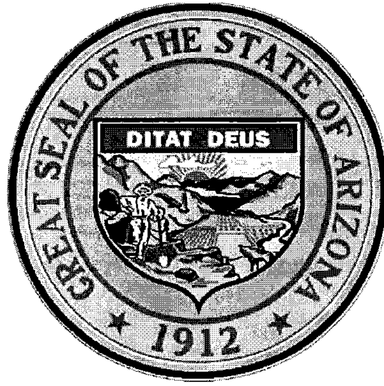

PROPOSAL TO ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

IN RESPONSE TO TASK ORDER # YH18-0031 ANALYSIS OF PROP 206 IMPACT ON PROVIDER NETWORK ADEQUACY

BURNS & ASSOCIATES, INC.

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SEPTEMBER 28, 2017

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Delivered via email to Michael.Kowren@azahcccs.gov

September 28, 2017

Mr. Michael Kowren
Procurement Specialist
AHCCCS Procurement Office
701 E. Jefferson, MD 5700
Phoenix, AZ 85034

Dear Mr. Kowren:

Burns & Associates, Inc. is pleased to submit this response to Task Order #YH18-0031 *Analysis of Prop 206 Impact on Provider Network Adequacy*. We are submitted our bid under the conditions set forth in our contract as an AHCCCS Health Care Financial Consultant, Contract # AHCCC16-098674, YH14-0033-03, Amendment #3 dated December 29, 2016.

Burns & Associates believes that with our recent experience working with two other State Medicaid Agencies on similar engagements, in conjunction with our extensive understanding of HCBS services delivered by Arizona providers, particularly for Arizona DDD, we are well poised to deliver to AHCCCS a comprehensive report under the tight project timeline.

There is nothing in the contents of this bid that Burns & Associates deems to be proprietary or confidential. As President of the firm, my signature commits Burns & Associates to the contents of this proposal. I will serve as the single point of contact for clarification of information. My contact information is listed below:

Burns & Associates, Inc.
mpodrazik@burnshealthpolicy.com
Mobile: (703) 785-2371

We appreciate your consideration.

Sincerely,

Mark A. Podrazik
President

EXPERIENCE AND CAPACITY

Burns & Associates (B&A) believes that it is well-suited to perform the work requested in this task order given our experience working on multiple projects similar in scope in just the past few years. The team that is being proposed has all performed the functions for which they will be assigned on this project on many similar projects for State Medicaid Agencies. Additionally, we believe that B&A's in-depth institutional knowledge of Arizona DDD's service array and provider base, in conjunction with our 15+ years of experience setting rates for DDD, will provide additional value to this engagement. Our office location in downtown Phoenix will also assist in efficiently administering the project and will provide the option to schedule ad hoc in-person meetings with AHCCCS, if needed, in addition to the meetings that have already been scheduled in the work plan.

Relevant Project Qualifications

In its 11 year history, B&A has worked with **31 state agencies in 24 states**: Arizona, California, Connecticut, Georgia, Illinois, Indiana, Louisiana, Maine, Minnesota, Mississippi, Missouri, Nevada, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, Texas, Vermont and Virginia. We have also done work for the Canadian province of Alberta and for the Medicaid and CHIP Payment and Access Commission (MACPAC).

For the tasks that will be required for this scope of work, B&A has completed nine projects among eight State Medicaid clients in the last five years that are relevant. A summary of this experience appears in the matrix on the next page. With respect to the five independent evaluations cited in the matrix, all of them have been completed in the last 18 months. Additionally, the B&A Project Manager assigned to this engagement wrote independent evaluations for three other state clients (Minnesota, New York and Oklahoma) and assisted writing a fourth evaluation (Nevada).

After the matrix, we present case studies for some of the projects that are listed. The remainder of this section introduces the project team. Resumes for all proposed team members appear in Appendix A. B&A is not proposing any subcontractors to work on this engagement. All team members are full-time employees of B&A. The project team proposed is prepared to start work October 6, 2017 and has the bandwidth to complete their assignments in the work plan in order to meet the deadline to deliver the report by January 2, 2018.

Matrix of Burns & Associates, Inc. Experience Related to this Project Scope of Work

Task Applicable to this Project	Clients Where Task Has Been Completed in the Last Five Years: Indiana OMPP - Annual EQR	Indiana OMPP - Independent Assessment	Ohio Department of Medicaid	Vermont Department of Health Access	New Mexico DDSD	Arizona DDD	Virginia DBHDS	Hawaii DDD	Oregon DDD
Conduct MCO provider adequacy study	x								
Conduct provider access study	x	x							
Conduct provider rate study / set rates where wages informed final rates			x	x	x	x	x	x	x
Conduct desk review of MCO or ACO policies and procedures	x	x		x					
Facilitate meetings with MCO or ACO representatives	x		x	x					
Map unique services to providers using claims/encounters	x	x	x	x	x	x	x	x	x
Compile comparative utilization statistics (e.g., usage rates, per 1,000 members, etc.)	x	x	x	x	x	x	x	x	x
Utilize Google Distance Matrix or BING to derive driving distances	x	x	x				x	x	x
Create data visualization maps (e.g., provider coverage areas, avg driving distances)	x	x	x		x		x	x	x
Conduct provider survey	x			x	x	x	x	x	x
Write independent evaluation report*	x	x	x	x		x			

*Other states for which independent evaluation reports have been written (but not in the last five years) include Minnesota, Nevada, New York and Oklahoma.

Project Case Study: Arizona Department of Economic Security, Division of Developmental Disabilities (DDD)

Since its founding, B&A has assisted the DDD on a wide variety of operational activities and strategic planning, most significantly related to the Published Rate System[1] utilized for its HCBS service array. B&A's founders also both participated in these activities with DDD going back to 2001 (while employed at another consulting firm). Most recently, B&A was instrumental in the rate setting activities completed in fiscal year 2014. Additionally, B&A has been supporting DDD with an annual review of the 'adequacy and appropriateness' of the rates utilized by DDD for services provided to its members though an Annual Rate Certification Letter.

During the most recent rate setting activities, B&A (in cooperation with another firm) provided the framework for the development of the updated independent rate models for approximately thirty major home and community based services, including most of the services outlined within this project. B&A facilitated a series of focus groups with several groups of providers, administered a comprehensive provider survey and identified other benchmark data. Based on this input and data, B&A proposed changes to the cost assumptions in the existing models, including updates to direct support worker wages, benefits and productivity as well as agency overhead costs. The focus groups further illuminated DDD's (and B&A's) understanding of provider cost structures and the sensitivity to impacts on providers related to wage and benefit changes which, for most HCBS services, comprise the majority of the costs built into the rate being developed. B&A led several meetings to explain the proposed changes to the rate models and helped in the review of public comments in response to the proposals.

Once finalized, the fiscal impact of the resulting final rate models was modeled. This analysis demonstrated that the Division did not have the resources to implement these rates. In response, B&A helped to establish 'adopted rates' that were transparently established at set percentages of the 'benchmark' rates. The provider community has used this information to lobby for additional funding, which has resulted in gradual increases in these rates. Since the implementation of the revised rate structure, B&A has performed ongoing maintenance for the Published Rate System to support changes through either DDD policy changes and/or additional funding appropriated through the Arizona Legislature. Maintenance activities have included analysis and guidance on the extent to which selected services from the Published Rate System would have to be adjusted to accommodate the changes in minimum wage after voter passage of an initiative to increase the State's minimum wage.

This rate setting process has evolved in sophistication since B&A's founders worked on the original rate setting project with DDD in 2000-2001. Since the first rate setting project over 15 years ago, B&A has assisted the DDD with major rate rebase efforts in 2004, 2009 and 2014. Three of the five team members proposed for this engagement have worked on projects for Arizona's DDD.

On an annual basis, B&A provides support to DDD with an annual review of the 'adequacy and appropriateness' of the rates utilized by DDD for HCBS services. This is commonly referred to as the Rate Certification Letter (this is one of the items to be considered in this Task Order). The review includes an in-depth review of: the number of members served; number of active providers; overall utilization (units and payments); and detailed analyses of the geographic differences for professional services the DDD has identified as having historical issues to acquire. The review is guided by and measured against the principle federal tests for adequacy and appropriateness contained in Section 1932 of the Social Security Act regarding the service network for Medicaid managed care organizations. These criteria are utilized due to the fact that the DDD is deemed as a Medicaid managed care organization for AHCCCS.

[1] The DDD provides a RateBook and Supplement detailing rates and methodology for HCBS services.

Project Case Study: Indiana Office of Medicaid Policy and Planning (OMPP)

B&A has been under contract with Indiana's OMPP since 2007. Prior to this, Mark Podrazik, B&A's President, worked with the OMPP from 2001 to 2006 prior to co-founding B&A. B&A serves as Indiana's External Quality Review Organization (EQRO). B&A is under contract to conduct an annual EQR and to write a report to submit to the Centers for Medicare and Medicaid (CMS). B&A is also contracted to write an annual independent evaluation of Indiana's Children's Health Insurance Program (CHIP). In 2009, B&A also conducted an independent evaluation of Indiana's Care Select program, a non-risk based program serving the ABD population. For this evaluation, B&A conducted a member survey (n=8,595).

Another recent evaluation that B&A completed for the OMPP was an Independent Assessment of the Hoosier Care Connect program. This program is the program subsequent to Care Select that is now under a risk-based arrangement. The program was created under 1915(b) waiver authority and, as such, is subject to an independent evaluation prior to renewal of the waiver. B&A conducted this evaluation and our report was submitted to CMS in March 2017. One of the many aspects of this evaluation included a review of access to services for 19 provider specialties. For each of the specialties, B&A compared the unique providers used, utilization per 1,000 member months, and average driving distance to the specialist during the "with waiver" and "without waiver" baseline period.

In each of the annual EQRs, B&A conducts onsite meetings with each of the State's managed care entities (MCEs, which is Indiana's term for MCOs). In some years, including the last two EQRs, B&A has also facilitated meetings that convened all of the MCEs together on specific topics such as care management reporting, performance improvement projects and results of the analysis of potentially preventable hospital readmissions.

In some years, the EQR is more general in nature with the review of MCE policies and procedures. In most years, however, B&A works with the OMPP to identify focus studies. Since CY 2011, B&A has conducted 23 unique focus studies in the EQRs covering a wide range of topics including utilization management, care management, disease management, access to care, member services, provider relations, program integrity, claims processing, and potentially preventable hospital readmissions and ED visits. In the CY 2009 EQR, B&A conducted a provider survey (n=1,084).

In CY 2016, B&A conducted three focus studies relevant to this Task Order—one was an audit of MCE provider directories, a second analyzed beneficiary access to 23 provider types, and the third was a more in-depth focus on the utilization and access to dental services. The EQR report submitted to CMS that contained this study has been included as Appendix B with our response.

All five team members proposed for this engagement have worked on projects for Indiana's OMPP.

Project Case Study: Ohio Department of Medicaid (ODM)

B&A, under subcontract to Mercer, has been working with the ODM since 2011 on a variety of projects including:

- Rebase of inpatient hospital rates (new rates implemented July 2013 and again in July 2017)
- Rebase of outpatient hospital rates (new rates implemented August 2017)
- Technical assistance related to ODM's preparation to migrate to ICD-10 coding (fee-for-service and managed care programs)
- Evaluation of the impact of ICD-10 coding on hospital payments one year after implementation
- Evaluation of opportunities to streamline prior authorization functions in the fee-for-service program
- Rebase of rates paid for power wheelchairs and related components

In addition to these projects, the one most relevant to this Task Order was completed in the Spring of 2016. B&A served as the technical consultant for the analysis and development of ODM's Access to Care Plan for its fee-for-service program that was required by CMS. B&A worked hand-in-hand with ODM's Project Manager to design the elements of the analysis and the format of the data presented that will serve as the baseline for future evaluations. Through this process, opportunities were identified to improve access for the provider specialties that were examined: primary care physicians, OB/GYNs, FQHCs, dentists, specialist physicians (cardiologists, urologists and radiologists), behavioral health providers and home health agencies.

The analytics completed for the Access to Care study included analyzing the number of unique providers accessed, utilization per 1,000 member months and average distance travelled. These analytics were conducted at the provider specialty level with additional drilldowns for the adult vs. pediatric population and the disabled vs. non-disabled populations. All data was further segmented down to the individual 88 counties in Ohio. A scorecard was developed to summarize the findings in an efficient manner to identify areas of concern for provider access. A databook was created that included tables and maps that drilled down into specific data points by service/aid category/county.

Three of the five team members proposed for this engagement worked on the ODM Access to Care project.

Other Project Examples: HCBS Rate Setting

B&A has completed, or is in the process of completing, HCBS rate setting projects for State Agencies in Arizona, California, Georgia, Hawaii, Louisiana, Maine, Mississippi, New Mexico, North Carolina, North Dakota, Oregon, Rhode Island and Virginia. In all of these states, B&A has created a customized provider survey that includes in-depth data collection for staffing costs (wages and benefits) as well as program and administrative expenses. Many surveys have also included questions about how providers have responded to statutory or regulatory changes, such as ACA health insurance requirements or FLSA rules.

Because the cost of direct care staff is the single largest cost for most all HCBS services, B&A conducts an in-depth analysis of the prevailing market wages, staff turnover rates and related costs to this cost category. We often conduct geographic analyses to evaluate the relative differences in service usage (the percent of enrolled members accessing a service and the average amount of services received among users), wage differentials, and the average driving distance travelled between beneficiaries and the providers they seek.

