CONSULTANT SERVICES AGREEMENT

This Services Agreement (the "Agreement") is between The Stephen Group ("TSG"), located at 814 Elm Street, Ste. 309, Manchester, New Hampshire, 03101, and the Bureau of Legislative Research ("BLR"), located in the State Capitol Building, Room 315, 500 Woodlane Street, Little Rock, Arkansas 72201. TSG provides Health Care Program Reform/Medicaid Consulting Services. The BLR desires to hire TSG to provide detailed and accurate information concerning the current state of health care programs in the State of Arkansas, as well as recommendations for alternatives to the current programs and options for modernizing Medicaid programs serving the indigent, aged, and disabled, as set forth in RFP No. BLR-150002 and TSG's response to the RFP (the "Services"), for the use and information of the Health Reform Legislative Task Force (the "Task Force") and the members of the Arkansas General Assembly.

TSG and the BLR hereby agree as follows:

1. **Services to be performed**. The BLR hereby retains TSG to perform the Services as set forth in RFP No. BLR-150002 (the "RFP") and TSG's Proposal in response to the RFP, including TSG's Official Proposal Price Sheet (the "Proposal"). Any and all assumptions stated by TSG in the Proposal shall not be considered part of this Agreement. The Services also include without limitation an audit of the rolls of all individuals receiving Medicaid and/or private option benefits within the State of Arkansas (to include all individuals, not a sample population) at a point in time with a listing of those individuals by identification number from the Medicaid and Private Option rolls that TSG deems potentially ineligible at that same point in time. The identifying information of the individuals deemed potentially ineligible by identification number shall be in a format useable by the Arkansas Department of Human Services at the time it is presented to the Task Force in TSG's final report on October 1, 2015. The RFP and the Proposal are attached hereto and incorporated into this agreement by reference as Attachment A.

2. **Data Required by TSG.** In order to perform the Services, TSG requires information that is held by various entities other than the BLR, including without limitation the Arkansas Department of Human Services, the Arkansas Department of Health, the Arkansas Insurance Department, and various private entities and providers. The parties acknowledge that such data and information is in the possession of third parties; that TSG must rely on these third parties to cooperate in providing this data and information; and that the data and information may be subject to laws restraining or preventing their release or dissemination. BLR authorizes TSG to contact the various entities holding the information that TSG requires in order to perform the Services under this Agreement. BLR Staff will be available to help to facilitate the contact with these entities upon request from TSG.

   TSG will keep and hold the Medicaid recipient data and any other information confidential in accordance with the "Business Associates Agreement" entered by and between TSG and the Arkansas Department of Human Services ("DHS") attached to this Agreement as Attachment B. The Business Associates Agreement imposes on TSG certain obligations in connection with Protected Health Information ("PHI") as required under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

3. **Deliverables.** TSG will prepare a report in electronic format (the "Deliverables") to be provided to the BLR for use by the Task Force and other committees of the Arkansas General Assembly. Except for the following, the BLR will own the Deliverables: (a) working papers of TSG; (b) pre-existing TSG materials or studies used in the provision of the Services and the Deliverables; (c) TSG know-how and processes used in the provision of the Services and Deliverables as well as any and all intellectual property owned by TSG that may be employed in providing the Services and Deliverables. TSG is providing the Services and Deliverables for the use and benefit of the Task Force and the Arkansas General Assembly. The Services and Deliverables are not for a third party's use, benefit or reliance, other than members of the General Assembly and as authorized by the Task Force Chairs. Except as described in Section 9 of this Agreement, TSG shall not discuss the Services or disclose the Deliverables until such time that the BLR provides TSG notice that the BLR has disclosed the Services and Deliverables to third parties.

4. **Term and Termination.** The term of this Agreement will commence on May 15, 2015, and terminate on December 31, 2016, with an option to renew for an additional six (6) month period upon mutual agreement of the parties if the need of the Task Force or the Arkansas General Assembly merits an extension.

   Either party may terminate the Agreement by giving ten (10) days prior written notice.

5. **Fees and Expenses.** The Fees and Expenses related to this Agreement are outlined in the Official Proposal Price Sheet that is part of the Proposal and incorporated in this Agreement by reference. The maximum amount BLR will pay to TSG for the provision of the Services is One Million Eighty One Thousand Five Hundred Dollars ($1,081,500.00). On a monthly basis (*e.g.* June 15, 2015, July 15, 2015, August 15, 2015) TSG shall submit itemized invoices to the BLR, per the requirements set forth in the RFP, based upon the per unit and per hour pricing set forth in TSG's response to the RFP. The monthly invoices will include reimbursements for travel related to the field work being performed by TSG. All mileage amounts will be calculated per Mapquest and copies of the Mapquest routes will be provided to the BLR with the monthly invoices, as well as copies of receipts for reimbursement of actual travel expenses.

   Upon receipt of the invoices from TSG, BLR will transmit the invoices and any accompanying documentation to DHS along with one half of the amount of the invoice per the terms of the Memorandum of Understanding entered by and between DHS and the BLR, and attached hereto as Attachment C.

   Per Section 4.2 of the RFP, in addition to the maximum contract amount, reimbursement for travel expenses related to attending meetings of the Task Force and other legislative committees of the Arkansas General Assembly, to which TSG was requested to attend by the chairs of the Task Force, will be reimbursed up to an amount not to exceed Thirty Five Thousand Dollars ($35,000.00). Reimbursement of any travel expenses related to attending meetings of the Task Force or other legislative committee meetings above this amount must be approved by the Task Force. TSG shall present receipts and Mapquest mileage routes with their invoices for these reimbursements. Payments for travel reimbursements under Section 4.2 of the RFP will be made solely by BLR and are not part of the Memorandum of Understanding at Attachment C hereto.

6. **Governing Law.** This Agreement shall be governed by the laws of the State of Arkansas, without regard to Arkansas's conflict of law principles. Nothing in this Agreement shall be construed as a waiver of sovereign immunity of the BLR, the Task Force, or the Arkansas General Assembly.

7. **Assignment.** This Agreement may not be assigned without the prior written consent of both parties, which either party may withhold for any reason. This Agreement shall be binding upon and inure to the benefit of the Parties hereto and their respective successors and permitted assigns.

8. **Amendment.** This Agreement may be amended upon agreement of both parties to the Agreement and the approval of the Task Force. Any amendment to this Agreement must be in writing and signed by both parties.

9. **Confidentiality.** "Confidential Information" under this Agreement means non-public information that a party marks as "confidential" or "proprietary" or that otherwise should be understood by a reasonable person to be confidential in nature. Confidential information does not include any information which is (a) rightfully known to the recipient prior to its disclosure; (b) released to any other person or entity (including governmental agencies) without restriction; (c) independently developed by the recipient without use of or reliance on Confidential Information; or (d) or later becomes publicly available without violation of this Agreement or may be lawfully obtained by a party from a non-party.

   Each party will protect the confidentiality of Confidential Information that it receives under the Agreement except as required by applicable law, rule, regulation, or professional standard, without the other party's prior written consent. Due to the BLR being a public entity within the State of Arkansas, all terms of this Agreement, including but not limited to fee and expense structure, are subject to disclosure under the Freedom of Information Act of 1967, Ark. Code Ann. § 25-19-101, *et seq.*

   If disclosure of TSG's Confidential Information is required by law, rule, regulation, or professional standard, (including any subpoena or other similar form of process), the BLR shall provide TSG with prior prompt written notice thereof.

   In consideration of TSG's and BLR's agreement to provide one another with access to their respective Confidential Information, TSG and BLR each agrees to maintain in confidence all Confidential Information of the other. Except as provided in this Agreement, neither TSG nor BLR shall in any manner disclose any Confidential Information of the other to any person, entity, firm or company whatsoever, without the express written consent of the other. TSG and BLR shall each take all steps necessary to ensure that their respective affiliates, officers, employees, independent contractors, agents and other representatives (collectively "Representatives") maintain the Confidential Information in confidence.

10. **Performance Standards.** At Section 1.2, Section 21., and Section 3.0 of the RFP, it is made clear that the final report of TSG regarding the work required under the RFP shall be provided to the BLR no later than October 1, 2015. This requires TSG to provide a final report that fully addresses all aspects of the Scope of Work under the RFP, including without limitation an audit of the rolls of all individuals receiving Medicaid and/or private option benefits within the State of Arkansas (to include all individuals, not a sample population) at a point in time. The audit of the rolls shall include a listing of those individuals by identification number in a

format useable by DHS for verification of the individuals eligibility from the Medicaid and Private Option rolls that TSG deems potentially ineligible at that same point in time, by October 1, 2015. Upon receipt of the final report, if a majority of the members of the Task Force find that the report does not fully encompass all aspects of the Scope of Work, TSG will be notified of the deficiencies and will have fourteen (14) calendar days to correct the stated deficiencies. If after resubmission of the corrected report, a majority of the Task Force finds that the deficiencies have not been cured, TSG will be assessed a performance penalty in the amount of $1,000.00 for each calendar day that TSG fails to provide the completed final report to the BLR, not to exceed ten percent (10%) of the total contract price.

[SIGNATURES APPEAR ON THE FOLLOWING PAGE]

IN WITNESS WHEREOF, TSG and BLR have executed this Agreement this 15th day of May, 2015.

The Stephen Group: _____

John Stephen, Managing Partner

_____

Printed Name

_____

Title

_____

Date

BUREAU OF LEGISLATIVE RESEARCH: _____

Marty Garrity, Director

_____

Printed Name

_____

Title

_____

Date

ATTACHMENT A

RFP No. BLR-150002

and

The Stephen Group Proposal in Response, including the Official Proposal Price Sheet

State of Arkansas
Bureau of Legislative Research

Marty Garrity, Director
Kevin Anderson, Assistant Director for Fiscal Services
Matthew Miller, Assistant Director for Legal Services
Richard Wilson, Assistant Director for Research Services

REQUEST FOR PROPOSAL

RFP Number: BLR-150002	
Commodity: **Health Care Program Reform/Medicaid Consulting Services**	Proposal Opening Date: **April 24, 2015**
Date: **March 30, 2015**	Proposal Opening Time: **4:30 P.M. CDT**

PROPOSALS WILL BE ACCEPTED UNTIL THE TIME AND DATE SPECIFIED ABOVE. THE PROPOSAL ENVELOPE MUST BE SEALED AND SHOULD BE PROPERLY MARKED WITH THE PROPOSAL NUMBER, DATE AND HOUR OF PROPOSAL OPENING, AND VENDOR'S RETURN ADDRESS. IT IS NOT NECESSARY TO RETURN "NO BIDS" TO THE BUREAU OF LEGISLATIVE RESEARCH.

Vendors are responsible for delivery of their proposal documents to the Bureau of Legislative Research prior to the scheduled time for opening of the particular proposal. When appropriate, Vendors should consult with delivery providers to determine whether the proposal documents will be delivered to the Bureau of Legislative Research office street address prior to the scheduled time for proposal opening. Delivery providers, USPS, UPS, FedEx, and DHL, deliver mail to our street address, State Capitol Building, Room 315, Little Rock, Arkansas 72201, on a schedule determined by each individual provider. These providers will deliver to our offices based solely on our street address.

MAILING ADDRESS: 500 Woodlane Street State Capitol Building, Room 315 Little Rock, Arkansas 72201 E-MAIL: thayerj@blr.arkansas.gov TELEPHONE: (501) 682-1937	PROPOSAL OPENING LOCATION: Bureau of Legislative Research Director's Office State Capitol Building, Room 315

Company Name: _____

Name (type or print): _____

Title: _____

Address: _____

Telephone Number: _____

Fax Number: _____

E-Mail Address: _____

Signature: _____

USE INK ONLY; UNSIGNED PROPOSALS WILL NOT BE CONSIDERED

Identification:	
Federal Employer ID Number	Social Security Number

FAILURE TO PROVIDE TAXPAYER IDENTIFICATION NUMBER MAY RESULT IN PROPOSAL REJECTION

Business Designation (check one):	Individual [ ]	Sole Proprietorship [ ]	Public Service Corp [ ]
	Partnership [ ]	Corporation [ ]	Government/ Nonprofit [ ]

GENERAL DESCRIPTION:	Health Care Program Reform/Medicaid Consulting Services
TYPE OF CONTRACT:	Term

MINORITY BUSINESS POLICY

Participation by minority businesses is encouraged in procurements by state agencies, and although it is not required, the Bureau of Legislative Research ("BLR") supports that policy. "Minority" is defined at Arkansas Code Annotated § 15-4-303 as "a lawful permanent resident of this state who is: (A) African American; (B) Hispanic American; (C) American Indian; (D) Asian American; (E) Pacific Islander American; or (F) A service-disabled veteran as designated by the United States Department of Veteran Affairs". "Minority business enterprise" is defined at Arkansas Code Annotated § 15-4-303 as "a business that is at least fifty-one percent (51%) owned by one (1) or more minority persons". The Arkansas Economic Development Commission conducts a certification process for minority businesses. Vendors unable to include minority-owned business as subcontractors may explain the circumstances preventing minority inclusion.

EQUAL EMPLOYMENT OPPORTUNITY POLICY

The Vendor shall submit a copy of the Vendor's Equal Opportunity Policy prior to the contract award. EO Policies may be submitted in electronic format to the Director of the Bureau of Legislative Research or as a hard copy accompanying the solicitation response. The Bureau of Legislative Research will maintain a file of all Vendor EO policies submitted in response to solicitations issued by the Bureau of Legislative Research. The submission is a one-time requirement, but Vendors are responsible for providing updates or changes to their respective policies.

TECHNOLOGY ACCESS FOR THE BLIND

Please reference Section 508 of the federal Rehabilitation Act, 29 U.S.C. 794d and Arkansas Code Annotated § 25-26-201 et seq. The Vendor expressly acknowledges that state funds may not be expended in connection with the purchase of information technology unless that system meets certain statutory requirements, in accordance with the State of Arkansas technology policy standards, relating to accessibility by persons with visual impairments.

Accordingly, the Vendor represents and warrants to the Bureau of Legislative Research that the technology provided to the Bureau of Legislative Research for purchase is capable either by virtue of features included within the technology or because it is readily adaptable by use with other technology of:

- Providing equivalent access for effective use by both visual and non-visual means;
- Presenting information, including prompts used for interactive communications, in formats intended for non-visual use; and
- After being made accessible, it can be integrated into networks for obtaining, retrieving, and disseminating information used by individuals who are not blind or visually impaired.

For purposes of this paragraph, the phrase "equivalent access" means a substantially similar ability to communicate with or make use of the technology, either directly by features incorporated within technology or by other reasonable means such as assistive devices or services that would constitute reasonable accommodations under the Americans with Disabilities Act or similar state or federal laws. Examples of methods by which equivalent access may be provided include, but are not limited to, keyboard alternatives to mouse commands and other means of navigating graphical displays and customizable display appearance.

EMPLOYMENT OF ILLEGAL IMMIGRANTS

The Vendor must certify prior to award of the contract that it does not employ or contract with any illegal immigrants in its contract with the Bureau of Legislative Research. Vendors shall certify online at https://www.ark.org/dfa/immigrant/index.php/user/login. Any subcontractors used by the Vendor at the time of the Vendor's certification shall also certify that they do not employ or contract with any illegal immigrant. Certification by the subcontractors shall be submitted within thirty (30) days after contract execution.

ALTERATION OF ORIGINAL RFP DOCUMENTS

The original written or electronic language of the RFP shall not be changed or altered except by approved written addendum issued by the Bureau of Legislative Research. This does not eliminate a Vendor from taking exception(s) to these documents, but it does clarify that the Vendor cannot change the original document's written or electronic language. If the Vendor wishes to make exception(s) to any of the original language, it must be submitted by the Vendor in separate written or electronic language in a manner that clearly explains the exception(s). If Vendor's/Contractor's submittal is discovered to contain alterations/changes to the original written or electronic documents, the Vendor's response may be declared non-responsive, and the response shall not be considered.

REQUIREMENT OF AMENDMENT

THIS RFP MAY BE MODIFIED ONLY BY AMENDMENTS WRITTEN AND AUTHORIZED BY THE BUREAU OF LEGISLATIVE RESEARCH. Vendors are cautioned to ensure that they have received or obtained and responded to any and all amendments to the RFP prior to submission.

DELIVERY OF RESPONSE DOCUMENTS

It is the responsibility of vendors to submit proposals at the place and on or before the date and time set in the RFP solicitation documents. Proposal documents received at the Bureau of Legislative Research Offices after the date and time designated for proposal opening are considered late proposals and shall not be considered. Proposal documents that are to be returned may be opened to verify which RFP the submission is for. Proposals may be submitted via e-mail to Jillian Thayer, Legal Counsel to the Director, at thayerj@blr.arkansas.gov.

INTENT TO AWARD

After complete evaluation of the proposal, the intent to award will be announced at the May 7, 2015 meeting of the Arkansas Health Reform Legislative Task Force (the "Task Force"). The purpose of the announcement is to establish a specific time in which vendors and agencies are aware of the intent to award. The Task Force reserves the right to waive this policy, The Intent to Award, when it is in the best interest of the state.

APPEALS

A Vendor who is aggrieved in connection with the award of a contract may protest to the Director of the Bureau of Legislative Research. The protest shall be submitted in writing within seven (7) calendar days after the intent to award is announced. After reasonable notice to the protestor involved and reasonable opportunity for the protestor to respond to the protest issues cited by the Director, the Arkansas Legislative Council, or the Joint Budget Committee if the Arkansas General Assembly is in session, shall promptly issue a decision in writing that states the reasons for the action taken. The Arkansas Legislative Council's or the Joint Budget Committee's decision is final and conclusive. In the event of a timely protest, the Bureau of Legislative Research shall not proceed further with the solicitation or with the award of the contract unless the co-chairs of the Arkansas Legislative Council or the Joint Budget Committee make a written determination that the award of the contract without delay is necessary to protect substantial interests of the state.

PAST PERFORMANCE

A Vendor's past performance may be used in the evaluation of any offer made in response to this solicitation. The past performance should not be greater than three (3) years old and must be supported by written documentation submitted to the Bureau of Legislative Research at the time of the proposal opening. Documentation may be in the form of either a written or electronic report, VPR, memo, file, or any other appropriate authenticated notation of performance to the vendor files.

DISCLOSURE FORMS

Completion of the EO-98-04 Governor's Executive Order contract disclosure forms located at http://www.dfa.arkansas.gov/offices/accounting/internalaudit/Pages/ExecutiveOrder98-04.aspx is required as a condition of obtaining a contract with the Bureau of Legislative Research.

SECTION I. GENERAL INFORMATION

1.0 INTRODUCTION

The purpose of this Request For Proposal ("RFP") issued by the Bureau of Legislative Research ("BLR") is to invite responses ("Proposals") from Vendors desiring to provide health care program reform/Medicaid consulting services for the Task Force. The Task Force intends to execute one contract as a result of this procurement ("the Contract"), if any contract is issued at all, encompassing all of the products and services contemplated in this RFP, and Proposals shall be evaluated accordingly. All Vendors must fully acquaint themselves with the Task Force's needs and requirements and obtain all necessary information to develop an appropriate solution and to submit responsive and effective Proposals.

1.1 ISSUING AGENCY

This RFP is issued by the BLR for the Task Force. The BLR is the sole point of contact in the state for the selection process. Vendor questions regarding RFP-related matters should be made in writing (via e-mail) through the Director of the BLR's Legal Counsel, Jillian Thayer, thayerj@blr.arkansas.gov. Questions regarding technical information or clarification should be addressed in the same manner.

1.2 SCHEDULE OF EVENTS

Release RFP	March 30, 2015
Closing for receipt of proposals and opening of proposals	April 24, 2015 at 4:30 p.m. CDT
Evaluation of proposals	Approximately 10 business days after proposal opening
Presentations/Intent to Award	May 6-7, 2015, meetings of the Task Force
Approval of draft contract by Task Force	Within 1 week after intent to award
Approval of draft contract by the Executive Subcommittee of the Legislative Council	May 14, 2015
Approval of contract by Legislative Council	May 15, 2015
Contract Execution/Contract Start Date	Upon approval of the Legislative Council
Final Report Due	October 1, 2015

Proposals are due no later than the date and time listed on Page 1 of the RFP.

1.3 CAUTION TO VENDORS

- During the time between the proposal opening and contract award, any contact concerning this RFP will be initiated by the issuing office or requesting entity and not the Vendor. Specifically, the person(s) named herein will initiate all contact.

- **Vendors are requested to respond to each numbered paragraph of the RFP.**

- Vendors must submit one (1) signed original proposal on or before the date specified on page one of this RFP. The Vendor should submit two (2) electronic versions (one (1) redacted electronic version and one (1) unredacted electronic version), preferably in MS Word/Excel format, on CD or via e-mail. **Do NOT include any pricing from the Official Proposal Price Sheet on the copies, including on the CD or in the e-mail. Pricing from the Official Proposal Price Sheet, attached as Attachment A, must be separately sealed and submitted from the proposal response and clearly marked as pricing information. The electronic version of the Official Proposal Price Sheet must also be sealed and submitted separately from the electronic version of the proposal and, if submitted via e-mail, the e-mail must clearly state that the attachment contains pricing information.** Failure to submit the required number of copies with the proposal may be cause for rejection. If the BLR requests additional copies of the proposal, they must be delivered within twenty-four (24) hours of request.

- For a proposal to be considered, an official authorized to bind the Vendor to a resultant contract must have signed the proposal and the Official Proposal Price Sheet.

- All official documents and correspondence shall be included as part of the resultant Contract.

- The Task Force reserves the right to award a contract or reject a proposal for any or all line items of a proposal received as a result of this RFP, if it is in the best interest of the Task Force to do so. Proposals will be rejected for one or more reasons not limited to the following:
    a. Failure of the Vendor to submit his or her proposal(s) on or before the deadline established by the issuing office;
    b. Failure of the Vendor to respond to a requirement for oral/written clarification, presentation, or demonstration;
    c. Failure to supply Vendor references;
    d. Failure to sign an Official RFP Document;
    e. Failure to complete the Official Proposal Price Sheet(s) and include them sealed separately from the rest of the proposal;
    f. Any wording by the Vendor in their response to this RFP, or in subsequent correspondence, which conflicts with or takes exception to a requirement in the RFP; or
    g. Failure of any proposed services to meet or exceed the specifications.

