HSAG HEALTH SERVICES ADVISORY GROUP

September 27, 2017

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

Via email: Michael.Kowren@azahcccs.gov

RE: Task Order #YH18-0031
"Analysis of Prop 206 Impact on Provider Network Adequacy"

Dear Mr. Kowren:

Health Services Advisory Group, Inc. (HSAG) is pleased to submit this response to the above-mentioned task order referencing our contract number ADSPO13-058531.

HSAG acknowledges receipt of answers to questions on Tuesday, September 26, 2017.

We understand the purpose of this analysis is to review the adequacy of the AHCCCS long-term care system provider network (including those providers contracted with DDD) and to identify any network deficiencies that may have resulted from the enactment of Prop 206, in order to ensure AHCCCS members' access to healthcare services.

I am the person authorized to bind the organization, and also the person responsible for our response to this task order. Please do not hesitate to contact me if you have any questions or require clarification. I can be reached at 602.801.6701 or mdalton@hsag.com.

Sincerely,

Mary Ellen Dalton

Mary Ellen Dalton, PhD, MBA, RN
President and Chief Executive Officer

MED:rp

Task Order Response

Health Services Advisory Group, Inc. (HSAG) is providing its response regarding the Arizona Health Care Cost Containment System (AHCCCS), Task Order #YH18-0031, Analysis of Prop 206 Impact on Provider Network Adequacy on the following pages.

The Required Elements 1-3 (8.1 on page 5 of 7 of the revised Task Order) are addressed in the cover letter submitted with this response.

HSAG Corporate Background & History

Since 1979, HSAG has provided innovative leadership on healthcare quality improvement projects for federal, state, and private sector clients, and is one of the most experienced quality improvement and external quality review organizations in the nation. HSAG is recognized as an agent of change in the healthcare industry because of its successful collaboration with providers across the continuum of care.

HSAG has more than 550 employees including healthcare and clinical professionals, technical researchers, data analysts, statisticians, and information technologists. HSAG's corporate headquarters is in Phoenix, Arizona, with satellite offices located in Glendale, California; Burlingame, California; Aurora, Colorado; Tampa, Florida; Honolulu, Hawaii; Columbus, Ohio; Oklahoma City, Oklahoma; and Christiansted, U.S. Virgin Islands. HSAG has a national presence and is directly involved in evaluating and improving the quality of care for a significant percentage of Medicare and Medicaid members.

MEDICARE

HSAG was originally established as a professional standards review organization (PSRO) reviewing Medicare hospitalizations for quality and utilization for the northern half of Arizona. HSAG was incorporated as a privately held, for-profit corporation under the laws of the State of Arizona in 1982, and is wholly-owned by its parent company, Health Services Holdings, Inc. (HSH). The Centers for Medicare & Medicaid Services (CMS) awarded HSAG the first peer review organization (PRO) contract for Arizona Medicare beneficiaries in 1984, later changing to a quality improvement organization (QIO). HSAG has performed QIO services for all CMS Scopes of Work (SOW). Today, HSAG is the Quality Innovation Network-Quality Improvement Organization (QIN-QIO) for Arizona, California, Florida, Ohio, and the U.S. Virgin Islands (25 percent of the Medicare population); and holds contracts for the End Stage Renal Disease Networks 7, 13, 15, and 17 (includes the states of Arkansas, Arizona, Northern California, Colorado, Florida, Hawaii, Louisiana, Oklahoma, New Mexico, Nevada, Wyoming and territories of American Samoa, Guam, and Mariana Islands (19 percent of the Medicare dialysis population).

MEDICAID

Since 1983, HSAG has been actively engaged in evaluating the quality of care received by Medicaid recipients. Currently, HSAG provides external quality review (EQR)-related services in 16 states: Arizona, California, Colorado, Florida, Georgia, Hawaii, Illinois, Iowa, Michigan, Nevada, New Hampshire, Ohio, Tennessee, Utah, Vermont, and Virginia, addressing quality, timeliness, and access to care for more than 45 percent of the nation's Medicaid population.

Experience and Capabilities

HSAG contracts with a broad range of government and private sector customers that allow it to employ a variety of staff members with specialized expertise. HSAG has built strong and lasting relationships with healthcare stakeholders, hospitals, practitioners, home health agencies, nursing homes, and health plans.

HSAG is the largest and most experienced External Quality Review Organization (EQRO) in the nation, offering services to 16 different and unique Medicaid agencies with local nuances and needs. HSAG is a subject matter expert in assessing managed long-term services and supports (MLTSS) programs and special needs plans (SNPs) as well as managed care organizations (MCOs). HSAG has the capability to bring to AHCCCS nationwide best practices and lessons learned in more states than any other organization. Moreover, the ability to compare data across similar plan structures and provide benchmarks is a unique resource sought after by many Medicaid agencies. In addition, HSAG is familiar with all Arizona Long Term Care System (ALTCS) MCOs. HSAG has a thorough understanding of the activities that AHCCCS wants addressed, and has included all information necessary to assist AHCCCS in assessing HSAG's abilities, experience, and personnel qualifications. Specifically, the following section highlights HSAG's experience in key components of this project: Assessing Network Adequacy, Survey Development and Administration, and Conducting Compliance and Readiness Reviews.

ASSESSING NETWORK ADEQUACY

For the past 15 years, HSAG has planned, organized, and completed managed care provider network adequacy reviews. The reviews ensure that each MCO has adequate provider networks to deliver healthcare services to its managed care beneficiaries in coverage areas. As a general approach, HSAG uses the following key steps to validate network adequacy:

- Assess the network analysis needs of the State, including a review of existing standards and MCOs' efforts. Based on the State's needs, initial activities may include gap analyses between existing standards and activities relative to the revised federal.
- Develop validation materials (e.g., work plan, methodology, and data collection tools).
- Identify data sources and obtain network information from the MCOs and the State. This includes technical assistance to the MCOs regarding data requirements and data submissions.
- Conduct retrospective and comparative data analyses to validate multiple dimensions of access, including:
  - Network capacity
  - Geographic distribution
  - Availability of services, as appropriate

DEVELOPING AND ADMINISTERING SURVEYS

As an industry leader in measuring the effectiveness of healthcare, HSAG has extensive experience in survey management, instrument design, and report development. In 1995, HSAG began to develop health outcomes expertise with surveys that included patient-reported health status, quality of life, and satisfaction. HSAG quickly became a leader in the field by designing and conducting scientifically sound surveys aimed at assessing member satisfaction and provider satisfaction.

HSAG's extensive expertise with surveys enables it to efficiently and effectively integrate survey results with findings derived from other activities in order to identity relevant impacts to the provider network.

CONDUCTING COMPLIANCE AND READINESS REVIEWS

HSAG has performed compliance monitoring reviews for MCOs in numerous states since 2001. HSAG uses the most recent version of the CMS protocols for conducting EQR compliance reviews (*EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review [EQR]*, Version 2.0, September 2012) to evaluate compliance with federal managed care regulations and select state contract standards related to access, structure and operations, as well as measurement and improvement standards. HSAG's compliance review team members are familiar with each state's contracts with the MCOs and they assist state personnel in achieving the goals outlined in a state's quality strategy. HSAG has proven methods for collaborating with states to design the focus of the review activities and the review process, and to develop the monitoring tools to assess quality and compliance. In several states, HSAG also is responsible for the corrective action plan process and follow-up reviews to ensure MCOs attain and maintain full compliance. Often, HSAG's findings of performance trends and the resulting recommendations are the catalyst to state level policy and contract revisions, statewide improvement initiatives, and technical assistance forums.

CMS requires state Medicaid agencies to provide quality oversight and monitoring of the MCOs' MLTSS providers, and to monitor the quality of services provided to MLTSS recipients. HSAG has conducted readiness reviews, quality oversight, and monitoring for MLTSS services. HSAG develops standardized desk readiness review data collection tools and processes to assess and document MCO compliance in key functional areas of health plan operations related to the delivery of MLTSS services.

The team working on this task order will include staff from Data Science & Advanced Analytics (DSAA) as well as State & Corporate Services (S&CS), who have supported AHCCCS in several activities, including performance measures (PM) calculations, Consumer Assessment of Healthcare Providers and Systems (CAHPS®[1]) survey activities, substance abuse studies, and production of the Annual Technical Report.

[1] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

DATA SCIENCE & ADVANCED ANALYTICS (DSAA)

DSAA consists of six operational areas and staffs an extensive team of analysts, statisticians, clinicians, and data scientists to support HSAG's contracts. With its commitment to the creation of quality products and reports, DSAA is well positioned to assist clients with any analytic need. The team works in collaboration with both internal and external clients to achieve efficient and effective solutions to today's healthcare questions. The following provides an overview of DSAA's teams and capabilities.

1. **Federal Analytics**: provides the data analyses to support the teams' efforts in providing technical assistance, sharing best practices, conducting targeted improvement initiatives, providing patient and provider education services, investigating grievances, supporting policy, determining annual payment updates, and monitoring program performance to thousands of healthcare facilities through several federal CMS contracts.
2. **Hospital Improvement Innovation Network (HIIN)**: collects data and calculates measure rates on behalf of hundreds of hospitals via standardized measures and created a secure web-based portal to allow hospitals to: select the measures they wish to monitor and track; submit measure data via file upload or web forms; and view, analyze, and track measure rates over time via an embedded visual dashboard and comprehensive downloadable reports.
3. **Performance Measures and Surveys**: calculates performance measure rates, creates consumer scorecards that rate plans based on performance, determines performance awards, oversees the administration of CAHPS® surveys, provider surveys, and produces reports assessing patient and provider satisfaction with healthcare services for several state Medicaid agencies.
4. **Advanced Analytics**: consults with several customers to develop novel methodologies that target the customers' questions of effectiveness of programs and policies.
5. **Data Science**: employs data-driven scientific methods to perform a wide variety of activities in support of federal agencies in the implementation, maintenance, and/or evaluation of several policy-driven initiatives.
6. **State Analytics**: provides analytic expertise for HSAG's EQR-related services in 16 states, including assistance with identifying project requirements, defining project methodologies, planning and executing analyses, and preparing final reports.