The administration of the provider survey typically includes piloting it with a select number of providers and offering a webinar tutorial on how to complete the survey. Upon receipt of survey responses, data is often summarized in a report with an accompanying databook where information is tabulated at the service level, regional level, or service/regional level. Baseline utilization data is often joined with the survey data results to obtain a holistic view of the impact of rate changes.

An example of a rate study report with accompanying databook completed for New Mexico has been included as Appendix C with our response. This report has been included as a way to illustrate the various ways that B&A has synthesized and presented data in a report. Please note that specific excerpts from this report, as well as others, are also provided in Appendix A for efficiency. These are cited on page 9 of our Methodology and Approach section.

Four of the five team members proposed for this engagement have worked on HCBS rate setting projects.

Introduction to the Project Team

The complete resumes for all staff appear in Appendix D.

<u>Mark Podrazik, Project Manager</u>

Mark Podrazik, B&A's President, will serve as the Project Manager for this engagement. In this capacity, he will serve as the primary contact to AHCCCS and will be the primary author of the final report. He will also serve as the lead for all meetings with MCOs and fully participate in the analytic plan designed for this project.

Mark has served as the Project Manager and lead author of the annual EQR report for B&A's engagement with Indiana's OMPP since 2007. He was also the Project Manager for B&A's Access to Care project with Ohio's Medicaid program. Mark has also written independent evaluations submitted either to legislators or to CMS for the States of Minnesota, New York, Oklahoma and Vermont.

Mark's affiliation with AHCCCS goes back to 1997 (while at a previous consulting firm). From 1997-2005, he was a team member or Project Manager for engagements with AHCCCS that included the rebase of inpatient rates (1997-98), calculation of DSH payments (2000 and 2001), rebase of nursing facility rates (2000 and 2001), rebase of outpatient hospital rates (2005) and evaluation of AHCCCS's reinsurance program (1999).

<u>Steven Abele, Senior Analyst</u>

Steven Abele, B&A Senior Consultant, will serve as a Senior Analyst on this engagement. Steve will assist in designing the analytic plan for the project. He will also lead the provider survey effort and participate with Mark Podrazik in meetings with the MCOs.

Steve has worked on all of B&A's engagements with Arizona's DDD since B&A's inception in 2006 (and, while at another consulting firm, from 2003-2006). He brings an in-depth knowledge of the services offered by DDD, its provider base, utilization patterns and areas where access has been of concern. Steve is also the principal evaluator in the development of the Rate Certification Letter submitted by DDD to AHCCCS each year.

In addition to his work with DDD, Steve has worked on HCBS rate setting projects with Arizona's Department of Health Services, Division of Behavioral Health Services and with six other states.

Ryan Sandhaus, SAS Programmer

Ryan Sandhaus joined B&A in 2016 but has used SAS for conducting analytical work for the past 11 years. Ryan will be responsible for the intake, validation and analysis of the files delivered by AHCCCS to B&A related to encounters, enrollment and providers. Since joining B&A, he has served as the lead programmer on B&A's projects for Indiana and Ohio related to access to care. He has also worked with the States of Connecticut, Maine and Vermont on hospital rate studies. Ryan will leverage the SAS programs already developed for B&A's other access to care projects and modify for use in this project in order to hit the ground running during this condensed project timeline.

Tina Brezenski, Research Associate

Tina Brezenski, a Consultant at B&A, has more than 17 years of experience in financial analysis and budgeting across multiple sectors including health care and nonprofits. Since joining B&A in 2014, Tina's area of focus has been working on B&A's HCBS rate setting projects. To date, she has conducted utilization and financial modeling on projects in seven states. She has also become adept on the use of geomapping software which she has used as a means to display results on all of these projects as well as B&A's Indiana EQR engagement.

For this project, Tina will be a key contributor to developing the maps showing provider service areas for each category of service within the GSAs. She will also utilize her expertise in using Google Distance Matrix and BING web services to compute average driving distances for members to each service provider.

Barry Smith, Research Associate

Barry Smith, a Consultant at B&A, joined the firm in 2007 and has provided a wide range of analytical support to B&A's engagements. More recently, his focus has been on administering, intaking and validating data received from provider surveys for B&A's HCBS rate setting projects. He also serves as an analyst on B&A's annual EQR for Indiana Medicaid. In 2016, Barry was a key contributor to both the Indiana EQR and Ohio Medicaid access to care studies. This included developing tables for databooks, computing average distances travelled and creating the maps to display findings.

For this project, Barry will perform similar tasks. He will manage the database for the release and intake of all provider surveys received and will analyze survey results. He will work with Ryan Sandhaus on the development of table shells for the planned databook to accompany the final report to AHCCCS.

METHODOLOGY AND APPROACH

Burns & Associates (B&A) proposes to utilize AHCCCS member enrollment, provider enrollment and encounter utilization from Calendar Year (CY) 2016 to build a baseline of service utilization for each of the 11 services requested in the Task Order: nursing facility, attendant care, personal care, homemaker, respite, habilitation, assisted living, DDD group homes, day treatment and training, adult day health, and center-based and group supportive employment programs. From the responses to bidders' questions, it appears that these services are easily segmented by provider type within AHCCCS's data warehouse. B&A proposes 12 baseline categories by splitting respite separately between the EPD and DD populations.

This analysis will serve multiple purposes in the project:

- The reporting of members (users), providers and location where services are being delivered will provide the baseline for future comparison as well as show where potential access may already be compromised;
- By analyzing CY 2016 volume for the delivery of each service, it will inform who are the highest-volume providers by locality for use in the survey stratification; and
- The baseline data, when joined with provider survey responses that will be attached to a specific service/location, can help inform predictions of future access challenges.

In addition to the primary data collection and analysis completed by B&A, we will also analyze and incorporate secondary data that has already been produced. This includes reports collected by AHCCCS or generated by the MCOs, contract requirements, and the DDD Rate Reimbursement Study (which was produced by our firm).

A detailed work plan is presented on the next two pages. There are 11 tasks identified and numerous sub-tasks. On the pages that follow the work plan, B&A identifies key aspects of each task that will build up to delivering the final report to AHCCCS. The 11 tasks with the intended completion date for each task appear below:

	Description of Task	Target Completion
1	Data request to AHCCCS	10/11/17
2	Data request to ALTCS MCOs	10/12/17
3	Analyze and synthesize non-encounter data from AHCCCS	10/20/17
4	Analyze and synthesize enrollment, provider and encounter data from AHCCCS	11/22/17
5	Analyze and synthesize data from ALTCS MCOs	10/27/17
6	Identify providers for survey release by service category	11/10/17
7	Develop draft survey and pilot with providers	11/3/17
8	Release survey and compile results	11/22/17
9	Facilitate focus group discussions with ALTCS MCOs	12/6/17
10	Cross-tab feedback from providers and MCOs with baseline access reports	12/13/17
11	Write report and prepare associated databook	1/2/18

Throughout the course of the engagement, B&A will keep AHCCCS project leads apprised of our ongoing work. In addition to planned or ad hoc conference calls, B&A has scheduled nine in-person meetings. Four meetings will be held with B&A and the AHCCCS team. Five meetings will be held with B&A and the MCOs, of which, four will be 1-on-1 meetings with each ALTCS MCO (Bridgeway, Mercy Care, United, DES/DDD) and one meeting will be with all ALTCS MCOs.

Task Number	Task Name	Responsibility	October				November				December			
			9	16	23	30	6	13	20	27	4	11	18	25
				Meeting w/AHCCCS						Meeting w/MCOs				
1	**Data Request to AHCCCS**		x											
1.1	Call with AHCCCS, prepare request for enrollment information covering CY2016	Podrazik	x											
1.2	Call with AHCCCS, prepare request for encounters dates of service from CY2016, Jan-Jun 2017	Podrazik	x											
1.3	Call with AHCCCS, prepare request for master provider file	Podrazik	x											
1.4	Request AHCCCS policies regarding network standards, including ALTCS EPD and DDD contracts	Podrazik	x											
1.5	Request Non Provision of Service Report information from CY2016 to present	Podrazik	x											
1.6	Request reports submitted by ALTCS MCOs regarding network adequacy, providers reducing services	Podrazik	x											
1.7	Annual Title XIX Rate Reimbursment Study conducted by DDD (*B&A already has in house)	Abele	x											
2	**Data Request to ALTCS MCOs**													
2.1	Request policies and procedures related to provider contracting	Podrazik	x											
2.2	Request Network Management and Development Plan	Podrazik	x											
2.3	Request internal reports, Geoaccess maps	Podrazik	x											
2.4	Request provider rosters for provider types in the study with emails, phone numbers	Podrazik	x											
3	**Analyze and synthesize non-encounter data from AHCCCS**													
3.1	Compile AHCCCS network standards information for each provider category	Podrazik, Abele		x										
3.2	Identify key points of the Non Provision of Service Report for use in this project	Podrazik, Abele		x										
3.3	Identify key trends found in network adequacy reports to AHCCCS, providers who reduced services	Abele		x										
3.4	Consider results from DDD Rate Reimbursement Study into access to service analysis	Abele		x										
4	**Analyze and synthesize enrollment, provider, encounter data from AHCCCS**													
4.1	Read in enrollment data and stratify AHCCCS members by GSA, county	Sandhaus		x	x									
4.2	Read in provider and encounter data, stratify providers based on service/MCO (using HCPCS)	Sandhaus		x	x									
4.3	Share preliminary results with AHCCCS and confirm definitions of service categories	Podrazik, Sandhaus			x									
4.4	Segment AHCCCS members who used each service category by MCO/county/service	Sandhaus				x								
4.5	Create baseline reports of unduplicated clients, providers, services, payments for CY16 by	Sandhaus, Smith				x								
4.6	Identify every member/provider 'pair' by service category	Sandhaus				x								
4.7	Prepare files with member lat/lon information	Sandhaus				x								
4.8	Run Google Distance Matrix or BING web services to assign driving distance per claim	Brezenski, Smith					x	x						
4.9	Validate and compile driving distance data for members within each service category	Brezenski, Smith						x						
4.10	Prepare baseline reports of avg distance travelled by service/county/GSA (for Maricopa, by MCO)	Brezenski, Smith							x					
4.11	Create data visualization maps to show service area by service/provider/county/GSA	Brezenski, Smith							x					
4.12	Review draft results with AHCCCS of these baseline access reports	Podrazik, Abele								M6				
5	**Analyze and synthesize data from ALTCS MCOs**													
5.1	Review each MCO's policies/procedures re: provider contracting to determine impact on this study	Podrazik, Abele			x									
5.2	Review each MCO's Network Development Plan, compare to each other and AHCCCS data	Podrazik, Abele			x									
5.3	Review other reports from MCOs (e.g. Geoaccess), compare to each other and AHCCCS reports	Podrazik, Abele			x									
5.4	Intake, validate and aggregate provider demographic files from MCO to assist in survey releast	Smith			x									
6	**Identify providers for survey release by service category**													
6.1	From results in Tasks 4.4-4.5, identify total potential count of providers to survey by service	Sandhaus				x								
6.2	Identify by name the providers in each category with minimum threshold of payments (e.g. $25,000)	Sandhaus, Smith				x								
6.3	Coordinate with AHCCCS and/or MCOs to obtain missing email/phone numbers for providers	Smith				x								
6.4	Compile tracking sheet of all providers by service with contact info	Smith					x							
6.5	Crosswalk providers that are listed in more than one provider list in Task 6.4	Smith					x							
6.6	Determine unique count of providers across all services combined based on results in Task 6.5	Smith					x							