1.4 RFP FORMAT

Any statement in this document that contains the word **"must"** or **"shall"** means that compliance with the intent of the statement is mandatory, and failure by the Vendor to satisfy that intent will cause the proposal to be rejected. It is recommended that Vendors respond to each item or paragraph of the RFP in sequence. Items not needing a specific vendor statement may be responded to by concurrence or acknowledgement; a failure to provide a response will be interpreted as an affirmative response or agreement to the BLR conditions. Reference to handbooks or other technical materials as part of a response must not constitute the entire response, and Vendor must identify the specific page and paragraph being referenced.

1.5 SEALED PRICES

The Official Proposal Price Sheet submitted in response to this RFP must be submitted separately sealed from the proposal response or submitted in a separate e-mail. ***Vendors must include all pricing information on the Official Price Proposal Sheet and*** **must clearly mark said page(s) and e-mail as pricing information. The electronic version of the Official Proposal Price Sheet must also be sealed separately from the electronic version of the proposal and submitted on CD or in a separate e-mail.** Vendors must expand on items to identify all costs as specified.

1.6 TYPE OF CONTRACT

This will be a term contract commencing on the date of execution of the Contract and terminating on December 31, 2016, with an option for one (1) renewal of up to six (6) months. The BLR will have the option to renegotiate at time of renewal.

1.7 PAYMENT AND INVOICE PROVISIONS

All invoices shall be delivered to the BLR and must show an itemized list of charges. The Invoice, Invoice Remit, and Summary must be delivered via email to Jillian Thayer, Legal Counsel to the Director, at thayerj@blr.arkansas.gov .

The BLR shall have no responsibility whatsoever for the payment of any federal, state, or local taxes that become payable by the Successful Vendor or its subcontractors, agents, officers, or employees. The Successful Vendor shall pay and discharge all such taxes when due.

Payment will be made in accordance with applicable State of Arkansas accounting procedures upon acceptance by the BLR. The BLR may not be invoiced in advance of delivery and acceptance of any services. Payment will be made only after the Successful Vendor has successfully satisfied the BLR as to the reliability and effectiveness of the services as a whole. Purchase Order Number and/or Contract Number should be referenced on each invoice.

The Successful Vendor shall be required to maintain all pertinent financial and accounting records and evidence pertaining to the Contract in accordance with generally accepted principles of accounting and other procedures specified by the BLR. Access will be granted to state or federal government entities or any of their duly authorized representatives upon request.

Financial and accounting records shall be made available, upon request, to the BLR's designee(s) at any time during the contract period and any extension thereof and for five (5) years from expiration date and final payment on the Contract or extension thereof.

1.8 PROPRIETARY INFORMATION

Proposals and documents pertaining to the RFP become the property of the BLR and after proposal opening shall be open to public inspection pursuant to the Arkansas Freedom of Information Act, § 25-19-101, *et seq*. It is the responsibility of the Vendor to identify all proprietary information and to seal such information in a separate envelope or e-mail marked as confidential and proprietary.

The Vendor must submit one (1) complete copy of the proposal from which any proprietary information has been removed, *i.e.*, a redacted copy. The redacted copy should reflect the same pagination as the original, show the empty space from which information was redacted, and be submitted on a CD or in a separate e-mail. Except for the redacted information, the CD or electronic copy must be identical to the original hard copy. The Vendor is responsible for ensuring the redacted copy on CD or submitted via e-mail is protected against restoration of redacted data.

1.9 BID EVALUATION

The Task Force will evaluate all proposals to ensure all requirements are met. The Contract will be awarded on the basis of the proposal that most thoroughly satisfies the relevant criteria as defined in the evaluation criteria.

1.10 ORAL AND/OR WRITTEN PRESENTATIONS/DEMONSTRATIONS

The Task Force will select a small group of Vendors from among the proposals submitted to attend the May 6 and 7, 2015 meetings of the Task Force to answer questions and to make oral and/or written presentations to the Task Force. All presentations are subject to be recorded.

All expenses of the Vendor associated with attending the May 6 and 7, 2015 Task Force meetings will be borne by the Vendor.

The Successful Vendor selected by the Task Force shall attend the May 14, 2015 meeting of the Executive Subcommittee of the Legislative Council and the May 15, 2015 meeting of the Legislative Council, and actual expenses of the Vendor in attending these meetings will be reimbursed.

1.11 PRIME CONTRACTOR RESPONSIBILITY

The Successful Vendor will be required to assume prime contractor responsibility for the Contract and will be the sole point of contact.

The Task Force reserves the right to interview the key personnel assigned by the Successful Vendor to this project and to recommend or require reassignment of personnel deemed unsatisfactory by the Task Force.

The Task Force reserves the right to approve subcontractors for this project and require primary contractors to replace subcontractors that are found to be unacceptable.

If any part of the work is to be subcontracted, the Vendor must disclose the same information for the subcontractor as for itself. Responses to this RFP must include a list of subcontractors, including firm name and address, contact person, complete description of work to be subcontracted, and descriptive information concerning subcontractor's business organization.

1.12 DELEGATION AND/OR ASSIGNMENT

The Vendor shall not assign the Contract in whole or in part or any payment arising therefrom without the prior written consent of the BLR, as approved by the Task Force. The Vendor shall not delegate any duties under the Contract to a subcontractor unless the BLR, as approved by the Task Force, has given written consent to the delegation.

1.13 CONDITIONS OF CONTRACT

The Successful Vendor shall at all times observe and comply with federal and state laws, local laws, ordinances, orders, and regulations existing at the time of or enacted subsequent to the execution of the Contract which in any manner affect the completion of the work. The Successful Vendor shall indemnify and save harmless the BLR, the Task Force, the Arkansas General Assembly, and the State of Arkansas and all of their officers, representatives, agents, and employees against any claim or liability arising from or based upon the violation of any such law, ordinance, regulation, order, or decree by an employee, representative, or subcontractor of the Successful Vendor.

1.14 CANCELLATION

In the event the Task Force no longer needs the service or commodity specified in the Contract or purchase order due to program changes, changes in laws, rules, or regulations, relocation of offices, or lack of appropriated funding, the BLR, with the approval of the Task Force, may cancel the Contract or purchase order by giving the Vendor written notice of such cancellation ten (10) days prior to the date of cancellation and a right to a hearing before the Task Force.

1.15 STATEMENT OF LIABILITY

The BLR and the Task Force will demonstrate reasonable care but shall not be liable in the event of loss, destruction, or theft of contractor-owned technical literature to be delivered or to be used in the installation of deliverables. The Vendor is required to retain total liability for technical literature until the deliverables have been accepted by the authorized BLR official. At no time will the BLR or the Task Force be responsible for or accept liability for any Vendor-owned items.

The Successful Vendor shall indemnify and hold harmless the Task Force and its members, the BLR and its officers, directors, agents, retailers, and employees, and the State of Arkansas from and against any and all suits, damages, expenses, losses, liabilities, claims of any kind, costs or expenses of any nature or kind, including, with limitation, court costs, attorneys' fees, and other damages, arising out of, in connection with, or resulting from the development, possession, license, modification, disclosure, or use of any copyrighted or non-copyrighted materials, trademark, service mark, secure process, invention, process or idea (whether patented or not), trade secret, confidential information, article, or appliance furnished or used by a vendor in the performance of the Contract.

Nothing in this RFP or the resulting contract shall be construed as a waiver of sovereign immunity.

1.16 AWARD RESPONSIBILITY

The BLR will be responsible for award and administration of any resulting contract(s).

1.17 INDEPENDENT PRICE DETERMINATION

By submission of this proposal, the Vendor certifies, and in the case of a joint proposal, each party thereto certifies as to its own organization, that in connection with this proposal:

- The prices in the proposal have been arrived at independently, without collusion, and that no prior information concerning these prices has been received from or given to a competitive company; and
- If there is sufficient evidence of collusion to warrant consideration of this proposal by the Office of the Attorney General, all Vendors shall understand that this paragraph may be used as a basis for litigation.

1.18 PUBLICITY

News release(s), media interviews, or other publicity by a Vendor pertaining to this RFP or any portion of the project shall not be made without prior written approval of the BLR. Failure to comply with this requirement is deemed to be a valid reason for disqualification of the Vendor's proposal.

The Successful Vendor agrees not to use the BLR's, the Task Force's, or the Arkansas General Assembly's names, trademarks, service marks, logos, images, or any data arising or resulting from this RFP or the Contract as part of any commercial advertising or proposal without the express prior written consent of the BLR and the Task Force in each instance.

1.19 CONFIDENTIALITY

The Successful Vendor shall be bound to confidentiality of any confidential information that its employees may become aware of during the course of performance of contracted services. Consistent and/or uncorrected breaches of confidentiality may constitute grounds for cancellation of the Contract.

The Successful Vendor shall represent and warrant that its performance under the Contract will not infringe any patent, copyright, trademark, service mark, or other intellectual property rights of any other person or entity and that it will not constitute the unauthorized use or disclosure of any trade secret of any other person or entity.

1.20 PROPOSAL TENURE

All Proposals shall remain valid for one hundred eighty (180) calendar days from the Proposal due date referenced on Page 1 of the RFP.

1.21 COST

All charges must be included on the Official Proposal Price Sheet, must be valid for one hundred eighty (180) days following proposal opening, and shall be included in the cost evaluation. The pricing must include all associated costs for the service being bid. **Pricing from the Official Proposal Price Sheet must be separately sealed from the proposal response and clearly marked as pricing information. Do not include any pricing from the Official Proposal Price Sheet on the copies, including the CD or e-mail. The electronic version of the Official Proposal Price Sheet must also be sealed and submitted separately from the electronic version of the proposal.**

The BLR will not be obligated to pay any costs not identified on the Official Proposal Price Sheet. Any cost not identified by the Vendor but subsequently incurred in order to achieve successful operation will be borne by the Vendor.

Official Proposal Price Sheets may be reproduced as needed. Vendors may expand items to identify all proposed services. A separate listing, which must include pricing, may be submitted with summary pricing.

1.22 WARRANTIES

- The Successful Vendor shall warrant that it currently is, and will at all times remain, lawfully organized and constituted under all federal, state, and local law, ordinances, and other authorities of its domicile and that it currently is, and will at all times remain, in full compliance with all legal requirements of its domicile and the State of Arkansas.

- The Successful Vendor shall warrant and agree that all services provided pursuant to this RFP and the Contract have been and shall be prepared or done in a workman-like manner consistent with the highest standards of the industry in which the services are normally performed. The Successful Vendor further represents and warrants that all computer programs implemented for performance under the Contract shall meet the performance standards required thereunder and shall correctly and accurately perform their intended functions.

- The Successful Vendor shall warrant that it is qualified to do business in the State of Arkansas and shall file appropriate tax returns as provided by the laws of this State.

1.23 CONTRACT TERMINATION

Subsequent to award and execution of the Contract, either party may terminate the Contract by providing ten (10) days prior written notice.

1.24 VENDOR QUALIFICATIONS

The Successful Vendor must, upon request of the Task Force, furnish satisfactory evidence of its ability to furnish products or services in accordance with the terms and conditions of this proposal. The Task Force reserves the right to make the final determination as to the Vendor's ability to provide the services requested herein.

The Vendor must demonstrate that it possesses the capabilities and qualifications described in Sections 3 and 5, including without limitation the following:

- Be capable of providing the services required by the Task Force;
- Be authorized to do business in this State; and
- Complete the Official Proposal Price Sheet in Attachment A.

1.25 NEGOTIATIONS

As provided in this RFP, discussions may be conducted with a responsible Vendor who submits proposals determined to be reasonably susceptible of being selected for award for the purpose of obtaining clarification of proposal responses and negotiation for best and final offers.

1.26 LICENSES AND PERMITS

During the term of the Contract, the Vendor shall be responsible for obtaining, and maintaining in good standing, all licenses (including professional licenses, if any), permits, inspections, and related fees for each or any such licenses, permits, and/or inspections required by the state, county, city, or other government entity or unit to accomplish the work specified in this solicitation and the contract.

1.27 OWNERSHIP OF DATA & MATERIALS

All data, material, and documentation prepared for the Task Force pursuant to the Contract shall belong exclusively to the BLR, for the use of the Task Force.

SECTION 2. OVERVIEW

2.0 ARKANSAS HEALTH REFORM ACT OF 2015 OVERVIEW

The Arkansas Health Reform Act of 2015 (the "Act"), enacted by the 90th General Assembly, represents the Arkansas General Assembly's intentions to "seek out strategies to provide health care for low-income and other vulnerable populations in a manner that will promote accountability, personal responsibility, and transparency; remove disincentives for work and social mobility; encourage and reward healthy outcomes

and responsible choices; and promote efficiencies that will deliver value to the taxpayers". In order to accomplish these goals, the Act created the Arkansas Health Reform Legislative Task Force and set forth two purposes of the Task Force, as follows:

- To recommend an alternative healthcare coverage model and legislative framework to ensure the continued availability of healthcare services for vulnerable populations covered by the Health Care Independence Program established by the Health Care Independence Act of 2013, §§ 20-77-2401, *et seq*., upon program termination; and

- To explore and recommend options to modernize Medicaid programs serving the indigent, aged, and disabled.

2.1 OBJECTIVES

It is the objective of the Task Force, by entering into a Contract for consultant services, to provide to the members of the Arkansas General Assembly detailed and accurate information concerning the current state of health care programs in the State of Arkansas, as well as recommendations for alternatives to the current programs and options for modernizing Medicaid programs serving the indigent, aged, and disabled. **The Vendor shall provide this information in a final report to be submitted to the Task Force no later than October 1, 2015.** This information will allow the Task Force to adequately assess the needs in the state in order achieve the requirements of the Arkansas Health Reform Act of 2015.

This Request for Proposal is designed to obtain a Contract to provide health care program reform/Medicaid consulting services to the Task Force. All responses to this RFP shall reflect the overall goals and objectives stated herein. The Vendor shall bill the BLR on an hourly basis for the services provided.

SECTION 3. HEALTH CARE PROGRAM REFORM/MEDICAID CONSULTING SERVICES

3.0 SCOPE OF WORK/SPECIFICATIONS

It will be the responsibility of the Vendor to provide the Task Force and, ultimately, the members of the Arkansas General Assembly with an accurate and detailed report, including information concerning:

- Recommendations for an alternative healthcare coverage model to ensure the continued availability of healthcare services for vulnerable populations covered by the Health Care Independence Program established by the Health Care Independence Act of 2013, §§ 20-77-2401, et seq., upon program termination, including an examination of the following:

    - Resources and funding necessary to ensure an effective and efficient transition from the Health Care Independence Program, while minimizing or eliminating any need for the General Assembly to raise additional state general revenue;

    - Populations eligible for and participating in the Health Care Independence Program, including both individuals newly eligible for health coverage under the program and individuals previously eligible for Medicaid before the effective date of the program, whether under a Medicaid waiver or some other eligibility criteria to specifically reference the complex populations;

    - The health care needs and other relevant characteristics of those populations served by the Health Care Independence Program;

    - Recommendations for measures and options to preserve access to quality health care for those populations served by the Health Care Independence Program;

- An estimate of the impact of the Health Care Independence Program and its termination on the state's economy as a whole and on the state's general revenue budget, including impact on hospitals, clinics, and ancillary health care providers;

- Descriptions and comparisons of other states' plans for implementing Medicaid expansion;

- Examination of the impact of the Health Care Independence Program on retention of physicians and other ancillary health care providers in the state;

- Examination of the impact of the Health Care Independence Program on performance of hospitals within the state, including a comparison to performance of hospitals in states that do not have Medicaid expansion programs;

- Examination of the short term and long term impacts of the use of premium assistance through the Health Care Independence Program on the private health insurance marketplace in terms of carrier competition, actuarial risk pool, provider payment rates, health care system stability, federal tax credits for individuals above 138% of the Federal Poverty Level, and client outcomes;

- Recommendations for options to modernize Medicaid programs serving the indigent, aged, and disabled, including an examination of the following:

  - An audit of the current Medicaid system in Arkansas to include without limitation an examination of: verification of eligibility of individuals currently on the Medicaid rolls and recommendations for removal of any individuals found not to meet eligibility criteria, determination of the number of services per enrolled individual, Medicaid provider categories and recommendations for the categories to reflect the appropriate performing providers, and the utilization and cost of prescription medications and recommendation for the reduction of those costs;

  - An examination of case management tracking for beneficiaries across social services programs;

  - Recommendations regarding contract consolidation and administrative efficiencies;

  - Comparison of the results of the audit of the Arkansas Medicaid program to programs in other states, including a comparison of the administration of the Arkansas program to other states' organization and administration of their programs, and any recommendations regarding the restructuring of the Arkansas program;

  - Descriptions and comparisons of successful Medicaid block grant programs;

  - Recommendations of procedures to optimize and streamline the legislative review and approval process for state plan amendments and other Medicaid rules, so as to promote efficiency, ensure agency responsiveness to changing market conditions, encourage transparency, and protect against undue influence by special interests;

- An examination of the roles of other agencies in the state that impact the patient populations under both the Health Care Independence Program and traditional Medicaid, including without limitation the Arkansas Department of Health, the Arkansas Department of Corrections, the Department of Community Corrections, and the Arkansas Insurance Department;

- An explanation of how the recommendations regarding the alternative health care coverage model and the recommendations regarding modernization of Medicaid programs serving the indigent, aged, and disabled will impact one another, including without limitation economic impact and impact on patient populations, and impact on the private sector. The explanation should include an explanation of any funding streams identified through Medicaid to assist with payment of the recommended alternative health care coverage models;

- Ad hoc reports regarding Medicaid claims data independent of current Business Object Software used by the Department of Human Services (DHS), Division of Medical Services (DMS); and

- A cost analysis or actuarial projection for the Vendor's recommendations based on specific categories of services.

All recommendations and options should demonstrate how the following shall be achieved and should be structured in such a way as to achieve:

- Protection of Arkansas workers and employers from federal mandates and regulations by limiting the role of the federal government in defining the health care choices and coverage available in the Arkansas health insurance market;

- Maximum flexibility for the state and limitations on federal restrictions on the state's ability to efficiently and effectively manage the Arkansas Medicaid Program;

- Opportunities to limit the size of the traditional Medicaid program by serving healthier beneficiaries in the most cost effective/beneficial method for the State of Arkansas;

- Strengthening the employer-sponsored health insurance market;

- Increased employment of able-bodied recipients of taxpayer-funded healthcare services;

- Healthier behaviors, increased accountability, and personal responsibility for beneficiaries;

- Reduction in number of unplanned pregnancies in the state;

- Enlistment of enough providers so that care and services are available at least to the extent that such care and services are available under the Health Care Independence Program;

- Access to health services in rural areas of the state, including use of technology to overcome distance and financial barriers;

- Improved access to health services for people with developmental disabilities;

- Continuity of coverage for eligible individuals as their income or life circumstances change; and

- Continued payment innovation, delivery system reform, and market-driven improvements, including without limitation the Arkansas Health Care Payment Improvement Initiative, Health Maintenance Organizations (HMOs), Patient-Centered Medical Home (PCMH)/Primary Care Case Management (PCCM) models, and concierge service arrangements (as implemented by Act 101 of 2015).

In addition to preparation of a final report, the Successful Vendor will provide the Task Force with monthly status updates on the project, which will require monthly attendance at meetings of the Task Force to answer questions regarding the status updates. The Successful Vendor will also need to be available to attend other meetings of the Task Force as requested by the Task Force Co-Chairs.

In the event that services in addition to those described in this Section 3.0 Scope of Work/Specifications are required during the term of the Contract, the Co-chairs of the Arkansas Legislative Council shall have the power to approve the additional services and an additional fee for those services in an amount not to exceed ten percent (10%) of the Vendor's total maximum amount of the bid as submitted in the Official Proposal Price Sheet and agreed upon in the Contract, upon recommendation of the Task Force.

The Vendor may find it necessary and prudent to pull data from existing studies recently undertaken by other consultants or state agencies. In the event that the Vendor utilizes any information from other

reports or studies, the Vendor shall first verify the methodology employed in compiling the data in the reports and the accuracy of the data therein. Documentation of this verification process shall be provided in the final report of the Vendor, which will be **due no later than October 1, 2015**.

3.1 HEALTH CARE PROGRAM REFORM/MEDICAID CONSULTING

The health care program reform/Medicaid consulting services provided by the Successful Vendor pursuant to this Request for Proposal must address the stated specifications and requirements. These services will be provided to the Task Force.

As requested by the Task Force, the Vendor must attend various meetings of the Task Force and other legislative committees of the Arkansas General Assembly. Hourly compensation will be paid for meeting times in addition to reimbursement of actual travel expenses. The Vendor shall explain any anticipated limitations in its ability to attend meetings of the Task Force.

All projects shall be paid pursuant to the fee schedule. The Vendor shall submit itemized invoices to the BLR, which will pay the invoices on a monthly basis.

The Task Force does not grant the Vendor exclusive rights to all health care program reform/Medicaid consulting services contemplated under this RFP. In the event the Task Force decides that the acquisition of these services by another Vendor is in the Task Force's best interest, the Task Force reserves the right to contract and purchase health care program reform/Medicaid consulting services from a different source outside of the contract resulting from this RFP, and the Task Force's action to procure services outside of the Contract does not infringe upon, nor terminate, the contract resulting from this Request For Proposal.

3.2 PROCUREMENT OF GOODS AND SERVICES

If the Vendor anticipates the need to procure additional goods or services in order to provide the health care program reform/Medicaid consulting services requested in this RFP, the Vendor must identify the goods and/or services that may be procured, the reason the procurement is necessary, the name of the vendor from whom the goods or services are to be procured, and the anticipated cost of the goods and/or services to be procured.

A Vendor does not need to restate each item listed in this Section 3.2 but will be bound by all applicable specifications. Information relating to these matters should be incorporated into the Proposal. A Vendor must provide in detail any limitations in meeting the requirements stated in Section 3.

SECTION 4. COST PROPOSAL

4.0 COMPENSATION

Compensation for health care program reform/Medicaid consulting services shall be paid based upon the work performed as specified in this RFP. The budget is subject to approval by the Task Force. A Vendor seeking consideration shall submit a compensation proposal as required below for health care program reform/Medicaid consulting services as provided throughout the RFP.

The fee schedule, as set forth on the Official Proposal Price Sheet, will cover the time spent in the completion of the requested task or project, as well as other administrative costs (including, but not limited to, secretarial, bookkeeping, budget preparation, monitoring and auditing services, etc.) The fee schedule will cover any and all travel expenses anticipated in relation to conducting the work required under this RFP and resulting Contract. The fee schedule will cover the time expended inclusive of all overhead or any other costs associated with the particular individuals who may be performing the services.