STATE & CORPORATE SERVICES (S&CS)

As an EQRO, HSAG evaluates MCOs, prepaid inpatient health plans (PIHPs), and Primary Care Case Management (PCCM) entities, as required by the Code of Federal Regulations 42 CFR Part 438, and aggregates information on the timeliness, access, and quality of healthcare services furnished to Medicaid enrollees. HSAG provides EQR-related services in 16 states and serves as the designated EQRO in 15 states. HSAG's quality review services affect more than 33 million Medicaid recipients, or more than 45 percent of the nation's Medicaid population.

With our extensive experience, HSAG is an NCQA HEDIS Certified Survey Vendor and NCQA Licensed Organization (LO) with the capability of conducting certified HEDIS compliance audits. HSAG staffs its EQRO and Medicaid contracts with highly skilled and credentialed professionals such as Certified HEDIS Compliance Auditors (CHCAs), Certified Professionals

in Healthcare Quality (CPHQs), registered nurses (RNs), Master's-prepared social workers (MSWs), statisticians, biostatisticians, and epidemiologists. HSAG also has the capacity to compare a large volume of data and create customized reports that assist states in monitoring their Medicaid programs. HSAG develops a customized strategy for each state that is designed to achieve the state's specific goals and objectives. This customized approach has proven effective in helping HSAG's clients achieve higher quality services in their managed care programs.

The EQR process currently consists of four mandatory activities and five optional activities, in addition to producing an annual EQR technical report and providing technical assistance, as needed. Each of the mandatory and optional activities has a corresponding EQR protocol, which HSAG follows when performing each EQR activity. In addition, HSAG performs the following EQRO activities:

- Performance improvement projects and validation
- Performance measure validation
- Compliance monitoring
- Clinical and non-clinical focused studies
- Technical assistance
- Technical reports
- Network adequacy assessments
- Readiness reviews
- NCQA HEDIS Compliance Audits™
- Pay for Performance (P4P) audits
- Health Insurance Marketplace qualified health plan audits
- Independent waiver assessments
- Medical case review
- Case management review
- Fraud and abuse reviews
- Independent peer reviews
- Quality improvement plan development/review
- Quality strategy development/review
- Utilization management review

Capacity/Availability to Complete Task Order on Schedule

If awarded the task order, HSAG can begin work immediately. HSAG can complete the activities included in the task order by January 2, 2018, assuming that data is provided in accordance with the schedules laid out in the Methodology and Approach section below and the data are of sufficiently high quality and accuracy as to not require extensive preparation and cleaning.

Key Personnel

HSAG has assembled a strong management and analytic team to support this project. Following is an overview of key personnel and their experience. Detailed resumes for all staff members are located in Appendix A.

Paul Niemann, PhD, MA, BS, BA, (Project Director), serves as Associate Director, DSAA, and has more than 9 years of experience in the healthcare industry with expertise in data and cost analysis, risk mitigation, and statistical and impact evaluations relating to Medicare and Medicaid healthcare reform. In his current role at HSAG, Dr. Niemann directs, coordinates, and provides oversight on a number of analytic activities for a wide array of clients. He provides research leadership, analytic expertise, and mentoring to junior level staff. Dr. Niemann acts as an internal and external liaison for analytic activities by planning, executing, and monitoring projects; as well as managing client relations, and providing technical assistance. He develops methodologically sound evaluations/studies to determine the impact of policy and programs on payments and payment reform, member utilization and outcomes, provider behavior, and estimates savings and implementation costs related to healthcare reform. Dr. Niemann is proficient in several statistical evaluation tools including Stata and SAS, and has extensively used administrative claims data as part of designing and implementing impact evaluations.

Prior to joining HSAG in 2016, Dr. Niemann was a senior consultant to Health Management Associates, Inc., in Denver, where he created caseloads and cost estimates for health plans to help them make informed decisions regarding participating in a pilot program for Medicare and Medicaid dual eligibles, as well as researching and developing risk mitigation strategies and performing data analyses. While at the Colorado Department of Health Care Policy and Financing, he was a supervisor in the Budget Division and a rates analyst in the Rate Section, where he developed rates for the State's home- and community-based services (HCBS) programs, including programs for people with intellectual and developmental disabilities (IDD).

Dr. Niemann earned a Doctorate and a Master of Arts in Economics from the University of California at Santa Barbara. He earned a Bachelor of Arts in Economics and a Bachelor of Science in Mathematics from the University of Colorado at Denver. Dr. Niemann has been published in various law and economics reviews.

Kim M. Elliott, PhD, CPHQ, (Project Director, Tasks 5 and 6), serves as Executive Director, HEDIS & PM Audits Team, State & Corporate Services, and has more than 25 years of experience in the healthcare industry with expertise in organizational management, stakeholder relationship development, system improvements, audits and survey, quality management, and performance improvements. Dr. Elliott is a national and local speaker on quality, maternal and child health, and intersection of quality and program integrity topics. She has advanced knowledge of managed care programs, as well as commercial, Medicaid, and Medicare products. In her current role at HSAG, Dr. Elliott directs the HEDIS and PM Audit Team for HSAG's EQRO contracts in various states. She coordinates the internal and external resources to achieve the goals and objectives of the contracts and is responsible for accurate and timely completion of activities and deliverables. Dr. Elliott is responsible for applying NCQA requirements, as well as state and federal Medicaid managed care regulations to daily activities, overall management of audit projects, budgets, and performing financial oversight. She is responsible for providing direction of medical record review and audit processes for validation of HEDIS, CMS Core Measure sets, and state-specific performance measures. Dr. Elliott analyzes data, measures project progress against project requirements, objectives, and success criteria, makes recommendations, and develops strategies and solutions. She also continues to serve as the director of state EQRO contracts, as well as lead various focus study projects.

In her previous role as Director, S&CS, Dr. Elliott provided oversight throughout all stages of the contract including responding to RFPs, project initiation, recruitment selection, orientation, training, staff supervision, client relations, project planning and budgeting, completion of field work, and report preparation and finalization. She was the primary contact, accountable for state and subcontract communications, staffing, and completion of all contracted EQRO activities, provided technical assistance to state Medicaid and managed care plan staff members related to all EQR activities, and provided actionable recommendations, when applicable, on quality improvement strategies.

Prior to joining HSAG in 2016, Dr. Elliott served more than 15 years for the AHCCCS as an administrator and manager of clinical quality management. She led a clinical quality management team of professional and non-professionals consisting of quality management, quality improvement, maternal and child health/early, periodic, screening, diagnostic and treatment, behavioral health quality, and electronic health record incentive project teams for the Medicaid and CHIP programs in Arizona. She led quality and clinical efforts related to acute, long-term care, special needs, behavioral health, foster children, and developmentally disabled populations. Dr. Elliott assumed leadership in the development and implementation of the State's quality strategy in compliance with CMS' requirements, and in alignment with the Agency's strategic plan focused on improving quality of care, member and provider satisfaction, cost effectiveness, and administrative efficiency.

Dr. Elliott earned a Doctor of Philosophy in health sciences from Honolulu University in Hawaii. She earned a Master of Arts in organizational management and a Bachelor of Science in business administration from the University of Phoenix. She is a Certified Professional in Health Care Quality (CPHQ) from the National Association of Health Care Quality, and is a Master Trainer in Chronic Disease Self-Management from Stanford University.

Amy Kearney, BA, serves as Director, DSAA, with more than 26 years of healthcare industry experience with expertise in leadership, mentoring, strategic communication, auditing, and self-motivational techniques. In her current role, Ms. Kearney directs and coordinates analyst work activities related to projects in support of EQRO activities. She provides research leadership, analytic expertise, and mentoring to junior level staff. Ms. Kearney acts as an internal and external liaison for analytic activities by planning, executing, and monitoring projects; supervising staff; managing client relations; and providing technical assistance. She is responsible for maintaining and monitoring company-client relationships and ongoing client satisfaction for assigned contracts. As the administrative lead for the team conducting numerous encounter data validation studies in various states, Ms. Kearney assists in the development and implementation of staff training related to conducting external quality review activities, study design, and execution. She is accountable for ensuring completion of assigned analytic tasks according to contract specifications and ensuring completed tasks meet client and budget requirements. In a prior role as associate director for the Informatics Research and Development Team, Ms. Kearney directed work related to S&CS projects, and as the administrative team lead for numerous encounter data validation activities.

Prior to joining HSAG in 2013, Ms. Kearney held several roles during her 12 years at TriWest Healthcare Alliance, including director, ICD 10/HIPAA, manager of data reporting and analysis, and manager of healthcare data-actuarial services. She worked for more than eight years in reimbursement analyses for Horizon Healthcare, located in Albuquerque, New Mexico.

Ms. Kearney earned a Bachelor of Arts in business administration at the University of New Mexico-Anderson School of Management, located in Albuquerque. She is a certified, licensed Analyst of the Predictive Index® system, a certified TriWest Lean Six Sigma Yellow Belt, and earned a TriWest Project Management Certification.

Brian Starr, MPP, BA, (Tasks 1, 2, 3, and 9), presently serves as Analyst, Data Science & Advanced Analytics (DSAA), with more than 6 years of experience in research and data analysis specializing in SAS programming, workflow procedures, and methods, as well as establishing methodologies. In his current role with HSAG, Mr. Starr's responsibilities include establishing methodologies and analyzing data to obtain meaningful results, reviewing reports for accuracy, and developing production codes for customized, as well as standardized, reoccurring reports. He is responsible for providing analyses on several projects, including the EQRO contract for the state of Ohio. For this EQRO contract, Mr. Starr is responsible for the calculation of 26 performance measures to evaluate the performance of the Ohio Medicaid Health Homes initiative. Further, Mr. Starr is responsible for the calculation, and reporting of clinical and access performance measures for the Aged, Blind or Disabled (ABD), and Covered Families and Children (CFC) populations for the state of Ohio.