Task Number	Task Name	Responsibility	October				November				December			
			9	16	23	30	6	13	20	27	4	11	18	25
			Meeting w/AHCCCS						Meeting w/MCOs					
7	**Develop draft survey and pilot with providers**													
7.1	Meet with select providers to discuss survey and pre-set responses vs open-ended responses	Podrazik, Abele		x										
7.2	Develop draft survey comprised of questions for all providers	Abele, Podrazik		x										
7.3	As necessary, develop questions that are specific to certain service categories	Podrazik		x										
7.4	Review draft survey(s) with AHCCCS for feedback	Podrazik, Abele			M1									
7.5	Revise survey(s) based on AHCCCS feedback	Abele			x									
7.6	Contact two providers within each service category by phone to pilot survey via phone	Abele, Smith				x								
7.7	Revise surveys based on provider feedback in pilot	Abele				x								
7.8	Create survey tool in Survey Monkey	Smith				x								
7.9	Build email blasts by service category for all providers targeted to complete survey	Smith					x							
8	**Release survey and compile results**													
8.1	Release survey(s) in the field	Smith					x	x	x					
8.2	Record and post online a webinar to explain and walk through the survey	Abele					x							
8.3	Track returned emails and attempt to obtain revised email addresses by calling providers	Smith					x							
8.4	Maintain daily tracking report of surveys completed by service category	Smith					x	x	x					
8.5	Respond to requests for technical assistance from providers as necessary	Abele					x							
8.6	Read in results of survey responses, validate completion of questions answered	Smith						x	x	x				
8.7	Review any qualitative responses and develop means to organize feedback into themes	Abele								x				
8.8	Build analytic shells/pie charts to present results of survey for each survey question	Abele, Smith							x					
8.9	Review preliminary survey results with AHCCCS	Podrazik, Abele								M6				
9	**Facilitate focus group discussions with ALTCS MCOs**													
9.1	Compile MCO-specific questions for 1-on-1 meetings with each MCO to discuss desk materials	Podrazik, Abele					x							
9.2	Conduct 1-on-1 mtgs with each MCO to discuss Network Develop Plan, reports, P&Ps	Podrazik, Abele						M2-5						
9.3	Conduct follow-up with individual MCOs, as needed, based on 1-on-1 meetings	Abele							x					
9.4	Conf call with AHCCCS to summarize content/feedback from 1-on-1 meetings	Podrazik, Abele					x							
9.5	Prepare talking points/baseline data for joint MCO focus group discussion, review w/AHCCCS	Podrazik, Abele								M6				
9.6	Facilitate an in-person focus group discussion with MCO reps re: network adequacy, challenges	Podrazik, Abele									M7			
10	**Cross-tab feedback from providers and MCOs with baseline access results**													
10.1	Intake provider survey responses flagging those that have terminated or reduced services	Smith								x				
10.2	Crosswalk providers in Task 10.1 to service category, geographic region, and MCO contract(s)	Smith								x				
10.3	Intake MCO responses from focus group discussion regarding challenges in contracting	Abele									x			
10.4	Crosswalk services/regions in Task 10.3 where MCOs state contracting challenges are greatest	Abele									x			
10.5	Summarize results from Tasks 10.2, 10.4 and propose approach to AHCCCS for use in report	Podrazik, Abele									M8			
10.6	Based on AHCCCS feedback, model scenarios of potential greatest impact on access against baseline	Entire B&A team										x		
10.7	Share results of comparison of baseline maps and future scenario maps with AHCCCS	Podrazik, Abele										M9		
11	**Write report and prepare associated databook**													
11.1	Construct outline of narrative report and detailed tables/maps for databook	Podrazik							x					
11.2	Review report outline and itemized reports/maps for accompanying deliverable with AHCCCS	Podrazik, Abele								M6				
11.3	Write draft report based on findings from baseline data, provider survey, MCO focus group	Podrazik, Abele									x	x		
11.4	Based on results, develop strategies for new network standards and evaluating workforce	Podrazik, Abele										x		
11.5	Walk through draft report and accompanying databook with AHCCCS	Podrazik, Abele										M9		
11.6	AHCCCS reviews draft report and provides feedback	AHCCCS											x	
11.7	Finalize report based on AHCCCS feedback	Podrazik, Abele												x
11.8	Finalize and deliver databook containing utilization and avg distance tables/maps	Entire B&A team												x
11.9	Finalize and deliver database containing all provider survey responses	Smith, Abele												x

Tasks 1 and 2: Data Requests to AHCCCS and ALTCS MCOs

Immediately upon notice of award, B&A will begin to develop the data request for both AHCCCS and the ALTCS MCOs. For AHCCCS, B&A will request a data dictionary of the enrollment, provider and encounter tables in AHCCCS's data warehouse. From this, we will develop a draft data request of the variables requested. No later than October 10, we would like to schedule a conference call with the appropriate AHCCCS staff to ask questions in order to refine our draft data request. We will submit the final data request on October 11 in the hopes that we can receive the data requested back by October 18.

In addition to data from AHCCCS's data warehouse, we will use the conference call to learn more about secondary data that we anticipate requesting as well as data that may only be available from the ALTCS MCOs. This will enable us to prepare a more formal request of secondary data to AHCCCS (on October 11) and to the ALTCS MCOs (on October 12). We will request a one-week turnaround for this information as well.

Tasks 3 and 5: Analyze and Synthesize Non-Encounter Data from AHCCCS and ALTCS MCOs

B&A's Project Manager, Mark Podrazik, and Senior Analyst, Steven Abele, will serve as point on the analysis of non-encounter data from AHCCCS and the ALTCS MCOs, including policies and procedures regarding network standards, MCO Network Management and Development Plans, AHCCCS or MCO-generated Geoaccess reports, any Non Provision of Service Report information and the Title XIX Rate Reimbursement Study conducted by DDD. Mark Podrazik will leverage his experience as Project Manager serving as the External Quality Review Organization (EQRO) for Indiana Medicaid and the in-depth network adequacy focus study he conducted in the 2016 EQRO to efficiently review these materials. Steven Abele is the author of the DDD Reimbursement Study so he can quickly identify the potential access concerns by locality for DD-related services.

Task 4: Analyze and Synthesize Enrollment, Provider and Encounter Data from AHCCCS

The team proposed for this task completed a project similar in scope in 2016 for the Ohio Department of Medicaid (ODM) in which B&A served as the technical analysts for Access to Care report required by CMS for Medicaid fee-for-service programs. This same team also worked on the 2016 Indiana EQR study. As a result, the foundation for analytical processes has already been built by B&A and we will determine how this prior work can be leveraged and then customized for this engagement.

In summary, B&A initially segments the membership into the demographic cohorts required for the project. In this case, we will segment by the member's home county (which can then be mapped to a GSA). For some projects, we have further refined by zip code or census tract which may be helpful for Maricopa County. Then, in consultation with our client, we determine the universe of services (usually by CPT/HCPCS) and providers (usually by provider type and/or specialty). In some cases, there needs to be additional customization for select services which we will discuss with the client.

Defining the members, providers and services is done by writing a SAS program specific to each project. Ryan Sandhaus is B&A's SAS programmer assigned to this engagement. He also completed the work on B&A's Ohio and Indiana engagements.

After an initial discussion with AHCCCS to set the parameters for the study, B&A will then share with AHCCCS our preliminary findings that tabulate unduplicated clients, unique providers used, count of services received and payments for the services. These reports will be standardized in the same format for each service category. Data will be segmented for the state overall, by GSA and by county within

each service. In consultation with AHCCCS, if the data does not match other benchmark data that AHCCCS may have, we will conduct drilldown analyses and refine our queries as necessary.

With the baseline data established, B&A then identifies unique member-to-provider pairings for a particular service. Using the latitude and longitude for the member's home from the enrollment file, we determine the driving distance (not crow flies) to the servicing provider. B&A uses unique pairings to control for different billing patterns across services. For example, for a DD day program, the member may attend the day program 5 days per week. If the provider bills daily for services, there may be 250 different encounters of the member-provider combination. B&A will only count one of these in our distance study.

B&A utilizes Google Distance Matrix or BING web services to submit batches of latitude/longitude combinations to obtain the driving distance information. We can usually submit tens of thousands of these combinations in a single batch and this runs overnight. At times, a distance cannot be obtained or the result is unreliable (e.g. the latitude/longitude data suggested a driving distance of 600 miles). B&A reviews all results from the web service and excludes outlier distances out when computing average distances travelled for a specific service (e.g., < 1 mile and > 100 miles). Both Tina Brezenski and Barry Smith, who are the B&A team members proposed to conduct this work, have performed this task on numerous B&A projects and have become very adept at using the Google Distance Matrix and BING web services. Once the distances are computed for all member-provider pairings, the average distance travelled can be computed by service category and by county or GSA.

It should be noted that the driving distance metric works for most services, but not all. B&A will discuss with AHCCCS the utility of running the analytics for this metric on respite, for example, where the provider often travels to the member's home and the provider address on record is the agency, not the individual staff person performing respite.

In addition to computing the distances, B&A will utilize the coordinates of each provider within a service category in order to plot provider locations. B&A will create "heat maps" that visually show service coverage areas within a county or GSA for each service. For example, a provider will be plotted on a county map and a circle showing a five-mile radius can be drawn then a second circle can display a ten-mile radius. These maps quickly identify where access is the greatest issue (that is, areas of a county that have no concentric circles).

Separate from plotting the provider service coverage areas, B&A has also used color-coding to identify zip codes, census tracts or counties where members have lower- or higher-than-average driving distances to access the service being reviewed. Whereas the provider service coverage maps show "accessibility" (the providers that members could potentially use), the average distance maps show "availability" (the providers that members actually used). B&A has seen in other projects similar to this that accessibility is never an issue (there are plenty of contracted providers on record). This issue pertains more to availability (not all potentially accessible providers will serve any new members, so there is not real accessibility).

B&A uses the data points plotted for both accessibility and availability (the actual providers used) to inform any assessment of potential access issues. B&A will share the draft accessibility and availability maps with AHCCCS. This is scheduled for the week of November 27.

Task 6: Identify Providers for Survey Release by Service Category

The data analyzed in Task 4 will inform the number of providers that members actually used for each of the 12 service categories (recall that B&A is proposing to split Respite between EPD and DD). B&A will be tracking payments made to each provider for CY 2016 services. The unique count of providers by service category will be compared to the counts of providers that AHCCCS released in response to Bidder Question #32 of this Task Order. Rather than completing a stratified sample of providers to survey, B&A is recommending that all providers within a specific service category be considered to survey provided that they meet a certain payment threshold (e.g. the provider was paid at least $25,000 in CY 2016 for the specific service rendered).

B&A anticipates that if a payment threshold is considered, then this means that almost 100 percent of some service category providers will be surveyed (such as nursing facility, DD group home, day treatment and training) while a subset is more likely for other service categories (such as attendant care and assisted living). B&A will work with AHCCCS to determine the most appropriate threshold to consider and whether any payment threshold should be applied at the CPT/HCPCS level or at the provider type level.

Once the universe of providers to be surveyed is defined, B&A will coordinate with AHCCCS or the MCOs to try to obtain missing email addresses or phone numbers. B&A intends to build a web-based survey so email addresses will be essential. The phone numbers are intended to call individual providers to obtain an email address, if necessary.

There will inevitably be providers who cross multiple HCBS services, particularly within the domain of DD services. Likewise, some providers will cut across multiple counties or GSAs. B&A will identify not only the unique number of providers to survey by service category but also the number of unique providers across all service categories.

Task 7: Develop Draft Survey and Pilot with Providers

Shortly after project initiation, B&A will start developing a survey tool. We are proposing a web-based survey that has more pre-set responses (i.e. check the box) than open-ended questions. This is an effort to make the survey as easy and quick to complete as possible and also due to the limited project timeline. Because most, if not all, answers will have pre-set responses, B&A will meet with select providers before sharing a draft with AHCCCS to obtain feedback on the variety of pre-set answers (and the terminology) to use for each question. Given our considerable work conducting provider surveys for DDD that have all considered wages and benefits in these tools, we believe we can work with providers to obtain a representation of the types of answers we would need to include for each question.

B&A anticipates that the survey will be 10-12 questions and should take no more than five to seven minutes to complete. B&A will factor in all of the items requested in Task Order Section 4.1. Specifically, we also anticipate asking the following in some manner:

- Starting and average wage prior to January 1, 2017 and today
- Turnover and vacancy rates in CY 2016 and year to date in CY 2017
- Wages as a percent of total business costs and benefits as a percentage of total business costs in CY 2016, then same information budgeted for CY 2017 or actual year to date in CY 2017
- Recruitment or hiring challenges (e.g., decrease in applicants, applicants cannot meet minimum qualifications or background check, irregular hours/cancelled shifts)
- Recruitment strategies taken, e.g., signing bonus, retention bonus, shift differentials, new benefits

- Actions taken in response to the increase in minimum wage, such as reduced benefits, reduced hours, reduced overtime, require more billable hours, reduce or eliminate services (this could be a "check all that apply" and can also have an open-ended write-in option, too)
- A "triggered" question for those who report reducing or eliminating services, pre-set responses may include the service was dropped altogether, the provider terminated members who require short visits or minimal hours per month, the provider terminated members that require too much travel time to their home

Once the possible pre-set answers have been vetted by select providers, B&A will share a draft of the survey tool with AHCCCS for review and comment. Once we integrate AHCCCS's feedback, we will then contact two providers from within each service category to administer the survey by phone. This will serve as the pilot in case the survey needs further revision. After conducting the pilot, B&A will finalize the survey and build the tool for uploading to Survey Monkey or an equivalent application. Once ready, B&A will email survey blasts to all providers with the link to the survey. The anticipated survey release date is November 6; the deadline to respond is November 22.

Task 8: Release Survey and Compile Results

B&A will also provide a link to those who were asked to complete the survey the option to view a webinar on how to complete it. It is anticipated that the survey instrument will be designed to be self-evident that a tutorial will not be required, but B&A will create one just in case. While the survey is in the field, B&A will develop the data repository to intake the responses and build the queries to summarize the results. We expect that this repository will be built in Microsoft Access.

As surveys come in, B&A will read in the results and also track the respondents against the master list. This will enable us to gauge the response rate by service category and payment threshold within each category (e.g., the 25 respondents in the category represent 88% of all payments in CY 2016).

The pre-set responses will be tabulated and displayed in an easy-to-understand manner (such as pie charts). In the event that there are open-ended qualitative responses, B&A will review all responses and then categorize these responses into common themes (which will include an indicator of the number of respondents who mentioned it). The preliminary results will be shared with AHCCCS the week of November 27.

Task 9: Facilitate Focus Group Discussions with ALTCS MCOs

B&A plans to convene one focus group meeting with representatives from all of the ALTCS MCOs during the week of December 4. The content of this meeting will be driven by the results we tabulate from our study of accessibility and availability using encounter data and the feedback from the provider survey. We anticipate that we will provide draft results from this information to help guide a facilitated discussion related to how the MCOs are ensuring that access to the specific services outlined is being maintained. We will brief AHCCCS on the content and format of this all-MCO meeting the week prior. AHCCCS representatives may also want to join us at this meeting.