4.1 PAYMENT SCHEDULE

The BLR shall pay the Vendor based on the hours expended for approved projects on a monthly basis or as otherwise may be agreed to in writing by the parties. The BLR may request and the Vendor shall

provide timesheets or other documentation as may be directed by the BLR prior to the payment for any services rendered. Failure to provide appropriate and satisfactory documentation will be sufficient grounds to withold payment for the disputed amount, but other nondisputed amounts must be paid in a timely manner.

4.2 TRAVEL, LODGING, AND MEALS

The Successful Vendor may submit invoices and receive reimbursement for travel expenses allowed by law related to attending meetings of the Task Force and other legislative committeess of the Arkansas General Assembly up to thirty five thousand dollars ($35,000). Reimbursement of any travel expenses above this amount must be approved by the Task Force.

Actual expenses as allowed by law for travel related to field work required by the Contract and this RFP should be included by the Vendor in the fee schedule, as required by Section 4.0.

SECTION 5. ADDITIONAL VENDOR REQUIREMENTS

5.0 COMPREHENSIVE VENDOR INFORMATION

All proposals should be complete and carefully worded and should convey all of the information requested by the Task Force. If significant errors are found in the Vendor's proposal, or if the proposal fails to conform to the essential requirements of the RFP, the Task Force will be the sole judge as to whether that variance is significant enough to reject the proposal. Proposals should be prepared simply and economically, providing a straightforward, concise description of the Vendor's capabilities to satisfy the requirements of the RFP. Emphasis should be on completeness and clarity of the content. Proposals that include either modifications to any of the contractual requirements of the RFP or a Vendor's standard terms and conditions may be deemed non-responsive and therefore not considered for award.

5.1 VENDOR PROFILE

Vendor must submit the following:

- Business Name;
- Business Address;
- Alternate Business Address;
- Primary Contact Name, Title, Telephone, Fax, and E-mail Address;
- How many years this company has been in this type of business;
- Proof that the Vendor is qualified to do business in the State of Arkansas;
- A disclosure of the Vendor's name and address and, as applicable, the names and addresses of the following: If the Vendor is a corporation, the officers, directors, and each stockholder of more than a ten percent (10%) interest in the corporation. However, in the case of owners of equity securities of a publicly traded corporation, only the names and addresses of those known to the corporation to own beneficially five percent (5%) or more of the securities need be disclosed; if the Vendor is a trust, the trustee and all persons entitled to receive income or benefits from the trust; if the Vendor is an association, the members, officers, and directors; and if the Vendor is a partnership or joint venture, all of the general partners, limited partners, or joint venturers;
- A disclosure of all the states and jurisdictions in which the Vendor does business and the nature of the business for each state or jurisdiction;
- A disclosure of all the states and jurisdictions in which the Vendor has contracts to supply health care program reform/Medicaid consulting services and the nature of the goods or services involved for each state or jurisdiction;

- A disclosure of the details of any finding or plea, conviction, or adjudication of guilt in a state or federal court of the Vendor for any felony or any other criminal offense other than a traffic violation committed by the persons identified as management, supervisory, or key personnel;

- A disclosure of the details of any bankruptcy, insolvency, reorganization, or corporate or individual purchase or takeover of another corporation, including without limitation bonded indebtedness, and any pending litigation of the Vendor;

- A disclosure of any conflicts of interest on the part of the Vendor or its personnel that will be working on this project, especially regarding financial interests that would be impacted depending on the recommendations ultimately made by the Task Force.

- Additional disclosures and information that the Task Force may determine to be appropriate for the procurement involved.

5.2 GENERAL INFORMATION

Vendor shall submit any additional information for consideration such as specialized services, staffs available, or other pertinent information the Vendor may wish to include.

5.3 DISCLOSURE OF LITIGATION

A Vendor must include in its Proposal a complete disclosure of any civil or criminal litigation or indictment involving such Vendor. A Vendor must also disclose any civil or criminal litigation or indictment involving any of its joint ventures, strategic partners, prime contractor team members, and subcontractors. This disclosure requirement is a continuing obligation, and any litigation commenced after a Vendor has submitted a Proposal under this RFP must be disclosed to the BLR in writing within five (5) days after the litigation is commenced.

5.4 EXECUTIVE SUMMARY

A Vendor must provide a summary overview and an implementation plan for the entire project being proposed. The intent of this requirement is to provide the Task Force with a concise but functional summary of the discussion of each phase of the Vendor's plan in the order of progression. While the Task Force expects a Vendor to provide full details in each of the sections in other areas of the RFP relating to its plan, the Executive Summary will provide a "map" for the Task Force to use while reviewing the Proposal.

Each area summarized must be listed in chronological order, beginning with the date of Contract execution, to provide a clear indication of the flow and duration of the project. A Vendor may use graphics, charts, pre-printed reports, or other enhancements as a part of this section to support the chronology or add to the presentation. Any such materials must be included in the original and each copy of the Proposal.

5.5 VENDOR'S QUALIFICATIONS

A Vendor shall provide resumes or short biographies and qualifications of all management, supervisory, and key personnel to be involved in performing the services contemplated under this RFP. The resumes shall present the personnel in sufficient detail to provide the Task Force with evidence that the personnel involved can perform the work specified in the RFP. A Vendor shall provide a brief history of its company, to include the name and location of the company and any parent/subsidiary affiliation with other entities. If a Vendor is utilizing the services of a subcontractor(s) for any of the service components listed, the Vendor shall include in its proposal response a brief history of the subcontractor's company to include the information requested herein.

Vendor shall verify its ability to extract the Medicaid claims data from the current Medicaid Management Information Systems (MMIS) to produce ad hoc reports independent of current Business Object Software used by the Department of Human Services, Division of Medical Services (DHS/DMS). The Vendor shall also verify its ability to produce a report utilizing the Current Proceducral Technology (CPT) codes, modifiers, and diagnosis per beneficiary, provider and performing provider.

A Vendor shall provide:

- A brief professional history, including the number of years of experience in health care program reform/Medicaid consulting and any professional affiliations and trade affiliations.
- A listing of current accounts and the longevity of those accounts.
- An organizational chart highlighting the names/positions that will be involved in the contract, including the individual who will be primarily responsible for managing the account on a day-to-day basis.
- An outline of the Vendor's or employees' experience in health care program reform/Medicaid assessment, research, and reporting.
- A full explanation of staffing, functions, and methodology to be used in areas of health care program reform/Medicaid assessment and account management, identifying specifically the personnel that will be assigned to the account. All such personnel are subject to Task Force approval. Describe any staff functions that are considered unique to the account.
- A detailed description of the plan for assisting the Task Force in meeting its goals and objectives, including how the requirements will be met and what assurances of efficiency and success the proposed approach will provide.
- An indication of how soon after the contract award the personnel named would be available and indicate any possible scheduling conflicts that might exist during the period of the contract. Any other limitations on the availability to perform under this RFP or to attend meetings must be fully explained.
- An indication of the timeframe the Vendor would require to assist the Task Force in meeting its goals and objectives.
- A detailed, narrative statement listing the three (3) most recent, comparable contracts (including contact information) that the Vendor has performed and the general history and experience of its organization.
- At least two (2) samples of the Vendor's work on comparable projects.
- At least three (3) references from entities that have recent (within the last three (3) years) contract experience with the Vendor and are able to attest to the Vendor's work experience and qualifications relevant to this RFP.
- A list of every business for which Vendor has performed, at any time during the past three (3) years, services substantially similar to those sought with this solicitation. Err on the side of inclusion; by submitting an offer, Vendor represents that the list is complete.
- List of failed projects, suspensions, debarments, and significant litigation.
- An outline or other information relating to why the Vendor's experience qualifies in meeting the specifications stated in Section 3 of this RFP.

The Vendor should demonstrate the work the Vendor has done for clients during the past three (3) years and indicate which individual on its staff was responsible for the work. Referenced work should provide a clear indication of the types of health care program reform/Medicaid consulting services that can be obtained for the Task Force.

A Vendor shall provide information on any conflict of interest with the objectives and goals of the Task Force that could result from other projects in which the Vendor is involved. Failure to disclose any such conflict may be cause for Contract termination or disqualification of the response.

A Vendor or its subcontractor(s) must list all clients that were lost between January 2012 and the present and the reason for the loss. The Task Force reserves the right to contact any accounts listed in this section. A Vendor must describe any contract disputes involving an amount of thirty-five thousand dollars ($35,000) or more that the Vendor, or its subcontractor(s), has been involved in within the past two (2) years. Please indicate if the dispute(s) have been successfully resolved.

5.5.1 BACKGROUND INVESTIGATION

Vendors must allow the BLR to perform an investigation of the financial responsibility, security, and integrity of a Vendor submitting a bid, if required by the Task Force.

5.6 SUBCONTRACTOR IDENTIFICATION

If Vendor intends to subcontract with another business for any portion of the work and that portion exceeds ten percent (10%) of the Proposal price, Vendor's offer must identify that business and the portion of work that they are to perform. Identify potential subcontractors by providing the business's name, address, phone, taxpayer identification number, and point of contact. In determining Vendor's responsibility, the Task Force may evaluate Vendor's proposed subcontractors.

SECTION 6. EVALUATION CRITERIA FOR SELECTION

6.0 GENERALLY

The Vendor should address each item listed in this RFP to be guaranteed a complete evaluation. After initial qualification of proposals, selection of the Successful Vendor will be determined in a meeting of the Task Force by evaluation of several factors.

The Task Force has developed evaluation criteria that will be used by the Task Force and that is incorporated in Section 6.1 of this RFP. Other agents of the Task Force may also examine documents.

The Task Force requires that the health care program reform/Medicaid consulting services requested under this RFP be available for use by the Task Force the day after the Contract Execution Date. Submission of a proposal implies Vendor acceptance of the evaluation technique and Vendor recognition that subjective judgments must be made by the Task Force during the evaluation of the proposals.

The Task Force reserves, and a Vendor by submitting a Proposal grants to the Task Force, the right to obtain any information from any lawful source regarding the past business history, practices, and abilities of Vendor, its officers, directors, employees, owners, team members, partners, and/or subcontractors.

6.1 EVALUATION CRITERIA

The following evaluation criteria are listed according to their relative importance; however, the difference between the importance assigned to any one criterion and the criteria immediately preceding and following is small:

Directly related experience;
Price, including individual amounts and total maximum amount;
Plan for providing services;
Availability to perform work and attend meetings;
Proposed schedule for providing services;
Proposed personnel and the credentials of those assigned;
Compliance with the requirements of the RFP; and
Past performance.

ATTACHMENT A

OFFICIAL PROPOSAL PRICE SHEET

Note: The Official Proposal Price Sheet must be submitted in a separate envelope or e-mail and not part of the technical evaluation. Any reference to pricing in the technical proposal shall be cause for disqualification from further considerations for award.

1. Any cost not identified on this schedule but subsequently incurred will be the responsibility of the Vendor.

2. Bids should provide at least a 180-day acceptance period.

3. By submission of a proposal, the proposer certifies the following:
   A. Prices in this proposal have been arrived at independently, without consultation, communication, or agreement for the purpose of restricting competition;
   B. No attempt has been made nor will be by the proposer to induce any other person or firm to submit a proposal for the purpose of restricting competition;
   C. The person signing this proposal is authorized to represent the company and is legally responsible for the decision as to the price and supporting documentation provided as a result of this RFP; and
   D. Prices in this proposal have not been knowingly disclosed by the proposer and will not be prior to award to any other proposer.

The Official Price Proposal Sheet must be submitted in the following form, allowing for the inclusion of specific information regarding positions, goods, services, etc., and signed by an official authorized to bind the Vendor to a resultant contract.

DESCRIPTION	PRICE PER HOUR	NUMBER OF POSITIONS
Supervisor		
Other Professional Staff (List by Position)		
Support Staff		
DESCRIPTION	**PRICE PER UNIT (if applicable)**	**TOTAL PRICE**
Subcontractors (if any)		
Travel		
Any Additional Goods & Services (List Individually)		
TOTAL MAXIMUM AMOUNT OF BID:		

THE STEPHEN GROUP

April 23, 2015

Jillian Thayer
Legal Counsel to Director
Bureau of Legislative Research
500 Woodlane Street
State Capitol Building, Room 315
Little Rock, Arkansas 72201

Dear Ms. Thayer

This letter is in response to Request for Proposal (RFP) – 150002, relative to Health Care Program Reform/Medicaid Consulting Services. The Stephen Group (TSG) is offering the following proposal in response and welcomes the chance to bid on this critical review of Arkansas' Medicaid program.

TSG is the right choice to partner with the Task Force to help make decisions and reforming the Medicaid program. TSG has an undeniable, proven track record of delivering positive change for states looking to transform human service programs, including Medicaid. Ultimately, we view our role as providing the technical and expert service to allow policy makers to choose the best decisions for the future of their state.

TSG has the advantage of having extraordinary knowledge of the Medicaid program and human services, with experts who have operated a high level with these programs, both inside government and as vendors. This perspective is of critical importance, since it is essential that the vendor selected hits the ground running with the aggressive timeframe necessary with this project.

Our staff has experience working within these agencies like the Department of Human Services, so we are able to develop close relationship with agency staff that frequently removes potential roadblocks. Our team has led transformation efforts from both inside government and as consultants and, thus, has a deep understanding of the process, challenges and methods to achieve success.

Our data-driven approach consists of rigorous analysis, and practical tactical advice, with the direct, hands-on involvement of senior professionals who have had many years of experience at

the highest levels of government and the private sector. We understand that recommendations can't just be on paper, but must be actionable and realistic.

Finally, as senior consultants who specialize in helping states transform programs, our team members are focused exclusively on improving the quality and efficiency of services. We are not compromised by conflicts of interest with any interests. Our focus is entirely on those who receive services and the taxpayers who pay for these benefits.

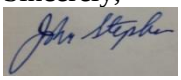
TSG views this RFP as an outstanding opportunity for Arkansas to become a national leader on Medicaid reform, and we sincerely welcome the chance to be involved in this effort. Please to not hesitate to contact us with any questions you might have.

Proposal

TSG has hereby submitted this proposal as follows:

- One electronic versions of the proposal with all signature pages signed. The cost proposal will be sent in a separate e-mail. There are no redactions. These are in in MS Word/Excel format required.

Sincerely,



John Stephen,
Managing Partner

Proposal by: The Stephen Group

To: Arkansas Bureau of Legislative Research

Health Care Program Reform/Medicaid Consulting Services

RFP No. BLR-150002

Submitted by:

THE STEPHEN GROUP
814 Elm Street, Suite 309
Manchester, NH, 03101
Main: (603)419-9592
www.stephengroupinc.com

April 21, 2015

Signature Page

The undersigned is authorized to bind TSG to a resultant contract and hereby signs the proposal and the Official Proposal Price Sheet submitted with this proposal:

Dated: 4-23-15

John Stephen, Managing Director
The Stephen Group

Table of Contents

1. Executive Summary

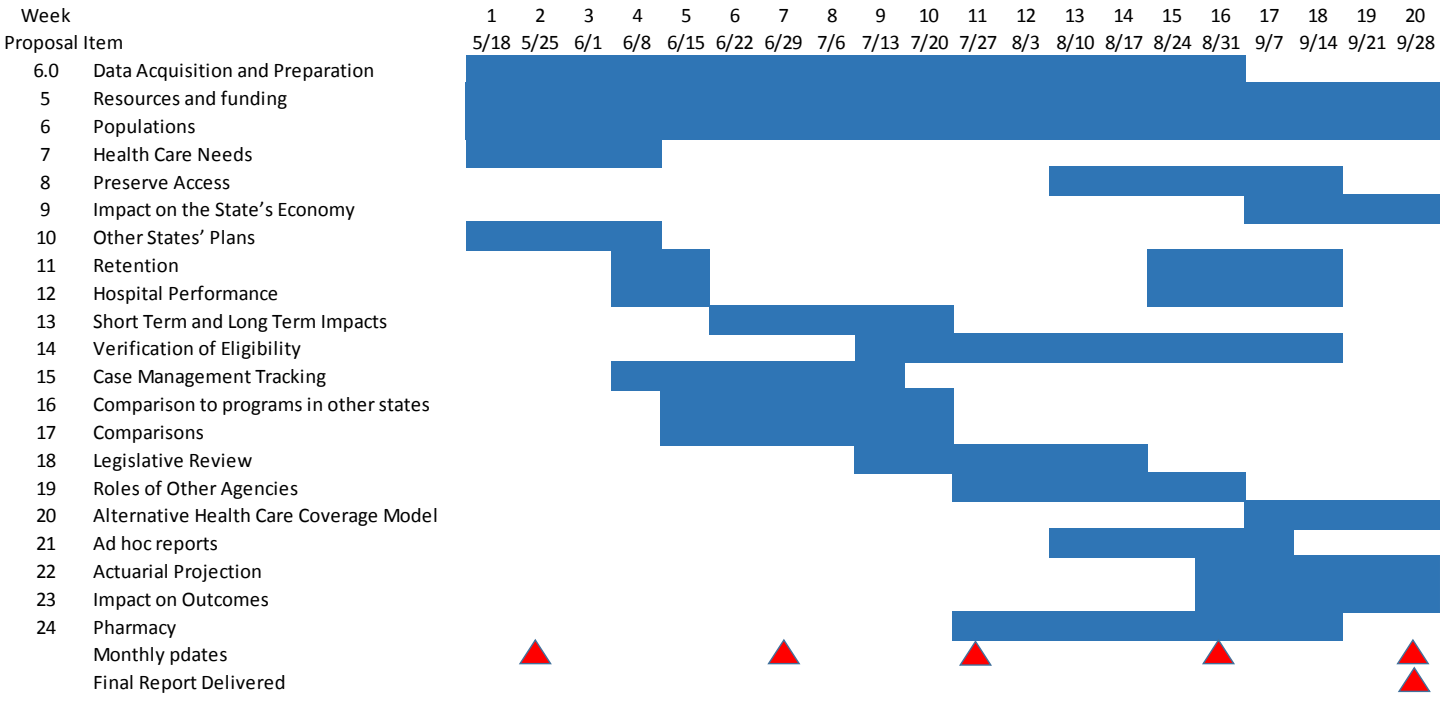
Arkansas currently stands at a crossroads relative the future of its Medicaid program generally and the expansion of Medicaid under the Affordable Care Act in particular. State leaders must make the critical choice of determining if the state should continue expansion and if so, in what form the services should take, or if the state should unwind the expansion and if so, deciding how to do so in way that offers the least impact for those individuals who currently receive this benefit.

Underpinning this evaluation and decision is a state Medicaid program in Arkansas that – like in every state – is rapidly growing as a larger share of the budget and putting pressure on other essential services. Ultimately, the future direction of both traditional Medicaid and expansion are intertwined indivisibly.

This project seeks to provide the tools and knowledge for policy makers to move forward with confidence in a course for Arkansas' future that will deliver the right services to the needy – as defined by state leaders – in a manner that offers the level of efficiency and effectiveness that the public and the taxpayers deserve.

The Stephen Group (TSG) has built a framework for success to provide the Task Force with the knowledge and tools to make the most informed decision possible.

Project Timeline



Assuming an actionable contract is executed on 5/15, per the request for proposal, TSG will begin to implement the project plan the following week.

Beginning immediately, TSG will work with the Task Force and Department of Human Services to acquire accurate Medicaid claims and encounter data, as without these data, it will be impossible to make substantive analyses of the Program's effectiveness, efficiency and consistency. This will begin a 16 week process of building an operational data set, validating the data and preparing the data to support useful assessment and recommendations. TSG experts have constructed superior tools and knowledge in identifying useful data collection and analytic capacity, which will be utilized throughout.

Also starting upon contract execution, TSG will begin a review and assessment of all programmatic aspects of the state's Medicaid and non-Medicaid human service programs and the populations that each covers. This will review the efficacy and efficiency of every Medicaid service, focusing also on high cost areas, the prospect of potential federal funding opportunities of programs not currently in the Medicaid program, the health care needs of those individuals served by these programs, with a specific focus on those in the Health Care Independence Program (HCIP), and what service delivery systems would best meet the needs for those on both traditional Medicaid and HCIP. This analysis will also review best practices of other states as they implemented an expanded Medicaid program, and assessing what data might be available, given the short sample size.

By week 4 after contract execution, TSG will work to assess the impact on provider retention and hospital performance of the decision to continue or unwind Medicaid expansion. While initial investigation will involve interviews and data collection from public sources and other states, the longer assessment will require the review of Medicaid claims and encounter data, which cannot happen until those data are extracted. All aspects will be used to build the impact analysis of the Task Force decision.

In the same time frame, TSG will review Agency case management systems to identify individuals who are receiving disjointed care for the possibility of providing better care coordination to reduce cost and improve outcomes. TSG will also assess the entire Medicaid organization and contract management to ensure maximum efficiency.

By week 5, TSG will begin the process of considering bringing innovation to Arkansas Medicaid, by reviewing best practices of other states that have engaged in transformation efforts and looking at the prospect of block grant for the state's Medicaid program to identify ways to improve the state's flexibility in managing the program.

In week 6, TSG will begin to assess the impact of continuing or unwinding HCIP on the insurance marketplace. This will consider the effect of premiums, marketplace stability, plans on the exchange and how all of these impacts carriers. The timing of the start is set to coincide with the anticipated U.S. Supreme Court ruling in *King v. Burwell*, which could significantly shape the future of federal subsidies on plans available on the exchange.

In week 9, TSG will begin an analysis of verifying the eligibility of Medicaid beneficiaries. TSG will work with data vendors that cross-match numerous national databases, and will develop a list of beneficiaries that are "red flagged" for potential ineligibility. This will give the Task Force an idea as to the scope of potential problem with program integrity, and TSG will provide concrete recommendations for enhancing to the entire eligibility process, to include providers as well.

During this same week, TSG will begin an analysis of the process involving how the Medicaid program interfaces with legislative review. The assessment will look to identify roadblocks and obstacles that slow and remove efficiency from the ability to implement change within the program, but to do so in a way that ensures policy decisions remain with the Legislature.

In week 11, TSG will work to assess the impact of Medicaid expansion in other state agencies, such as Corrections and Insurance Departments. At the same week, TSG will begin a specific analysis and assessment of the pharmacy benefit program, to identify opportunities in that area for cost reduction and program improvement.

After substantially gathering considerable data on program finances and operations, TSG will begin a review of methods to preserve access to care for those currently covered under HCIP if the program is not continued. This process is slated to begin in week 13, as TSG anticipates that a significant review of opportunities across other aspect of the Medicaid program, including operations, organization and contract management, and non-Medicaid human services must take place first. Similarly, an assessment in improvements in ad hoc DHS reporting will begin only at this same time, in order to develop an understanding of the system structure and deficiencies.