Prior to joining HSAG in 2014, Mr. Starr held the positions of senior associate and research analyst for the Global Economics Group, where he managed and conducted complex economic and statistical analysis for use in class action securities litigation on the plaintiffs' behalf. He also trained new research analysts in SAS programming, workflow procedures, and research methods. His work as lead economist served the Cook County Health & Hospital System with the analytical and economic framework to better quantify healthcare costs and expenditures at the patient level, utilizing extensive and thorough patient care data. Mr. Starr developed SAS programs to compute economic damages from possible liber manipulation on thousands of corporate and municipal bond holdings over a period of more than four years.

Mr. Starr earned a Master of Public Policy from the School of Public Affairs, Arizona State University, located in Tempe, Arizona. He earned a Bachelor of Arts in economics, cum laude, from Knox College in Galesburg, Illinois.

Cindy Strickland, JD, (Task 4), serves as Senior Research Analyst, DSAA, and has more than 4 years of experience in the healthcare industry with expertise as a former private practice attorney with extensive experience in research strategies, oversight of focus groups, and statutory, regulatory, and contract analysis. She has a strong understanding of public health, and medical and healthcare policy issues. In her current role at HSAG, Ms. Strickland performs research, review, and writing in support of HSAG's contract for the Agency for Healthcare Research and Quality (AHRQ) Patient Safety Organization Privacy Protection Center (PSOPPC). She aids in development of the Common Formats for Community Pharmacy Version 1.0, and the update of the Common Formats Hospital Version 2.0, participating in preparation of support documentation including event descriptions, specifications for patient safety aggregate reports, delineation of data elements to be collected for various types of events, creation of flowcharts and documenting technical specifications for submission and reporting of Patient Safety Event data. Ms. Strickland was responsible for evaluation and reporting related to Task 3, the Leading Edge Advanced Practice Topics (LEAPT) program, part of the Partnership for Patients (PfP) Evaluation contract for the Centers for Medicare & Medicaid Services (CMS). She was also partially responsible for research and analysis on the American Recovery and

Reinvestment Act, Health Information Technology for Economic and Clinical Health (ARRA HITECH) Hospital eMeasures contract.

Prior to joining HSAG in 2012, Ms. Strickland served as lead counsel and staff attorney for 18 years, working on a variety of cases such as medical malpractice, product liability, toxic tort, and commercial tort. She worked closely with healthcare providers to evaluate clients' past treatment, future needs, and insurance issues. She is familiar with state agencies and programs including AHCCCS ALTCS, and Division of Developmental Disabilities (DDD), and the operation and regulation of nursing homes, hospitals and other healthcare providers.

Ms. Strickland earned a Juris Doctor, *cum laude*, and a Bachelor of Science in anthropology, *summa cum laude*, from Arizona State University, located in Tempe, Arizona.

Mary Wiley, MEd, BSW, RN, (Tasks 5 and 6), serves as Project Director, State & Corporate Services, and has more than 39 years of experience in the healthcare industry as a registered nurse (RN) in a variety of clinical and government settings with expertise in project management, contract management, quality improvement, utilization management, strategic planning, and oversight of regulatory activities. In her current role at HSAG, Ms. Wiley provides oversight and project management support for HSAG's EQRO contracts and other projects as assigned. She serves as the contract manager for the Florida and Arizona EQRO contracts, and coordinates activities for both states in the areas of performance improvement projects, performance measure validation, compliance reviews, and technical reports. In addition, Ms. Wiley conducts quarterly meetings that enhance the managed care plans' knowledge of EQRO activities, as well as encounter data validation and focused studies in Florida. She has served as a compliance review auditor for the state of Utah. Previously, Ms. Wiley was director, professional services, managing stakeholder activities for the California QIO; including the California Department of Public Health (CDPH), Medi-Cal, California Culture Change Coalition, California Association of Health Facilities, LeadingAge, California Department of Aging, and the California Association of Long Term Care Medical Directors. She co-led the Partnership to Improve Dementia Care initiative, sponsored by CMS, to decrease the use of unnecessary antipsychotics and implement resident-centered care in Arizona nursing homes.

Prior to joining HSAG in 2012, Ms. Wiley worked for the Arizona Department of Health Services for more than 19 years where she was responsible for the oversight and management of the survey and certification program for all healthcare and child care facilities. She also held the position of director of quality resource management for the Arizona State Hospital managing programs that included performance improvement, utilization review, risk management, and safety programs; contract monitoring; health records and information management system departments. She coordinated all accrediting and licensing activities, including Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and Medicare surveys.

Ms. Wiley earned a Master of Education from Northern Arizona University in Flagstaff; a Bachelor of Social Work from Arizona State University in Tempe; and an Associate of Arts in Nursing from Mesa Community College, also in Arizona. She is certified in the Accelerated Leadership Development Program and Advanced Interviewing; and is a National Certified Investigator/Inspector (NCIT).

Methodology and Approach

The analysis described below is intended to provide a review of the impact to the AHCCCS long-term care system provider network (including those providers contracted with DDD) from the enactment of Proposition 206, in order to ensure AHCCCS members' access to healthcare services. The following services will be included in each phase of the analysis: Nursing Facility and HCB services. HCB services include the following: Attendant Care; Personal Care; Homemaker; Respite; Habilitation and Assisted Living and DDD Group Homes; and Day Treatment and Training and Adult Day Health; and Center Based and Group Supportive Employment Programs. Analysis and projections will be performed by the Healthcare Common Procedure Coding System (HCPCS) service codes, managed care organization, and geographic areas of the state. The geographic areas of the state are defined as the following Geographical Service Areas (GSA):

- GSA 1 – Mohave, Coconino, Navajo, Apache, Yavapai
- GSA 2 – Maricopa, Gila, Pinal
- GSA 3 – La Paz, Yuma, Pima, Santa Cruz, Graham, Cochise, Greenlee

TASK 1 – PROVIDER SURVEY

HSAG is cognizant of the urgency of this activity's timeline considering the report delivery to legislature on February 2, 2018. To maximize efficiency and encourage maximum participation, HSAG is proposing to conduct the provider survey using Survey Monkey, as opposed to a traditional mail or phone survey. Providers will be contacted by email two weeks prior to the opening of the survey to let them know the purpose of the survey and when the survey will be released. A second email will be sent to providers inviting them to participate in the survey and contain a link to the survey on Survey Monkey. To minimize skipped questions and increase the completion rate, the invitation to participate in the survey will include a copy of the survey in the email to allow the provider to look at questions and gather data before signing on to Survey Monkey to complete the online survey.

Based on its previous experience with provider surveys, HSAG typically allows the survey to be open for at least one month. Given the abbreviated schedule necessary for this survey, HSAG would recommend the survey be open for three weeks. HSAG will make efforts to maximize the response rate by sending out notifications prior to survey administration and increase communication frequency.

To meet the expectation of stratifying survey results by provider type while ensuring a sufficient sample size, HSAG recommends that all providers be included in the survey. This is due to the fact that the smaller the population to be surveyed, the larger the sample size must be as a proportion of the total population to obtain a given level of statistical significance. This means that when the population size is less than approximately 1,500, 95% statistical significance requires sample sizes of at least 20% of the total population. Given that survey fielding will need to be less than one month, HSAG recommends that all providers of each provider type be included in the survey. For the few provider types with more than 1,500 providers, the additional survey will only improve the sample size and improve the statistical significance of the results.

Additionally, it is important to recognize that there is a probability of significant response bias when surveying providers about impacts from changes in public policy. Providers who have been, or believe they will be, negatively impacted by Proposition 206 are more likely to respond to the survey. Under normal circumstances, this is controlled using random sampling and the use of incentives to encourage even participation. However, under a voluntary survey with no financial incentive for participation, the results and projections from the survey will be presented as upper bound estimates of the impact of Proposition 206.

The survey will be designed to capture a wide range of information pertaining to the impact of Proposition 206. This will allow for a detailed picture of provider cost structures and other characteristics. This, in combination with the implementation schedule of Proposition 206, will allow for a projection of future impacts resulting from Proposition 206.

The proposed schedule of primary activities is presented below.

Task and Sub-Task/Description	Start Date	End Date
Study Planning		
Identify Providers and Provider Groups and Obtain Provider Email Addresses from AHCCCS	10/06/2017	10/11/2017
Develop Survey Instrument and Submit to AHCCCS	10/06/2017	10/13/2017
Send Preliminary Email Announcing Forthcoming Survey	10/11/2017	10/13/2017
AHCCCS Provides Feedback on Survey Instrument	10/13/2017	10/15/2017
Finalize Survey Instrument	10/18/2017	10/20/2017
Load Survey Instrument into Survey Monkey and Conduct Testing	10/23/2017	10/27/2017
Data Collection & Analysis		
Send Survey Invitation Email	10/30/2017	10/30/2017
Survey Open	10/30/2017	11/17/2017
Download Data and Conduct Analysis	11/27/2017	12/01/2017
Reporting		
Prepare Survey Results Section of the Comprehensive Network Report	12/04/2017	12/15/2017
Compile Comprehensive Network Report	12/18/2017	12/22/2017
Submit Final Comprehensive Network Report to AHCCCS	01/02/2018	01/02/2018

TASK 2 – ANALYSIS OF NON-PROVISION OF SERVICE REPORT

The first phase of this task will consist of an analysis of the non-provision of service rate as a fraction of units of service provided by type of provider. This measure will be calculated for 2014–2016 as well as for the first six months of 2017.

Analysis of the impact of Proposition 206 will be based on dates of services in the first six months of 2017. HSAG assumes that it will have access to claims and encounter data through September 2017. This will provide a three-month runout for services provided through June 2017. Failure to consider runout would lead to results that overstate any impact of Proposition 206 by undercounting the units of service provided. HSAG understands that it takes at least six months after the date of service for all claims to be available. However, HSAG believes that enough claims will be available with a three-month runout for a valid analysis. If a six-month runout were used, the analysis would be limited to only three months of Proposition 206 impact, likely eliminating any observable impacts.