Separate from the all-MCO meeting, B&A believes it will be helpful to conduct 1-on-1 meetings with each MCO separately. These meetings will be in-person and will be scheduled for the week of November 13. The purpose of these meetings is for B&A to ask questions of each MCO related to their specific reports or policies and procedures related to provider access. Specifically, we will ask any clarification questions necessary about the MCO's Network Management and Development Plan, Non Provision of Service Reports, Geoaccess reports or other related materials.

Task 10: Cross-tab Feedback from Providers and MCOs with Baseline Access Results

By the end of November, B&A's preliminary results for the Databook that we are building will be complete. The preliminary findings from the provider survey will also be tabulated. Within the Databook reports, we will have mapped each provider by service area and geographic area. The same mapping assignment will be given to each provider in the survey release. When the survey tools are returned, the results will be tabulated not just at the statewide level but at the regional (county and GSA) level. By doing this, we can map whether there are indications of future potential access concerns within specific areas of the state for specific services.

B&A will also incorporate the feedback we receive from the MCOs in the all-MCO focus group meeting to enhance the feedback received from providers. We will identify if patterns in provider access challenges voiced by the MCOs comport with what was learned from providers.

B&A plans to provide an approach to synthesize the baseline data showing with whom AHCCCS members accessed services in CY 2016 ("as is") and compare this to a model of a potential "to be". For example, homemaker services may already be compromised in a specific geographic region (such as there is only one provider in that region). If this provider responds in the survey that they will be limiting the provision of services only to clients who can guarantee them a minimum number of hours per week or that they are limiting their scope to a smaller geographic area, then this region is potentially threatened for future access to homemaker services. B&A will cross-tabulate the responses to specific questions in the survey against the baseline utilization and average distance metrics already computed.

B&A will share the proposed approach with AHCCCS for feedback. We anticipate that we will tie together the two data points (baseline utilization and distance data with survey responses) in the detailed reports which will be delivered in the Databook. For the final report, however, we will develop a "scorecard" that shows by service/GSA/county a projected status of the impact on members for accessing the service based on the minimum wage increase. For example, a color-coded schema showing red equals high threat, yellow equals medium threat, and green equals no threat may be considered. This will allow AHCCCS to have a one-page snapshot for the final report but have the details that support each assessment in the Databook.

Task 11: Write Report and Prepare Associated Databook

B&A will prepare a proposed outline of the contents of the final report and discuss this with AHCCCS. We will also share the proposed pro forma templates of the reports that will be generated for the Databook that will accompany the final report. Once we receive feedback from AHCCCS on these items, we will write the draft version of the report and populate the table shells in the Databook. We anticipate meeting with AHCCCS by December 15 to brief them on the contents of the draft version of the report and deliver this version. AHCCCS will have approximately one week to review the report. We will make modifications to the report, as necessary, in order to deliver the final version by January 2, 2018.

When we deliver the final report, we will also deliver the final version of the Databook. We anticipate that this will be delivered in a consolidated PDF format but also, at AHCCCS's request, we will deliver Excel files that contain all of the data shown in the Databook in native format. Additionally, at AHCCCS's request, we are prepared to deliver the Microsoft Access database in which we will have stored information on all providers outreached for the survey along with the responses from the actual survey respondents.

Description of Recommended Deliverables

In addition to the final report and Databook, B&A anticipates providing AHCCCS with "mini deliverables" over the course of the entire engagement which will include the following:

- Preliminary results of enrollment/encounter analytics (Task 4.3)
- Draft results of baseline access reports (Task 4.12)
- List of providers to send survey (Task 6.6)
- Mockup of draft survey tool (Task 7.4)
- Preliminary survey results (Task 8.9)
- Agenda items, meeting materials and approach to MCO focus group meeting (Task 9.5)
- Proposed approach to utilize provider and MCO feedback into final report (Task 10.5)
- Draft of baseline and potential future scenario maps pertaining to access (Task 10.7)
- Draft report outline (Task 11.2)
- Draft report (Task 11.5)
- Final report (Task 11.7)
- Final databook of tables/maps to accompany report (Task 11.8)
- Final database of providers surveyed and responses received (Task 11.9)

A suggested outline of the reports that will be included in the Databook appears on the next page. Each report is anticipated to be one page in length so that each one can easily be pulled out if there are future questions either on a specific service or geographic region. The specifics of the content and layout of each report series (A, B, C and D) will be discussed with AHCCCS prior to B&A populating the reports.

In order to assist AHCCCS with visualizing how these reports may look, B&A has provided Appendix A to this proposal to show illustrative examples from deliverables produced for other clients. Appendix A contains seven pages, with each page being its own report.

- Page 1 is an example of a summary table showing baseline statistics for specific service (occupational therapy). A layout such as this is envisioned for this project's Databook Section A.

- Page 2 is an example of a service area coverage map produced for the City of Phoenix. A layout such as this is envisioned for each service/GSA for this project's Databook Section B to show the current (CY 2016) situation. If we were to project a potential future state by factoring in provider survey responses, we could mimic this layout for Section C as well.

- Page 3 is an example from the same deliverable shown on page 1, but this time the information is county-focused. Once again, the information presented is for a specific service (occupational therapy). A layout such as this is envisioned for this project's Databook Section D.

- Page 4 is not necessarily proposed for the Databook, but it provides another way to view trends in the average distance travelled by members. In this example, B&A compared the average distance travelled by Indiana Medicaid members in its Healthy Indiana Plan to seek dental care. The comparison maps show the variance by each MCE (MCO) contracted in the program.

- Pages 5 through 7 are related and were generated as a means to discern the difference between Geoaccess reports submitted by MCOs against the actual utilization by members and the number of providers used. Page 5 (Exhibit VI.3) compiles each MCO's member-to-provider ratio across 23 acute care specialties against target thresholds. Page 6 (Exhibit VI.4) contrasts where the MCO stated that it had sufficient access to the specialty against the average distance that B&A computed using actual utilization for members in the MCO seeking the service. Page 7 (Exhibit

VI.5) joins the self-reported data by the MCO of the number of contracted providers against B&A's independent examination of the number of providers used by members for each specialty. The purpose of this report was to validate the accuracy of each MCO's stated provider network.

Proposed Inventory for Databook to Support Final Report - 120 reports/maps in all

A. Tabular Data by Service Category (12)	
Nursing Facility	Data summarized by:
Attendant Care	Statewide
Personal Care	By 3 GSAs
Homemaker	By counties under each GSA
Respite - EPD only	
Respite - DD only	Data presented on each service report (CY16 utilization):
Habilitation	Total members in geographic region
Assisted Living	Total users of service in region
DD Group Homes	Total providers located in region
Day Treatment & Training	Units per use per year in region
Adult Day Health	Breakdown of services based on distance member travelled
Center Based & Group Supported Employment	(range of distance travelled to be discussed with AHCCCS; e.g., 0-10, 11-20, 20-30, 30-50, 50-100, >100)

B. Service Area Coverage Maps - BASELINE (36)

For the 12 service categories above, show 3 maps for each - GSA 1, GSA 2, GSA 3

Each map plots location of provider for that service and plots diameter of "coverage area".

* The selection of coverage area will be in consulation with AHCCCS; e.g. within 5 miles, 10 miles

**For some services, it may be necessary to break Maricopa County into more discrete areas.

***For some services, it may be necessary to break Flagstaff out due to even higher minimum wage.

C. Service Area Coverage Maps - PROJECTION (36)

In consultation with AHCCCS, these maps could be separate from Baseline or side-by-side on page with Baseline.

For the 12 service categories above, show 3 maps for each - GSA 1, GSA 2, GSA 3

Intent is to show projection of coverage area if impacted by fewer providers delivering service due to wage increase.

Information obtained from provider survey would inform assumption of potential projected change.

* The selection of coverage area will be in consulation with AHCCCS; e.g. within 5 miles, 10 miles

**For some services, it may be necessary to break Maricopa County into more discrete areas.

***For some services, it may be necessary to break Flagstaff out due to even higher minimum wage.

D. Service Utilization and Average Distance x GSA (36)

Cross-references data displayed in tables in Section A with map of region that plots where users are.

For the 12 service categories above, show three 1-page reports for each GSA separately - GSA 1, GSA 2, GSA 3

Provides comparison data between the GSA and other GSAs/statewide for the same measures.

Summarizes the key responses from providers for this service in the GSA to measure impact of wage increase for this service/GSA region specifically.

PRICING PROPOSAL

Burns & Associates (B&A) proposes a total budget for this engagement of **$194,656**. This price is all-inclusive to complete all tasks in the work plan proposed. The budget assumes 926.75 hours incurred over a 12-week period distributed across five team members.

On the next page, an itemization of the hours and cost by task and by staff person is shown. The percent of the total budget assigned to each of the 11 tasks appears in the last column.

The hourly rates shown for each staff member represent our current rates under Contract #AHCCCS16-098674, YH14-0033-03 (AHCCCS Healthcare Financial Consultants), Amendment #3 dated December 29, 2016. The hourly rates are inclusive of travel and associated business expenses. Please note that B&A does not bill for hours travelling to or from a client site.

Burns & Associates, Inc. Pricing Proposal for Task Order # YH18-0031 for Analysis of Prop 206 Impat on Provider Network Adequacy

Task	Task Name	Mark Podrazik	Steven Abele	Ryan Sandhaus	Tina Brezenski	Barry Smith	Total	Mark Podrazik	Steven Abele	Ryan Sandhaus	Tina Brezenski	Barry Smith	Total	Pct of Budget
		Project Manager	Senior Analyst	SAS Programmer	Research Associate	Research Associate		$255.00	$233.75	$220.00	$175.00	$175.00		
		179.75	**200.00**	**141.00**	**98.00**	**308.00**	**926.75**	**$45,836**	**$46,750**	**$31,020**	**$17,150**	**$53,900**	**$194,656**	**100.0%**
1	Data Request to AHCCCS	8.75	0.00	3.00	0.00	0.00	11.75	$2,231	$0	$660	$0	$0	**$2,891**	**1.5%**
2	Data Request to ALTCS MCOs	4.00	0.00	0.00	0.00	0.00	4.00	$1,020	$0	$0	$0	$0	**$1,020**	**0.5%**
3	Analyze and synthesize non-encounter data from AHCCCS	6.00	14.00	0.00	0.00	0.00	20.00	$1,530	$3,273	$0	$0	$0	**$4,803**	**2.5%**
4	Analyze and synthesize enrollment, provider, encounter data from AHCCCS	24.00	6.00	92.00	62.00	92.00	276.00	$6,120	$1,403	$20,240	$10,850	$16,100	**$54,713**	**28.1%**
5	Analyze and synthesize data from ALTCS MCOs	22.00	22.00	0.00	0.00	10.00	54.00	$5,610	$5,143	$0	$0	$1,750	**$12,503**	**6.4%**
6	Identify providers for survey release by service category	4.00	5.00	10.00	0.00	40.00	59.00	$1,020	$1,169	$2,200	$0	$7,000	**$11,389**	**5.9%**
7	Develop draft survey and pilot with providers	7.00	26.00	0.00	0.00	23.00	56.00	$1,785	$6,078	$0	$0	$4,025	**$11,888**	**6.1%**
8	Release survey and compile results	8.00	40.00	0.00	0.00	75.00	123.00	$2,040	$9,350	$0	$0	$13,125	**$24,515**	**12.6%**
9	Facilitate focus group discussions with ALTCS MCOs	24.00	32.00	0.00	0.00	8.00	64.00	$6,120	$7,480	$0	$0	$1,400	**$15,000**	**7.7%**
10	Cross-tab feedback from providers and MCOs with baseline access results	12.00	32.00	20.00	16.00	32.00	112.00	$3,060	$7,480	$4,400	$2,800	$5,600	**$23,340**	**12.0%**
11	Write report and prepare associated databook	60.00	23.00	16.00	20.00	28.00	147.00	$15,300	$5,376	$3,520	$3,500	$4,900	**$32,596**	**16.7%**

Mark Podrazik, M.B.A.
President / Project Manager
Burns & Associates, Inc.

Mark Podrazik has 21 years of experience in health care consulting, specializing in the operational, reimbursement, and evaluation components of public health care programs. He has managed projects for Medicaid agencies in 14 states (AZ, CA, CT, GA, IN, LA, ME, MN, NV, NY, OH, PA, RI and VT). He co-founded Burns & Associates in 2006 and prior to this worked for another national health care consulting practice for 10 years.