The final phases of the project revolve around the recommendation for an alternate plan for health care coverage for those currently in HCIP, and analyses of the impact on the state's economy, health care outcomes and an actuarial assessment of the new proposed plan. This will begin in week 16 when TSG has successfully extracted, prepared and reviewed Medicaid data, engaged in a programmatic review of the Medicaid program and assessed the ancillary impacts across state government and the private sector economy.

The final work product will encompass an extraordinarily rigorous review of externalities within Medicaid, the health provider community, the broader economy and the public as a whole. It will include the best practices of other states and the private sector in order to provide an integrated product that seeks to provide quality care, promote access and protect Arkansas taxpayers in the short and long term.

2. TSG Qualifications

1. Firm Qualifications and Prior Experience

The Stephen Group is knowledgeable of state solutions that address Medicaid expansion through market based approaches rather than the expansion of traditional Medicaid and we have been a proponent of self-responsibility and beneficiary "skin in the game" in the form of co-pays and deductibles in and out of state government for some time.

Our strategic experts have years of experience providing comprehensive analytic and data mining methods and direct experience with Medicaid systems modernization in the public sector and Medicare/dual eligible systems in the private sector. We help states address complex issues and make rigorous, value and fact-based recommendations for systemic solutions. Where appropriate, we assist states in taking action to implement and achieve superior outcomes.

Our core competencies include: government efficiency and reform; extensive knowledge of Medicaid/Medicare and private health funded systems; financial, actuarial, and analytical services; Medicaid cost containment, pharmacy systems management; the Aged, Blind and Disabled populations served by Behavioral Health, Intellectual/Developmental Disabilities and Long Term Home and Community Based Services (HCBS') waivers; organizational redesign; regulatory reform; and contract management that produce innovative private sector oriented solutions for government. It is this portfolio of values, expertise, and rigorous effort that The Stephen Group will bring to the detailed work necessary to produce a high quality Final Report required by the Arkansas Health Reform Act of 2015.

TSG experience Specific to this project

TSG has experience working in a number of states on Medicaid reform over the past few years. We have worked and provided comprehensive Medicaid reform plans and recommendations for the states of Texas, Florida, Maine, Illinois, South Carolina, and Mississippi.

In Maine, TSG prepared a comprehensive plan for Medicaid reform, cost containment, and quality improvements for the Governor's Office of Policy and Management. Additionally we provided a comprehensive strategy for a Section 1115 Global Budget MaineCare/Medicaid program improvement and cost containment strategy to the Maine Department of Health and Human Services.

We developed a comprehensive Medicaid Reform Strategy and cost containment methods paper for the Illinois Policy Institute that was provided to the Illinois Legislature.

TSG developed a "Strategic Vision for Re-Balancing Long Term Care" for South Carolina that included comprehensive strategies to improve quality, reduce cost and consider Medicaid reform

using managed care principles. Several of our key recommendations were supported by the Governor and adopted by the Legislature.

In Mississippi, we produced "An Eligibility and Enrollment Feasibility Study" across the Medicaid, SNAP, and TANF programs that recommended interoperable IT integration for enrollment and eligibility systems that would be more efficient, reduce enrollment fraud, and save money.

State of Mississippi: ***Assessment of A 87 Medicaid Integration Waiver for Department of Human Services System Upgrades to Integrate Eligibility with Medicaid Program***. March to July 2013. TSG proposed Arkansas team involved in this project: John Stephen, Dr. William Oliver and Richard Kellogg.

State of Florida: ***Assessment of State's Medicaid Fraud Benefit Recovery Unit Operations and Identification of Areas of Efficiency and Opportunity to Improve Recoveries, Including TANF and SNAP Programs.*** October to December 2012. TSG proposed Arkansas team involved in this project: John Stephen and Dr. William Oliver.

State of Florida: ***Implementation of Recommendations to address Medicaid Benefit Recovery Fraud Backlog and Develop Plan to Integrate State Department Systems and Prioritization Tool for Claims Management.*** TSG was able to far exceed state's expectations and recover over $800,000 in fraud recoveries while identifying a future prioritization and integration design to save millions of dollars in the future for taxpayers. April to July 2013. TSG proposed Arkansas team involved in this project: John Stephen and Dr. William Oliver.

"I would like to thank you and your team for your diligence and expertise with this project. I believe with your teams recommendations we are headed in the right direction in becoming a world class organization. I am grateful to have had the opportunity to work with such an excellent group of individuals within your team." Sheri Lynn, Florida Benefit Recovery Unit Director, Department of Children and Family Services, Program Integrity Division

State of Maine: ***TSG developed plan for Governor's Office of Policy Management to Identify Over $30 Million in Health Care Reform and Medicaid Fraud Savings.*** TSG delivered its report to the Governor's Policy Management Director on March 22, 2013 and it became part of the final report delivered to the Legislature in September. Most of the savings identified by TSG were in the area of Medicaid reform and cost containment. March 2013. TSG proposed Arkansas team involved in this project: John Stephen, Richard Kellogg and Bob Chin.

State of Illinois: ***Medicaid Cost Containment Analysis and Report***. Conducted detailed Medicaid cost and program analysis and identified short term and long term Medicaid cost savings ideas for the Illinois Policy Institute and presented these cost containment ideas to Chair of the House Medicaid Reform Committee. Savings initiatives were valued over $1 Billion and initiatives contained in the TSG recommendations were eventually adopted by both the

Republicans and Democrats in the 2013 SMART Act and obtained joint budget and Governor approval. TSG proposed Arkansas team involved in this project: John Stephen, Richard Kellogg and Bob Chin

State of South Carolina: ***Assessment of State Medicaid Long Term Care Program with Recommendations for Future Reform and Savings***. TSG was the lead consultant for The Lucas Group (a Boston based consulting group) in assessing the state's entire long term care program and budget, and developed a set of recommendations for future changes that would transform the Long Term Care program for Governor Nikki Haley to one focusing more on community based care rather than high cost institutional care. Many of the recommendations contained in the report delivered to the South Carolina Department of Human Services were implemented as the state has recently worked to integrate the long term care Medicaid dual eligible population into a managed care strategy recommended by TSG and The Lucas Group. TSG proposed Arkansas team involved in this project: John Stephen, Richard Kellogg and Rory Rickert.

State of Texas: ***Assessment of the State's Child Welfare and Medicaid IV E program, with Recommendations for Improvement and Implementation Plan***. April 2014 to current. TSG continues to provide technical assistance and project management to the State of Texas in implementing its Transformation Plan, which arose out of the TSG operational report and a legislative task force review aligned with these efforts. TSG proposed Arkansas team involved in this project: John Stephen, Richard Kellogg, Dr. Will Oliver, Martha Tuthill, and Lindsay Littlefield.

> "[A] consulting group, The Stephen Group, reviewed CPS exit interviews from an entire year as part of an overall agency review. That report was remarkably insightful" *San Antonio News-Express editorial*
>
> http://www.mysanantonio.com/opinion/editorials/article/Let-public-see-CPS-exit-interviews-5976244.php
>
> "[T]he Department of Family and Protective Services hired a consulting group — The Stephen Group — to conduct a top to bottom review of Child Protective Services. The result was a remarkably informative 475-report filled with details on how the agency operates, what's not working and how to fix it." *Austin American Statesman*
>
> http://investigations.blog.statesman.com/2014/12/03/72/

State of Mississippi: ***Assessment of the State's Child Support Program and Medicaid IV D Spending, Along with Recommendations for Improvement***. March 2014 to October 2014. TSG proposed Arkansas team involved in this project: John Stephen, Richard Kellogg, Dr. William Oliver, and Martha Tuthill.

State of Mississippi: ***Technical Assistance to State with Outsourcing 17 Counties in Child Support/Medicaid IV D Program, Including Drafting RFP, Assisting in Evaluation of Vendor***

and in Developing State's Continuous Quality Improvement Plan for Non-outsourced Counties. October 2014 to January 2015. TSG proposed Arkansas team involved in this project: John Stephen and Martha Tuthill.

State of Mississippi: ***Providing Project Management and Technical Assistance to State in Developing and Sustaining Continuous Quality Improvements in the Child Support and Medicaid IV D Funding and Integration Efforts with State Medicaid***. Chosen as vendor for this contract, effective April 1, 2015 to April 1, 2016. TSG proposed Arkansas team involved in this project: John Stephen and Martha Tuthill.

Rhode Island: ***Global Waiver*****.** The Stephen Group team that will be involved in this Arkansas Medicaid reform effort include senior consultants with years of experience helping states with Medicaid Reform efforts. Three of the proposing team members were part of the consulting team that designed and developed the Rhode Island Medicaid Waiver which was approved by CMS in 2009.

Specifically, TSG managing partner and project manager for this proposal, John Stephen, assisted Rhode Island Governor Donald Carcieri in drafting and negotiating the Rhode Island Global Medicaid Waiver. This landmark Medicaid Waiver was subsequently adopted by the Rhode Island General Assembly in January of 2009. The Waiver was the first Medicaid Waiver ever to place a cap on total Medicaid spending and provide a state with unprecedented flexibility from federal regulations.

According to a report by The Lewin Group in December of 2011, the Waiver has generated savings of over $100 million in its first two years. Governor Carcieri called John's work "an unqualified success" and one that his state is "tremendously grateful for." TSG senior consultants Dr. Will Oliver and Rory Rickert also took part in the Waiver's analysis and program design.

2. TSG References

1. John Davis, Mississippi Department of Human Services, Deputy Administrator, (601)359-4458, john.davis@mdhs.ms.gov.
2. Dr. Kyle Janek, Secretary, Texas Health and Human Services Commission, 512-424-6502.
3. John Specia, Commissioner, Texas Department of Family and Protective Services, 512-438-5947, john.specia@dfps.state.tx.us
4. Katie Olse, Associate Commissioner, Texas Department of Family and Protective Services, 512-438-5947, Katie.Olse@dfps.state.tx.us
5. Richard Rosen, Commissioner State of Maine, Department of Administrative and Financial Services, 207-624-7800

6. Sam Adolphsen, Chief Operating Officer, Maine Department of Health and Human Services, 207-287-3707
7. Sheri M. Lynn, Chief, Benefit Recovery, Office of Public Benefits Integrity, Florida Department of Children and Families, 352-330-5801, Sheri_M_Lynn@dcf.state.fl.us
8. Governor Bruce Rauner, State of Illinois, Office of Governor, 217-782-0244, contact Holly Griff, holly.griff@illinois.gov
9. Governor Craig Benson, former New Hampshire Governor Craigrbenson@comcast.net, 603-502-2900
10. Illinois Representative and Chair of House Medicaid Reform Committee Patty Bellock, 217-782-1448, Rep@pbellock.com

3. The Team

The Stephen Group team that will be involved in this project include senior consultants with years of experience helping states with Medicaid Reform efforts, and the private health care sector with innovative health care strategies:

John Stephen

TSG Managing Partner John Stephen will be the project director for this project and he will also work with the TSG team overseeing Medicaid reform policy, assessment and recommendations. John was a form Commissioner of Health and Human Services in New Hampshire from 2003 to 2007. In that capacity, John was in charge of the state's largest department and was the only Commissioner nationally to contain Medicaid costs to less than a 1% growth during his four year term. John did so by leading his Department through a period of major innovation, including improving Medicaid operations and engaging families on assistance in work activities. He developed and implemented a nationally recognized Health Care Reform program that focused Medicaid on prevention, wellness and rebalancing long term care. John initiated disease management and care coordination programs that transitioned New Hampshire Medicaid away from treating the sick to keeping people healthy. Through John's efforts, Medicaid long term care home and community placements increased 23%, replacing more expensive nursing home placements, which dropped 11%. Moreover, during each of the four years John was Commissioner, New Hampshire ranked first nationally in the Kids Count survey. During that same period, the enrollment of low income, uninsured children into the State's Medicaid and SCHIP program increased by 7,500. John also oversaw the state's welfare program, Special Nutritional Assistance Program (SNAP) and Temporary Aid to Needy Families (TANF) program. In this role, John was able to transform welfare in New Hampshire, reducing the rolls by 20 percent and dramatically increasing work participation rates by bringing accountability to the program.

In addition, John Stephen is the founder and managing partner of TSG and prior to that John was a partner at The Lucas Group from 2008 to 2011, where he led the firm's Government practice, and assisted the firm's private equity division in evaluating transactions impacted by government regulation, and offering strategies for value based growth.

John also led a team that reviewed the South Carolina Medicaid system for Governor Nikki Haley and provided the state with recommendations on rebalancing long term care by offering an integrated Medicaid managed care solution. John had earlier drafted a report for Illinois Governor Pat Quinn's Taxpayer Action Board, which recommended over $2 billion dollars in health and human service savings over a 5-year period. A number of these recommendations have been implemented. John was also asked by the State of Illinois Senate Special Committee on Medicaid Reform to provide key testimony in December of 2010 that led to Illinois passing legislation that will result in substantial savings by rebalancing long term care away from high cost nursing home care. John, acting as the TSG lead, completed a Medicaid cost efficiency study for the Illinois Policy Institute, which led to a series of recommendations incorporated by the Illinois legislature this past session, which will result in over $1 Billion in program savings. Recently, John assisted newly elected Illinois Governor Bruce Rauner and his Transition team in identifying a number of innovative Medicaid reform cost savings ideas, which are currently in the process in Illinois.

John and TSG Senior Consultant Dr. Will Oliver also led the TSG team project in in assessing the State of Florida's Program Integrity Office, Benefits Recovery Unit and its efforts in recovering Medicaid funds from individuals who commit Medicaid fraud, along with Food Stamp and TANF fraud. His team's efforts led to recommendations that identified over $125 Million in additional fraud and overpayment recovery opportunities for Florida.

John was also asked during the 2012 legislative sessions to assist both the States of Illinois and New Hampshire in developing legislation that would require enhanced social service eligibility verification solutions. These efforts have led to both states passing laws that will save an estimated $300 Million.

Richard Kellogg

Richard Kellogg is a senior consultant for TSG and he will work closely with the team on all aspects of Medicaid policy, research and recommendations for reform. Richard's scope of experience and knowledge includes medical/pharmacy services, adult and children's mental health and substance abuse service systems, psychiatric hospitals, ICF/IDs, SNFs, community based services and supports, and long-term care services systems. Richard has served in state leadership positions as Commissioner, Deputy, or Director in the states of Virginia, Tennessee, New Hampshire and Washington beginning in 1994 through 2011. In Washington, Richard was a senior member of the Medicaid Executive Committee, served the Department of Social and Health Services ($11 billion budget) as Director of Integrated Health Services, reporting directly to the Secretary, and was a member of the Governor's Sub-Cabinet on Health Reform. He has an

extensive background and responsibility for Medicaid managed care models and contracts, waivers, and integrated Medicaid policy and budget strategies.

Dr. William Oliver

Dr. William Oliver is a senior consultant with TSG and will lead the Medicaid program data acquisition and analysis effort. Dr. Oliver has led numerous Health and Human Services and Medicaid process improvement and data analysis projects in Indiana, Missouri, Pennsylvania, Rhode Island, South Carolina, Texas and New York. In addition, he has assisted other aspects of Medicaid benefits management in Florida and Michigan. Dr. Oliver brings extensive experience working with private sector healthcare payers and providers as well.

Rory Rickert

Rory Rickert R. Ph. is a senior consultant subject matter expert for TSG. He has more than 30 year's progressive experience in the pharmaceutical industry. Rory is a nationally recognized speaker and industry expert in managed care, drug utilization and cost control, distribution channels and rebates, marketing, sales and delivery models in the pharmaceutical industry. He has been deposed as an expert witness in many cases including: Hall v. Medical Security Card, Co., Superior Court of Arizona, Association Benefit Services, Inc., v. AdvancePCS, a Delaware corporation, Caremark Rx Inc. a Delaware corporation and CaremarkPCS, a Delaware corporation, United States District Court for the Northern District of Illinois and State of Hawaii v. Abbott Laboratories, Inc. et al., (Merck) in the Circuit Court of the First Circuit State of Hawaii. Rory is an expert on Medicaid pharmacy cost containment strategies and was part of the consulting team that identified Medicaid pharmacy benefit management initiatives as part of Rhode Island's Global Medicaid Waiver. Rory has published papers on numerous pharmacy benefit management items.

Robert Chin

Robert Chin is a senior consultant and subject matter expert for TSG in reviewing and analyzing medical claims and on this project Bob will head up the team reviewing and analyzing Medicaid claims data related to DRG, CPT and related facility charges so as to determine the opportunity for savings through transparency and competition. Bob has lead TSG efforts to identify Medicaid cost savings by conducting a thorough analysis of Medicaid claims data, particularly the episodic care related to DRG and CPT codes. Bob is an expert data analyst in reviewing such codes and identifying high, medium and low cost providers. In 2011, Bob worked with TSG and the Pennsylvania Department of Public Welfare in conducting deep, big-data, medical claims analysis and constructed an ambitious proposal to drive down the total cost of care by leveraging the cost differential among different medical providers. One aspect of potential savings Bob and the team uncovered, related just to inpatient services alone, yielded a gross cost reduction opportunity of over 120 million dollars per year.

Martha Tuthill

Martha Tuthill is a TSG senior consultant on this project and she will specialize in the assessment and recommendations relative to Medicaid contracts management and organizational review and design. Martha managed the delivery organization within Accenture for Health and Public Services from 2008 to 20011. There, she was responsible for the North America Health and Public Service Operating Unit, where over 10,000 professionals delivered services on 500 contracts to 150 clients across the United States. One of the clients was Texas Medicaid. In addition, Martha worked closely with Partners HealthCare while at Accenture. They are the parent org for the Mass General Hospital/Brigham and Women's Hospital (a total of 18 different health care centers). Martha also worked with United HealthCare, Highmark (the BCBS based in Pittsburgh serving 5 million customers in W VA, Delaware, and Pennsylvania), Aetna, and Ascension (the largest catholic healthcare system including a hospital in Arkansas).

Lindsay Littlefield

Lindsay Littlefield is a senior consultant at The Stephen Group, where she focuses on budget and financial analysis, project management and Health and Human Services subject matter expertise. Lindsay will work with Dr. Oliver on this project in providing detailed Medicaid program cost analysis and budget projections and will focus on costs associated with long term care, developmentally disabled and medically fragile populations. Lindsay formerly worked as a budget analyst with the Texas Legislative Budget Board (LBB), assigned to the Health and Human Services Budget Team. At the LBB, Lindsay developed policy recommendations to improve the efficiency and effectiveness of state government Medicaid operations; Monitored trends and innovations at the federal level and in other states and analyzed applicability to Texas; and frequently briefed internal management, state legislative members, and state executive leadership and staff on areas of research, including providing frequent testimony before policy and budget committees.

Lindsay also has a strong policy background in Medicaid acute care budget and policy issues, having authored several legislative reports on healthcare payment and delivery reform, hospital quality, using data to drive healthcare systems improvements.

Jason Melancon and Michael Walker

Both Jason Melancon and Michael Walker serve as TSG subject matter experts on projects relating to Medicaid or Human Services Eligibility. In this Arkansas project, Jason and Michael will assess the Medicaid beneficiary and provider eligibility system to determine opportunities in program integrity for eliminating waste, fraud and abuse.

Both Jason and Michael and experts in the use of highly-rated Business Intelligence tools, including QlikView. They are working with the Maine Department of Health and Human Services (DHHS), building applications to assist DHHS staff in finding and prioritizing their investigations of fraud in the use of EBT cards. This work involves working within the SNAP eligibility system and analyzing more than 50 million transactions from 200,000 EBT cards.

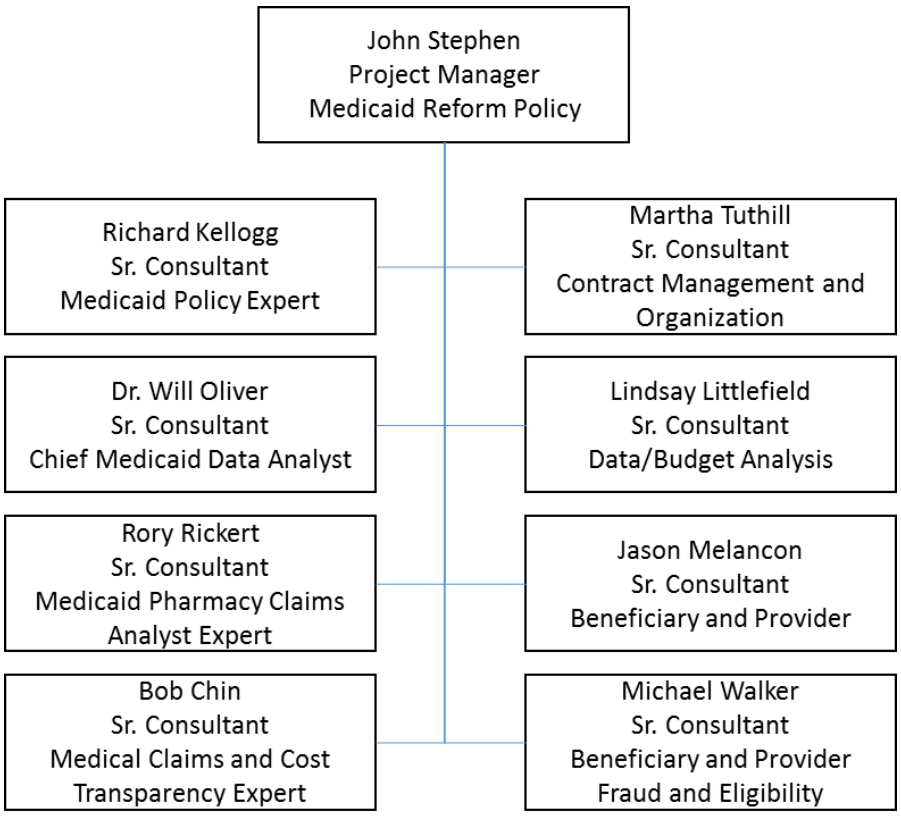
Investigators use tools that Jason and Michael created to pinpoint the largest and most frequent possible abusers of the system. Since the start of the project in July 2014, the tools have saved the state over $500,000, and provides policymakers the solid data analysis to make systemic changes to the program in order to reduce fraud.

3. Key Team Biographies

For more complete proposal team resumes see Attachment A.

4. Project Organization

TSG has discarded the standard "pyramid" that many firms use to staff a project. This allows TSG to be faster and more responsive, and provide better service, at a lower cost. This shows in the proposed organization chart—flat rather than hierarchical.