In the second phase, HSAG will conduct an analysis of the providers who appear to have been most impacted by Proposition 206 based on the first phase of the analysis. The purpose of the second phase is to identify common characteristics of impacted providers. Characteristics may include provider type, geographic location, as well as provider size, as measured by number of units of service or total reimbursement.

Task and Sub-Task/Description	Start Date	End Date
Data Collection and Data Preparation		
Obtain Claims and Encounter Data for 01/2014 through 09/2017 from AHCCCS	10/06/2017	10/11/2017
Obtain Non-provision of Service Reports for 01/2014 through 06/2017 from AHCCCS	10/06/2017	10/11/2017
Generate Statewide and Provider-specific Data from Claims/Encounter Data and Provider File Data	10/12/2017	11/03/2017
Calculate Annualized Non-provision of Service Rate for Each Service and Identify Impacted Providers	11/06/2017	11/10/2017
Data Analysis		
Conduct Analysis of Characteristics of Impacted Providers	11/13/2017	12/01/2017
Reporting		
Prepare Non-provision of Service Section of the Comprehensive Network Report	12/04/2017	12/15/2017
Compile Comprehensive Network Report	12/18/2017	12/22/2017
Submit Final Comprehensive Network Report to AHCCCS	01/02/2018	01/02/2018

TASK 3 – ANALYSIS OF PROVIDERS REDUCING SERVICES OR TERMINATING CONTRACTS

The approach for Task 3 is similar to that for Task 2. In the first phase, HSAG will calculate the service-reduction rate as the number of providers that have made a reduction in service provision or termination divided by the number of providers for each type of provider. This measure will be calculated for 2014–2016 as well as for the first six months of 2017. Similar to Task 2, the analysis of the impact of Proposition 206 will be based on dates of services in the first six months of 2017, assuming HSAG will have access to claims and encounter data through September 2017.

Using the results of the first phase analysis, HSAG will conduct an analysis of providers who appear to have been most impacted by Proposition 206. The purpose of this second phase is to identify common characteristics of impacted providers. Characteristics may include provider type, geographic location, as well as provider size, as measured by number of units of service or total reimbursement. These characteristics will allow AHCCCS to identify providers who are at greater risk of reducing services provided or terminating contracts.

Task and Sub-Task/Description	Start Date	End Date
Data Collection and Data Preparation		
Obtain Claims and Encounter Data for 01/2014 through 09/2017 from AHCCCS	10/06/2017	10/11/2017
Obtain Service Reduction Data from AHCCCS for 01/2014 through 06/2017	10/06/2017	10/11/2017
Generate Statewide and Provider-specific Data from Claims/Encounter Data and Provider File Data	10/12/2017	11/03/2017
Calculate Annualized Service-reduction rate for Each Service and Identify Impacted Providers	11/06/2017	11/10/2017
Data Analysis		
Conduct Analysis of Characteristics of Impacted Providers	11/13/2017	12/01/2017
Reporting		
Prepare Service-reduction Section of the Comprehensive Network Report	12/04/2017	12/15/2017
Compile Comprehensive Network Report	12/18/2017	12/22/2017
Submit Final Comprehensive Network Report to AHCCCS	01/02/2018	01/02/2018

TASK 4 – FOCUS GROUP

HSAG will host a focus group at its headquarters in Phoenix with ALTCS MCOs, including DDD, to identify issues and/or challenges with access and availability of services, member choice and member satisfaction including time between the identification of a service need and the member receiving the needed service.

Questions and discussion topics will be developed by HSAG experts in MLTSS and the ALTCS population including persons with developmental disabilities, persons with physical disabilities and the elderly. The focus group will be led by HSAG staff with extensive experience with focus groups. To maximize participation, HSAG suggests that the focus group be conducted before the holiday season, which starts Thanksgiving week.

Task and Sub-Task/Description	Start Date	End Date
Planning		
Work with AHCCCS to Identify Focus Group Participants	10/06/2017	10/11/2017
Coordinate with Invitees to Schedule Meeting	10/11/2017	10/17/2017
Prepare Questions and Topics for Discussion in Conjunction with AHCCCS	10/06/2017	10/30/2017
Prepare Materials	10/31/2017	11/03/2017
Focus Group & Analysis		
Conduct Focus Group	11/06/2017	11/17/2017
Conduct Analysis of Focus Group Results	11/27/2017	12/01/2017
Reporting		
Prepare Non-Provision of Service Section of the Comprehensive Network Report	12/04/2017	12/15/2017
Compile Comprehensive Network Report	12/18/2017	12/22/2017
Submit Final Comprehensive Network Report to AHCCCS	01/02/2018	01/02/2018

TASK 5 – REVIEW & ANALYSIS OF PROVIDER CONTRACTING POLICIES AND PRACTICES

HSAG's subject matter experts will review the ALTCS MCOs' policies and practices, and DDD's policies related to provider contracting to determine to what extent the contractors' current policies ensure the availability of a sufficient network of contracted providers to meet the needs of individuals enrolled with the contractor and ensure they are compliant with AHCCCS network requirements. HSAG will also review contractor policies that support contractor operational processes for identification of gaps in services or adverse outcomes to identify methods used by the contractor to self-identify and implement interventions regarding network sufficiency and capacity. ALTCS contractor provider network policies and practices will be reviewed to determine whether the documents support the contractors' ability to serve the future projected growth of the aging population. HSAG may also review contractor policies and practices related to the self-directed ALTCS population.

HSAG will develop an audit tool to create a standard approach to review each contractors' and DDD's policies and practices. The audit tool will define the scope of the review, the required documentation ALTCS contractors must submit, and the timeline for submission. HSAG will submit the documentation request to the AHCCCS contractors and notify them of the HSAG secure file transfer protocol (SFTP) site where the documentation can be loaded.

HSAG will initiate the document review process once the required documentation is received from AHCCCS contractors. HSAG staff with expertise in the following areas will perform the review: the ALTCS program; contractors' ALTCS policies and practices; the ALTCS population including persons with developmental and intellectual disabilities, persons with physical disabilities and the elderly; MLTSS requirements; and ALTCS provider network standards. The results will receive a secondary review to ensure accuracy, completeness, and a consensus of the participating subject matter experts.

The results of the review and analysis will be documented in a written report and include recommendations for any appropriate changes to the ALTCS contractors' and DDD's policies and practices. The report will include strategies/methodologies for establishing additional network standards that result in the identification, evaluation, and implementation of interventions to address current and projected workforce capacity, deficiencies, and needs. The report will indicate whether the AHCCCS contractor policies and practices addressed identified gaps in the availability of nursing facility or HCB services, decreases in the quality of those services, reduction in available providers, or lack of community placements or services resulting in members who could be served in the community being placed in nursing facilities. The analysis, when appropriate, will include the impacts by provider type, as well as delineate the GSA.

Task and Sub-Task/Description	Start Date	End Date
Planning		
Develop Audit Tool and Documentation Requirements	10/06/2017	10/13/2017
Request Required Documentation from ALTCS Contractors	10/13/2017	10/13/2017
Receive Required Documentation from ALTCS Contractors	10/27/2017	10/27/2017
Review & Analysis		
Conduct Reviews of ALTCS Contractors' and DDD's Provider Contacting Policies and Practices	11/06/2017	12/01/2017
Reporting		
Prepare Policy and Practices Section of the Comprehensive Network Report	12/04/2017	12/15/2017
Compile Comprehensive Network Report	12/18/2017	12/22/2017
Submit Comprehensive Network Report to AHCCCS	01/02/2018	01/02/2018

TASK 6 –REVIEW & ANALYSIS OF NETWORK MANAGEMENT AND DEVELOPMENT PLANS

The process for the review and analysis of ALTCS contractors' Network Management and Development Plan will follow a similar process as was used for the review and analysis of ALTCS contractors' policies and practices related to provider contracting described in the previous section.

HSAG's subject matter experts will review the ALTCS contractors' and DDD's Network Management and Development Plans to determine to what extent the current Plans may hinder network adequacy in the new environment created by Proposition 206. The review and analysis will result in recommendations for changes in the MCOs' Network Management and Development Plans that may enhance network adequacy in the higher-wage environment created by implementation of Proposition 206. The review will be targeted at those elements of the contractors' Network Management and Development Plans that may be impacted by the market changes resulting from the new increases in minimum wages and sick leave requirements.

HSAG will also review ALTCS contractors' Network Management and Development Plans for processes to address gaps in services or adverse outcomes and the methodologies used by the contractor to implement interventions regarding network sufficiency and capacity. The ALTCS contractor Network Management and Development Plans will be reviewed to determine whether it supports the contractor's ability to serve the future projected growth of the aging population.

HSAG will develop an audit tool to create a standard approach to review each MCO's and DDD's Network Management and Development Plan. The audit tool will define the scope of the review, the required documentation ALTCS contractors must submit, and the timeline for submission. HSAG will submit the documentation request to the AHCCCS contractors and notify them of the HSAG secure FTP site where the documentation can be loaded.

HSAG will initiate the document review process once the required documentation is received from ALTCS contractors. HSAG staff with expertise in the following areas will perform the review: the ALTCS program; contractors' ALTCS policies and practices; the ALTCS population including persons with developmental and intellectual disabilities, persons with physical disabilities and the elderly; MLTSS requirements; and ALTCS provider network standards. The review results will receive a secondary review to ensure accuracy, completeness, and a consensus of the participating subject matter experts.

The results of the review and analysis will be documented in a written report and include recommendations for any appropriate changes to the ALTCS contractors' and DDD's Network Management and Development Plans. The report will include strategies/methodologies for establishing additional network standards that result in the identification, evaluation, and implementation of interventions to address current and projected workforce capacity, deficiencies, and needs. The report will indicate whether the contractors' and DDD's Network Management and Development Plans describe processes to address: identified gaps in the availability of nursing facility or HCB services; decreases in the quality of those services; reduction in available providers; lack of community placements or services that could result in members who could be served in the community being placed in nursing facilities. The analysis, when appropriate, will include the impacts by provider type, as well as delineate by GSA.