Representative Accomplishments

- Project manager for B&A's engagement with Indiana's Office of Medicaid Policy and Planning since 2007 and, prior to this, with a prior firm's engagement with the OMPP from 2001 to 2006. Mr. Podrazik has managed and been the lead author on each of the deliverables that have been provided to the OMPP during this time. These have included:
  - The annual independent evaluation of Indiana's Children's Health Insurance Program (2001 to the present)
  - A Databook Monitoring Manual that tracks enrollment, utilization, access and expenditure trends (2002 to 2010)
  - The External Quality Reviews of the Hoosier Healthwise program (2005, 2007- 2017), the Care Select program (2009) and the Healthy Indiana Plan (2009-17)
  - Managed the independent evaluation of Indiana's 1915(b) waiver for its managed care program for the aged, blind, disabled and foster children (Hoosier Care Connect) in 2017
  - Technical assistance in submitting Indiana's annual CMS CHIP report
  - Conducting 28 focus studies as part of EQRs. The 2016 topics included well child visits, prenatal care, initiation and engagement of alcohol/drug treatment and member access to services from 19 provider specialties.
  - Administering a Primary Medical Provider and member survey (both in 2009)

- Provided assistance to the Arizona Health Care Cost Containment System on a number of projects including:
  - Project manager and lead analyst on AHCCCS's transition to a new fee schedule-based payment system for outpatient services to Medicaid beneficiaries.
  - Project manager for a project to update AHCCCS's rates paid to Medicaid fee-for-service providers of nursing home care.
  - Project manager for an engagement to calculate hospital DSH payments.
  - Key analyst on a project to evaluate AHCCCS's self-funded reinsurance program for acute care and long-term care services.

- Assisting the Louisiana Department of Health (under subcontract to Mercer) with conducting a rate study of its inpatient and outpatient hospital payments. At the conclusion of the study, it has been determined that LDH will move forward to convert from a per diem payment methodology to an APR-DRG payment methodology for inpatient services. An examination of options to realign the State's supplemental payment program is also being included.

- Assisting the Connecticut Department of Social Services with a hospital payment rate study as it responds to appeals from hospitals related to both its inpatient and outpatient payment methodologies.

- Managing B&A's engagement with Maine's Department of Health and Human Services with a hospital payment rate study of both inpatient and outpatient hospital services to identify opportunities to rebase rates using more current costs, realigning peer groups and making changes to its hospital supplemental payment program.

- Assisted Minnesota's Medicaid program reset its physician fee-for-service rates to the Medicare RBRVS system. This engagement is a follow-up to another engagement with the State led by Mr. Podrazik in which B&A measured the impact that rates had on member's access to services throughout the state. As part of this study, other state Medicaid rates were examined, provider availability was measured, and mail surveys were conducted of physicians and members.

- Managed B&A's multi-year engagement with Rhode Island's Department of Behavioral Health, Developmental Disabilities and Hospitals (BHDDH) to redesign its program serving individuals with intellectual and developmental disabilities. Phase I included redefining services, establishing a new assessment tool (Supports Intensity Scale), setting rates paid to providers, technical assistance for a new authorization system, assistance in writing new regulations, and negotiating changes to the system with CMS. Facilitated or co-facilitated over 40 stakeholder meetings in the first year of the project across three workgroups (assessment tools, service definitions and rate setting). Conducted onsite reviews of support coordinators to assess the effectiveness of Individualized Service Plans. Phase II included establishing billing procedures, developing ongoing monitoring procedures, and measuring expenditures against person-specific funding levels. Phase III involved developing new funding levels based on the Supports Intensity Scale assessment results.

- Principal analyst on an initiative whereby a Governor-appointed task force in Nevada was commissioned to evaluate and develop recommendations for changing the methodology and updating rates paid to Medicaid providers who serve the developmentally disabled population and those with behavioral health needs. Developed and evaluated the results of cost survey tools administered as part of the process of refining the rates.

- Assisted New Jersey's Division of Developmental Disabilities, under subcontract to Mercer, in writing a new Supports Waiver and setting new rates for providers to move from a cost-based system to a prospective fee-for-service system.

- Assisted San Diego County in a redesign of its Medical Services program for the indigent. Tasks included conducting multi-day interviews with functional areas within the Department to determine current processes and the interests of how to change them in the redesign. A strategic plan was developed as well as an outline of work plan activities for a steering committee work group.

- Managed B&A's engagement while at B&A (2009-2010) and a prior firm (2004-2005) to conduct an annual evaluation of the Healthy NY program which is offered through the New York Department of Insurance. The report which was submitted to the Legislature included results from surveys administered by B&A to members enrolled through small businesses as well as sole proprietors and small business owners. Mr. Podrazik also conducted interviews with representatives from 11 participating health plans. The report also includes a financial analysis of the costs of the reinsurance component of the program which is funded by the State and a longitudinal study of premium changes.

- Managed an engagement to conduct an independent evaluation of the Insure Oklahoma program in 2008. This program offers state subsidies to low-income working uninsured residents of the state who purchase insurance through their small employer. The evaluation included in-person interviews with over two dozen stakeholders that were part of the design, implementation and ongoing operation of the program. B&A also completed an onsite review of the operational flows of the entity responsible for administering Insure Oklahoma and offered suggestions for process improvement. A survey of enrolled small business employees was also administered in the evaluation.

- Conducted nine focus groups of small employers who do and do not offer health insurance and insurance agents in November 2007 in three regions in Minnesota. The focus groups were intended to elicit feedback on policy decisions that were being contemplated related to increasing the accessibility and affordability of health care in Minnesota. Findings were summarized in a report to the Minnesota DHS.

- Managed the successful negotiation of a settlement between a hospital chain and a County government over the payment of outstanding hospital claims for indigents that had crossed a five-year period. The parties accepted Mr. Podrazik's settlement methodology for evaluating County responsibility.

- Key staff member and contributing author of an independent evaluation of Mississippi's Medicaid program which was delivered to the Mississippi Legislature. Also served as the principal analyst for Mississippi's waiver application extending eligibility for a population currently covered by Medicaid with state-only funds.

- Providing technical assistance to the Department of Vermont Health Access (DVHA) since November 2006 and the Green Mountain Care Board (GMCB) on numerous projects including:
    - Assisting DVHA in the implementation of its Vermont Medicaid Next Generation (VMNG) model for a contract effective in January 2017. Within a 12 month span, assistance was provided pertaining to:
        - Writing the RFP to contract with an accountable care organization (ACO)
        - Define the attribution methodology
        - Examining historical expenditures for the actuaries setting the monthly payment rate (including the repricing of claims)
        - Assisting in building the business rules with DVHA and its fiscal agent
        - Providing technical assistance to DVHA's actuaries on ACO rate development
        - Facilitating operational change meetings with DVHA Subject Matter Experts
        - Developing and participating in an ACO readiness review protocol
    - Managing B&A's engagement assisting in the design, fiscal forecasting and implementation of the Vermont Medicaid Shared Savings Plan; providing monthly and ad hoc reporting to the ACOs.
    - Analyzed bundled payment options for the GMCB using Medicaid, Medicare and commercial (VHCURES) data for episodes focused on chronic disease inpatient stays.
    - Examined episodes for opiate detoxification for consideration by DVHA and an IMD as well as episodes for cancer treatment among St. Johnsbury providers.
    - Examined episode of care options for DVHA as part of its State Innovation Model. The targeted areas were pregnancy-related, preventable ED visits, neonatal, and asthma/URI.
    - Compared rates of pay between Medicaid, Medicare and commercial plans to assess cost shift and how provider taxes influence the cost shift.
    - Conducted an independent analysis of medical cost savings of the Vermont Chronic Care Initiative.

- Built a databook that compares longitudinal utilization and expenditure trends across population cohorts and categories of service.
- Setting rates for physicians and other health professionals using the Medicare Resource Based Relative Value Scale (RBRVS) system (2010 and ongoing).
- Developed and refined the methodology to make disproportionate share payments to hospitals. Assist in calculating annual allotments (2007 and ongoing).
- Assisted in design and implementation of new reimbursement systems to pay for inpatient and outpatient hospital services (both 2006 and ongoing). For inpatient hospital services, this included a full rebase in 2008, 2012 and 2016.
- Assisted in the development of calculations and ongoing maintenance to support medical education payments made by DVHA (2011 and ongoing).
- Serve as reviewer of cost settled payments for involuntary psychiatric placements at acute care hospitals in light of the closure of Vermont State Hospital.
- Assist with responses to CMS on state plan amendment changes effecting provider reimbursement, including the calculation of Upper Payment Limit tests.
- Serve as technical resource to work with the DVHA's fiscal agent to implement new payment systems.
- Served as resource for provider training and systems remediation testing as DVHA prepares for implementation of ICD-10 diagnosis and inpatient procedure codes.

- Managing B&A's multi-year engagement, under subcontract to Mercer, to assist the Ohio Department of Medicaid (ODM) with multiple projects related to reimbursement—both traditional fee-for-service and quality based initiatives—as well as related identifying operational efficiencies and managed care oversight. Specific projects include:
    - Rebasing inpatient hospital rates which included migration to the 3M All Patient Refined Diagnostic Related Grouper (APR-DRG) effective July 2013. A second project was undertaken to rebase the rates once again effective July 2017.
    - Rebasing outpatient hospital rates which includes migrating to the 3M Enhanced Ambulatory Patient Grouping System (EAPG) effective July 2017.
    - Implementing and developing public report cards tracking hospital potentially preventable readmissions (PPRs) rates which were released in February 2015. These report cards are at the individual hospital level and at the MCO level. Report cards are now updated semi-annually.
    - Developing and implementing a quality incentive payment for nursing facilities utilizes the results of NF residents and their rate of Potentially Preventable Admissions (PPA) to hospitals (using 3M's grouper).
    - Led the B&A team that evaluated ODM's fee-for-service authorizations unit to report on areas of opportunity for streamlining processes and evaluating services that require prior authorization.
    - Participated on the team that assisted ODM in transitioning its systems and policies to prepare for implementation of ICD-10 coding in October 2015. In particular, developed a testing pilot with over 35 hospitals to assess the fiscal impact on payments coding inpatient stays in both ICD-9 and ICD-10.

Education & Academic Qualifications

M.B.A., Johns Hopkins University, 2001
B.S., Finance and Marketing, Syracuse University, 1991

Steven C. Abele, M.A.
Senior Analyst
Burns & Associates, Inc.

Steve Abele has over 15 years of experience consulting with state agencies on public sector health care delivery systems. Mr. Abele joined Burns & Associates (B&A) at its start in 2006 and worked with the B&A principals at another firm for four years prior to this. Prior to his consulting career, Mr. Abele worked for a large tertiary hospital where he developed expertise in revenue performance monitoring, performance improvement, financial analysis, and admitting and patient financial services.

Representative Accomplishments

- Provided analytical support to the Arizona Department of Economic Security, Early Intervention Program (DES/AzEIP). Activities included:
  - Developed and rebased provider rates for a team-based service model for individuals eligible for early intervention services. This involved refining service definitions, seeking stakeholder input and building a budget forecasting model.
  - Developed detailed fiscal reports to review program utilization patterns by individual, service and service provider.
  - Reviewed and recommended appropriate use of modifiers for services.
  - Reviewed billing processes to streamline service provider billing processes to increase efficiency of remittance.

- Provided general and analytical support for the Arizona Department of Economic Security, Division of Developmental Disabilities (DES/DDD). Activities included:
  - Developed and rebased provider rates for home- and community-based services for individuals with developmental disabilities.
  - Maintained rates paid to various DES/DDD providers by adjusting independent rate models for over 30 services, including group home, day treatment and training, in-home care, supported employment, nursing, and therapists.
  - Author of the annual Rate Certification Letter that DES/DDD is responsible for submitting to AHCCCS that measures the adequacy and appropriateness of provider rates.
  - Ongoing review and development of operational issues and processes created and modified for the Fiscal Intermediary program.
  - Ongoing support for the maintenance of a Microsoft Access-based rate assessment tool used to determine consumer-specific rates paid to DES/DDD providers based on the client's needs.
  - Developed documentation for the Requests for Qualified Vendor Application process, an online procurement system.
  - Created utilization and budget forecasts.

- Provided support for the DES/DDD Fiscal Intermediary program implementation, with duties including:
  - Conducted the readiness review of the FI.
  - Ongoing review and development for operational issues and processes created and modified during the implementation.
  - Oversight and testing for new processes.

- Assisting North Carolina's Department of Health and Human Services (under subcontract to HSRI) update and maintain Support Intensity Scale (SIS) tier and budget assignments

that are then passed on to the State's contracted MCOs. Also building a monthly financial reporting package in support of managing expenditures against the SIS-based allocations.

- Assisted Cardinal Innovations Healthcare with the review and implementation of individual resource allocations for the developmentally disabled population. During the engagement, Mr. Abele provided the primary support for:
  - Built base resource allocation models.
  - Compared historical resource utilization with resource allocation models.
  - Developed strategies to implement the resource allocation models.
  - Verified and reviewed Support Intensity Scale (SIS) scoring and category assignments.
  - Assisted with design and maintenance of operational reporting to monitor the population during implementation.

- Assisted in B&A's External Quality Reviews conducted for the Indiana Office of Medicaid Policy and Planning (OMPP) that monitor health plan performance. During the engagement, Mr. Abele's focus was on the validation of performance measures selected in each year's review which included validating reports submitted by the health plans against raw data sources, identifying differences, and meeting with the health plans to develop root cause analyses.

- Assisted the Louisiana Office for Citizens with Developmental Disabilities (OCDD) with the development of a case management rate based on a 15-minute unit. Assistance included developed and administering a provider cost survey, developing a rate model based on the analytics from the cost survey, and drafting contracts and manuals for OCDD.

- Assisted the Arizona Department of Health Services, Division of Behavioral Health Services in reviewing institutional and community-based rates paid to providers. Duties included ongoing discussions with a multi-disciplinary team to review independent rate models that utilize market-based benchmarks to modify the design to provide appropriate reimbursement for best practices.