5. Examples of Prior TSG Work:

TSG will provide the Task Force, along with the submission of its bid, with a thumb drive consisting of samples of prior state work, analysis, assessment, and recommendations. This will give the Task Force the opportunity to observe the in-depth analysis conducted in the past by TSG and proposing team member. The prior TSG work contained in the thumb drive is as follows: (Mississippi: Mississippi DHS OMB Final 7-11-13; Florida: Final BR Assessment Findings Report 12-10; Florida: Final BR Assessment Recommendations 12-10; South Carolina: SC Rebalancing LTC Project Report 5-3-12; South Carolina: SC Rebalancing LTC Project Final Report Slides 12-20-11; Texas: CPS Assessment Findings Final 6-17-14; Texas: Recommendations Report 6-17 Final.PDF; Maine: TSG Maine Plan Document Final 3-23-13).

4. The Stephen Group Action Strategy

The Stephen Group is an experienced government solutions consulting firm that is in the business of helping government entities in their efforts to deliver extraordinary advantages to taxpayers and those who receive service. We do this through exceptional efficiency, accountability and responsiveness in the most cost effective ways possible with a priority focus on state Medicaid programs and related services such as Medical/Pharmacy, Long Term Care, Intellectual/Developmental Disabilities, Behavioral Health, and Child Welfare and Support.

The approach we bring to our work is based on market based values, systemic subject matter knowledge and expertise, data analytics, on the ground environmental scanning, innovative thinking, relationship building, and a strong transparent relationship with our clients. Our Team possesses comprehensive subject matter expertise of the entire Medicaid program based on years of government and private sector experience. We conceptualize and support individual state solutions that meet our client's objectives based on assessing state market conditions, current approach to the Medicaid and private health insurance markets, rigorous budget and trend analysis and data analytics, and "best solution" options.

Our comprehensive solutions are often based on service integration strategies, market based purchasing strategies, and innovative approaches to CMS/Medicaid rules and regulations that maximize state flexibility.

We strive to recommend sustainable solutions that result in cost savings, improved service delivery that produces health status improvements, provide base budget resources for Policy Maker innovative reinvestment strategies, and reduce taxpayer burden.

Scope of Work

The following section reflects our response to the Scope of Work contained in Section 3 of the RFP:

Recommendations for an alternative healthcare coverage model to ensure the continued availability of healthcare services for vulnerable populations covered by the Health Care Independence Program established by the Health Care Independence Act of 2013, §§ 20-77-2401, et seq., upon program termination, including an examination of the following:

6. Resources and funding

Resources and funding necessary to ensure an effective and efficient transition from the Health Care Independence Program, while minimizing or eliminating any need for the General Assembly to raise additional state general revenue:

TSG Approach:

Working from the baseline Health Care Independence Program (HCIP) benefits package requirements, costs, revenue sources, and known outcomes, The Stephen Group will construct a research based analysis that identifies transition options from the current HCIP model including the PPACA section 1332 waiver, as well as more traditional waiver options, such as an 1115 transformation waiver. This analysis would include an initial perspective on further CMS flexibility on the potential use of any funds not requiring a state match and an assessment of other state non-traditional approaches to Medicaid expansion such as Indiana, Iowa, and Michigan.

Additionally, we will identify potential savings from the Arkansas Medicaid program available for the General Assembly's consideration to invest in an alternative coverage model for the HCIP population based on our audit assessment of the Arkansas Medicaid Program.

How the Services Will Be Delivered:

TSG will assess the impact of these four key "levers" in managing health: use of third-party payers, managing provider rates, closely managing the care of high-cost populations and wellness programs. This deliverable will identify those efforts and policies that have effectively improved health value (quality improvements that reduce cost) and those that have not.

To conduct this assessment, TSG will need to obtain claims-level data from the Department to support data analysis. This will include the encounter data from third-party payers. The data will be managed within the constraints of HIPAA and other regulations. Throughout the data collection and analysis process, TSG will conduct targeted interviews and work sessions both in state and out.

TSG will use four primary tools to assess the cost and effectiveness of healthcare expenditures for the population covered by expansion. Each of these involves a significant amount of data collection, cleansing, analysis and evaluation:

1. Benefit of premium-based payment. Using Arkansas encounter data for the expansion population evaluate the premium by patient group compared to FFS
2. Provider cost variation. Comparing the payment per service across many providers, identifying those that are far out of range
3. Long Term Care. Reviewing policies, practices and historic costs for the high-cost populations including elderly and those with developmental disabilities
4. Wellness programs. Evaluating the cost impact of various wellness programs offered either by the state or by third-party payers

Deliverable:

TSG will deliver an Alternative Coverage Options Matrix along with recommendations for improvement in each of the four main areas of leverage. Final Report section that identifies the resources, funding, and transition options from the Health Care Independence Program.

7. Populations

Populations eligible for and participating in the Health Care Independence Program, including both individuals newly eligible for health coverage under the program and individuals previously eligible for Medicaid before the effective date of the program, whether under a Medicaid waiver or some other eligibility criteria to specifically reference the complex populations:

TSG Approach:

Arkansas has placed differential actuarial values on the ACA eligible population and the traditional Medicaid eligible population (Arkansas Insurance Department: 3A-2013). Given the goal of the General Assembly is to identify an alternative healthcare coverage model, TSG will focus on identifying cost effective and innovative coverage options, in lieu of HCIP for both populations. Additionally, our work will focus on the known percentage of formerly Medicaid covered individuals enrolled in the HCIP's QHIPs who have been determined to be medically fragile. We will identify Medicaid cost savings, efficiencies and program improvements that will help guide decisions made related to funding the alternative approaches.

How the Services Will Be Delivered:

TSG will conduct an audit of the current Medicaid system in Arkansas to include, a review of known characteristics and costs of the covered populations, and identify optional coverage and Waiver approaches for any grouping of the HCIP covered populations. This will include a detailed cost containment approach as outlined in this RFP response, an examination of: verification of eligibility of individuals currently on the Medicaid rolls and recommendations for removal of any individuals found not to meet eligibility criteria, determination of the number of services per enrolled individual, Medicaid provider categories and recommendations for the categories to reflect the appropriate performing providers, and the utilization and cost of prescription medications and recommendation for the reduction of those costs.

TSG will conduct three forms of analysis:

1. Assess the process: TSG will evaluate the process by which the expansion population obtains eligibility including both the in-office and Internet-based eligibility processes. It will include review of eligibility policies as well as quality control and quality management over processes. TSG will also focus on the assessment of costs associated with the aged, blind and disabled population
2. Audit "through the system": TSG will review the eligibility test standard and protocols to assure that the system effectively manages the boundaries of eligibility
3. Audit "around the system": TSG will work with a commercial data provider to test the status of those currently deemed to be eligible in the Arkansas system. It will verify that the information in the eligibility system is based on externally verifiable fact and look for alternative and more fiscally prudent and quality enriched solutions.

TSG will conduct a detailed analysis of available data from HCIP QHIPs and related Arkansas Medicaid data specific to identifying transitions from Medicaid eligibility to QHIP coverage and re-transition back to Medicaid enrollment.

Deliverable:

The Final Report will include a section that examines the current populations covered by the HCIP, discusses known characteristics and costs of the covered populations, and identifies optional coverage and Waiver approaches for any grouping of the HCIP covered populations.

TSG will deliver specific findings of opportunities to improve:

- Policy
- In-office process
- Staffing, capabilities, organization of the human resources supporting eligibility
- Eligibility systems supporting the expansion population
- Quality control
- Quality management

8. Health Care Needs

The health care needs and other relevant characteristics of those populations served by the Health Care Independence Program:

TSG Approach:

Our examination of the health care needs and other relevant characteristics of the HCIP covered populations will include available information and data from the HCIP carrier vendors, the state Medicaid program, and comparative populations served by other states that have chosen to use alternative coverage options than traditional Medicaid to assess the historic utilization of health services for population subgroups.

How the Services Will Be Delivered:

TSG will conduct a detailed analysis of known covered population's health needs based on historical facts, and based on Arkansas encounter data for the appropriate population groups. This will include on the ground interviews with HCIP carrier vendors and the state Medicaid program; review of any available relevant data from the HCIP vendors and state Medicaid program; and analyses and summary of any relevant national data on comparable HCIP and uncovered populations.

Deliverable:

Final report will include a section that provides a summary of historical claims experience by diagnosis, acuity, demographic and geographic groupings. This will inform the Legislature and Agency about the levels and types of care being provided. This will highlight patient counts, cost of care and types of services provided. It will clearly articulate the health care needs and

other relevant characteristics of populations covered by the current HCIP program, with a focus on the medically fragile identified while covered by HCIP. This information will inform any optional recommendations related to alternative coverage options to HCIP and traditional Medicaid.

9. Preserve Access

Recommendations for measures and options to preserve access to quality health care for those populations served by the Health Care Independence Program:

TSG Approach:

Arkansas has embraced a groundbreaking vision that seeks to find alternative options to the state's traditional Medicaid program and the population covered by Medicaid expansion through ACA that would allow quality coverage based on the values articulated in Act 46 and available resources from the state's taxpayers. Access and quality services are key components of the analytical framework TSG will utilize to produce comprehensive recommendations and options for alternative coverage.

How the Services Will Be Delivered:

TSG will conduct two forms of analysis. First, it will consider alternative benefit models for populations currently served by the expansion that maintain quality standard of the existing program. This effort will review private sector models, and other state models of care in considering a benefit redesign. With a relatively healthy population included in expansion, there are many models to consider and tailor that will allow access to care in a more efficient fashion. Second, TSG will determine current provider usage patterns and compare these to the provider cost data analysis (above). The analysis will identify a "heat map" showing geographies that are abundantly served by providers of various types, and which areas may be underserved. It will show where high-cost providers are located in over served areas. This will inform the legislature and Agency the real cost of 100% access compared to variations that would be consistent with the Waiver, but dramatically reduce cost.

This assessment will allow the legislature and Agency to model the cost and access impact of alternative coverage models developed in the first part of this analysis.

Deliverable:

Final Report sections:

- List of quality standards required by the HCIP program and related CMS waiver and recommendations for options in alternative coverage models and impact on cost.
- Heat map showing pockets in which high cost providers compete directly with adjacent lower costs providers. This will allow policy decision makers to have the detailed information needed in the alternative design to assure access and, at the same time, allow for cost transparency, meaningful choice and market competition.

10. Impact on the State's Economy

An estimate of the impact of the Health Care Independence Program and its termination on the state's economy as a whole and on the state's general revenue budget, including impact on hospitals, clinics, and ancillary health care providers:

TSG Approach:

The Program impacts many aspects of Arkansas' economy and state budget. The effect of either unwinding or overhauling the Program will be nontrivial to forecast. TSG will estimate impact using three methods: measuring the historical effect of launching, developing a financial forecast of unwinding, and considering varying impacts of benefit redesign.

How the Services will be Delivered:

TSG will estimate the financial impact of Program termination in two manners. First, TSG will estimate the historic impact the State has experienced since the Program was launched. It will review the total healthcare expenditures statewide before and after the Program was launched. This will include estimates of uncompensated care, the impact on private market healthcare premiums and a view into healthcare employment levels. Second, TSG will forecast potential impact on State budgets as well as the Arkansas economy.

Deliverable:

This will result in two sections of the final report: a financial forecast of the impact of termination and a review of possible benefit redesign.

11. Other States' Plans

Descriptions and comparisons of other states' plans for implementing Medicaid expansion

TSG Approach:

As mentioned in #1 above, TSG will analyze and interview other states that have chosen alternative methods to traditional Medicaid expansion as well as states still considering Medicaid expansion and states that may be considering revision prior to state match being required. In particular, states like Indiana and Michigan have expanded Medicaid in non-traditional manners and other states, like Virginia are considering different models for benefit delivery.

How the Services Will Be Delivered:

TSG will work with the Task Force and make recommendations to identify the specific states whose approach or current deliberations regarding Medicaid expansion and alternative options would be most beneficial to meet the objectives of identifying alternative coverage models. TSG

will conduct analyses of the identified states, conduct interviews with key leaders in the identified states, and create a matrix of comparative state models standards and attributes.

Deliverable

Final Report section that lists selected states models in a matrix format.

12. Retention

Examination of the impact of the Health Care Independence Program on retention of physicians and other ancillary health care providers in the state:

TSG Approach:

TSG makes no assumption that there is a direct link between the Program and physician retention. We suspect that the Program shifted some care from uncompensated to covered care and from acute care facilities to physician practices. Thus, we suspect expansion also increases the demand for care, and likewise the physician revenues. However, we have an open mind as to what effect this has on retention both in the short and long-terms. The data will tell the story. Healthcare is already an industry that is growing at twice the rate of general economic expansion nationally. Other studies have not demonstrated a strong link between changes in Medicaid and retention rate of healthcare providers. Thus, TSG is focused on what the numbers will say.

How the Services Will Be Delivered:

TSG will consider the evidence concerning the relationship between the Program and physician retention from two perspectives. First, the numbers: TSG will review the historical evidence in Arkansas to determine if the Program has increased physician retention. To conduct this analysis, TSG will use Medicaid program data to determine the number and size of Medicaid practice before and after the Program. Second, it will consider what previous studies in similar states have shown is the real effect of changes in Medicaid program. Finally, TSG will collect input through interview and focus group.

Deliverable:

This will result in a section of the final report that describes:

- Actual change in physician Medicaid practice levels (including the Program) comparing before and after launch of the Program
- Review of the best studies nationally of the factors affecting and actual experience in changes in physician retention

13. Hospital Performance

Examination of the impact of the Health Care Independence Program on performance of hospitals within the state, including a comparison to performance of hospitals in states that do not have Medicaid expansion programs:

TSG Approach:

TSG proposes to examine the impact of the HCIP on hospital performance by assessing the baseline costs of uncompensated care, reductions in avoidable ER use, reductions in avoidable hospital admissions, overall hospital utilization among the newly insured and costs of uncompensated care in the year prior to the roll out of the HCIP program and the most recent available data on these measures since the program has been in place.

Hospital performance is complicated to understand. Hospitals have a variety of private and non-profit orientations are at different stages in their own economic life cycle, are in different market sectors – in general are difficult to assess using conventional financial metrics. Thus, TSG will work with the Task Force to agree on a series of performance metrics which might include things such as: bed occupancy, patient discharges, employment levels and total compensation, outcome metrics, net income and the like.

TSG will work with the Task Force and make recommendations to identify the states without Medicaid expansion that would be most useful for comparison analysis with Arkansas' hospitals on the three performance measures.

How the Services Will Be Delivered:

TSG data analytics team members will collect the data; format the data; interview the chosen comparative states and collect their data from each state, Hospitals/Hospital Association, or other sources; develop comparison analyses, and explain and comment on the conclusions of the examination. Hospital data can be obtained from several private/quasi-government sources. TSG will use publically available electronically fielded data for this analysis.

Deliverable:

Final Report section that exhibits and discusses the hospital performance data pre and post HCIP program for Arkansas and comparative states.

14. Short Term and Long Term Impacts

Examination of the short term and long term impacts of the use of premium assistance through the Health Care Independence Program on the private health insurance marketplace in terms of carrier competition, actuarial risk pool, provider payment rates, health care system stability, federal tax credits for individuals above 138% of the Federal Poverty Level, and client outcomes:

TSG Approach:

Expansion is expected to have a multi-faceted impact on Arkansas, as suggested by the RFP. Each requires careful data analysis.

> **Carrier competition**- TSG will use the "Porter Five Forces" method of reviewing the competitive landscape, one which analyzes destabilizing market forces, for hospitals before and after Program launch.

Actuarial risk pool- TSG will approach this question by considering population demographics of those that joined the program compared to those that did not (are still receiving uncompensated care).

Provider payment rates- TSG will use claims and encounter data to compare rates before and after Program launch.

Health care system stability- It is too early to see much long term effect the Program may have had on stability of the healthcare system. TSG will again use the "Porter Five Forces" model to consider the strategic health of the industry.

Federal tax credits for individuals above 138% of the federal poverty level- TSG will use Arkansas budget data to estimate the total size of the federal tax credits the Program has brought to the State.

Client (patient) outcomes- TSG will review patient outcomes using the outcome metrics used to measure hospitals as well as review comprehensive studies of those newly insured of similar demographic and health profiles.

How the Services Will Be Delivered:

TSG will conduct the following assessments:

- Competitive Strategy analysis (Porter Five Forces) of the insurance carriers and hospitals
- Patient and care demographics assessment using Medicaid and encounter data provided to Medicaid
- Federal tax credit assessment, using data from the Program eligibility system
- Patient outcomes comparison using published outcomes data from Arkansas hospitals before and after Program launch and review of clinical studies of comparable populations that are newly covered under similar programs

Deliverable:

These analyses will be documented in a section of the report that describes data, method, and findings as well as recommendations.

Recommendations for options to modernize Medicaid programs serving the indigent, aged, and disabled, including an examination of the following:

15. Verification of Eligibility

An audit of the current Medicaid system in Arkansas to include without limitation an examination of: verification of eligibility of individuals currently on the Medicaid rolls and recommendations for removal of any individuals found not to meet eligibility criteria, determination of the number of services per enrolled individual, Medicaid provider

categories and recommendations for the categories to reflect the appropriate performing providers, and the utilization and cost of prescription medications and recommendation for the reduction of those costs.

TSG Approach:

TSG believes that program integrity is essential to providing quality care to those who are truly in need of services. Giving services to those who are not qualified costs taxpayers, while also undermining the public's confidence in state services.

Therefore, TSG will examine the state's Medicaid population to identify potential ineligible individuals receiving benefits to ensure program integrity.

TSG will also conduct an analysis of individuals and providers to identify patterns of misuse or abuse of services. While each case is different, an appropriate utilization screening can spot red flags for more attention.

TSG will review existing best practices in pharmacy management to determine the best solution for reducing inappropriate utilization and using economies of scale to lower costs.

How the Services Will Be Delivered:

TSG will work with national data vendors to identify potential ineligible beneficiaries and make recommendations on a process for the Department to ensure beneficiary and program integrity at the eligibility systems level. TSG will provide the Task Force with its findings and recommendations for moving forward on current and future eligibility system improvements that remove these and other beneficiaries committing fraud.

TSG will assess the current state of inspecting Medicaid claims for individuals and providers to determine the effectiveness of existing system and determine gaps. Work with fraud vendors to develop an Arkansas solution that ensures rapid and accurate fraud and misuse detection.

TSG will review the state pharmacy benefit management to ensure that the state has adopted best practices in keeping pharmacy costs as efficient as possible.

Deliverable:

The final report will include a section that included these analyses and proposes programmatic and structural changes to ensure that program integrity of Arkansas Medicaid, as well as potential saving estimate from a robust verification and anti-fraud system.

16. Case Management Tracking and Contract and Administrative Efficiencies

An examination of case management tracking for beneficiaries across social services programs. Recommendations regarding contract consolidation and administrative efficiencies.

TSG Approach:

Medicaid paid "case management" services are often provided in federally required Medicaid "silos" such as HCBS waivers, primary care oriented integration strategies with behavioral health and patient centered medical homes (PCMH). The risk to the states is that beneficiaries may have multiple case managers and/or care coordinators resulting in fragmented continuity of care, duplication of case and care management functions, and avoidable costs.

In order to provide the Health Reform Legislative Task Force and Arkansas General Assembly with a comprehensive examination of case management practices and tracking across social service programs TSG will review and assess all Medicaid State Plan/amendments, all HCBS waivers, and the ARKidsB 1115 waiver (specific EPSDT requirements for case management) case and care management requirements from the perspective of assessing and treating the whole person allowing for population health based solutions that inform comprehensive state Medicaid policy.

TSG will also look to contracts and administrative costs and determine if there are efficiencies that can be gained through consolidation, reduction in duplication and non-essential effort, as well as coordination of Human Service functions.

How the Services Will Be Delivered:

Our examination will be focused on assuring continuity of care, reducing duplication across the Arkansas Medicaid program and partner state social service agencies, and reducing costs, looking at the organization as a whole and identifying administrative efficiencies. Our review will also include a high level assessment of the interoperability of the Medicaid IT system and related social service agencies such as Aging and Adult Services, Behavioral Health, Children and Families, Developmental Disabilities Services, Services for the Blind, Youth Services, and TANF with a focus on client tracking capability.

Deliverable:

The final report will include a section that will include recommendations based on common sense and known state best practice.

17. Comparison to programs in other states

Comparison of the results of the audit of the Arkansas Medicaid program to programs in other states, including a comparison of the administration of the Arkansas program to other states' organization and administration of their programs, and any recommendations regarding the restructuring of the Arkansas program.

TSG Approach:

TSG will implement a comprehensive program and budget audit and assessment of the current Arkansas Medicaid Programs serving the indigent, aged, and disabled populations. Audit and

assessment findings will drive TSG recommendations to modernize the Arkansas Medicaid Program based on the values articulated by the General Assembly in Act 46.

The comprehensive audit, assessment, and recommendations will include:

- Organizational design of the Arkansas Medicaid Enterprise
- Cost and trend analysis of medical/pharmacy, all waivers, and DME compared to other states
- Focus on ABD population (low numbers/high cost/high needs)
- Current strategy to reduce avoidable use of ERs and hospitalizations
- Long Term Care Services and Supports for Aged/Physically Disabled individuals; people with Intellectual/Developmental Disabilities; and people with severe and persistent mental illness and all related waivers
- Medicaid paid case management services across state plan services, waiver services, and other Arkansas social services agencies
- Case tracking, care coordination, communication, and high risk case identification across all state agencies of individuals who are enrolled in the Arkansas Medicaid program
- Medicaid provider licensing, regulation, credentials, and debarment practices
- Current utilization methods for high cost services
- Current strategy for a Preferred Drug List, Pharmacy Benefits Management, dispensing fees, appropriate use of anti-psychotics for children/youth and cost
- Current strategy of Arkansas Medicaid Program Integrity plan, including eligibility and identity verification, recoupment, detecting fraud, assets verification
- Management, purchasing and cost of Durable Medical Equipment
- Administrative and clinical use of data, high cost case identification through stratification and predictive analytics designed to coordinate care, achieve positive health outcomes, healthy behaviors and reduce cost
- Arkansas Medicaid Program contract administration, compliance monitoring, and cost management
- Current beneficiary personal responsibility for healthy behaviors
- Current job seeking responsibilities for healthy adults

How the Services Will Be Delivered:

The TSG expert team will deliver an on the ground comprehensive assessment of the organizational, administrative, benefits and services, waivers, IT and use of data, rules/regulations, contract management and oversight, program integrity, coordination with other state agencies and cost components of the Arkansas Medicaid Program.