Task and Sub-Task/Description	Start Date	End Date
Planning		
Develop of Audit Tool and Documentation Requirements	10/06/2017	10/13/2017
Request Required Documentation from ALTCS Contractors	10/13/2017	10/13/2017
Receive Required Documentation from ALTCS Contractors	10/27/2017	10/27/2017
Review & Analysis		
Conduct Reviews of ALTCS MCOs' Network Management and Development Plan	11/06/2017	12/01/2017
Reporting		
Prepare Network Management and Development Plan Section of the Comprehensive Network Report	12/04/2017	12/15/2017
Compile Comprehensive Network Report	12/18/2017	12/22/2017
Submit Comprehensive Network Report to AHCCCS	01/02/2018	01/02/2018

TASK 7 – REVIEW & ANALYSIS OF NETWORK STANDARDS

HSAG will review and analyze the AHCCCS policy regarding network standards, including a review of current standards for Nursing Facility and HCB services. This review will include evaluating AHCCCS policies and current health plan contracts. HSAG will collaborate with AHCCCS to define priority network standards and access-related requirements, which typically fall into four categories:

1. Time and distance standards
2. Timely access standards, such as appointment availability
3. Provider-to-member ratios
4. Other access related standards, such as those related to cultural or physical accessibility

HSAG will focus on reviewing standards for the provider types that may have resulted in a deficiency due to Proposition 206, including Nursing Facilities and the following HCB services:

- Attendant Care
- Personal Care
- Homemaker
- Respite
- Habilitation and Assisted Living and DDD Group Homes
- Day Treatment and Training and Adult Day Health
- Center Based and Group Supportive Employment Programs

HSAG's review will also include an evaluation of current standards, a peer state review to identify standards in other states, and recommendations to monitor network adequacy in light of Proposition 206 and the changing provider networks.

Peer State Network Standards Assessment

HSAG will conduct a review of network standards in other states to guide the proposal of network adequacy standards for AHCCCS' health plans. Specifically, HSAG will conduct a peer state review and assess network and access standards in up to three comparable states. HSAG will select the states to be included in the peer state survey based on the following criteria:

1. States that currently have network standards for nursing facilities and HCB providers
2. States within the same region of the United States
3. States with approximately the same population size as Arizona
4. States with urbanicity patterns similar to Arizona (i.e., the geographic distribution of urban and rural populations within the state)

HSAG will leverage its connections as an EQRO to identify appropriate contacts within each peer state and request documentation on provider network standards. HSAG will compare network standards across the peer states, synthesizing the results to compare Arizona's network standards with the peer states.

Upon completion of the peer state review, HSAG will summarize AHCCCS' network standards related to nursing facilities, including highlighting areas where AHCCCS' network standards align with other states, are more or less stringent than other states, and areas where AHCCCS may want to consider adopting network standards to continue to monitor network adequacy as the minimum wage continues to increase per Proposition 206.

Task and Sub-Task/Description	Start Date	End Date
Study Planning		
Draft and Submit Brief Methodology and Timeline to AHCCCS	10/06/2017	10/13/2017
Review Methodology and Timeline; Provide Feedback to HSAG	10/13/2017	10/16/2017
Incorporate Feedback, Review and Submit Final Methodology to AHCCCS	10/17/2017	10/20/2017
Data Collection & Analysis		
Submit Network Standards Documentation to HSAG	10/02/2017	10/11/2017
Select Peer States and Obtain Network Standards Documentation	10/16/2017	10/30/2017
Analyze AHCCCS and Peer State Network Standards	10/31/2017	11/29/2017
Reporting		
Prepare Network Standards Section of the Comprehensive Report	11/30/2017	12/15/2017
Compile Comprehensive Network Report	12/18/2017	12/22/2017
Submit Final Comprehensive Network Report to AHCCCS	01/02/2018	01/02/2018

TASK 8 – REVIEW AND CONSIDERATION OF ANNUAL TITLE XIX RATE REIMBURSEMENT STUDY

HSAG has performed a preliminary review of the Annual Title XIX Rate Reimbursement Study conducted by DDD. The result that fewer providers are providing more services to more people suggests that there may be economies of scale in the market for DD-related services. This may be a result of the flexibility that larger providers may have to shift costs. As a result, HSAG is proposing analyses that will look at provider characteristics, including size, to test this hypothesis across different provider types and to determine if there is a differential impact that depends on provider size. HSAG will continue to review the results of the Annual Title XIX Rate Reimbursement Study conducted by DDD when developing analyses based on provider characteristics. This will provide a fine-tuned picture of the impact of Proposition 206 across several provider characteristics. HSAG will complete its review of the Annual Title XIX Rate Reimbursement Study conducted by DDD by October 13, 2017.

TASK 9 – ADDITIONAL CLAIMS & ENCOUNTER METRIC OR MEASURES (AS NEEDED)

HSAG will be using the claims and encounter data from January 2014 through September 2017 to calculate both the non-provision of service rate and the service-reduction rate, as described above. HSAG will also use the claims and encounter data to generate provider size data to combine with elements of the provider data file to create a portrait of each provider to be incorporated into in the analysis.

Additional metrics or measures such as provider or service density may be calculated from the claims and encounter data based on the results of reviewing the Annual Title XIX Rate Reimbursement Study conducted by DDD or the results of other analyses.

METHODOLOGIES AND APPROACH – DELIVERABLES

Once the reviews and analyses in each task have been completed and validated, the results and methods will be written up. The narrative for each task will be combined into a single Comprehensive Network Report and delivered to AHCCCS no later than January 2, 2018. The Comprehensive Network Report will contain an executive summary for quick review of the significant results of the analysis. The report will also include recommendations for changes that may be considered to minimize the impact of Proposition 206 on provider network adequacy. Along with the results of the analyses, the report will also present complete descriptions of the methods used in the reviews and analyses.

The methods and approaches described above provide a balanced approach that combines technical review by subject matter experts combined with data analytical methods. This approach will provide a thorough and rigorous analysis of the impact of Proposition 206 on provider network adequacy within the required time frame.

PRICING PROPOSAL

Provide an all-inclusive overall project price for performance of the services listed. Pricing shall be broken down by job category and hourly rate as described in the contract. Pricing shall be inclusive of travel and any other expense necessary to perform the service.

Pricing Proposal			
Job Category	**Hourly Rate**	**Hours**	**Total**
Project Manager	$ 125.00	194	$ 24,250
Analyst	$ 104.00	398	$ 41,392
Project Coordinator	$ 72.00	134	$ 9,648
Senior Analyst	$ 137.00	203	$ 27,811
Senior Consultant	$ 187.00	35	$ 6,545
Statistician/Data Analysis	$ 99.00	42	$ 4,158
Staff Consultant	$ 138.00	460	$ 63,480
Technical Writer	$ 92.00	18	$ 1,656
Total		**1,484**	**$ 178,940**

Appendix A – Resumes for Key Personnel

HSAG HEALTH SERVICES ADVISORY GROUP

Paul Niemann, PhD, MA, BS, BA
Associate Director, Data Science & Advanced Analytics

Personal Information

Health Services Advisory Group, Inc.
3133 East Camelback Road, Suite 100
Phoenix, Arizona 85016
602.801.6845
pniemann@hsag.com

Qualification Highlights

Dr. Niemann has more than 9 years of experience in the healthcare industry with expertise in data and cost analysis, risk mitigation, and statistical and impact evaluations relating to Medicare and Medicaid healthcare reform.

Relevant Experience

Health Services Advisory Group, Inc. (HSAG), Associate Director, Data Science & Advanced Analytics (DSAA): Dr. Niemann directs, coordinates, and provides oversight on a number of analytic activities for a wide array of clients. He provides research leadership, analytic expertise, and mentoring to junior level staff. Dr. Niemann acts as an internal and external liaison for analytic activities by planning, executing, and monitoring projects; as well as managing client relations, and providing technical assistance. He develops methodologically sound evaluations/ studies to determine the impact of policy and programs on payments and payment reform, member utilization and outcomes, provider behavior, and estimates savings and implementation costs related to healthcare reform. Dr. Niemann is proficient in several statistical evaluation tools including Stata and SAS, and has extensively used administrative claims data as part of designing and implementing impact evaluations.

Health Management Associates, Inc., Senior Consultant:
Dr. Niemann created caseloads and cost estimates for health plans to influence decision in participating in a pilot program for Medicare and Medicaid dual eligibles. He developed estimates of impact to the Colorado calculated upper payment limit resulting from a Medicaid payment reform proposal. Dr. Niemann researched and developed risk mitigation strategies, performed data analysis based on technical economic and statistical models, and provided regular reports for a state hospital association for the distribution of payments and collection of assessments totaling over $100 million. He drafted and managed several funded project proposals. Dr. Niemann performed data and statistical analysis for the implementation of a new rate structure for statewide home and community-based services waiver for persons with intellectual and developmental disabilities. He developed a statistical model of provider behavior under risk adjusted home health rate structure, and also performed financial and utilization impact analysis and evaluation for a Medicaid home health model using Medicaid

claims data. Dr. Niemann performed claims data-based statistical evaluation of a case management pilot program based on claims, encounter, and medical record data. Additionally, he conducted evaluations of new programs to estimate impact on service utilization and costs on the basis of client characteristics such as chronic health conditions.

Colorado Department of Health Care Policy and Financing, Supervisor, Budget Division: Dr. Niemann developed a model to recover approximately $3 million in misapplied federal funding and ensured compliance with all state and federal statutes. He researched and/or assigned Joint Budget Committee and Governor's Office of State Planning and Budgeting questions regarding the department's budget and programs. Dr. Niemann oversaw the development and production of reports that guide senior department leadership in its discretionary spending. He developed estimates and wrote narrative defense for several departmental budget requests.

