified employees are competitively selected on the basis of merit, free from political influence, and will protect classified employees from dismissal or disciplinary actions for religious or politically-motived reasons.
3. The Commission will approve contracts that are entered into for reasons of efficiency and economy, provided that the decision to privatize is made without political motivation as to the civil servants.
4. The Commission will request all documents from the agency which are necessary to determine if any classified employee will be involuntarily displaced from civil service and if so, whether the contract was entered into for reasons of efficiency and economy and not for politically-motivated reasons.
5. The Commission will not determine whether a service should or could be provided within the classified system, whether the contract is in the best interest of the State, or whether the fiscal restraints presented by the state justify privatization.
6. The Commission will challenge in the court system of Louisiana any contract that it has good cause to believe was entered into as a pretext for the discriminatory dismissal or treatment of civil servants for religious or political reasons.

APPOINTING AUTHORITY ACKNOWLEDGEMENT FOR CONTRACTS REQUIRING SCS COMMISSION APPROVAL

I hereby acknowledge that I have reviewed the information listed above pertaining to the authority of the Civil Service Commission in relation to contracts and further verify, to the best of my knowledge, that the proposed contract has been entered into for reasons of efficiency and economy and not for politically motivated reasons.

Name of Appointing Authority	Date

Title of Appointing Authority

AGENCY INFORMATION

Signature of Appointing Authority or Designee	Date
Teresa Bravo	4/21/2017

Title of Person Signing this Request
Medicaid Program Manager 2

Contact Information *(Human Resources Contact)*

Name	Sherry Nevels		
Email	sherry.nevels@la.gov	Phone Number	(225) 342-8407

SAM Search Results
List of records matching your search for :
Record Status: Active
DUNS Number: 616213125
Functional Area: Entity Management, Performance Information

ENTITY MERCER HEALTH & BENEFITS LLC Status:Active

DUNS: 616213125 +4: CAGE Code: 4GZ22 DoDAAC:

Expiration Date: Sep 19, 2017 Has Active Exclusion?: No Delinquent Federal Debt?: No

Address: 1166 AVE OF THE AMERICAS, FL-30
City: NEW YORK State/Province: NEW YORK
ZIP Code: 10036-2708 Country: UNITED STATES

SUMMARY OF INFORMATION

CONTRACTOR NAME	Amount
Mercer Health & Benefits, LLC	**$16,158,890.00**
CONTRACT DATES Effective Date 05-16-2017 Termination Date 05-15-2020	**BA-22 ATTACHED** ☒

Certification Requirements: (Check Applicable Items)

☒ 1. Either no employee of this agency is both competent and available to perform the services called for by the proposed contract and/or the services called for are not the type readily susceptible of being performed by persons who are employed by the State on a continuing basis.

☒ 2. The services are not available as a product of a prior or existing professional, personal, consulting, or social services contract.

☒ 3. When applicable, the requirements for consulting or social services, as provided for under the Louisiana Procurement Code, LSA-R.S. 39:1554 et seq., have been complied with as necessary.

☒ 4. The using agency has developed and fully intends to implement a written plan providing for the assignment of specific using personnel to a monitoring and liaison function. Identify name of individual of staff unit responsible for monitoring this contract:

Name	Phone No.
Teresa Bravo	225-342-0941
Location 628 N. 4th Street, Baton Rouge, Louisiana 70802	

Summary of Monitoring Plan: (This must include periodic review of specified reports, documents, exception reporting, or other indicia or performance, etc.). Additional pages may be attached if necessary.

The DHH contractor monitor will:
1. Be available for consultation by phone, e-mail, and face-to-face meetings to discuss priorities and provide direction;
2. Meet with the contractor weekly as necessary to ensure that work toward the completion of deliverables is being accomplished;

The ultimate use of the final product of the services: (Specify)

The ultimate use will be the establishment of actuarially sound rates for Medicaid managed care programs as required by federal law and regulations.

☒ 5. Respond to questions A or B on all contracts except those funded by "Other Charges" (3600 series) of Budget:

A. What critical services will go unprovided and to whom?

Per member, per month rates cannot be paid to managed care entities to provide services to Medicaid eligibles unless certified by an actuary.

B. How many hours will the contractor have to work?

☒ 6. Completed monitoring report will be submitted to the Office of State Procurement within **60** days after termination of contract. **(For Personal, Professional, Consulting contracts exceeding $2,000)**

☒ 7. The services have not been artificially divided to as to constitute a small purchase (not exceeding $2,000).

☒ 8. A cost-benefit analysis has been conducted which indicates that obtaining such services from the private sector is more cost-effective than providing such services the agency itself or by any agreement with another state agency and includes both a short-term and long-term analysis and is available for review.

☒ 9. The cost basis for the proposed contract is justified and reasonable.

☒ 10. A description of the specific goals and objectives, deliverables, performance measures and a plan for monitoring the services to be provided are contained in the proposed contract.

☒ 11. An inquiry has been conducted to determine if the contract outsources a key internal control of the agency. The results have been documented in the agency's files and are available for review, upon request. If warranted, the RFP and contract have included provisions which address the need for assurances and/or monitoring of the key internal control.