- Provided support for the Nevada Department of Health and Human Services while modifying and negotiating a HIFA demonstration waiver with the Centers for Medicare and Medicaid Services (CMS). Duties include the review and revision of the HIFA demonstration application, demonstration financial projections, and development and assistance with new processes related to the demonstration implementation.

- Collected data and completed analysis and process mapping for the State of Louisiana HIFA design. Assisted in the development and submission of the HIFA application to CMS, including sections relevant to budget neutrality. Participated in a cross-functional team to identify and assess information technology needs associated with eligibility and enrollment of individuals identified to participate in the program.

- Worked with the State of Vermont under its State Innovation Model grant to assemble, validate and build a unified dataset of information to assess the financial performance of Designated Agencies. The project has involved:
  - An iterative review of financial reports with the State and provider community.
  - The development of summary provider-specific financial trend reports.
  - Building a dynamic model to test value-based bundled payments to designated agencies for a defined set of services for distinct populations.

- Assisted the Ohio Department of Medicaid trend the results of changes in payment due to the coding change from ICD-9 to ICD-10 in its inpatient payment system. Trend reports are being developed at the hospital-specific level and the diagnostic category (DRG) level.

- Assisting Maine's Department of Health and Human Services (DHHS) rebase provider rates for home health services. During the course of the engagement stakeholder input was obtained through a survey process and a budget forecasting model was developed to assess fiscal implications.

- Assisted the Department of Vermont Health Access (DVHA) in the development of potential models to convert its payment methodology for home health services to a service-specific payment to a 60-day episodic payment. The model simulations created factored in the acuity of each patient and the type and duration of home health visits delivered.

- Also for DVHA, analyzed payment-to-cost trends for federally qualified health centers (FQHCs) and rural health centers (RHCs) over a nine-year period in an effort to develop a standardized prospective reimbursement methodology.

Education and Academic Qualifications
M.A., Mathematics, University of Kansas, 1994
B.S., Mathematics, Wichita State University, 1991

Ryan Sandhaus
SAS Programmer
Burns & Associates, Inc.

Ryan Sandhaus has 10 years of experience using SAS for analytical work. Ms. Sandhaus joined Burns & Associates (B&A) in 2016 and has worked on projects using large Medicaid claims datasets, member eligibility files, and provider files that range from hospital rate setting and rate evaluation, access to care and report validations. Prior to joining B&A, Mr. Sandhaus worked for Blue Cross Blue Shield of Arizona (BCBSAZ) within the Informatics Department. He also brings a robust background in advanced analytics, forecasting and predictive modeling within the healthcare industry.

Representative Accomplishments

While at Burns & Associates

- Analyzed utilization for a variety of provider specialties and Medicaid eligibility groups in support of B&A's project to the Ohio Department of Medicaid (ODM) to provide technical assistance in delivering the Access to Care report for its fee-for-service program to the Centers for Medicare and Medicaid. As part of the project, Mr. Sandhaus worked closely with the ODM team to define the utilization that was computed and presented on maps at the county level using filters by claim type, provider type, provider specialty and CPT code. Tables and maps were generated showing the number of providers that members accessed as well as the utilization per 1,000 member rates by provider specialty.

- Conducting analytics for multiple aspects of B&A's External Quality Review for Indiana's Office of Medicaid Policy and Planning. In 2016, Mr. Sandhaus computed access and utilization rates by specialty and enrollment category for the EQR similar to work stated above for Ohio ODM. In 2017, he is reading in large datasets of encounters from the State's data warehouse to validate reports submitted by the managed care entities related to claims volume reports between paid and denied claims by claim type and method of transmission (paper vs. electronic) to encounter submission completeness.

- Served as the technical analyst for B&A's engagement to deliver a report to the Medicaid and CHIP Payment and Access Commission (MACPAC) examining the trends in the utilization and delivery methods of non-emergency medical transportation in two states.

- Served as lead programmer in B&A's project with the Maine Department of Health and Human Services (DHHS) to rebase its outpatient hospital rates using Medicare's outpatient prospective payment system (OPPS) fee schedule as its basis. The project included replicating the pricing logic of Medicare OPPS for the Maine Medicaid claims and then using this to build rates for DHHS within its budget targets by hospital peer group.

- Conducted analytics on outpatient hospital volume trends, payment trends and cost trends for the Connecticut Department of Social Services (DSS) under an engagement to provide technical assistance to DSS as it relates to provider rate appeals. Analytics have been completed over an eight-year study period. Mr. Sandhaus has also repriced the Medicaid claim volume under Medicare pricing compare Medicaid outpatient payment rates as a percent of Medicare rates.

- Conducting analytics for the Department of Vermont Health Access (DVHA) to inform potential options for creating value-based purchasing models for its Payment Reform team.

- Conducting analytics for a Northeast hospital association as it navigates the nuances of potential changes to the State Medicaid's outpatient payment system. The project includes simulating the fiscal impact of scenarios proposed by the Medicaid agency for hospital members.

While at Blue Cross Blue Shield of Arizona

- Analyzed and designed solutions using healthcare data, including enrollment, claims and pharmacy.
- Built, tested and implemented statistical models by investigating appropriate methods and algorithms.
- Conducted predictive analyses for forecasting and marketing campaign management.
- Prepared and presented reports of model performance and business recommendations at a consumer level with internal clients.

While at Arizona State University/CAPS Research

- Organized and tracked benchmarking activities while ensuring the standardization and accuracy of survey data.
- Examined, analyzed and compiled statistical data for benchmark reports.
- Developed benchmarking performance surveys.
- Key liaison between CAPS Research and benchmarking participants.

While at Joseph D. Fail Engineering

- Analyzed market survey data and presented results to determine support of business plans for Rural Utility.
- Serviced loan applications to the United States Department of Agriculture.
- Calculated sample sizes to satisfy defined confidence levels.
- Responsible for developing and delivering verbal and visual presentations of company products and services.

Education & Academic Qualifications

M.S., Business Administration-Marketing, Arizona State University, 2010
B.S., Business Administration-Marketing, University of Missouri 2004

Tina J. Brezenski
Consultant
Burns & Associates, Inc.

Ms. Brezenski has more than 17 years of experience in financial analysis and budgeting across multiple sectors including health care and nonprofit. Since joining B&A in 2014, she has been assisting in data, geospatial, and rate setting analysis. Ms. Brezenski has worked on rate setting and/or resource allocation projects in Georgia, Maine, Mississippi, New Mexico, Hawaii, Oregon, and Virginia. She has also worked on projects related to foster care and early childhood development in Arizona and access to dental care in Indiana. Prior to joining B&A, Ms. Brezenski was Senior Accountant/Financial Analyst at a community hospital in Arizona, where she developed expertise in claims analysis, budgeting and forecasting, fiscal analysis, and process improvement.

Relevant Experience and Expertise

While at Burns & Associates, Inc.

- Providing analytical support as the lead analyst on B&A's engagement with the State of Oregon related to the-review of provider rates for residential and other home and community based services for individuals with intellectual and developmental disabilities for the Office of Developmental Disabilities Services. Activities include:
    - Developed a provider survey, provided technical support to providers, completed survey analysis
    - Geographic analysis of driving distances between member residence and services.
    - Estimated fiscal impact of proposed rate models.

- Served as the lead analyst on B&A's engagement with the State of Oregon related to the-review of provider rates for Supported Employment Services for the Office of Developmental Disabilities Services. This included development of a provider survey, survey analysis, and estimated fiscal impact analysis of proposed rate models.

- Developed supporting documentation for Appendix J for 1915(c) Waiver Applications to Centers for Medicare and Medicaid Services for the states of Virginia, Hawaii, and Oregon.

- Analyzed service utilization and evaluated geographic differences for Virginia Department of Behavioral Health and Developmental Services (DBHDS) for select services of their Intellectual Disabilities and Developmental Disabilities waivers. Analysis included heat maps demonstrating average driving distance by county for select services.

- Key contributor to fiscal impact analysis for B&A's engagement with the State of Maine as it transitions to a Supports Intensity Scale (SIS) informed resource allocation methodology to assign service packages to their intellectual and developmental disabilities waiver program members. Also, analyzed authorization and claims data to determine usage at individual level.

- Analyzed population access to Crisis Stabilization Units (CSUs) for Maine Department of Health and Human Services by building maps of CSU locations and population by county based on 2010 Census.

- Analyzed average driving distances and built data visualization maps in support of B&A's External Quality Review of Indiana's Medicaid managed care programs in 2016.

While at Casa Grande Regional Medical Center

- Analyzed Medicare payments over the look back period to assess financial exposure for potential CMS RAC Takebacks.
- Completed budgeting process for over 50 departments, both variable and fixed, with imported historical data and projected revenue and expense changes.
- Prepared monthly consolidated financial statements, board packages, operations reports, cash flow statements and variance analyses for senior management.

Education and Academic Qualifications
Bachelor of Arts, Economics, Women's Studies (double major), Northwestern University 1995

Barry A. Smith
Consultant
Burns & Associates, Inc.

Barry Smith has over fourteen years of experience with financial analysis and data mining. Mr. Smith joined Burns & Associates (B&A) in 2007 and has provided a wide range of analytic assistance to agencies since that time. Prior to joining B&A, Mr. Smith worked as a financial analyst at a large private mortgage lender specializing in data mining and monthly financial analysis for the bank's corporate headquarters.

Representative Accomplishments

- Provided data analysis and support each year since 2008 for several deliverables for Indiana's Office of Medicaid Policy and Planning for B&A's annual independent evaluation of the Children's Health Insurance Program and the annual External Quality Reviews of Indiana's Hoosier Healthwise, Care Select and Healthy Indiana Plan programs. Examples include:
  - Compiling and presenting results from HEDIS measures and CAHPS surveys
  - Examining enrollment trends by eligibility category
  - Utilizing mapping geodistance software to compute distances travelled by enrollees to seek services and to map these results as well as utilization trends at the county level

- Created Microsoft Access databases for use in the data entry and analysis of results from numerous surveys conducted by B&A in 2008 through 2016 including:
  - A member survey for Indiana's Care Select program
  - Primary Medical Provider survey for Indiana's Hoosier Healthwise and Care Select programs
  - Surveys administered to small employers and members of the Healthy NY program
  - A member survey for the Insure Oklahoma program
  - Rhode Island caseworker quality review

- Analyzed utilization statistics, generated average driving distances and created data visualization maps in support of B&A's project with the Ohio Department of Medicaid to submit its Access to Care report to the Centers for Medicare and Medicaid.

- Assisted in the administration and tabulation of provider utilization and cost surveys for services delivered to individuals with developmental disabilities. The Excel-based surveys are read into analytical templates from which trend analyses are completed. Surveys have been administered to providers in the States of Arizona, Georgia, Hawaii, Maine, New Mexico, North Carolina, Oregon, Rhode Island and Virginia.

- Supported the state agencies in the nine states mentioned above in the development of home- and community-based rates for services provided to individuals with developmental disabilities.

- Provided analytical support for the Arizona Division of Developmental Disabilities by preparing a monthly utilization and budget forecasting report for use in analyzing trends.

Education and Academic Qualifications

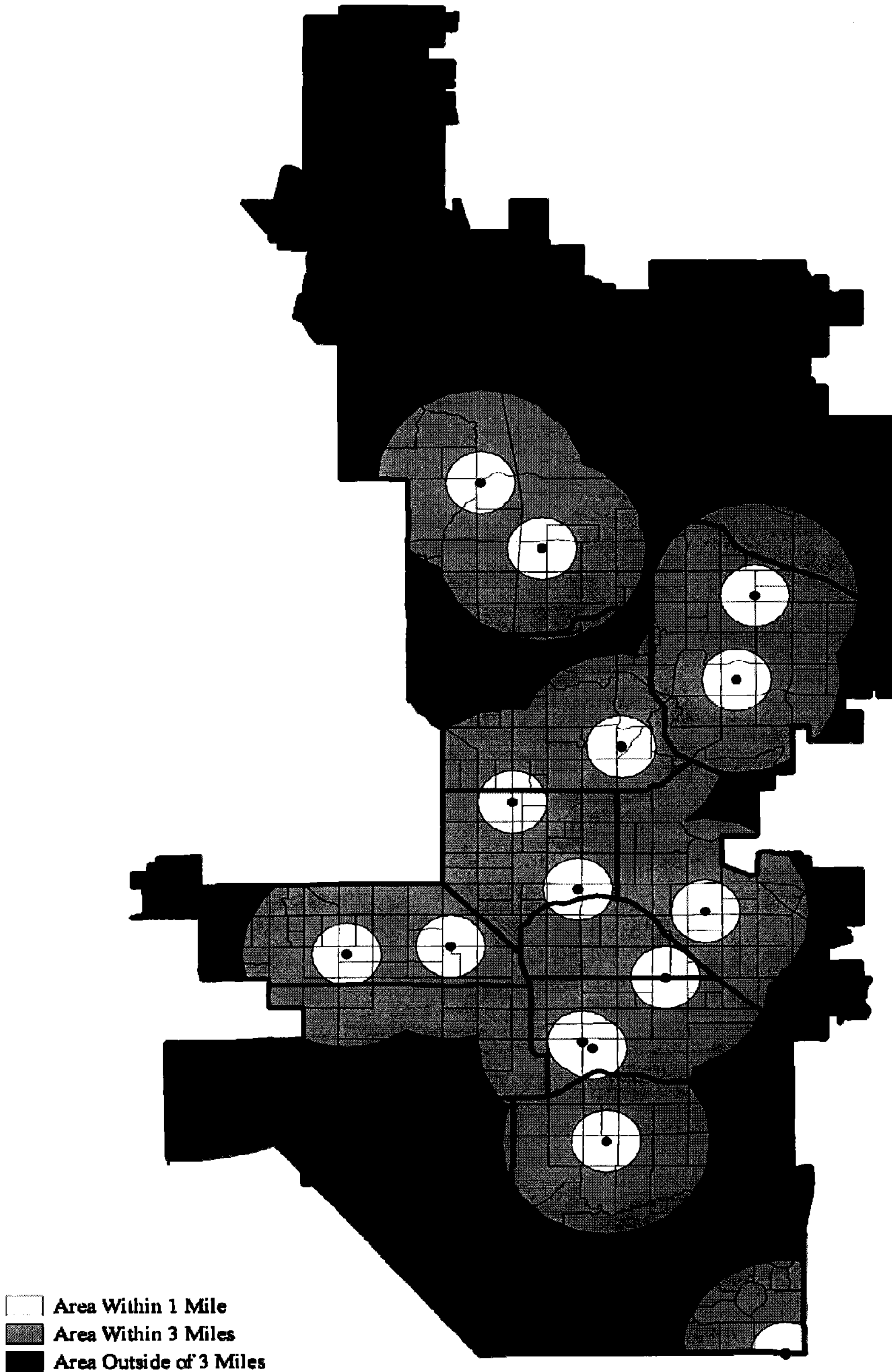
B.S., Economics with Business Administration Minor, University of Arizona, 2002