Colorado Department of Health Care Policy and Financing, Rates Analyst, Rates Section: Dr. Niemann reviewed a variety of home- and community-based services (HCBS) rates to ensure compliance with state and federal regulations. He provided technical oversight for statistical analysis of nursing facility enrollment for Program of All-Inclusive Care for the Elderly (PACE) enrollees. Dr. Niemann reviewed new provider rates for the Children's Habilitation Residential Program Waiver (CHRP), based on unaudited provider cost data, ensuring reasonableness and inclusion of all allowable costs. He provided guidance for future development of CHRP rates, and analyzed and developed recommendations regarding fiscal soundness monitoring of providers for the PACE. Dr. Niemann led the implementation of telehealth rates for home health and HCBS programs. In addition, he developed economic analysis and complex Excel models highlighting adverse-selection danger and resulting budgetary impacts of capitated telehealth rates.

Professional History

HSAG, Phoenix, Arizona: Associate Director, DSAA; 9/16–Present

Health Management Associates, Inc., Denver, Colorado: Senior Consultant; 10/12–8/16

Colorado Department of Health Care Policy and Financing, Denver, Colorado: Supervisor, Budget Division; (10/07–10/12); Rates Analyst, Rates Section (12/06–10/07); 12/07–10/12

Education

Doctorate, Economics, University of California, Santa Barbara, California, 2006

	Master of Arts, Economics, University of California, Santa Barbara, California, 2001
	Bachelor of Arts, with distinction, Economics, University of Colorado, Denver, Colorado, 2000
	Bachelor of Science, with distinction, Mathematics, May 2000, University of Colorado, Denver, Colorado, 2000
Technical Experience	Proficient with STATA, RATS, Mathematica, MATLAB, LATEX, MS Word, MS Excel, MS Access, SQL, MS Outlook, and MS PowerPoint. Basic knowledge of R and Visual Basic.
Licenses, Certifications, Professional Organizations, and Publications	***Publications***
	"Compensation for Taking When Both Equity and Efficiency Matter," with Perry Shapiro, in Property Rights: Eminent Domain and Regulatory Takings Re-Examined, (2010), edited by Bruce L. Benson, Palgrave Macmillan, New York.
	"Efficiency and Fairness: Compensation for Takings," with Perry Shapiro, International Review of Law and Economics 28 (2008), pp. 157-165.
	"Equity Effects of Alternative Assignments of Global Environmental Rights," with Stephen J. DeCanio, Ecological Economics 56 (2006), pp. 546-559.

Kim M. Elliott, PhD, CPHQ
Executive Director, HEDIS & PM Audits Team, State & Corporate Services

Personal Information

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Qualification Highlights

Dr. Elliott has more than 25 years of experience in the healthcare industry with expertise in organizational management, stakeholder relationship development, system improvements, audits and survey, quality management, and performance improvements. She is a national and local speaker on quality, maternal and child health, and intersection of quality and program integrity topics. Dr. Elliott has advanced knowledge of managed care programs, as well as commercial, Medicaid, and Medicare products.

Relevant Experience

Health Services Advisory Group, Inc. (HSAG), Executive Director, HEDIS & PM Audits Team, State & Corporate Services (S&CS): Dr. Elliott directs the HEDIS and Performance Measure (PM) Audit Team for HSAG's external quality review organization (EQRO) contracts in various states. She coordinates the internal and external resources to achieve the goals and objectives of the contracts and is responsible for accurate and timely completion of activities and deliverables. Dr. Elliott is responsible for applying NCQA requirements, as well as state and federal Medicaid managed care regulations to daily activities, overall management of audit projects, budgets, and performing financial oversight. She is responsible for providing direction of medical record review and audit processes for validation of HEDIS, CMS Core Measure sets, and state-specific performance measures. Dr. Elliott analyzes data, measures project progress against project requirements, objectives, and success criteria, makes recommendations, and develops strategies and solutions. She also continues to serve as the Director of State EQRO contracts as well as lead various focus study projects.

HSAG, Director, S&CS: Dr. Elliott served as a director and overseer of the EQRO contracts in various states and coordinated internal and external resources to achieve contract goals and objectives. She provided oversight throughout all stages of the contract including responding to RFPs, project initiation, recruitment selection, orientation, training, staff supervision, client relations, project planning and budgeting, completion of field work, and report preparation and finalization. As the primary contact, Dr. Elliott was accountable for state and subcontract communications, staffing, and completion of all

contracted EQRO activities. Additionally, Dr. Elliott provided technical assistance to state Medicaid and managed care plan staff members related to all EQR activities, and provides actionable recommendations, when applicable, on quality improvement strategies.

Arizona Health Care Cost Containment System (AHCCCS), Administrator, Clinical Quality Management: Dr. Elliott led the Clinical Quality Management team (34 professional and non-professional staff) consisting of quality management, quality improvement, maternal and child health/early, periodic, screening, diagnostic and treatment, behavioral health quality, and electronic health record incentive project teams for the Medicaid and CHIP Program (AHCCCS) in Arizona. She led quality and clinical efforts related to acute, long-term care, special needs, behavioral health, foster children, and developmentally disabled populations. Dr. Elliott assumed leadership in the development and implementation of the State's quality strategy in compliance with the Centers for Medicare and Medicare Services (CMS) requirements, and in alignment with the Agency's strategic plan focused on improving quality of care, member and provider satisfaction, cost effectiveness, and administrative efficiency. She led federal, state and legislative reporting related to quality activities and performance metrics. Dr. Elliott led the quality management, quality improvement, and maternal and child health teams as well as the Medical Management area, to maintain clinical policies according to the standard of care and in compliance with federal and state requirements and in accordance with the Arizona Waiver and the Arizona State Plan. She recommended and led the transition of quality and performance metrics from a process driven set, to outcomes measures that include measures required by CMS, those required to evaluate the effectiveness of program integration and measures that are meaningful to all lines of business in the Medicaid program. Dr. Elliott led the development and implementation of performance improvement projects that led to improved care, outcomes, administrative and cost efficiencies. She developed and implemented a quality management program that focused on individual and systemic issues, improved care and services throughout the system of care, addressed care needed today and challenging member needs, and improved processes for health and safety in emergency situations. Dr. Elliott developed the first medical management/utilization management policies for the AHCCCS managed care program. Additionally, she represented the Agency at the federal, state and local level, including work with community organizations, other state agencies, federal programs, and stakeholder groups with a focus on aligning and achieving positive outcomes in a win-win environment. Dr. Elliott served on federal subject matter expert panels including those focused on CMS Core Measure sets, access to care, upper respiratory and critical care and long-term care.

Arizona Physicians IPA (now United Healthcare), Director, Prevention and Wellness; Manager, Prevention and Wellness; Project Manager/Systems Operations Manager: Dr. Elliott was responsible for meeting state and federal requirements for an acute care, long-term care, and developmentally disabled population. She provided leadership, direction, and management of the quality management, prevention and wellness, maternal and child health, and behavioral health programs for the acute, long-term care, developmentally disabled, CHIP healthcare group, and children with special healthcare needs (CSHCN) programs. Dr. Elliott developed, managed, and implemented quality metrics including HEDIS quality measures, Medicaid measures, audits, studies, and report cards. As project manager she led the National Committee for Quality Assurance accreditation processes related to quality and disease management, and was responsible for annual HEDIS audits. Dr. Elliott developed and implemented care coordination and disease management programs for chronic conditions including diabetes, asthma, hypertension, and congestive heart failure. She led quality review, peer review, and compliance review teams to meet federal/state requirements, and she was selected by United Corporate to train United Healthcare state Medicaid programs nationwide on the development and implementation of preventive health programs, outreach programs, EPSDT requirements, and the development of corrective actions plans.

CIGNA Health Care, Provider Relations and Contracting Representative: Dr. Elliott was responsible for developing and growing a successful provider relations and contracting area in a new private practice model for a traditionally facility-based managed care organization. She successfully expanded provider network state-wide through negotiations with non-managed care providers, and participated in a team to develop and implement some of the first value-based or pay-for-performance based payment models. Dr. Elliott developed and implemented provider report or score cards focusing on areas of opportunities in utilization management by wellness or disease state.

Professional History

HSAG, Phoenix, Arizona: Executive Director, HEDIS & PM Audits Team, S&CS (11/16–Present); Director, S&CS; 3/16–11/16

Arizona Health Care Cost Containment System (AHCCCS), Phoenix, Arizona: Administrator, Clinical Quality Management (11/02–3/16); Manager, Clinical Quality Management (7/01–11/02); 7/01–3/16

Arizona Physicians IPA, (now United Healthcare), Phoenix, Arizona: Director, Prevention and Wellness (6/99–7/01); Manager, Prevention and Wellness (7/95–6/99); Project Manager/Systems Operations Manager (5/93–7/95); 5/93–7/01

	CIGNA Health Care, Phoenix, Arizona: Provider Relations and Contracting Representative, 9/85–5/93
Education	Doctor of Philosophy, Health Sciences, Emphasis in Preventive Health, Honolulu University, 2001 Master of Arts, Organizational Management, University of Phoenix, 1988 Bachelor of Science, Business Administration, University of Phoenix, 1986
Technical Experience	Proficient in the development and use of quality of care case review databases, InterQual Criteria tools, survey development, inter-rater reliability tools, medical record abstraction and chart-tracking software and Visio process flow tools.
Licenses, Certifications, Professional Organizations, and Publications	***Certifications*** Certified Professional in Health Care Quality (CPHQ), National Association of Health Care Quality Master Trainer, Chronic Disease Self-Management (CDSMP), Stanford University Certification in the Science of Improvement, Quality Improvement and Patient Safety, Institute for Healthcare Improvement, Open School ***Board/Leadership Council Positions*** Inter-Agency Leadership Committee, Arizona Community Health Worker Workforce Vaccine Finance Committee (Legislatively Mandated Committee) Centers for Medicare and Medicaid Services Quality Technical Assistance Group, Region IX Representative Centers for Medicare and Medicaid Services Oral Health Technical Assistance Group Attorney General's TASA Committee Attorney General's TASA Health Care Committee BUILD Arizona Health Care Committee Department of Health Services CoIIN Leadership Committee Newborn Screening Advisory Board (Director Appointed) TAPI Steering Committee Governor's School Readiness Board, represent the Agency Director Governor's School Readiness Board, Health Committee First Things First Health Committee Arizona Association for Health Care Quality Board Officer Arizona Medical Association Maternal and Child Health, Sub-Committee Arizona Medical Association Adolescent, Sub-Committee Arizona Diabetes Steering Committee