☒ 12. The Board of Regents has been notified in accordance with LSA- R.S. 39:136 of services that are readily susceptible of being performed by persons who are employed by or who are students of a postsecondary institution of the state.

PRIOR CONTRACT INFORMATION MUST BE FILLED OUT (IF NO PRIOR CONTRACT PUT N/A)

PRIOR YEAR SERVICES PROVIDED BY (Contractor Name):

Mercer Health & Benefits, LLC

LaGov#:	LDH#:	EFF:	TERM:
2000113046	060056	05-16-2014	05-15-2017
AMOUNT: $13,297,835.00	**PREVIOUSLY ISSUED UNDER RFP?** IF YES, DATE: YES ☐ NO ☒ DATE:		

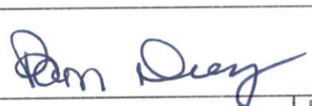
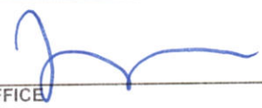
YES	NO		
☒	☐	1.	Contains a date upon which the contract is to begin and upon which the contract will terminate.
☒	☐	2.	Contains a description of the work to be performed and objectives to be met.
☒	☐	3.	Contains an amount and time payment to be made.
☒	☐	4.	Contains a description of reports or other deliverables to be received, when applicable.
☒	☐	5.	Contains a date of reports or other deliverables to be received, when applicable.
☒	☐	6.	When a contract includes travel and/or other reimbursable expenses, it contains language to effect the following:
☒	☐		A. Travel and other reimbursable expenses shall constitute part of the total maximum payable under the contract; (or)
☒	☐		B. No more than (a certain sum) of the total maximum amount payable under this contract shall be paid or received as reimbursement for travel and other reimbursable expenses; (and)
☒	☐		C. Travel expenses shall be reimbursed in accordance with Division of Administration Policy and Procedure memorandum 49 (The State General Travel Regulations).
☒	☐	7.	Contains the responsibility for payment of taxes.
☒	☐	8.	Contains the circumstances under which the contract can be terminated either with or without cause and contains the remedies for default.
☒	☐	9.	Contains a statement giving the Legislative Auditor the authority to audit records of the individual(s) or firm(s).
☒	☐	10.	Contains an assignability clause as provided for under LAC-4:4.
☒	☐	11.	Budget From BA-22, fully completed and attached to back of each contract.

DETERMINATION OF RESPONSIBILITY

YES	NO		
☒	☐	1.	Had adequate financial resources for performance, or has the ability to obtain such resources as required during performance.
☒	☐	2.	Has the necessary experience, organization, technical qualifications, skills and facilities or has the ability to obtain them (including probable subcontractor arrangements).
☒	☐	3.	Is able to comply with the proposed or required time of delivery or performance schedule.
☒	☐	4.	Has a satisfactory record of integrity, judgment and performance (contractors which are seriously delinquent in current contract performance, considering the number of contracts and the extent of delinquencies of each, shall in the absences of evidence to the contrary or compelling circumstances presumed to be unable to fulfill this agreement).
☒	☐	5.	Is otherwise qualified and eligible to receive an award under applicable laws and regulations.
☒	☐	6.	If a contract for consulting services is for $50,000 or more: The head of the using agency has prepared, signed and placed in the contract file a statement of the facts on which a determination of responsibility of offer or potential subcontractors have been filed with the statement.
☒	☐	7.	On subcontracting, it has been established that contractors recent performance history indicates acceptable subcontracting systems; or, major subcontractors have been determined by the heads of the using agency to satisfy this standard

R.F.P. CONSULTING CONTRACTS FOR $50,000 OR MORE; UNLESS DETERMINED EXEMPT AS PER ACT 673 of 1985, R.S. 39:1621.

☐ Contract file attached and this includes:
☐ Criteria for selection ☐ Proposals ☐ Pertinent Documents ☐ Selection Memorandum

PROGRAM / FACILITY SIGNATURE		ASSISTANT SECRETARY OR DESIGNEE SIGNATURE
		
OFFICE	PHONE NUMBER	OFFICE
Bureau of Health Services Financing		Bureau of Health Services Financing

STATE OF LOUISIANA
DIVISION OF ADMINISTRATION

Date: 4/11/2017 | Dept/Budget Unit/Program #: 09-305 / Prg 200

Dept/Agency/Program Name: LDH / Medical Vendor Administration / MVA | OCR/CFMS Contract #:

Agency/Program BA-22 # : 85 | LAGOV PO# 2000255086

Fiscal Year for this BA-22: 2016-2017 *(yyyy-yy)* | **BA-22 Start/End Dates:** 05/16/17 *(Start Date)* 06/30/17 *(End Date)*

Multi-year Contract (Yes/No): Yes | *If "Yes", provide contract dates:* 5/16/2017 *(Start Date)* 05/15/20 *(End Date)*

Mercer Health & Benefits LLC *(Contractor/Vendor Name)* | 310089776 *(Contractor/Vendor No.)*

Develop actuarially sound capitation rate ranges for the State of Louisiana's managed care program in accordance with federal regulations.