NM OCCUPATIONAL THERAPY SERVICES

Regional & County High Level Direct Services Overview

		All Full Year/ Served Clients	Therapy Clients	Pct of Clients	Hours/ User/ Year	Current Providers	Trips by Distance Group					Total Trips	Avg Provider/Client Distance
							0-25	25-50	50-75	75-100	100+		
Metro Region		**1,881**	**670**	**35.6%**	**38.5**	**39**	**18,864**	**2,829**	**10**		**12**	**21,715**	**12.8**
Bernalillo	Urban	1,432	524	36.6%	38.2	35	16,640	72	10		11	16,733	8.9
Sandoval	Rural	171	50	29.2%	34.7	19	1,544					1,544	9.7
Torrance	Frontier	24	5	20.8%	44.3	3	73	68			1	142	28.6
Valencia	Rural	254	91	35.8%	41.9	12	607	2,689				3,296	32.8
Northeast Region		**367**	**124**	**33.8%**	**36.1**	**10**	**1,716**	**1,059**	**868**	**221**	**74**	**3,938**	**32.2**
Colfax	Frontier	11											
Harding	Frontier	0											
Los Alamos	Urban	21	5	23.8%	42.4	1	77	114				191	23.8
Mora	Frontier	5	2	40.0%	20.4	1	4	35				39	44.9
Rio Arriba	Frontier	80	29	36.3%	35.6	5	188	370	263	1	74	896	46.0
San Miguel	Frontier	58	16	27.6%	38.2	2	353	105				458	10.7
Santa Fe	Urban	143	51	35.7%	35.2	9	1,094	434	52			1,580	15.3
Taos	Rural	48	21	43.8%	37.0	2		1	553	220		774	64.8
Union	Frontier	1											
Northwest Region		**256**	**86**	**33.6%**	**27.3**	**6**	**887**	**143**	**236**	**94**	**290**	**1,650**	**45.5**
Cibola	Frontier	38	19	50.0%	29.9	2		43	236	82		361	69.4
McKinley	Rural	121	6	5.0%	8.9	2				12	16	28	109.9
San Juan	Rural	97	61	62.9%	28.3	3	887	100			274	1,261	37.3
Southeast Region		**384**	**62**	**16.1%**	**24.3**	**5**	**173**	**31**			**1,356**	**1,560**	**146.6**
Chaves	Rural	121	32	26.4%	26.0	2					823	823	148.7
Curry	Rural	107	19	17.8%	16.2	2	157				242	399	153.1
De Baca	Frontier	0											
Eddy	Rural	61	9	14.8%	34.1	2					291	291	151.6
Guadalupe	Frontier	10	1	10.0%	50.3	1		31				31	27.1
Lea	Rural	67											
Quay	Frontier	9											
Roosevelt	Rural	9	1	11.1%	8.0	1	16					16	17.6
Southwest Region		**576**	**192**	**33.3%**	**32.7**	**4**	**3,876**	**143**	**1,196**	**585**	**37**	**5,837**	**26.4**
Catron	Frontier	1											
Dona Ana	Urban	364	112	30.8%	35.5	2	3,672	52				3,724	4.4
Grant	Rural	55	27	49.1%	20.0	1		17		521	25	563	89.9
Hidalgo	Frontier	1	1	100.0%	11.0	1					12	12	113.7
Lincoln	Frontier	18	4	22.2%	6.6	2				26		26	94.1
Luna	Rural	20	11	55.0%	23.5	1		39	197			236	55.0
Otero	Rural	87	25	28.7%	45.9	1			891	38		929	66.0
Sierra	Frontier	7	2	28.6%	35.1	1			65			65	57.9
Socorro	Frontier	23	10	43.5%	24.8	2	204	35	43			282	17.6
Statewide Total		**3,464**	**1,134**	**32.7%**	**35.6**	**46**	**25,516**	**4,205**	**2,310**	**900**	**1,769**	**34,700**	**24.8**

Appendix K-V: Senior Center Service Area Coverage
1 Mile & 3 Mile Diameter Areas from Senior Center Locations

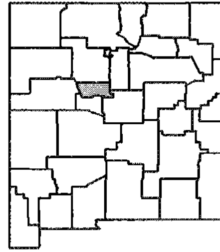


OCCUPATIONAL THERAPY TRAVEL DISTANCE BY COUNTY DETAIL REPORT

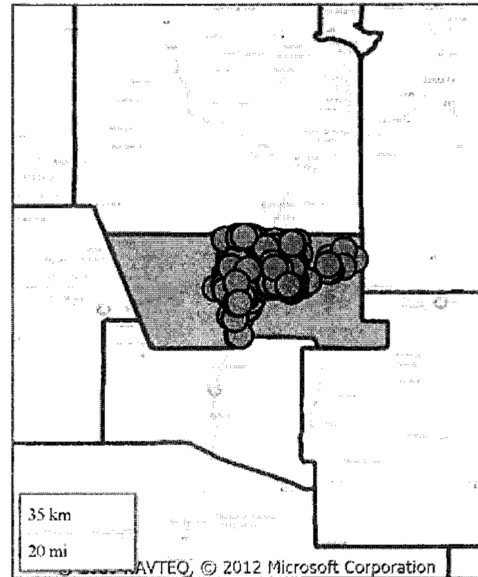
Bernalillo County

DDSD Region: Metro

Primary Care Group: Urban



Client Address Locations



Bernalillo County Details by Single Trip Distance Group

	Undup. Clients	Undup. Providers	Service Hours	Total Paid	Total Miles Traveled	Total Trips
0-25	521	32	19,914	$1,828,382	145,574	16,640
25-50	3	2	86	$7,679	1,922	72
50-75	1	1	14	$1,317	562	10
75-100						
100+	2	1	14	$1,326	1,588	11
Total	524	35	20,029	$1,838,705	149,646	16,733

Comparative, Region & Primary Care Group Summary Statistics

	Undup. Clients	Undup. Providers	Service Hours	Total Paid	Total Miles Traveled	Total Trips	Single Trip Distance Group 0-25	25-50	50-75	75-100	100+
Statewide	1,134	46	40,395	$3,676,215	861,321	34,700	25,516	4,205	2,310	900	1,769
Metro	670	39	25,800	$2,371,607	276,882	21,715	18,864	2,829	10		12
Urban	692	41	26,010	$2,389,354	194,849	22,228	21,483	672	62		11

Bernalillo County Details by Zip Code

Zip Code	Undup. Clients	Undup. Providers	Service Hours	Total Paid	Total Miles Traveled	Total Trips	0-25	25-50	50-75	75-100	100+
87008	3	4	132	$11,935	1,025	88	88				
87022	2	2	91	$8,428	844	57	57				
87047	2	2	83	$7,566	823	56	56				
87059	2	2	97	$8,966	714	59	59				
87102	9	6	262	$24,166	2,230	221	221				
87104	11	7	397	$36,514	2,518	314	314				
87105	39	20	1,264	$115,739	12,302	1,032	962	70			
87106	8	7	341	$31,117	1,687	273	273				
87107	24	18	983	$90,032	6,133	795	795				
87108	16	13	664	$60,925	3,974	521	521				
87109	52	19	2,080	$191,000	12,922	1,781	1,781				
87110	40	19	1,375	$126,675	8,047	1,187	1,187				
87111	56	27	2,105	$192,360	15,153	1,753	1,749				4
87112	64	26	2,464	$226,032	16,988	2,152	2,150	2			
87113	17	12	654	$60,189	5,213	581	574				7
87114	26	17	993	$90,512	8,564	830	830				
87120	65	21	2,564	$235,386	24,778	2,141	2,141				
87121	43	20	1,446	$133,255	12,551	1,245	1,235		10		
87122	8	7	356	$32,904	2,249	275	275				
87123	36	16	1,645	$151,725	10,862	1,345	1,345				
87125	1	1	36	$3,279	70	27	27				

Exhibit VII.8

Average Driving Distance to Dentists for Healthy Indiana Plan Members, by MCE

(Average distances shown in miles for members using single one-way trips from member home to provider location.)

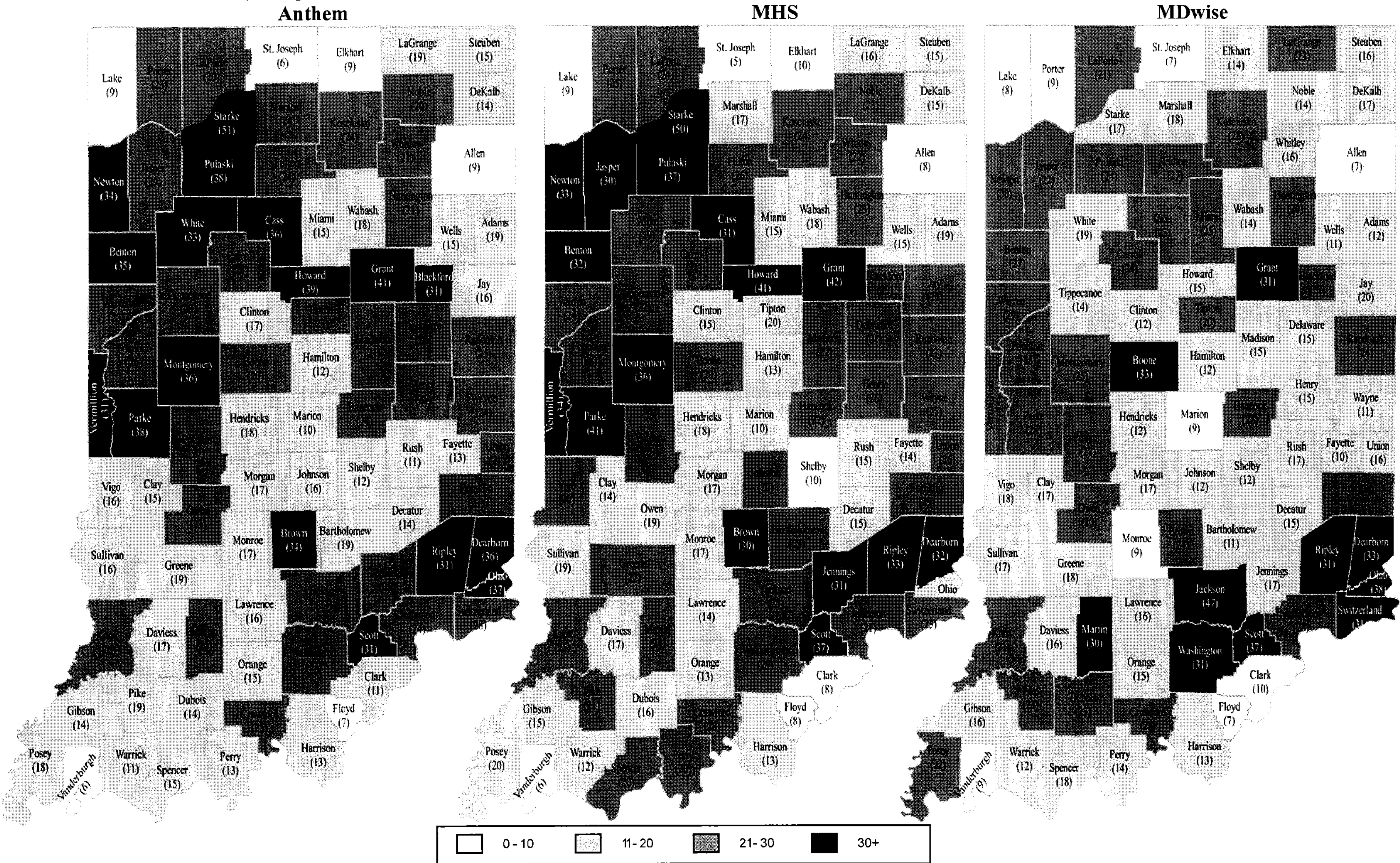


Exhibit VI.3

Member-to-Provider Ratios by MCE / Program / Specialty Category

Member and Provider Numbers reported by the MCEs on Geoaccess reports submitted to OMPP. Tabulation of regions above threshold calculated by Burns & Associates.