Our assessment will be based on face to face interviews with key Medicaid program managers and related state agencies, review of documents, data and financial analysis. We will utilize cost, effective purchasing strategies, market based innovation, and recognized Best Practice from

other state Medicaid programs as benchmarks for the state Medicaid programs that we will compare with the Arkansas Medicaid Program. We will also identify areas of Best Practice within the Arkansas Medicaid Agency.

Deliverable:

Final Report section that explains the detailed findings of the TSG comprehensive assessment of the Arkansas Medicaid Program ("What We Found") and Recommendations for Improvement ("What We Recommend") based on other state and health care innovation and best practice analysis.. Final recommendations will include a five year financial plan based on recommended program changes and will include identified savings opportunities.

18. Comparisons

Descriptions and comparisons of successful Medicaid block grant programs:

TSG Approach:

Congress is currently considering the concept of comprehensive state Medicaid Block Grants, and versions of these unified grants have been in included in both the U.S. House and U.S. Senate budgets. At this point, several states have been able to (TN, RI, CA) to organize their entire Medicaid program within an 1115 waiver with a Global Budget and augmented non-matched CMS funding known as "Costs Not Otherwise Matched" which are generally not bound by restrictive rule/regulation. Additionally, Section 1332 of the ACA allows for state innovation waivers on several provisions of the law as long as several standards are met.

How the Services Will Be Delivered:

TSG proposes to analyze the TN, RI, and CA 1115 waivers for common standards and unique innovations that could have significance for the goal of transitioning from the Health Care Independence Program and modernizing the Arkansas Medicaid programs serving the indigent, aged, and disabled. Additionally, TSG proposes to analyze the rules governing the 1332 waiver, conduct intelligence with other key states who have chosen non-traditional Medicaid for expansion to explore their consideration and perspective on the waiver.

Deliverable:

Final Report section that discusses the commonalities and unique characteristics of the TN, RI, and CA "Global Budget" 1115 waivers and the opportunities, challenges, and applicability of the PPACA 1332 waiver and recommendations on options that could assist Arkansas transitioning from the Health Care Independence Program.

19. Legislative Review

Recommendations of procedures to optimize and streamline the legislative review and approval process for state plan amendments and other Medicaid rules, so as to promote

efficiency, ensure agency responsiveness to changing market conditions, encourage transparency, and protect against undue influence by special interests:

TSG Approach:

TSG would initially create a process template of the current legislative review and approval process for state plan amendments and other Medicaid rules including required time frames and process ambiguities, if any. TSG would also conduct research that identifies other state legislative processes that are considered as "best practices" or provide options that could meet the goals of the Arkansas General Assembly to improve the legislative review and approval process.

How the Services Will Be Delivered:

TSG would research existing Arkansas law, rules, and practice that support the current practice of legislative review and the approval process of Medicaid state plan amendments and rules. TSG would conduct an on the ground interview with The Bureau of Legislative Research to assure accuracy and context. This information will provide the basis of process template and timeline.

TSG would research other state legislative review and approval processes for Medicaid program business that are considered efficient, effective, transparent and objective. TSG would interview knowledgeable staff at the National Council of State Legislators and the National Association of Medicaid Directors to assist with the identification of potential states of interests. TSG would then interview up to three states to determine the applicability of their Medicaid program review and approval process to meet the goal of streamlining and optimizing current Arkansas' current process.

Deliverable:

Final Report section that makes procedural recommendations to optimize and streamline the Arkansas legislative review and approval process for Medicaid state plan amendments and rules based on an assessment of current practice, assessment of other state practices known to be effective.

20. Roles of Other Agencies

An examination of the roles of other agencies in the state that impact the patient populations under both the Health Care Independence Program and traditional Medicaid, including without limitation the Arkansas Department of Health, the Arkansas Department of Corrections, the Department of Community Corrections, and the Arkansas Insurance Department:

TSG Approach:

TSG will document roles of other agencies and talk with both Medicaid and the other agencies about any potential issues or opportunities for improved collaboration. This will be critical to

assessing the budgetary impact of unwinding expansion for corrections and examining the impact to the marketplace with the reduction in covered lives brought in through HCIP.

How the Services Will Be Delivered:

TSG will develop an overall map documenting which various agencies collaborate to support Arkansans' health. Then armed with this map, TSG will discuss issues with the forms and levels of collaboration with representatives of all agencies and their IT personnel. This is based on the awareness that we will not "get the full story" from any one. TSG will conduct a series of discussions with representatives of key agencies to document opportunities for better collaboration. Case tracking, care coordination, communication, and high risk case identification across all state agencies of individuals who are enrolled in the Arkansas Medicaid program will be the goal of these interactions.

Additionally, it will be critical to validate budget impacts proposed by the corrections and insurance agencies through legislative budget staff.

Deliverable:

A section in the final report that includes:

- Diagram mapping paths of agency collaboration
- Description of the various forms of collaboration
- Description of opportunities of improve collaboration
- Recommendations for improving healthcare through interagency collaboration
- Potential impact on budget through corrections unwinding of HCIP
- Assessment of insurance marketplace impact of ending HCIP

21. Alternative Health Care Coverage Model

An explanation of how the recommendations regarding the alternative health care coverage model and the recommendations regarding modernization of Medicaid programs serving the indigent, aged, and disabled will impact one another, including without limitation economic impact and impact on patient populations, and impact on the private sector. The explanation should include an explanation of any funding streams identified through Medicaid to assist with payment of the recommended alternative health care coverage models

TSG Approach:

TSG will begin with a rigorous review and analysis of Arkansas' Medicaid program to determine opportunities for savings in the traditional Medicaid benefit. Once these are isolated and modeled for cost avoidance, TSG will look for areas in human services that could potentially be wrapped into the Medicaid program for federal participation.

Once a final potential pool of resources is identified, TSG will develop an alternative model to provide a benefit to those who gained Medicaid eligibility through expansion. This model will focus on assuring the highest quality at the most efficient prices possible.

How the Services Will Be Delivered:

TSG will use three techniques to find, prioritize and recommend improvements in management of these high-cost populations:

- Document the current cost of serving. Based on current reports and data analysis, TSG will identify the current costs of serving the health needs of these patient groups. This will be a sufficient level of detail to identify improvement and savings opportunities
- Identify areas for federal participation and program improvement for more efficient service delivery and savings
- Describe alternatives now being used in other states (and countries) to improve care management.
- Forecast the potential for improving healthcare value from alternate approaches
- Review various cost containment initiatives and program options for funding. One important aspect of this cost containment effort will be the comprehensive review of inpatient and outpatient medical claims data and a review of CPT and DRG codes. TSG, through the use of its data mining tools, has conducted similar detailed research for the Pennsylvania Department of Public Welfare's (State Medicaid Agency) Fee For Service populations, and was able to identify hundreds of millions of dollars of variations and disparities within the cost of the same medical procedure among different medical facilities. This information will be highly valuable to the Task Force and to TSG in arriving at, among other things, its decision on cost efficiencies within the existing Medicaid program that can be used to fund an alternative approach. Based on the prior use of this cost transparency tool in a number of jurisdictions, TSG will bring this unique value of being able to identify significant acute care savings through a more transparent and quality enriched program.
- Build a plan, based on available resources, that best offers care to population that would otherwise be displaced from unwinding of HCIP

Deliverable:

A section of the final report that describes the findings and recommendations for policy and program changes that would increase care and reduce cost for the elderly, disabled, and other high-cost patient groups.

22. Ad hoc reports

Ad hoc reports regarding Medicaid claims data independent of current Business Object Software used by the Department of Human Services (DHS), Division of Medical Services (DMS)

TSG Approach:

TSG will investigate the opportunity for improving ad-hoc reporting from the perspectives of need and tools.

How the Services Will Be Delivered:

TSG will review each of the requests the Legislature has made for ad hoc reporting over the past several years. It will document the underlying policy need, the form of the request and the success the Agency has had in meeting the need.

TSG will review with Agency IT personnel the personnel and technical limitations on providing ad hoc reports

TSG will review the tools available for providing ad hoc reporting, given the current technical constraints.

TSG will recommend short and long term solutions.

Deliverable:

A section of the final report will specifically spell out short and long term options for improving the Legislature (and Agency's) ability to develop ad hoc reports

23. Actuarial Projection

A cost analysis or actuarial projection for the Vendor's recommendations based on specific categories of services

TSG Approach:

TSG shares a passion that every change to Medicaid or the Program should lead to real improvements in healthcare value. Accordingly, every program improvement should result in a financial or programmatic benefit, or both. Thus, a rigorous analysis of the impact that these changes have on taxpayers is essential. Accordingly, the ongoing process of identifying improvements to the Medicaid system will go hand-in-hand with an ongoing financial analysis.

How the Services Will Be Delivered:

TSG will begin a comprehensive financial audit of the existing Medicaid program, broken down by category and service type. As each component of program improvement is contemplated, it will specifically be evaluated against the financial implications. Ultimately, there analyses will be included in the final report.

Deliverable:

Financial analyses will be embedded throughout the final report. The functions will be fundamentally built into each component. The report will also include a separated financial projection with the proposed recommendations.

Integral Services not Specifically Required

TSG recognizes that the question of improving healthcare requires some aspect of consideration not specifically called out by the RFP. We describe these below and offer them as part of the proposal.

24. Impact on Outcomes

The goal of a Medicaid program should be finding the right balance of cost and outcome to create optimum healthcare value. The state of the art in measuring outcomes is embodied in CMS's Hospital Performance Reports. The Task Force should understand the Program's impact on outcomes as well as costs.

TSG Approach:

TSG will consider what (if any) Program changes have had on patient outcomes as measured by CMS.

How the Services Will Be Delivered:

TSG will obtain provider-level reports in order to assess any improvement or degradation in outcomes following Program launch. This will be conducted at the level of individual providers and rolled up statewide. Of course, there may be a tendency for all hospitals nationally to improve, in response to measurement and improved medical practice. So, TSG will benchmark Arkansas providers against national metrics.

Deliverable:

TSG will include in its final report a section that provides the data on any change in quality metrics. It will highlight areas with significant change, and discuss the potential underlying causes as well as any remedial action that might be required.

25. Pharmacy

Over the past decade or so, pharmacy has become an increasingly important aspect of healthcare cost—growing faster than healthcare costs overall. Therefore the Task Force project should focus specifically on pharmacy opportunities, going into greater focus than mentioned in section #13.

TSG Approach:

After nearly a decade of single digit pharmacy spend trend, both public and private sector plan sponsors are once again experiencing double digit growth in pharmacy costs. The primary cost driver are approval of new specialty pharmacy products, growth in use of existing specialty pharmacy products, compounded prescriptions, and generic drug cost inflation.

Expenditures on compounded prescriptions have grown at inexplicable rates over the last 3 years. Our experts are fully aware of the cost drivers and can analyze the current situation in the State. Once a picture of the current state is known, we will propose, seek approval and implement a plan to normalize costs for these important prescriptions.

Recently, generic drugs have grown to represent nearly 85% of all ambulatory prescriptions fills. Most are reimbursed according to a Maximum Allowable Cost (MAC) list, but with supply chain disruptions, the costs of some generic drugs have skyrocketed. The approach with generics will be to understand the drug mix, analyze the MAC price list for competitiveness and recommend changes to reduce these costs.

How the Services Will Be Delivered:

TSG will include a thorough examination of the acquisition model for specialty pharmacy products. After examining the distribution channel, negotiated discounts and rebates (for both medical and pharmacy benefit coverage) and the utilization management approaches (including site of care) for patients receiving these expensive products, recommendations will be put forward to reduce these costs.

This examination will use several specific examples to observe any relationship between higher pharmacy and lower acute care costs. For example, TSG might consider the relationship between expenditures on statins and total costs of acute care for diagnoses related to heart disease, expecting there to be a positive trade-off of pharmacy to acute care even in the short run.

Deliverable:

A section in the final report that includes:

- Discussion of opportunities in Arkansas' preferred drug list
- Discussion of opportunities to improve Arkansas' drug approval process
- Analysis of pharmacy spending both in straight Medicaid and the Program
- Specific opportunities to adjust the preferred drug list
- Recommendations for short and long-term improvement in pharmaceuticals management

5. Other Information and Assurances

26. Project Plan

TSG will work with the Task Force to develop a detailed description of the project to ensure a clear commitment to delivering results that meet legislative intent, including how the requirements will be met and building a clear understanding of the nature of the final report and milestones for updating the Task Force throughout the process. This will be agreed upon within 30 days of contract date

27. Staff Availability

Personnel will be ramped into the team beginning within 24 hours of contract signing. Project team will be named and available before the work plan is finalized. Task Force will agree as to any other requirements on the availability of staff to perform under this RFP before those staff are assigned to the project. In general, TSG will make sure that staff is fully available

28. Timing

The most significant limiting factor to this project will be the Agency's willingness and ability to provide the requisite claims and encounter data for the analysis. TSG will work with Agency IT personnel immediately upon contract to design the required data extract and environments. TSG will begin building data analysis routines based on a data dictionary and sample data provided by the Agency.

TSG will coordinate daily with the Agency to assure timely performance and report any issues to the Task Force as needed. Once full data are available, the project will require 4 weeks for data analysis. A large part of the non-data project work will be conducted during the period we are waiting for data.

29. Additional Services

TSG may from time to time propose services in addition to those described in this Scope of Work. No work will begin on such proposals without prior written approval.

30. Reliance on Other Reports

Where appropriate, TSG will endeavor to leverage existing studies. If this is done, TSG will give credit to the studies in its final report, disclaim any credit or accountability for accuracy, and make best efforts to communicate the methodology employed in compiling those reports.

31. Assurances

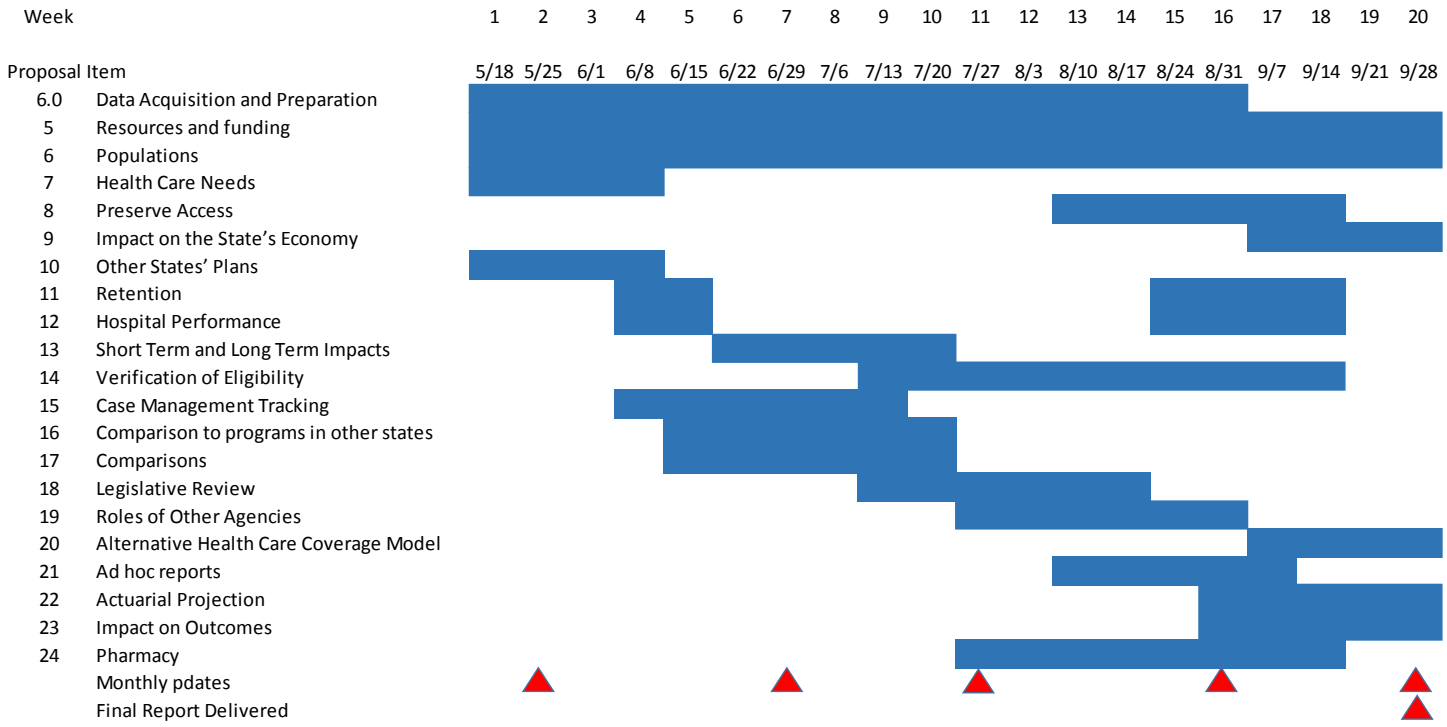
All recommendations and options will demonstrate how the following shall be achieved and should be structured in such a way as to achieve:

- Protection of Arkansas workers and employers from federal mandates and regulations by limiting the role of the federal government in defining the health care choices and coverage available in the Arkansas health insurance market;
- Maximum flexibility for the state and limitations on federal restrictions on the state's ability to efficiently and effectively manage the Arkansas Medicaid Program;
- Opportunities to limit the size of the traditional Medicaid program by serving healthier beneficiaries in the most cost effective/beneficial method for the State of Arkansas;
- Strengthening the employer-sponsored health insurance market;
- Increased employment of able-bodied recipients of taxpayer-funded healthcare services;
- Healthier behaviors, increased accountability, and personal responsibility for beneficiaries;
- Reduction in number of unplanned pregnancies in the state;
- Enlistment of enough providers so that care and services are available at least to the extent that such care and services are available under the Health Care Independence Program;
- Access to health services in rural areas of the state, including use of technology to overcome distance and financial barriers;
- Improved access to health services for people with developmental disabilities;
- Continuity of coverage for eligible individuals as their income or life circumstances change; and
- Continued payment innovation, delivery system reform, and market-driven improvements, including without limitation the Arkansas Health Care Payment Improvement Initiative, Health Maintenance Organizations (HMOs), Patient-Centered Medical Home (PCMH)/Primary Care Case Management (PCCM) models, and concierge service arrangements (as implemented by Act 101 of 2015).

6. Project Timing

TSG is eager to support the Task Force in completing the project within the requirements of the legislative budget cycle. However, this is a significant project for the State of Arkansas with far-reaching implications. Accordingly, time management will be key.

32. Project Gantt



33. Time-related terms and conditions

The requested project is highly data-intensive. It requires original data suited to assessment of patient and provider-level costs and experience. We envision that this analysis will be conducted using an extract of data from two sources: Fee For Service data in the Medicaid claims system, and Encounter data provided by the insurance companies covering the Program lives. TSG is familiar with the issues of obtaining such data.

In our previous experience, even "high-priority" projects are subject to personnel and technical constraints. In addition, we have found issues of accuracy in the data provided for similar projects in the past.

Yet, in order to meet the tight time frame required by the proposed project, TSG will dual-track the project. This means investing in creating the analytical process before the data is ready. This is a challenging strategy in the world of systems, since it assumes that the data will arrive on time and with high accuracy.

Accordingly, TSG will conduct its side of the project in good faith, and depend on the Medicaid Agency to assure that the data requested is provided.

- Concurrent with design analysis plan, TSG will work with Agency IT to design the data extract, we expect this to be completed with 4 weeks of contract. To be successful, TSG needs the Agency to deliver data dictionary within 1 week and sample data within 3 weeks of the data extraction plan approval
- Moreover, TSG will also require Agency to deliver complete accurate data within 6 weeks after extract plan agreement (i.e. 10 weeks from contract start date)
- TSG will complete the data analysis within 4 weeks. After data analysis, TSG will develop the final report within 2 weeks. Thus, with these assumptions about Agency cooperation the project could be completed in 16 weeks from contract date

TSG recognizes and assumes that the Task Force and Agency already have access to data that will be important to this review, and could be of value to TSG in its analysis and is readily available to save time. Thus, while TSG is working with the Agency on the data extract and data-related needs as stated above, TSG will also use available data to conduct its analysis and assumes that both the Task Force and Agency will make such data available.

Likewise, TSG will require access to leadership and management of the Medicaid and other agencies for interviews and focus groups. TSG will provide the Task Force at least one week advance notice of meeting requirements. TSG assumes that the Task Force will organization meeting times with agency personnel.

Additionally, TSG must receive access to Medicaid eligibility system data, policies and vendors for provider and beneficiary review and screening in order to assess verification process within 4 weeks of project start.

34. Monthly Status Updates

TSG will meet regularly with Task Force project leadership and available monthly to meet with the whole Task Force. These meetings will be attended in person by the TSG Project Lead. Other personnel will attend as needed, and may also be asked to attend by audio or video conference. In advance, TSG will provide a written update covering at least:

- Project tasks performed during the most recent period
- Preliminary observations during the period
- Planned activities during the upcoming period
- Key project issues for which added Task Force intervention is required (i.e. road blocks)

35. Additional Meetings

TSG will attend various meetings of the Task Force and other legislative committees of the Arkansas General Assembly, if requested.

7. Data

At the crux of the project is a new look at the details of cost. TSG will endeavor to conduct the analysis using standard reports from the Agency. However, since the project asks questions that are not anticipated by most regular reporting systems, TSG assumes that the project will require original data analysis.

Data analysis will sit at the core of much of the project analysis, including:

- Changes in cost
- Changes in retention
- Changes in beneficiary demographics (e.g. adverse selection)
- Opportunities in pharmaceuticals
- Opportunities from improved provider management
- Opportunities for improvements to eligibility management

This will require either an existing data warehouse (data mart) suited to the task or a custom extract. Based on our experience in other states, TSG does not assume that Arkansas has a suitable data mart. To create the required data repository, TSG will need data including:

- Medicaid claims for a year prior to the Program through current
- Encounter data at the claims level for a year prior to the Program and through current
- Eligibility data

All data needs to be inside the HIPAA firewall. That is, TSG must be licensed as a provider and able to use client identified data.

All extract must be tested for data accuracy before TSG receives them. TSG and the agency will agree on a data quality test plan to be executed by the Agency's IT personnel. Although TSG will review the data quality test results, it will accept no responsibility for accuracy of the underlying data. TSG will be responsible for analysis of the data provided.