Contract Amendment (Yes/No): | **Amendment Start/End Dates:** *(Start Date)* *(End Date)*

Contract Cancellation (Yes/No): No | **Date of Cancellation:**

(Provide rationale for amendment or cancellation)

This information is to be provided at the Agency/Program Level

MEANS OF FINANCING	AMOUNT			
	Current Year	%	Total Contract	%
State General Fund	$348,125.00	50.00%	$8,079,445.00	50%
Interagency Transfers	$0.00	0.00%	$0.00	0%
Fees and Self Gen.	$0.00	0.00%	$0.00	0%
Statutory Dedication	$0.00	0.00%	$0.00	0%
Federal	$348,125.00	50.00%	$8,079,445.00	50%
TOTALS	$696,250.00	100.00%	$16,158,890.00	100.00%

**Specify Source (i.e., grant name, fund name, IAT sending agency and revenue source, fee type and source, etc.)*

Are revenue collections for funds utilized above in line with budgeted amounts? ***(Yes/No)*** Yes

If not, explain.

This information is to be provided at the Agency/Program Level

Name of Object Code/Category:	**Professional Services - Other Professional Services**
Object Code/Category Number:	3460
Amount Budgeted:	$155,787,253
Amount Previously Obligated:	**$ 69,134,244.62**
Amount this BA-22:	$696,250
Balance:	$86,653,008

The approval of the aforementioned contract will not cause this agency/program to be placed in an Object Category deficit.

Agy/Prg Contact: Rebecca Harris
Name: Rebecca Harris
Title: FMO Budget Analyst
Phone: 225-342-8454

Reviewed/Approved By: Debra Hyde for
Name: Lana Goldsmith
Title: Medicaid Program Manager 4
Phone: 225-342-4312

FOR AGENCY USE ONLY

AGENCY	PROGRAM	ACTIVITY	ORGANIZ.	OBJECT	REPT CAT	AMOUNT
305	200	FY17	7201	3460	4436	$ 696,250.00
305	200	FY18	7201	3460	4436	$ 5,448,580.00
305	200	FY19	7201	3460	4436	$ 5,171,155.00
305	200	FY20	7201	3460	4436	$ 4,842,905.00

305-187

2017 Request for Expenditures

This form should accompany all P-Card Statements to LDH Budget and Planning, HR2s to LDH Human Resources, and Payment Requests to LDH Fiscal Management

This form-**Section A**-should be sent to the LDH Budget Office for expenditure approval from the Undersecretary

Agency Number and Name	Date
305/Medical Vendor Administration	3/31/2017

Preparer Name	Preparer Title	Preparer Phone Number
Teresa Bravo	Medicaid Program Manager 2	225-342-0941

Assistant Secretary, Medicaid Director, or Executive Director Signature	Date
	4/6/17

SECTION A. This section is to be used for expenditures that **ARE SUBJECT TO THE FREEZE** as per Executive Order JBE 16-03. Approval from the Undersecretary is REQUIRED for these expenditures.

Category of Request (Double-click a checkbox, and then choose *Checked* under *Default value*.)

☐ **Operating Services** ☒ **Professional Services** ☐ **Supplies** ☐ **Acquisitions**

☐ **Salaries (T.O.)** ☐ **Other Comp (Non-T.O.)**

Position # _____ Position Name _____ Date of Vacancy _____

Budget Activity Associated with the Position _____
Total # of Positions included in the budget activity_____ Total vacancies in the budget Activity _____
If the position has been vacant for > 4 months, how have these duties been absorbed? _____
_____

☐ **Travel** Purpose of Travel _____

How many persons are going to the same destination at the same time? _____
Why is this travel critical to the agency? _____
What is the benefit to the agency as a result of the travel? _____
_____

Source of Funding (Double-click a checkbox, and then choose *Checked* under *Default value*.)

☒ **State General Fund** ☐ **IAT** ☐ **Fees/Self Gen** ☐ **Statutory Dedication** ☒ **Federal**

Agency Number	Organization	Object	Amount
305	7201	3460	$696,250

Description AND Justification for Expenditure ***(If additional space is needed, please include on the back of this form)***

Vendor: Mercer Health & Benefits, LLC
LaGov PO#: New/TBD
Description of Services: The contractor develops actuarially sound capitation rate ranges for the State of Louisiana's managed care program in accordance with federal regulations. (See next page for additional information.)

Undersecretary Signature	Date

☑ Approved by Undersecretary ☐ Disapproved by Undersecretary

Justification: The current contract with Mercer ends 5/15/2017. Mercer is currently working on a number of tasks—most significantly, the initiation of 2/1/2018 rate development (data validation, etc). They are also working on Financial Reporting Requirements (analysis of Q3 and Q4 of 2017, revisions for 2017), policy consulting, waiver consulting (1915b CMS-64 reporting), and the data book for the 2019 MCO RFP. A new contract is needed so there is no break in services. The entire amount of SFY 17 costs is anticipated to be spent in SFY 17.
MOF: 50% FFP ($348,125 SGF, $348,125 Federal)