	Member-to-Provider Ratio			# Regions Exceeding Standard (out of 8)			Member-to-Provider Ratio			# Regions Exceeding Standard (out of 8)			Member-to-Provider Ratio			# Regions Exceeding Standard (out of 8)		
	Anthem			Anthem			MHS			MHS			MDwise			MDwise		
Provider Specialty	HHW	HCC	HIP	HHW	HCC	HIP	HHW	HCC	HIP	HHW	HCC	HIP	HHW	HCC	HIP	HHW	HCC	HIP
Primary Care	77	14	23	1	0	0	69	22	65	5	1	1	29	11	21	0	0	1
OB/GYN	56	10	67	0	0	0	208	75	224	1	1	1	156	81	125	0	0	1
Behavioral Health	47	9	22	0	0	0	96	9	94	0	0	1	246	59	229	2	0	1
Cardiologist	30	5	35	0	0	0	170	61	177	0	1	1	107	104	86	0	0	0
Cardiothoracic Surgeon	213	39	NR	0	0	NR	3,213	1,083	2,896	7	3	6	498	330	378	4	2	4
Dermatologist	514	94	495	3	0	2	1,954	1,024	1,944	6	2	4	1,297	623	987	5	3	5
Gastroenterologist	96	18	154	0	0	0	500	212	540	4	1	1	307	226	249	0	2	1
General Surgeon	96	17	87	0	0	0	282	116	290	0	1	1	279	132	222	0	0	1
Nephrologist	95	17	112	0	0	0	794	285	811	5	1	3	379	302	332	3	2	2
Neurologist	119	22	88	0	0	0	605	224	609	2	1	1	278	123	197	2	0	2
Neurosurgeon	485	89	617	2	0	5	2,259	611	2,252	6	3	6	765	1,206	669	5	3	5
Occupational Therapist	194	35	112	0	0	0	1,302	457	1,326	4	2	3	505	262	483	3	1	3
Oncologist	116	21	144	0	0	0	541	258	579	5	2	2	220	167	483	1	1	3
Ophthalmologist	177	32	194	0	0	0	983	368	1,014	5	1	1	442	386	380	2	2	1
Optometrist	134	25	164	0	0	0	NR	NR	NR	NR	NR	NR	381	271	367	0	1	1
Orthopedist	79	14	96	0	0	0	334	133	350	0	1	1	222	148	178	1	1	1
Otolaryngologist	199	36	146	0	0	0	738	281	731	4	1	1	432	84	371	0	0	1
Physical Therapist	47	9	19	0	0	0	452	169	452	2	0	2	243	260	219	2	1	1
Psychiatrist	87	16	96	0	0	0	NR	NR	NR	NR	NR	NR	749	106	689	5	0	3
Pulmonologist	85	16	184	0	0	0	567	209	589	4	1	1	340	238	287	0	1	1
Radiologist	NR	4	NR	NR	0	NR	1,129	375	1,126	5	1	4	280	61	148	2	0	2
Speech Therapist	642	117	1,182	2	0	4	2,409	861	2,628	6	3	5	1,352	579	1,264	5	2	3
Urologist	166	30	164	0	0	0	637	269	625	3	1	1	385	426	328	1	1	1

Thresholds set by Burns & Associates to calculate number of regions exceeding threshold.	
Primary Care	Greater than 100 members to 1 provider.
Behavioral Health	Greater than 500 members to 1 provider.
OB/GYN	Greater than 500 members to 1 provider.
20 other specialties	Greater than 1,000 members to 1 provider.

NR means that the MCE did not report information about this provider specialty on the Geoaccess report.

MHS did report Psychiatrist information on a report to OMPP. However, they are blended in the generic Behavioral Health category.

Exhibit VI.4
Average Distance to Contracted Provider by MCE / Program / Provider Specialty

Number of counties meeting target reported by the MCEs on Geoaccess reports submitted to OMPP. Average distance reported by the MCEs but tabulated by B&A.

	Number of Counties Meet OMPP Target (out of 92)			Value of County with Highest Avg. Dist. (in miles)			Number of Counties Meet OMPP Target (out of 92)			Value of County with Highest Avg. Dist. (in miles)			Number of Counties Meet OMPP Target (out of 92)			Value of County with Highest Avg. Dist. (in miles)		
	Anthem			Anthem			MHS			MHS			MDwise			MDwise		
Provider Specialty	HHW	HCC	HIP	HHW	HCC	HIP	HHW	HCC	HIP	HHW	HCC	HIP	HHW	HCC	HIP	HHW	HCC	HIP
Primary Care	92	92	92	17.4	18.4	17.9	92	92	92	17.2	16.4	17.1	92	92	92	13.8	15.3	14.0
OB/GYN	92	92	92	26.5	26.5	25.6	92	92	92	35.2	34.4	33.7	92	90	92	24.9	26.2	25.2
Behavioral Health	92	92	92	24.9	27.5	16.4	92	92	92	26.3	26.5	27.8	92	92	92	19.8	29.7	19.9
Cardiologist	92	92	92	28.0	28.0	27.6	92	92	92	34.3	40.1	34.8	92	91	92	27.8	33.4	28.2
Cardiothoracic Surgeon	92	92	NR	35.8	37.3	NR	92	92	92	60.0	78.7	61.3	92	91	92	50.7	63.1	50.8
Dermatologist	92	92	92	40.7	40.9	39.4	92	92	92	75.5	75.5	75.5	92	90	92	68.4	71.2	68.2
Gastroenterologist	92	92	92	33.8	35.2	32.6	92	92	92	52.9	53.0	52.6	92	90	92	29.9	54.0	NR
General Surgeon	92	92	92	30.1	30.8	30.1	92	92	92	37.3	32.1	34.1	92	90	92	NR	33.3	28.5
Nephrologist	92	92	92	35.3	35.9	23.8	92	92	92	42.7	46.5	42.8	92	90	92	28.4	45.4	27.4
Neurologist	92	92	92	23.8	24.1	35.7	92	92	92	54.3	55.1	54.5	92	90	92	35.5	36.3	35.3
Neurosurgeon	92	92	92	37.0	38.1	54.1	92	92	92	76.0	78.8	76.7	92	90	92	52.8	77.7	53.1
Occupational Therapist	92	92	92	37.2	39.7	40.4	92	92	92	45.7	43.5	45.0	92	90	92	42.0	54.9	42.0
Oncologist	92	92	92	34.9	34.9	27.5	92	92	92	45.3	45.0	45.5	92	90	92	35.1	36.3	42.0
Ophthalmologist	92	92	92	31.8	33.4	29.7	92	92	92	45.7	45.1	46.6	92	90	92	33.2	42.3	28.8
Optometrist	92	92	92	24.5	25.9	22.4	NR	NR	NR	NR	NR	NR	92	90	92	30.9	53.2	32.0
Orthopedist	92	92	92	29.3	30.1	30.9	92	92	92	33.8	38.2	30.5	92	90	92	28.0	29.6	27.6
Otolaryngologist	92	92	92	29.7	29.8	30.5	92	91	92	54.1	**61.8**	54.0	92	80	92	30.9	**89.4**	35.0
Physical Therapist	92	92	92	31.2	31.5	30.7	92	92	92	41.3	41.4	41.2	92	91	92	37.1	40.7	36.8
Psychiatrist	92	92	92	28.7	28.2	31.5	NR	NR	NR	NR	NR	NR	92	92	92	36.7	NR	37.1
Pulmonologist	92	92	92	22.1	21.9	27.3	92	92	92	48.3	46.2	47.4	92	88	92	42.7	**64.3**	38.1
Radiologist	NR	92	NR	NR	26.2	NR	92	90	92	55.3	**62.6**	55.3	92	90	92	38.4	36.3	35.2
Speech Therapist	92	92	91	42.5	42.8	**61.9**	84	84	86	**75.7**	**79.2**	**76.1**	92	90	92	42.2	58.1	47.2
Urologist	92	92	92	20.0	20.5	33.4	91	91	91	**60.6**	**63.7**	**61.7**	92	90	92	30.9	49.0	26.9

Cells in red represent situations where the county with the highest average distance exceeds the OMPP contractual standard.

Exhibit VI.5
Comparison of Unique Providers Contracted with MCEs and their Geoaccess Reports by MCE / Program / Provider Specialty
Number of unduplicated providers summed from provider directories submitted to B&A for this project.

	Number of Providers in MCE Directory (Unduplicated Count)			Ratio of Unduplicated Providers to Geoaccess Report Coverage			Number of Providers in MCE Directory (Unduplicated Count)			Ratio of Unduplicated Providers to Geoaccess Report Coverage			Number of Providers in MCE Directory (Unduplicated Count)			Ratio of Unduplicated Providers to Geoaccess Report Coverage		
	Anthem			Anthem			MHS			MHS			MDwise			MDwise		
Provider Specialty	HHW	HCC	HIP	HHW	HCC	HIP	HHW	HCC	HIP	HHW	HCC	HIP	HHW	HCC	HIP	HHW	HCC	HIP
Primary Care	2,461	2,461	3,766	1.0	1.0	1.6	2,734	2,464	2,618	0.8	0.7	0.8	9,012	7,156	9,911	0.9	0.7	1.0
OB/GYN	1,142	1,142	1,181	3.0	3.0	1.8	781	698	749	0.9	0.7	0.8	1,081	779	1,142	1.3	0.9	1.5
Behavioral Health	2,307	2,509	1,110	1.7	1.6	5.7	653	689	687	2.3	6.2	2.2	489	1,038	118	1.8	0.9	7.7
Cardiologist	1,581	1,581	2,047	4.0	4.0	2.0	942	863	943	0.9	0.7	0.9	1,771	893	1,866	1.2	0.6	1.3
Cardiothoracic Surgeon	334	327	762	2.7	2.7	NR	113	98	110	0.4	0.4	0.4	272	175	293	1.6	1.0	1.9
Dermatologist	149	149	195	2.5	2.5	1.5	65	58	66	1.1	0.6	1.1	143	114	141	1.2	0.8	1.5
Gastroenterologist	436	436	570	4.5	4.5	1.6	26	222	260	11.1	0.8	1.0	594	260	615	1.2	1.0	1.4
General Surgeon	866	866	804	2.3	2.3	2.0	494	426	484	1.0	0.8	1.0	695	510	714	1.1	0.8	1.3
Nephrologist	449	449	758	4.4	4.4	1.7	243	232	241	0.7	0.6	0.7	455	207	488	1.3	0.9	1.3
Neurologist	545	545	841	2.9	2.9	1.9	2	2	1	119.5	84.5	233.0	758	466	782	1.1	1.0	1.3
Neurosurgeon	165	165	182	2.4	2.4	1.3	91	73	87	0.7	0.8	0.7	162	77	161	1.8	0.6	1.9
Occupational Therapist	723	723	819	1.4	1.4	1.6	165	164	179	0.7	0.5	0.6	371	268	371	1.2	0.8	1.2
Oncologist	900	585	1,372	1.8	2.8	0.7	104	80	104	2.6	1.8	2.4	859	388	371	1.2	0.9	1.2
Ophthalmologist	582	582	622	1.8	1.8	1.2	197	181	200	0.7	0.6	0.7	398	162	401	1.3	0.9	1.4
Optometrist	1,084	1,084	665	1.3	1.3	1.3	259	259	249	NR	NR	NR	441	253	429	1.3	0.8	1.3
Orthopedist	908	908	969	2.7	2.7	1.5	544	456	541	0.8	0.6	0.7	934	483	970	1.1	0.8	1.2
Otolaryngologist	417	417	604	2.3	2.3	1.6	310	252	305	0.6	0.5	0.6	435	362	445	1.2	1.9	1.3
Physical Therapist	3,553	3,553	0	1.1	1.1	0.0	328	298	328	1.0	0.8	1.0	978	286	968	0.9	0.8	1.0
Psychiatrist	698	698	845	3.1	3.1	1.8	637	605	633	NR	NR	NR	119	132	122	2.5	4.0	2.5
Pulmonologist	440	440	509	5.1	5.1	1.5	21	33	20	12.1	5.5	12.1	593	277	616	1.1	0.9	1.2
Radiologist	198	2,313	189	NR	3.7	NR	5	5	5	25.6	20.2	25.2	1,039	1,122	1,324	0.8	0.8	1.1
Speech Therapist	136	136	156	2.2	2.2	0.8	74	81	74	0.8	0.5	0.7	147	122	148	1.1	0.8	1.1
Urologist	468	469	23	2.4	2.4	1.3	237	131	232	1.0	1.1	1.0	407	170	420	1.4	0.8	1.5

NR means that the MCE did not report this information on their Geoaccess report.
Therefore, the ratio of providers in the MCE directory to Geoaccess availability could not be calculated.
Cells in red highlight ratios at or below 1.2. This indicates that there are more unique providers in the MCE directory than the Geoaccess reports state.
Cells in green highlight ratios at or above 10.0. This indicates that there are far fewer unique providers in the MCE directory than the Geoaccess reports state.