Arizona Asthma Coalition
American Lung Association, Breathe Easy Member
Phoenix Children's Hospital, Children With Special Health Care Needs Care Coordination Quality Improvement Committee

Professional Awards/Recognition

Selected for and served on the CMS Technical Expert Panel for the Children's Health Insurance Program Core Measure set
Selected for and served on the CMS Technical Expert Panel for the Access to Care Measures

- Selected for and served on the CMS Technical Expert Panel for the Medicaid Children's Core Measure set
- Selected to provide subject matter expert guidance to CMS long Term Care quality measures
- Selected to provide subject matter expert guidance to the National Quality Forum on Respiratory Care and Critical Care Measures
- Selected as one of two states to review the Office of the National Coordinator field specifications for the Children's Electronic Health Record
- Recognized by CMS for the Childhood Obesity Model, Chronic Care Model development that was promoted and implemented in many Medicaid programs across the country
- Selected as one of 20 state representatives by CMS/NCQA/CHCS to meet nationally to develop implementation of Core Performance Measures for Medicaid
- The Arizona Partnership for Immunizations-long Shot Award, April 2008
- Arizona Academy of Pediatrics- Community Partner Award for work on pediatric developmental assessment program, June 2007
- Center for Health Care Strategies Grant recipient Pay for Performance, 2006
- Center for Health Care Strategies Grant recipient Return on Investment, 2006
- AHRQ Grant recipient Value Driven Health Care, 2005
- Wyeth-Ayerst HERA Award- Bronze Award, National Managed Health Care Congress-Innovative Preventive Health Programs, Children and Women's Health, Pediatric Asthma Disease Management Program September, 2001
- Wyeth-Ayerst HERA Award-Bronze Award, National Managed Health Care Congress-Innovative Preventive Health Programs, Children and Women's Health, July 2000
- Merck Vaccine Division- American Association of Health Plans-Third Place in the category of Innovative Quality Improvement, Child/Adolescent Immunization in the Celebrating Innovation in Immunization Awards Program, August 2000

- Exemplary Performance Award Health Care Quality Improvement Projects that Enhanced the Quality of life and level of Care Received by Arizona Medicare/Medicaid Beneficiaries, Influenza and Pneumococcal, April 2000
- Arizona Turning Point Project, Technology Subcommittee, Data Work Group, recognition of dedicated service and commitment toward improving the health of Arizona's communities, August 1999

Amy Kearney, BA
Director, Data Science & Advanced Analytics

Personal Information

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akearney@hsag.com

Qualification Highlights

Ms. Kearney has more than 26 years of experience in the healthcare industry with expertise in leadership, mentoring, strategic communication, auditing, and self-motivational techniques.

Relevant Experience

Health Services Advisory Group, Inc. (HSAG), Director, Data Science & Advanced Analytics: Ms. Kearney directs and coordinates analyst work activities related to projects in support of external quality review organization (EQRO) activities. She provides research leadership, analytic expertise, and mentoring to junior level staff. She acts as an internal and external liaison for analytic activities by planning, executing, and monitoring projects; supervising staff; managing client relations; and providing technical assistance. Ms. Kearney is responsible for maintaining and monitoring company/client relationships and ongoing client satisfaction for assigned contracts. She is the administrative lead for the team conducting numerous encounter data validation studies, focused studies, and network adequacy studies in various states. Ms. Kearney assists in the development and implementation of staff training related to conducting external quality review activities, study design, and execution. She is accountable for ensuring completion of assigned analytic tasks according to contract specifications and ensuring completed tasks meet client and budget requirements.

HSAG, Associate Director, Informatics Research and Development Team: Ms. Kearney directed work related to S&CS' projects. As the administrative team lead for numerous encounter data validation activities, she provided leadership, expertise, and mentoring to staff. She provided analytic expertise by planning and executing projects and ensuring the tasks met budget requirements.

TriWest Healthcare Alliance, Director, ICD-10/HIPAA 5010: Ms. Kearney served as project leader with overall responsibility for the 5010/ICD-10 conversions. She facilitated a steering committee and provided regular project status updates, action plans, contingency plans, and escalated issues to senior leadership. She had responsibility for the oversight of a clinical decision support tool which supported the

authorization approval process and claims processing. Ms. Kearney led a project team to become HIPAA 5010 compliant by the deadline.

TriWest Healthcare Alliance, Manager, Data Reporting and Analysis: Ms. Kearney managed healthcare data reporting and workflow of ad hoc data requests from internal and external customers. She provided management and direction in overseeing the performance of seven data analysts, and was responsible for the coordination of the reporting needs of key customers from claims, provider services, accounting, healthcare services, TRICARE-Regional Office West, TRICARE Management Activity, and military treatment facilities. Ms. Kearney oversaw the creation and submission of over 500 monthly government reports.

TriWest Healthcare Alliance, Manager, Health Care Data-Actuarial Services: Ms. Kearney was responsible for the management of healthcare data reporting for the actuarial services department. She developed key reports to track healthcare costs and provided analysis to the executive team. Ms. Kearney trained department staff on data querying in DB2, government reporting, and document standardization; and coordinated healthcare cost reporting for government change orders.

TriWest Healthcare Alliance, Senior Health Care Analyst: Ms. Kearney maintained reporting for healthcare claims, provider discounts, beneficiary counts, and utilization and costs for applicable areas. She supervised staff, provided analysis and recommendations for monthly reports and other ad hoc reporting; and provided data expertise on claims and data integrity to transition from querying in a mainframe environment with an outside subcontractor to an in-house data warehouse. Ms. Kearney also created SQL queries, developed a process for analyzing and evaluating healthcare change orders for cost impact, and worked with a subcontractor and information technology to resolve data integrity issues with claims data on mainframe.

Professional History

Health Services Advisory Group, Inc., Phoenix, Arizona: Director, DSAA (7/14–Present); Associate Director, Informatics, Research and Analysis Team (4/13–6/14); 4/13–Present

TriWest Healthcare Alliance, Phoenix, Arizona: Director, ICD-10/HIPAA 5010, (2010–2013); Manager, Data Reporting and Analysis (2003–2010); Manager, Health Care Data-Actuarial Services (2002–2003); Senior Health Care Analyst (2001–2002); Health Care Analyst (1998–2001); 1998–2013

Horizon Healthcare Corporation, Albuquerque, New Mexico: Reimbursement Team Leader, (1997–1998); Reimbursement Analyst, (1996–1997); Assistant Reimbursement Analyst, (1990–1996); 1990–1998

Education	Bachelor of Arts, Business Administration, University of New Mexico–Anderson School of Management, Albuquerque, New Mexico, 1996 ***Professional Training*** Crucial Conversations® Training TriWest Path to Leadership Excellence
Technical Experience	Proficient in the use of MS Office Suite, MS Reporting Services, MS Project, Cognos Report & Query Studio, Cleverpath Forest and Trees, DB2 UDB, and SQL/QMF.
Licenses, Certifications, Professional Organizations, and Publications	***Certifications*** Certified, Licensed Analyst of the Predictive Index® system TriWest Lean Six Sigma Yellow Belt Certification TriWest Project Management Certification

Brian Starr, MPP, BA
Informatics Analyst II, Data Science & Advanced Analytics

Personal Information

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Qualification Highlights

Mr. Starr has more than 6 years of experience in research and data analysis with expertise in SAS programming, workflow procedures, and methods, as well as establishing methodologies.

Relevant Experience

Health Services Advisory Group, Inc. (HSAG), Analyst, Data Science & Advanced Analytics (DSAA): Mr. Starr's responsibilities include establishing methodologies and analyzing data to obtain meaningful results, reviewing reports for accuracy, and developing production codes for customized, as well as standardized, reoccurring reports. He is responsible for providing analyses on several projects, including the external quality review organization (EQRO) contract for the state of Ohio. For the EQRO contract, Mr. Starr is responsible for calculating 26 performance measures to evaluate the performance of the Ohio Medicaid Health Homes initiative. He works on program evaluation and performance measure activities. For the evaluation activities, Mr. Starr conducts impact assessments of various programs to determine whether or not they are saving money and/or reducing utilization. Specifically, this involves developing an analytic methodology, working with a very large database of administrative claims data, and the use of statistical techniques such as propensity score matching and panel regression. He is responsible for calculating and reporting clinical and access performance measures for the Aged, Blind, or Disabled (ABD), and Covered Families and Children (CFC) populations for the state of Ohio. The goal of the initiative is to transform the delivery of healthcare services for Medicaid consumers with severe and persistent mental illness (SPMI) and consumers that are seriously emotionally disturbed (SED), resulting in patient-centered care through an integrated and coordinated system of service delivery and a multi-disciplinary team approach that addresses consumers' chronic and complex conditions.

HSAG, Informatics Analyst I, Informatics: Mr. Starr was responsible for providing analyses on several projects, including the EQRO contract for the state of Ohio. He was also responsible for the calculation and reporting of clinical and access performance measures for the ABD, and CFC populations for the state of Ohio.

Global Economics Group, Senior Associate: Mr. Starr managed and conducted complex economic and statistical analysis for use primarily in Section 10(b)-5 and Section 11 class action securities litigation on the plaintiffs' behalf. He drafted and prepared arguments for class certification, loss causation, and expert rebuttal reports. Ms. Starr also trained new research analysts in SAS programming, workflow procedures, and research methods. He assisted the lead economist in providing the Cook County Health & Hospital System with the analytical and economic framework in which to better quantify healthcare costs and expenditures at the patient level, utilizing extensive and thorough patient care data. In addition, Mr. Starr developed SAS programs to compute economic damages from possible LIBOR manipulation on thousands of corporate and municipal bond holdings over a period of more than four years.