8. Other Requirements

8. Other Requirements

35. Information Sheet

MAILING ADDRESS: 500 Woodlane Street State Capitol Building, Room 315 Little Rock, Arkansas 72201 E-MAIL: thayerj@blr.arkansas.gov TELEPHONE: (501) 682-1937	PROPOSAL OPENING LOCATION: Bureau of Legislative Research Director's Office State Capitol Building, Room 315

Company Name: The Stephen Group, LLC

Name (type or print): John Stephen

Title: Managing Partner

Address: 814 Elm Street, Manchester, NH 03101

Telephone Number: (603)419-9592

Fax Number:

E-Mail Address: Jstephen@stephengroupinc.com

Signature:

USE INK ONLY; UNSIGNED PROPOSALS WILL NOT BE CONSIDERED

Identification:

45-5280316	003-50-4134
Federal Employer ID Number	Social Security Number

FAILURE TO PROVIDE TAXPAYER IDENTIFICATION NUMBER MAY RESULT IN PROPOSAL REJECTION

Business Designation (check one):	Individual [ ]	Sole Proprietorship [ ]	Public Service Corp [ ]
	Partnership [ ]	Corporation [x]	Government/ Nonprofit [ ]

GENERAL DESCRIPTION:	Health Care Program Reform/Medicaid Consulting Services

TYPE OF CONTRACT:	Term

36. General Confirmations

TSG agrees by reference to be bound by the following as described in the RFP, these include:

- Minority business policy
- Equal employment opportunity policy
- Technology access for the blind
- Employment of illegal immigrants
- Appeals
- Payment and invoice provisions
- Proprietary information
- Prime contractor responsibility
- Delegation and/or assignment
- Publicity
- Confidentiality
- Licenses and permits

37. Representations

TSG makes the following required representations:

- Proposal shall remain valid for one hundred eighty (180) calendar days from the proposal due date
- Warranties
- TSG is capable of providing the services required by the task force;
- TSG is authorized to do business in this state
- Business Name
- TSG nor any of its subcontractors are engaged in any civil or criminal litigation or indictment litigation

38. Disclosures

Business Address;

The Stephen Group, LLC. 814 Elm Street, Suite 309, Manchester, NH 03104

Alternate Business Address

Same

Primary Contact Name, Title, Telephone, Fax, and E-mail Address;

John Stephen, Managing Partner, TSG, (603)-419-9592, Jstephen@stephengroupinc.com

How many years this company has been in this type of business;

5 years

Proof that the Vendor is qualified to do business in the State of Arkansas

Vendor will furnish proof it is qualified to do business in the State of Arkansas

Names and addresses of officers, directors, and each stockholder

John Stephen, Managing Partner, The Stephen Group, LLC.

States and Jurisdictions in which the Vendor Does Business

A disclosure of all the states and jurisdictions in which the Vendor does business and the nature of the business for each state or jurisdiction;

See Section 2.1 Vendor Qualifications

States and Jurisdictions: contracts

A disclosure of all the states and jurisdictions in which the Vendor has contracts to supply health care program reform/Medicaid consulting services and the nature of the goods or services involved for each state or jurisdiction;

Texas and Mississippi – See Section 2.1 Vendor Qualifications

Criminal Offense

A disclosure of the details of any finding or plea, conviction, or adjudication of guilt in a state or federal court of the Vendor for any felony or any other criminal offense other than a traffic violation committed by the persons identified as management, supervisory, or key personnel;

None

Bankruptcy

A disclosure of the details of any bankruptcy, insolvency, reorganization, or corporate or individual purchase or takeover of another corporation, including without limitation bonded indebtedness, and any pending litigation of the Vendor;

None

Conflicts of Interest

A disclosure of any conflicts of interest on the part of the Vendor or its personnel that will be working on this project, especially regarding financial interests that would be impacted depending on the recommendations ultimately made by the Task Force.

None

Additional Disclosures

Additional disclosures and information that the Task Force may determine to be appropriate for the procurement involved.

None

39. Independent Price Determination

TSG certifies that the prices in the proposal have been arrived at independently, without collusion, and that no prior information concerning these prices has been received from or given to a competitive company; and

40. Disclosure Forms

TSG will complete the required disclosure forms if selected as the vendor and upon contract. These are sourced from:
http://www.dfa.arkansas.gov/offices/accounting/internalaudit/Pages/ExecutiveOrder98-04.aspx

- Contract & Grant Disclosure Report
- Employee Disclosure Report

Appendix A TSG Team Biographies

Staff Member	Qualifications
John Stephen	**Biography**: John Stephen is the founder and managing partner of The Stephen Group, a business and government consulting firm, focusing on assisting business and governments in healthcare and social services intelligence, public sector growth strategies and innovation. Prior to founding The Stephen Group, John was a partner at The Lucas Group from 2008 to 2011, where he led the firm's Government practice, and assisted the firm's private equity division in evaluating transactions impacted by government regulation, and offering strategies for value based growth. In addition to his experience consulting with business and government, John has the benefit of heading two large state agencies through a period of major change. Among his many accomplishments, John has successfully led large scale state agency projects in numerous aspects of Health and Human Services. John recently worked alongside TSG consultants in the MDHS 2014 Child Support Enforcement Assessment project, which resulted recommendations to improve the efficiency of CSE operations, including Medicaid IV D funding. John also was a member of the TSG team that provided similar technical expertise to MDHS in preparing for the RFP for outsourced counties. John has led additional successful projects in states of Texas (child welfare agency assessment and recommendations for operational improvements and implementation of child protection system, Medicaid IV E transformation project that resulted in TSG recommendations): Mississippi (child welfare, Medicaid IV D, TANF and SNAP systems redesign for the Department of Human Services) recommending systems redesign to improve the delivery of services and leverage available federal funding; Florida (Medicaid fraud and benefit recovery assessment and implementation for the Department of Children and Families) that will assist the state in enhancing fraud recoveries by over $125 million over a five year period; Illinois (Child Welfare, Medicaid and Human Services), by serving as the Governor's lead facilitator for the Taxpayer Action Board Human Services (Child Welfare) and Medicaid Reform Committees and recommending over $2 billion in program changes and savings, many of which are occurring today; Rhode Island (Medicaid) in drafting and negotiating the state's landmark Medicaid Global Section 1115 Waiver); South Carolina (Medicaid) in assessing the states long term care system and providing recommendations for modernization and re-design, many of which are occurring today. John also led efforts in early 2010 to assist the State of South Carolina in re-organizing the state agency responsible for putting people back to work, and identifying over $1.2 billion dollars in savings for the state unemployment insurance system, while offering a plan to cut taxes for small businesses. The Chairman of South Carolina's Senate Labor, Commerce and Industry Committee, W. Greg Ryberg, applauded John's efforts and stated that "John's

Staff Member	Qualifications
	clear-headed and forthright analysis and advice illuminated the path for SC to fix its UI system and relieve the burden on small business." John served from 2003 to 2007 as Commissioner of New Hampshire's largest Department, the Department of Health and Human Services, where he was in charge of a $1.8 billion dollar annual budget, and was able to contain Medicaid cost to less than a 1% growth during his four year term. As Commissioner, John led the Department through a period of major innovation, including improving the efficiency of the Child Support program and the state Medicaid operations, and in engaging families on assistance in work activities. He helped develop and implement the state's Child Support payment reform program and assure the efficient delivery of support payments; John also developed a national recognized Health Care Reform program that focused Medicaid on prevention, wellness and rebalancing long term care, as well as embracing a family centered practice for at-risk youth. His child welfare agency was recognized nationally for its permanency planning and solutions. John also initiated disease management and care coordination programs that transitioned New Hampshire Medicaid away from treating the sick to keeping people healthy. During each of the four years John was Commissioner, New Hampshire ranked first nationally in the Kids Count survey. During that same period, the enrollment of low income, uninsured children into the State's Medicaid and SCHIP program increased by 7500. John also oversaw the state's welfare program, Special Nutritional Assistance Program (SNAP) and Temporary Aid to Needy Families (TANF) program. In this role, John was able to transform welfare in New Hampshire, reducing the rolls by 20 percent and dramatically increasing work participation rates by bringing accountability to the program. Prior to heading the $1.8 billion annual budget at HHS, John served as Assistant Commissioner of the Department of Safety, where he was appointed as the state's first Homeland Security Coordinator. John was a prosecutor for 10 years, taking him from the county level to an Assistant Attorney General. John is a respected author; he has written or co-authored eight books on various legal matters. **Educational background:** John received his BA in 1984 from the Whittemore School of Business and Economics at the University of New Hampshire, and his JD in 1987 from the Detroit College of Law.

Staff Member	Qualifications
Richard Kellogg	**Biography**: Richard Kellogg is a senior consultant with TSG. Richard has served in Executive Branch health and human services positions as Commissioner, Deputy, or Director in the states of Virginia, Tennessee, New Hampshire and Washington beginning in 1994 through 2011. Richard's scope of responsibility has included medical and pharmacy services, mental health

Staff Member	Qualifications
	and substance abuse service systems, psychiatric hospitals and developmental residential programs, developmental/intellectual disabilities community based services and support systems, and long-term care services systems. He has extensive experience with comprehensive Medicaid budgeting, cost containment, waivers integration, IT, and managed care procurement, contracting, and oversight. Prior to beginning his career in state government Richard was a successful CEO of local government and private sector organizations charged with managing and delivering comprehensive mental health, substance abuse, developmental/intellectual disabilities and long term care services including community based and inpatient services on behalf of local government and non-profit organizations. Richard provided leadership to the successful resolution of several Department of Justice lawsuits involving CRIPA/ADA/Olmstead issues within state psychiatric hospitals and developmental residential centers, access to community services, and EPSDT litigation while serving as Commissioner of BH/DD for the Commonwealth of Virginia. He is an expert witness in matters directly related to the medical, psychiatric, recovery and protection of state psychiatric hospital patients and residents of state developmental centers including community based systems based on assessment, acuity, and outcomes. While Commissioner for Virginia Richard served as the Chair of the State's Executive Council of the State's Comprehensive Services Act, encompassing Foster Care/IVE, Special Education, and Juvenile Justice funding. In this role Richard was responsible for integrated services, including Medicaid policy for primary care, behavioral health, prevention and intervention, for children/adolescents at risk. Richard helped lead the development of a comprehensive plan addressing CMS concerns and moratorium on TennCare HCBS waivers and on-going Department of Justice litigation for Tennessee's system of care for adults with developmental/intellectual disabilities. While serving as Director of Community Based Services Richard was administered the Bureaus of Behavioral Health, Developmental Disabilities, and Long Term Care Services. Under the Commissioner's leadership and Richard's efforts New Hampshire was able to successfully rebalance the long term care system to a community first choice culture and option. Richard was also Acting Medicaid Business Director when New Hampshire moved ahead on disease management and effective cost containment strategies (2005). From 2006-2011 Richard served the $11 billion dollar Washington State Department of Social and Health Services as Director of Integrated Health Services and Director of Medicaid Mental Health Policy. Richard was responsible for advising the Secretary of DSHS and the Governor's Policy Office on all aspects of national health reform, organizational structure between DSHS and the Health Care Authority, and was a member of the

Staff Member	Qualifications
	Governor's Sub-Cabinet on Health Care Reform. **Educational background:** Richard received his BA (History, Economics, and Political Science) and his M. Ed. (Organizational Development) from the University of Vermont. He has taken advanced education at Dartmouth College: CAS: Administrative Psychiatry: 1989, and Harvard University: CAS: New World of Health Care Economics: 2001

Staff Member	Qualifications
Dr. Will Oliver	**Biography**: Dr. William J. Oliver is a Senior Consultant at The Stephen Group and has over 25 years of experience leading teams and helping senior technology and operating executives improve their organizations' effectiveness. Dr. Oliver has many years of experience assisting public and private healthcare organizations. As a consultant, he has assisted MDHS in the past in the Child Support Assessment conducting much of the data analysis needed to make recommendations. He has also consulted on Health and Human Service process improvement-related projects in Indiana, Missouri, Pennsylvania, Rhode Island, South Carolina, and New York. In addition, he has assisted other aspects of benefits management in Florida and Michigan. Dr. Oliver brings extensive experience working with private sector healthcare payers and providers as well. Dr. Oliver is deeply experienced in managing resources and helping organizations reduce their costs and improve performance. Recently, Dr. Oliver worked alongside the TSG team in Mississippi in 2014 during the Child Support Enforcement program Assessment, conducting process mapping focus groups in the regions and also analyzing numerous data to provide the TSG team with support for its recommendations. In 2011, Dr. Oliver worked with John Stephen in furthering the vision of the Secretary of the Department of Children and Families to enhance the safety and well-being of all Florida children by strengthening the child protection and investigation process, and recognize Florida as a world class child welfare agency. Dr. Oliver's efforts as project manager for the state's Child Protection Transformation initiative established the initial framework for the Department's program implementation. Dr. Oliver also has in the past led a project to assist the State of Indiana Family and Social Services Department to re-invent Medicaid eligibility processing. After considering current costs and options, Dr. Oliver helped write the RFP and manage vendor selection for the largest benefits eligibility privatization in US history. Dr. Oliver also has led a team supporting Pennsylvania Office of Income Maintenance. He worked with Agency leadership to organize many separate improvement initiatives into a comprehensive process improvement program. In the process, he led teams to document current processes and create better ones. Working with Missouri's Family Support Division, Dr. Oliver led a change

Staff Member	Qualifications
	program that launched a major multi-year program to improve Medicaid eligibility determination. Also, in Missouri, Dr. Oliver worked with the Governor's office to evaluate current state operations in order to develop cost savings initiatives the state is implementing to save $150 million annually. During his career, Dr. Oliver has worked with various hospitals, payers, and other players in the medical community. Prior to joining The Stephen Group, Dr. Oliver worked as a government solutions consultant with The Lucas Group, and was part of the team that designed the Rhode Island Global Medicaid Waiver. He has also served as COO of BridgeHRO (HR outsourcing services), Vice President of 3i Venture Capital, Client Partner of Granitar Systems (web development), Director of Gemini Consulting (process improvement consulting for hospitals), senior manager of KMPG (consulting to BCBS of MA), and with Bain & Company, where he was a founding member of Bain's well known healthcare cost reduction practice. **Educational background:** Dr. Oliver holds a Doctorate in Management from Case Western Reserve University, a Masters in Management from MIT's Sloan School of Management, and a BBA in Accounting from the University of Alaska. Dr. Oliver is a CPA.

Staff Member	Qualifications
Martha Tuthill	**Biography:** Martha Tuthill is a senior consultant with The Stephen Group and has over 30 years of experience helping clients achieve their business and technology goals. Her experience includes public sector clients at the federal and state level as well as private industry. She has extensive experience with helping organizations change the way they do business to achieve faster, more cost effective solutions. She has extensive procurement and contracting experience from both a vendor and a state agency perspective and resolved issues between state agencies and vendors as problems arose. She has a Bachelor's Degree in Computer Science from The College of William & Mary and has spent much of her career bridging the gap between the needs of the business and organizational leaders and the technology personnel who support them. She also is on the local board of CASA in her hometown in Maryland. She also serves on the Colonial Williamsburg Foundation's President's Council. **Prior Experience:** 30 years

Staff Member	Qualifications
	Mississippi Department of Human Services (2014) - Assisted MDHS with an assessment of the Child Support Enforcement Operations and an insource/outsource decision on legal and child support enforcement personnel. Reviewed the call center and field operations for strengths, weakness, and opportunities. Assisted MDHS conduct a vendor information day and draft an RFP for outsourced services for 17 counties. **Texas Department of Families and Protective Services (2014 – 2015)** - Conducted an end-to-end assessment of the Child Protective Services organization, process, and technology. Concentrate review and assessment of contracts management, including IV E contracts, organizational design and continuous quality improvement. Developed recommendations and presented findings to leadership and to Texas Legislature. - Led regional teams to facilitate over 20 significant initiatives to improve field operations including reduced time to permanency, improved provisioning of services to families, improved working relationships within the Department, and accelerated closing of investigations that met criteria for administrative closure, and improved training of new hires. Overall goals of transformation to reduce turnover, decrease time to permanency, and decrease time to close investigations. **Florida Department of Children and Families - Child Welfare Transformation (2011 – 2015)** - **Child Welfare Transformation Vision** – Worked directly for Secretary Wilkins to identify issues in the Florida Abuse Hotline and the Child Protective Investigators. Worked with the central office and the regional personnel to identify people, process, and technology issues and make recommendations to correct deficiencies. Working with John Stephen and Will Oliver, we created the vision that enabled the Secretary to obtain funding from the Legislature to advance the Department's transformation agenda. - **Florida Abuse Hotline** – Worked with State staff to write RFP, conduct vendor negotiations, select appropriate vendor, and on-board the selected vendor to address technology challenges in the Abuse Hotline. Identified ways to reduce call volume through greater automation of web-based intakes. - **Child Protective Investigator Transformation– Phase 1, 2, and 3** – Worked with the State staff to write the ITN for $100 million of technology work to support the Child Welfare Transformation as well as the maintenance and operations to support the SACWIS system. Coached the State team on commercial best practices for project and enhancements delivery, service level agreements, negotiation strategy,

Staff Member	Qualifications
	and transition from the incumbent to the new service provider. Worked with the State and the selected vendor to deliver the results from the three phases of Transformation including Created a person book and case book feature to allow investigators to get a quick overview of the alleged victim and alleged perpetrator and all the history the Department had about these families. Implemented new approaches for Unified Home Studies, support for legislatively mandated changes to Independent Living and Affordable Care Act, and a new Safety Decision Making Framework, Safety Plan, and Family Functioning Assessment. Worked with Agency leadership to resolve issues between the State and the vendor as necessary. Worked with key business leaders to resolve issues with the organization's ability to absorb the new technology and process changes. **Florida Department of Children and Families - Information Technology Strategic Plan (2014)** - Led the development of a long range Information Technology Strategic Plan across all areas of the Agency. The plan included the development of short, medium and long term initiatives to support the needs of the organization across Eligibility, Substance Abuse and Mental Health, Family and Community Services, Finance, HR, and Legal. The plan will enable the agency to focus on the legislative funding cycle and the continuous need to keep technology costs down while delivering more support to the business. Worked with the Agency leaders to standardize the governance process across IT work across the agency. From 2008 – 2011, Ms. Tuthill managed the delivery organization within Accenture for Health and Public Services, including delivery of consulting services to State Medicaid operations. Responsible for 10,000 professionals delivering services on 500 contracts to 150 clients across the United States. Managed the work to on-time and on-budget services in alignment with the contract terms and conditions. Worked with the most complex situations to negotiate the contracts and resolve issues. Accenture is one of the leading consulting and outsourcing companies in the world. From 1997 – 2008, Ms. Tuthill managed the delivery of outsourcing contracts for Communications and High Tech clients. She worked with top executives across clients like AT&T, Verizon, BellSouth and Microsoft to achieve their strategic goals through successful vendor partnerships for accounting services, call center services, and information technology services. The typical contract required a 40% improvement in the productivity and output of the existing workforce. Applied best practices in process improvements, organizational improvements and technology improvements in order to deliver these results. She rose through the organization from managing a single contract to having global responsibility for delivery of over $6B of services.

Staff Member	Qualifications
	From 1986 – 1997, Ms. Tuthill led the implementation teams serving gas and electric companies around the globe. She worked with the call center operations for over 20 utility companies to improve customer service, reduce operational costs, improve collections and reduce fraud. Applied best practice techniques and industry leading technology to deliver significant improvements. Specialized in minimizing the time it took to move the workforce from the old ways of doing work to the new processes with minimal learning curve.

Staff Member	Qualifications
Rory Rickert	**Biography**: Rory Rickert is a senior consultant with TSG and a national Medicaid Pharmacy cost containment expert. Rory is also a principal at Quarterline-HIS, where he is responsible for overall leadership, management and vision for the commercial consulting practice and national pharmacy practice and sales for the entire firm. Rory has more than 30 years progressive experience in the pharmaceutical industry. Starting as a clinical pharmacist at the Minneapolis Children's Medical Center and progressing to the position of Corporate Vice President for AdvancePCS, Mr. Rickert was responsible for the oversight of corporate accounts and Government marketplace for the nation's largest independent health and wellness company, and was Corporate Director for Home Nutritional Services, a national provider of home infusion therapy. Rory is a nationally recognized speaker and industry expert in managed care, drug utilization and cost control, distribution channels and rebates, marketing, sales and delivery models in the pharmaceutical industry. Rory, has also served as a pharmacy expert witness in a number of cases, including: *Hall v. Medical Security Card, Co.,* CV 2002-010900, Superior Court of Arizona, in and for the County of Maricopa. Rickert was deposed December 6, 2004 as part of this matter. *Association Benefit Services, Inc., v. AdvancePCS, a Delaware corporation, Caremark Rx Inc. a Delaware corporation and CaremarkPCS, a Delaware corporation,* No. 04 C 3271, United States District Court for the Northern District of Illinois. State of Hawaii v. Abbott Laboratories, Inc. et al. Rory has also been retained to act as a consulting expert in other matters related to pharmacy benefits since 2004 and was a member of the team that assisted the State of Rhode Island in Medicaid cost containment solutions as part of the work on the RI Global Medicaid Waiver. **Educational background:** Rory Rickert holds a Bachelor of Science in Pharmacy from the University of Minnesota

Staff Member	Qualifications
Robert Chin	**Biography**: Robert Chin is a senior consultant and subject matter expert for TSG. Bob will be responsible for reviewing and analyzing Medicaid hospital inpatient and outpatient costs, including costs associated with DRG and CPT codes. Bob is an expert in the use of cost transparency tools for the private health care consumer market and also worked with TSG in 2012 to assist the State of Pennsylvania Department of Public Welfare in assessing the difference between medical costs between hospitals and outpatient clinics in the state for the same medical procedures. Bob's analysis introduced a wide disparity of health care costs and the Secretary subsequently used the analysis to launch a health care cost transparency program in Pennsylvania Medicaid. Bob is an expert in looking at transparency of costs within the hospital inpatient and outpatient acute care network. Bob is an experienced executive and entrepreneur in healthcare and technology with over 37 years of experience in health insurance, operations and information systems. He has a strong mix of skill and experience in strategy, technology, operations and analytics, particularly in the field of health care and health insurance. These capabilities have been developed and honed over decades in various roles and at various levels of management. Moreover, Bob has served as senior officer at multi-billion-dollar, public companies, as well as de novo start-ups (self-funded, government-loan-funded & equity funded). Bob was formerly a senior partner and board member with Compass Healthcare Advisers where he assisted a number of health care clients in cost savings through the use of medical cost intelligence tools, which also allowed consumers to achieve medical savings. Bob also provided innovation and expertise for various programs as CIO at Averde Health in the introduction of game-changing products and services into the health insurance market. There Bob also developed and deployed state-of-the-art business intelligence and monitoring of performance metrics, business continuity assurance, client outcomes and service level requirements. In 2012, Bob was part of a veteran team of healthcare executives who organized, applied for and received approval for a Consumer Operated and Oriented Plan (a provision of the ACA) in Massachusetts, called Minuteman Health. In 2013, Minuteman was approved to expand into New Hampshire. At this writing, in total across both states, Minuteman has currently enrolled almost 15,000 members. Bob continues to provide senior entrepreneurial leadership for Minuteman Health. Bob also has executive management experience in several health care and technology organizations. Instrumental as CoFounder, Lead Angel and/or Key Executive for three successful M&A exits ($1.7B at Healthsource; $4.3B for Oxford; $122M for NaviNet). Numerous large consulting engagements,

Staff Member	Qualifications
	mostly in health care and technology. **Educational background:** Bob holds a BA in Applied Mathematics from Harvard University.