Professional History

HSAG, Phoenix, Arizona: Informatics Analyst II, DSAA (7/15–Present); Informatics Analyst I, Analytics & Informatics (3/14–7/15); 3/14–Present

Global Economics Group, Chicago, Illinois: Senior Associate; (1/13–2/14); Research Analyst, (6/10–1/13); 6/10–2/14

Knox College Center for Teaching and Learning, Galesburg, Illinois: Statistics Tutor; 9/08–6/10

Education

Master of Public Policy, School of Public Affairs, Arizona State University, Tempe, Arizona, 2015

Bachelor of Arts, Economics, *cum laude*, Knox College, Galesburg, Illinois, 2010

Technical Experience

Proficient in Word, Excel, PowerPoint, SAS, Stata, SPSS, Photoshop, Illustrator and InDesign

Licenses, Certifications, Professional Organizations, and Publications

Publications

Coffman, Chad, Tara O'Neil, and Brian Starr, "An Empirical Analysis of the Impact of Legacy Preferences on Alumni Giving at Top Universities," *Affirmative Action for the Rich,* Ed. Richard Kahlenberg, 2010, pp. 101–121

Cindy H. Strickland, JD
Senior Informatics Research Analyst, Data Science & Advanced Analytics

Personal Information

Health Services Advisory Group, Inc.
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Qualification Highlights

Ms. Strickland has more than 4 years of experience in the healthcare industry with expertise as a former private practice attorney with extensive experience in research strategies, oversight of focus groups, and statutory, regulatory, and contract analysis. She has a strong understanding of public health, and medical and healthcare policy issues.

Relevant Experience

Health Services Advisory Group, Inc. (HSAG), Senior Research Analyst, Data Science & Advanced Analytics (DSAA):
Ms. Strickland performs research, review, and writing in support of HSAG's contract for the Agency for Healthcare Research and Quality (AHRQ) Patient Safety Organization Privacy Protection Center (PSOPPC). She aids in development of the Common Formats for Community Pharmacy Version 1.0, and the update of the Common Formats Hospital Version 2.0, participating in preparation of support documentation including event descriptions, specifications for patient safety aggregate reports, delineation of data elements to be collected for various types of events, creation of flowcharts and documenting technical specifications for submission and reporting of Patient Safety Event data.

Ms. Strickland was responsible for evaluation and reporting related to Task 3, the Leading Edge Advanced Practice Topics (LEAPT) program, part of the Partnership for Patients (PfP) Evaluation contract for the Centers for Medicare & Medicaid Services (CMS). She was responsible for monitoring and evaluating the progress made with regard to the measures developed and data reported by six Hospital Engagement Networks (HENs) selected to participate in this program targeting rapid cycle innovation in reducing patient harms.

Ms. Strickland was also partially responsible for research and analysis on the American Recovery and Reinvestment Act, Health Information Technology for Economic and Clinical Health (ARRA HITECH) Hospital eMeasures contract. In that role, she was involved in the development and testing of electronic quality measures (eCQMs) under the guidance of CMS with the intent of submitting the measures to NQF for endorsement. Her work included participating in a team that recruited hospitals and electronic health record (EHR) vendors for

specification and field testing of candidate measures, and designing and administering tools to evaluate eCQM feasibility by assessing whether and where required data elements were stored in electronic records and how they could be extracted. She was involved in analysis and reporting on risk-adjustment modeling and testing measure validity and reliability in the field. Ms. Strickland was also responsible for research and analysis on the Physician Public Reporting Programs (PPRP) contract. She researched and synthesized information from a variety of different sources, including websites, reports, journal articles, and interviews, to assist with the alignment of the CMS public reporting websites.

Treon, Aguirre, Newman & Norris, P.A., Attorney: Ms. Strickland worked as lead counsel and staff attorney in the preparation and trial of a variety of cases, including medical malpractice, toxic tort, product liability, and commercial tort cases. She planned and supervised comprehensive research strategies, working with third-party subject matter experts and focus groups to build an understanding of industry best practices and public perceptions. Ms. Strickland ensured timely delivery of accurate and detailed written products in compliance with both internal time tables and court deadlines, coordinating the necessary contributions from multiple sources. She worked closely with healthcare providers to evaluate clients' past treatment and future needs and insurance issues, including providing for funding necessary to protect clients' life care needs. Ms. Strickland is familiar with state agencies and programs including Arizona Health Care Cost Containment System (AHCCCS), Arizona Long Term Care System (ALTCS), and Division of Developmental Disabilities (DDD) and the operation and regulation of nursing homes, hospitals, and other healthcare providers. She has drafted and enforced contracts and settlement and trust agreements, representing clients before judges and juries and in settlement negotiations.

Professional History

HSAG, Phoenix, Arizona: Informatics Research Analyst, DSAA; 7/12–Present

Self-employed, Phoenix, Arizona: Writer; 10/09-7/12

Treon, Aguirre, Newman & Norris, P.A., Phoenix, Arizona: Attorney; 11/88–9/09

Education

Post-doctoral work in Law of Genomics and Biotechnology, Sandra Day O'Connor College of Law, Arizona State University, Tempe, Arizona, 2012

Juris Doctor, *cum laude*, Arizona State University, Tempe, Arizona, 1984

Bachelor of Science, Anthropology, *summa cum laude*, Arizona State University, Tempe, Arizona, 1980

Mary Wiley, MEd, BSW, RN
Project Director, State & Corporate Services

Personal Information

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Qualification Highlights

Ms. Wiley has more than 39 years of experience in the healthcare industry as a registered nurse (RN) in a variety of clinical and government settings with expertise in project management, contract management, quality improvement, utilization management, strategic planning, and oversight of regulatory activities.

Relevant Experience

Health Services Advisory Group, Inc. (HSAG), Project Director, State & Corporate Services (S&CS): Ms. Wiley provides oversight and project management support for HSAG's external quality review organization (EQRO) contracts and other projects as assigned. She serves as the contract manager for the Florida and Arizona EQRO contracts, and coordinates activities for both states in the areas of performance improvement projects, performance measure validation, compliance reviews, and technical reports. In addition, Ms. Wiley conducts quarterly meetings that enhance the managed care plans' knowledge of EQRO activities, as well as encounter data validation and focused studies in Florida. She has served as a compliance review auditor for the state of Utah.

HSAG., Director, Professional Services: Ms. Wiley managed stakeholder activities for the California QIO; including the California Department of Public Health (CDPH), Medi-Cal, California Culture Change Coalition, California Association of Health Facilities, LeadingAge, California Department of Aging, and the California Association of Long Term Care Medical Directors. She co-led the Partnership to Improve Dementia Care initiative, sponsored by CMS, to decrease the use of unnecessary antipsychotics and implement resident-centered care in Arizona nursing homes. Ms. Wiley was a key participant in the California Partnership to Improve Dementia Care in California nursing homes, including serving on a sub group that worked on education and outreach.

Arizona Department of Health Services (ADHS), Assistant Director, Division of Licensure Services: Ms. Wiley managed the survey and certification program for all healthcare and child care facilities for the State of Arizona, including all aspects of strategic planning, budgeting, rule development, quality improvement and performance measurement, and media and legislative relations. She championed quality management

processes in the Division through participative management. Ms. Wiley also led emergency planning activities in the Division and throughout the State, including coordination with CMS and Arizona counties. She coordinated regulatory processes with the Board of Nursing and the Board of Medicine to improve safety for residents of Arizona. Ms. Wiley also coordinated enforcement processes with health and child care facilities with AHCCCS (Arizona Medicaid agency), program contractors for the health plans, the Medicare QIO, and CMS to improve the functioning of the facilities. She initiated the Empower Program, a collaborative between the divisions of Public Health and Licensing Services to improve physical activities and nutrition in child care facilities. She led the federal regulatory activities for Arizona, including serving on national and regional committees to improve quality of care for Medicare beneficiaries.

ADHS, Manager in the Director's Office for the Office of Strategic Initiatives: Ms. Wiley coordinated strategic planning and quality management initiatives for ADHS. She facilitated development of the strategic plans including addressing critical budget issues and performance measures. She was responsible for leadership development, training, and mentoring of 40 facilitators and performance improvement teams and coordinated two program authorization reviews (PARs), which reviewed all aspects of government programs for the legislature and the governor.

Arizona State Hospital, Director of Quality Resource Management: Ms. Wiley managed the performance improvement, utilization review, risk management and safety programs as well as contract monitoring and the health records and information management system departments. She coordinated all accrediting and licensing activities, including JCAHO (the Joint Commission) and Medicare surveys. Ms. Wiley designed, organized, and managed the Arizona State Hospital Quality Improvement Program, including establishment of the Executive Steering Council, the Employee Recognition Committee, and a team of 25 facilitators. She coordinated two JCAHO surveys (100 percent and upper one-third of hospitals) and one Medicare survey (no deficiencies). She coordinated two JCAHO surveys, one of which scored 100 percent, and one Medicare survey with no deficiencies.

Professional History

HSAG, Phoenix, Arizona: Project Director, State & Corporate Services (2/13–Present); Director, Professional Services (4/12–2/13); 4/12–Present

ADHS, Phoenix, Arizona: Assistant Director, Division of Licensure Services (10/98–12/11); Manager, Office of Strategic Initiatives (2/97–10/98); Director of Quality Resource Management, Arizona State Hospital (7/92–2/97); 7/92–12/11

St. Luke's Health System, Phoenix, Arizona: Director of Nursing, Skilled Nursing Facility (1/91–7/92); Director of Quality Management, Behavioral Health Center (9/84–1/91); Registered Nurse (5/77–9/84); 5/77–7/92

Education

Master of Education, emphasis in Human Relations, Northern Arizona University, Flagstaff, Arizona, 1986

Associate of Arts in Nursing, Mesa Community College, Mesa, Arizona, 1977

Bachelor of Social Work, Arizona State University, Tempe, Arizona, 1974

Certifications, Professional Organizations, and Publications

Licenses

Registered Nurse–Arizona

Certifications

Accelerated Leadership Development Certification Program, 2009

National Certified Investigator/Inspector Training (NCIT) accreditation through the Council on Licensure, Enforcement and Regulation (CLEAR).

Advanced Investigation Analysis, Advanced Investigation Report Development and Advanced Interviewing Certification, 2005