Staff Member	Qualifications
Lindsay Littlefield	**Biography**: Lindsay Littlefield is a senior consultant at The Stephen Group, where she focuses on budget and financial analysis, project management and Health and Human Services subject matter expertise. Prior to joining The Stephen Group, Lindsay worked as a budget and performance analyst at the Texas Legislative Budget Board (LBB) and was a senior consultant at MAXIMUS. At the LBB, Lindsay was the lead budget analyst for the Department of Aging and Disability Services and has a policy and budget background in Medicaid acute care and long-term services and supports. Lindsay developed a subject-matter expertise in services and supports for persons with intellectual and developmental disabilities. She managed a cross-agency project team on the state supported living center system and authored the report "Decrease the Number of State Supported Living Centers to Reduce Costs and Improve Care." In addition to institutional services, she has conducted research and written legislative reports on other topics across the continuum of long-term services and supports including Texas General Revenue-funded community services for persons with intellectual and developmental disabilities, Community First Choice program/habilitation services, and Medicaid 1915(c) waiver programs. Lindsay also has a strong policy background in Medicaid acute care budget and policy issues, having authored several legislative reports on healthcare payment and delivery reform, hospital quality, using data to drive healthcare systems improvements. Throughout her tenure at the LBB, Lindsay developed budget and policy recommendations to improve the efficiency and effectiveness of state government operations; monitored trends and innovations at the federal level and in other states and analyzed applicability to Texas; and briefed internal management, state legislative members, and state executive leadership and staff on areas of research, including providing frequent testimony before policy and budget committees. Prior to her work at the LBB, Lindsay was a senior consultant with MAXIMUS, where she was selected to participate in the Management Development Program. The program provided participants with intensive

Staff Member	Qualifications
	mentoring resources and afforded the opportunity to rotate throughout the firm. Lindsay worked primarily on the Texas Eligibility Support Services Project and performed a variety of communication, reporting, and change management functions in the project management office, including establishing internal policies and procedures, preparing reports, and conducting data and policy analysis. Lindsay also worked as an analyst in Washington DC at the National Conference of State Legislators where she tracked state and federal legislation on immigration policy and created a database of state legislation; conducted analysis and prepared reports on federal immigration reform, state legislative trends in immigration policy, the Violence Against Women Act, and federal appropriations for select Health and Human Services programs. **Educational background:** Lindsay has a Master's in Public Affairs at the LBJ School of Public Affairs at the University of Texas, and a B.A, in Political Science and Communications from Wake Forest University, where she graduated Summa cum laude and was a 2002 Harry S. Truman Scholar.

Staff Member	Qualifications
Jason Melancon & Michael Walker	**Biography**: Jason Melancon and Michael Walker are subject matter expert consultants for TSG. Both Jason and Michael have over 70 years' experience with information technology projects in the public and private sector. They co-founded DataMadeUseful, a Colorado Limited Liability Company. There, they build tailored, virtual project teams. Each team is chosen specifically for the job at hand. Jason is a seasoned executive level Organizational Development, Information Technology, and Change Management consultant. As Vice President of DMU, Jason is responsible for finalizing project specifications, and recruiting and managing the project teams. The core of Jason's career has revolved around Project and Program Management – particularly project assessment and the recovery of projects in trouble. He understands practical project management, from effective use of tools and methods to the interpersonal and organizational aspects that must be mastered for projects to succeed. He has been responsible for complex programs requiring the skills of more than one hundred professionals as well as many smaller projects. He has helped develop and has taught a variety of technical and managerial Project Management and Applied Systems Theory Courses. Jason's line and consulting responsibilities have been with a variety of service and production industries at both the wholesale and retail levels,

Staff Member	Qualifications
	including: Aerospace, Federal Aviation Administration, Wood Products, Food and Electronic Manufacturing, Printing, Retail Soft Goods, and Automotive Product Distribution. More recently his work has revolved around Human Service Nonprofits, from database systems in support of evaluation, operations and outcome reporting to strategic planning. Michael has a succeeded in wide variety of jobs and industries during his 35-year business career, often working his way up from line employee to manager. He uses his broad and deep background in business to help him understand the total organization, and to inform his dealings with stakeholders both inside and outside his organization. As President of DMU, Michael concentrates on business development and has developed an expert-level competence at building applications with QlikView. This skill enables him to translate the often vague customer requirements into a concrete roadmap, which the technical team can use to build applications that precisely meet the customer's needs. DMU is currently under contract to the Maine Department of Health and Human Services, building applications to assist DHHS staff in finding and prioritizing their investigations of fraud in the use of EBT cards. This work involves the analysis of SNAP eligibility and more than 50 million transactions from 200,000 EBT cards. Investigators use our tools to pinpoint the largest and most frequent possible abusers of the system. Since the start of the project in July 2014, the tools have saved the state over $500,000, and provides policymakers the solid data analysis to make systemic changes to the program in order to reduce fraud.

State of Arkansas
Bureau of Legislative Research

Marty Garrity, Director
Kevin Anderson, Assistant Director for Fiscal Services
Matthew Miller, Assistant Director for Legal Services
Richard Wilson, Assistant Director for Research Services

ATTACHMENT A

OFFICIAL PROPOSAL PRICE SHEET

Note: The Official Proposal Price Sheet must be submitted in a separate envelope or e-mail and not part of the technical evaluation. Any reference to pricing in the technical proposal shall be cause for disqualification from further considerations for award.

1. Any cost not identified on this schedule but subsequently incurred will be the responsibility of the Vendor.

2. Bids should provide at least a 180-day acceptance period.

3. By submission of a proposal, the proposer certifies the following:
   A. Prices in this proposal have been arrived at independently, without consultation, communication, or agreement for the purpose of restricting competition;
   B. No attempt has been made nor will be by the proposer to induce any other person or firm to submit a proposal for the purpose of restricting competition;
   C. The person signing this proposal is authorized to represent the company and is legally responsible for the decision as to the price and supporting documentation provided as a result of this RFP; and
   D. Prices in this proposal have not been knowingly disclosed by the proposer and will not be prior to award to any other proposer.

The Official Price Proposal Sheet must be submitted in the following form, allowing for the inclusion of specific information regarding positions, goods, services, etc., and signed by an official authorized to bind the Vendor to a resultant contract.

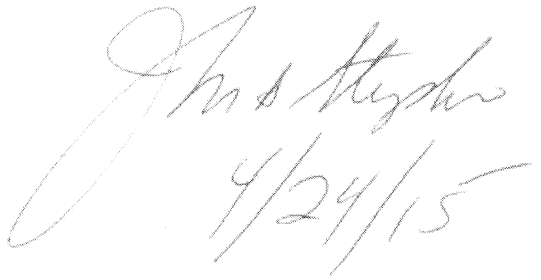
DESCRIPTION	PRICE PER HOUR	NUMBER OF POSITIONS
Supervisor/Project Manager	$290	1
Other Professional Staff (List by Position) Senior Consultants	$250	8
Support Staff		
Research Analysts	$75	4
Data Analysts	$75	4
Actuary	$200	1
		$1,036,500.00
DESCRIPTION	**PRICE PER UNIT (if applicable)**	**TOTAL PRICE**
Subcontractors (if any)		0

Travel	$45,000	$45,000.00
Any Additional Goods & Services (List Individually)		0
TOTAL MAXIMUM AMOUNT OF BID:		$1,081,500.00

Janet Stephen, Managing Partner
The Stephen Group

4/24/15
Date

STAFF/POSITION TITLE	Project Hours	Rate	Fees	Trips	Expenses
John Stephen; Project Manager/Supervisor	600	290	$174,000	10	$10,000
Dr. Will Oliver: Sr. Consultant/Chief Data Analyst	600	250	$150,000	10	$10,000
Richard Kellogg: Sr. Consultant/Medicaid Policy	600	250	$150,000	10	$10,000
Rory Rickert: Sr. Consultant/Pharmacy Claims	250	250	$62,500	2	$2,000
Robert Chin: Sr. Consultant/Medical Claims	300	250	$75,000	2	$2,000
Michael Walker: Sr. Consultant/Ben and Prov Integ	200	250	$50,000	3	$3,000
Jason Melancon: Sr. Consultant/Ben and Prov Integ	200	250	$50,000	2	$2,000
Martha Tuthill: Sr. Consultant/Contract Mgt/Org	300	250	$75,000	4	$4,000
Lindsay Littlefield: Sr. Consultant/Data/Budget	200	250	$50,000	2	$2,000
Data Analyst	300	75	$22,500		
Data Analyst	300	75	$22,500		
Data Analyst	300	75	$22,500		
Data Analyst	300	75	$22,500		
Research Analyst	300	75	$22,500		
Research Analyst	300	75	$22,500		
Research Analyst	300	75	$22,500		
Research Analyst	300	75	$22,500		
Actuary	100	200	$20,000		
Total			$1,036,500		$45,000



ATTACHMENT B

BUSINESS ASSOCIATES AGREEMENT

by and between

the Department of Human Services and The Stephen Group

Agreement_____
Action_____New
Attachment_____

BUSINESS ASSOCIATE AGREEMENT

Between

ARKANSAS DEPARTMENT OF HUMAN SERVICES

And

_____

(Business Name)

_____

(Business Taxpayer Identification Number)

This Business Associate Agreement ("Agreement") is made effective on _____, (the "Effective Date") by and between the Arkansas Department of Human Services ("Covered Entity") and_____, ("Business Associate,") (collectively, the "Parties").

Background

a) Covered Entity has been designated as a hybrid entity for the purposes of the HIPAA Privacy Rule, and it has designated several of its component agencies as health care components.

b) In accordance with the laws of Arkansas, Business Associate provides services for Covered Entity unrelated to treatment, payment, or healthcare operations and therefore the Parties believe a Business Associate Agreement is required. The provision of such services may involve the disclosure of individually identifiable health information from Covered Entity to Business Associate.

c) The relationship between Covered Entity and Business Associate is such that the Parties believe Business Associate is or may be a "business associate" within the meaning of the HIPAA Privacy Rule.

d) The Parties enter into the Agreement with the intention of complying with the HIPAA Privacy and Security Rule provisions and the Health Information Technology for Economic and Clinical Health (HITECH) Act, that a covered entity may disclose protected health information to a business associate, and may allow a business associate to create or receive protected health information on its behalf, if the covered entity obtains satisfactory assurances that the business associate will appropriately safeguard the information.

Definitions

Catch-all definition:

The following terms used in this Agreement shall have the same meaning as those terms in the HIPAA Rules: Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health

Agreement_____
Action_____ New
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Information (PHI), Required by Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

Specific definitions:

(a) "Breach" shall have the meaning set out in its definition at 45 C.F.R. 164.402, as such provision is currently drafted and as it is subsequently updated, amended, or revised.

(b) "Business Associate" shall generally have the same meaning as the term "business associate" at 45 CFR 160.103, and in reference to the party to this agreement, shall mean _____.

(c) "Covered Entity" shall generally have the same meaning as the term "covered entity" at 45 CFR 160.103, and in reference to the party to this agreement, shall mean Arkansas Department of Human Services.

(d) "HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

(e) "Protected Health Information" or "PHI" shall have the same meaning as the term "protected health information in 45 CFR 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

(f) "Required By Law" shall have the same meaning as the term "required by law" in 45 CFR 164.103.

(g) "Secretary" shall mean the Secretary of the United States Department of Health and Human Services or his/her designee.

(h) "Unsecured Protected Health Information" shall have the meaning set out in its definition at 45 C.F.R. 164.402; protected health information that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of a technology or methodology specified by the U.S. Secretary of DHHS in the guidance issued under section 13402(h)(2) of Pub. L. 111-5; as such provision is currently drafted and as it is subsequently updated, amended, or revised.

Unless otherwise defined in this Agreement, terms used herein shall have the same meaning as those terms have in the HIPAA Privacy Rule.

Obligations and Activities of Business Associate

Business Associate agrees to:

(a) Not use or disclose protected health information other than as permitted or required by the Agreement or as required by law;

(b) Use appropriate safeguards, and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information, to prevent use or disclosure of protected health information other than as provided for by the Agreement;

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(c) Report to covered entity any use or disclosure of protected health information not provided for by the Agreement of which it becomes aware, including breaches of unsecured protected health information as required at 45 CFR 164.410, and any security incident of which it becomes aware;

(d) Business Associate agrees to report to Covered Entity any unauthorized acquisition, access, use, or disclosure of unsecured PHI the Business Associate holds on behalf of the covered entity, including the identity of each individual who is the subject of the unsecured PHI of which it becomes aware, no case later than ten calendar days after the discovery of the breach;

(e) In accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any subcontractors that create, receive, maintain, or transmit protected health information on behalf of the business associate agree to the same restrictions, conditions, and requirements that apply to the business associate with respect to such information;

(f) Make available protected health information in a designated record set to the covered entity as necessary to satisfy covered entity's obligations under 45 CFR 164.524;

(g) Make any amendment(s) to protected health information in a designated record set as directed or agreed to by the covered entity pursuant to 45 CFR 164.526, or take other measures as necessary to satisfy covered entity's obligations under 45 CFR 164.526;

(h) Maintain and make available the information required to provide an accounting of disclosures to the Covered Entity as necessary to satisfy covered entity's obligations under 45 CFR 164.528;

(i) To the extent the business associate is to carry out one or more of covered entity's obligation(s) under Subpart E of 45 CFR Part 164, comply with the requirements of Subpart E that apply to the covered entity in the performance of such obligation(s); and

(j) Make its internal practices, books, and records available to the Secretary for purposes of determining compliance with the HIPAA Rules.

Permitted Uses and Disclosures by Business Associate

(a) Business Associate may only use or disclose PHI to perform functions, activities, or services for, or on behalf of, the Covered Entity as specified in:

Contract #_____, dated_____,

(known as "the Contract") between the parties, provided that such use or disclosure does not violate the policies and procedures of all HIPAA rules.

(b) Business Associate may use or disclose protected health information as required by law.

(c) Business Associate agrees to make uses and disclosures and requests for protected health information consistent with covered entity's Privacy and Security policies and procedures.

Agreement_____
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(d) Business Associate may not use or disclose protected health information in a manner that would violate Subpart E of 45 CFR Part 164 if done by covered entity, except for the specific uses and disclosures set forth below.

(e) Business Associate may disclose protected health information for the proper management and administration of business associate or to carry out the legal responsibilities of the business associate, provided the disclosures are required by law, or business associate obtains reasonable assurances from the person to whom the information is disclosed that the information will remain confidential and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies business associate of any instances of which it is aware in which the confidentiality of the information has been breached. The Business Associate will notify Covered Entity within 10 calendar days of such a disclosure.

(f) Business Associate may provide data aggregation services relating to the health care operations of the covered entity.

Discovery and Notification of Breach or Incident

(a) Business Associate shall implement reasonable systems, policies, and procedures for discovery of possible HIPAA violations and breaches (as defined by HIPAA rules), and shall ensure that its workplace members and other agents are adequately trained and aware of the importance of timely reporting of possible breaches.

(b) Upon the discovery of any HIPAA violation by the Business Associate or any member of its workforce, (which includes, without limitation, employees, subcontractors and agents), with respect to PHI, the Business Associate shall promptly perform a risk assessment to determine whether a breach of unsecured PHI has occurred and whether or not the breach has resulted in any harm to the owner of the PHI as required by HITECH Act.

(c) The Business Associate shall take immediate steps to mitigate any HIPAA violation with respect to the Covered Entity's PHI that is discovered and shall provide the Covered Entity with written documentation of such steps.

(d) If the Business Associate determines that a breach of unsecured PHI may have occurred, the Business Associate shall notify the Covered Entity of such breach or incident within ten calendar days. The Business Associate will specifically notify the DHS Privacy Officer in writing via posted mail as well as email and will confirm receipt of the email immediately by phone.

Such notice shall include:

(i) A brief description of the occurrence, including the date of the breach and the date of discovery, if known;

(ii) To the extent possible, the identity of each individual whose unsecured PHI has been, or is reasonably believed to have been, breached;

(iii) A description of the types of unsecured PHI involved;

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(iv) A brief description of what the owners of the PHI can do to protect themselves;

(v) A brief description of what the Business Associate is doing to investigate the breach, mitigate harm to affected individuals, and protect against further breaches; and,

(vi) Any other information that the Covered Entity reasonably believes necessary to enable it to comply with its obligations under HIPAA.

(e) The Business Associate shall continue to provide the Covered Entity with any additional information related to the required disclosures that becomes available following initial notice of the breach. The Business Associate will fully cooperate with the Covered Entity's investigation.

1) For a breach involving unsecured PHI of more than 500 individuals of a state or jurisdiction, the Business Associate shall promptly provide notice of such breach to the Covered Entity, the U.S. Secretary of Health and Human Services and any other federal authorities as required by HIPAA.

2) The Business Associate agrees to maintain documentation of all breaches of unsecured PHI for a minimum of six years after the creation of the documentation, and shall make such documentation available to the U.S. Secretary of Health and Human Services upon request.

(i) The Business Associate hereby agrees to indemnify and hold the Covered Entity harmless from and against liability and costs, including attorney's fees that are created by any breach resulting from the acts of its employees, agents or workforce members.

Permissible Requests by Covered Entity

Covered entity shall not request business associate to use or disclose protected health information in any manner that would not be permissible under Subpart E of 45 CFR Part 164 if done by covered entity.

Term and Termination

(a) Term. This Agreement shall be effective as of the effective date stated above and shall terminate when all of the protected health information provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to the Covered Entity, or if it infeasible to return or destroy the protected health information protections acceptable to Covered Entity are extended to such information in accordance with the termination provisions below, or on the date covered entity terminates for cause as authorized in paragraph (b) of this Section, whichever is sooner.

(b) Termination for Cause. Business associate authorizes termination of this Agreement by covered entity, if covered entity determines business associate has violated a material term of the Agreement and Business Associate has not cured the breach or ended the violation within the time specified by covered entity.

Agreement_____
Action New
Attachment_____

(c) Obligations of Business Associate Upon Termination.

Upon termination of this Agreement for any reason, business associate shall return to covered entity or, if agreed to by covered entity, destroy all protected health information received from covered entity, or created, maintained, or received by business associate on behalf of covered entity, that the business associate still maintains in any form. Business associate shall retain no copies of the protected health information.

(d) Survival. The obligations of business associate under this Section shall survive the termination of this Agreement.

Miscellaneous

(a) Regulatory References. A reference in this Agreement to a section in the HIPAA Rules means the section as in effect or as amended.

(b) Amendment. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for compliance with the requirements of the HIPAA Rules and any other applicable law.

(c) Interpretation. Any ambiguity in this Agreement shall be interpreted to permit compliance with the HIPAA Rules.

IN WITNESS WHEREOF, each of the undersigned has caused this Agreement to be executed in its name and on its behalf effective as of the Effective Date at the top of this document.

Business Associate:_____

Signed: _____

Title: _____

Date: _____

DHS: Division of Medical Services _____

Signed: _____

Title: _____

Date: _____

ATTACHMENT C

MEMORANDUM OF UNDERSTANDING

by and between

the Bureau of Legislative Research and the Arkansas Department of Human Services

Memorandum of Understanding
Between
Arkansas Department of Human Services, Division of Medical Services
And
Bureau of Legislative Research
For
Health Reform Legislative Task Force Consultant Services Agreement
May 15, 2015 to December 31, 2016
And As Extended

This Memorandum of Understanding ("MOU") between the Arkansas Department of Human Services, Division of Medical Services ("DMS") and the Bureau of Legislative Research ("BLR") (also referred to as "the parties") addresses the Consultant Services Agreement by and between the BLR and The Stephen Group for the benefit of the Health Reform Legislative Task Force, which was established by Act 46 of 2015 (the "Agreement").

BLR agrees to reimburse DMS for expenses incurred under the Agreement at the 50% state match rate under the Arkansas State Medicaid Plan and Federal and State Laws in accordance with the applicable Medicaid contract agreements.

BLR agrees to pay DMS the required 50% match amount on all approved and submitted monthly invoices received by BLR from The Stephen Group. This amount is recognized as an intergovernmental transfer (IGT) associated with Medicaid payments. The total amount of the related expenditures shall not exceed One Million Eighty One Thousand Five Hundred Dollars ($1,081,500.00) .

BLR agrees to reimburse DMS any funds paid to it under this agreement that are disallowed or otherwise recouped or recovered by the federal government.

Changes made during the period will be added as formal amendments that all parties must acknowledge by signature.

This MOU will continue in effect until completion of all transactions required by the Agreement.

This is the only IGT agreement between the parties regarding the payments and transfers described in paragraph 2, above, and supersedes and repeals any other such IGT agreement between BLR and DMS.

All of the terms and provisions of any agreement or State plan between the State of Arkansas and the Secretary of Health and Human Services entered into on the date of execution of this MOU by both parties, pursuant to §1864 or §1902, respectively, of the Social Security Act, as amended, which are applicable to DMS also shall be applicable to the BLR in its performance on behalf of DMS of the functions herein enumerated.

This MOU is effective for the period May 15, 2015 through December 31, 2016. It may be extended upon written agreement of both parties. The number of extensions is not limited.

Any changes or amendments to this agreement must be made in writing acknowledged by the signature of both parties.

This constitutes the entire agreement between the parties.

Signature Date
Dawn Stehle
Medicaid Director,
Division of Medical Services
7th & Main Street, P.O. Box 1437
Little Rock, AR 72203

Signature Date
Marty Garrity
Director
Bureau of Legislative Research
500 Woodlane Street
State Capitol Building, Rm. 315
Little Rock, AR 72201