ATTACHMENT D: BIDDER RESPONSE FORM This form is broken into Seven sections: Section 1. Administrative Response; Section 2. EO 18-03 Response; Section 3. Management Response; Section 4. Technical Response. Bidders must respond to all questions in the order and in the expandable space provided. If a question requires Bidder to submit additional documents, please attach them to this document and label them clearly as part of your response to this Attachment D.		
1	**BIDDER INFORMATION (ADMINISTRATIVE RESPONSE)** Bidder's response to the questions in this Section 1, combined with the information provided in Bidder's Submittal Letter and Certifications and Assurances, comprise Bidder's Administrative Response to this Solicitation. While the Administrative Response is not given a number score, the information provided as part of Bidder's Administrative Response may cause the Bid to be disqualified and may be considered in evaluating Bidder's qualifications and experience.	**NOT SCORED**
a	Please indicate whether you employ or contract with current or former state employees. If the answer is yes, provide the following information with respect to each individual: 1. name of employee or contractor; 2. the individual's employment history with the State of Washington; 3. a description of the Individual's involvement with the response to this Solicitation; and 4. the Individual's proposed role in providing the services under this any Contract that may be awarded.	NOT SCORED
	ANSWER: 1. Joseph Whitley, Shalini Prakash, Benjamin Davis-Bloom 2. **Whitley:** Fiscal Information and Data Analyst (HCA); April 2016 – July 2018 **Prakash:** Data Science Manager, Analytics, Research & Measurement (HCA); March 2016 – January 2022 **Davis-Bloom:** Operational Research Specialist (Financial Services Division of HCA); December. 2016 – March 2023 3. The three employees listed above are not involved with this solicitation. 4. The three employees listed above will not provide services under this contract.	
b	Please list the names and contact information of three individuals you agree may serve as Bidder references and may freely provide information to DSHS regarding the reference's experience and impressions of Bidder. In providing these names, Bidder represents that it shall hold both DSHS and the organizations and individuals providing a reference harmless from and against any and all liability for seeking and providing such reference.	NOT SCORED
	ANSWER:	

HAWAI`I DEPARTMENT OF HUMAN SERVICES – MED-QUEST DIVISION

Contact name: Jon Fujii

Title: Health Care Services Branch Administrator

Email: jfujii@dhs.hawaii.com

Address: 601 Kamila Blvd. Ste 518
Kapolei, Hawai`i, 96707-2021

Phone: 808 692 8083

Years Retained: 2005 to Present

Description of Services:

Milliman has supported the QUEST programs since 2005. This includes the prior QUEST program (excluding full expansion,) Medicaid expansion, QExA including the conversion of Medicaid and dually-eligible members to managed care including medical and LTSS services, the development of the Community Care Services (CCS) behavioral health program, and the most recent transition to the QUEST Integration program. Prior to QExA, Milliman supported PACE rate development. Milliman has supported these programs addressing the unique challenges in Hawai`i with five MCOs containing a varied mix of enrollment while serving a relatively small population.

The scope of work has included:

- Development of methodology for the MLTSS capitated rates
- Calculations of MCO specific rates for the 1115 waiver
- Behavioral health rates under the Community Care Services (CCS)
- Develop rates for budget neutrality purposes
- Development of other carved-out rates as needed by the State
- Work with CMS OACT to get rates approved
- Resetting risk adjustment factors
- Assist in development of the medical RFP
- Risk share settlements calculations
- Supplemental payment support, including pre-prints
- MCO encounter data issues
- Development of prospective reimbursement systems
- Supporting federal funding strategies
- In-person rate development and strategy meetings

WASHINGTON HEALTHCARE AUTHROIRTY

Contact name: Megan Atkinson

Title: Chief Financial Officer

Email: Megan.Atkinson@hca.wa.gov

Address: 626 8th Avenue SE Olympia, WA

Phone: 360 725 1222

Years Retained: 1996 to Present

Description of Services:

For more than 25 years, Milliman has worked closely with HCA and other prior agencies to support the development of key HCA programs, including most recently:

- Expansion of managed care to disabled members in the Apple Health program
- Expansion of managed care to foster care members in the Apple Health program
- Medicaid expansion through the ACA, including conversion of the MCS program into Apple Health
- Serving a key role in developing the PEBB Accountable Care Program (ACP)
- Collaborating with HCA staff as well as Office of Financial Management (OFM) and Legislative staff in the development and implementation of the SEBB Program
- Support for the Washington Cascade Care program
- Support for the development of 90/180 day civil commitment beds
- Support for the Safety Net Assessment Fund (SNAF)

Milliman has supported the above endeavors through managed care capitation rate development for medical, pharmacy, and behavioral health services, procurement support, rate review, board and legislative meeting support, reserve calculations, trend development, network procurement, data processing and financial reporting, reconciliation, and risk mitigation settlements.

	IDAHO DEPARTMENT OF HEALTH AND WELFARE **Contact name: Alexandra Fernández, MHS** **Title:** Bureau Chief, Bureau of Long-Term Care, Division of Medicaid **Email:** Alexandra.Fernandez@dhw.idaho.gov **Address:** 3232 Elder St. Boise, ID 83705 **Phone:** 208 287 1179 **Years Retained: 2009 to Present** **Description of Services:** For more than a decade, we have provided actuarial consulting services for the Idaho Department Health and Welfare. Our efforts to date include: • Medicaid managed care rate setting – We provide annual support for setting dental, mental health, and dual program (Medicare Medicaid Coordinated Plan FIDE SNP and Idaho Medicaid Plus MLTSS) rates for Idaho's Medicaid managed care programs. Supported state with rollout of the Expansion program in 2020, and risk mitigation during the COVID-10 PHE. • Accountable Care Program development and support – We have been involved in the development of the Medicaid ACO Shared Savings Program. Idaho's shared savings program is a risk adjusted, trend-based evaluation between an ACO and benchmark trend. Our involvement has included program development, illustrative settlement scenarios based on their actual experience, and providing support for their negotiations with the ACOs. • Support for transition to DRG reimbursement basis including financial implications and stakeholder communications.	
c	**Please indicate whether your Response contains any variations from the requirements of the Solicitation Document. If the answer is yes, list each variation with specificity and include the pertinent page numbers containing the variation.**	NOT SCORED
	ANSWER: **No.**	

<table>
<tr><td>d</td><td>Please indicate whether you are requesting that DSHS consider any exceptions and/or revisions to the sample contract language found in Attachment A. If so, state the page of Attachment A on which the text you request to change is found, and state the specific changes you are requesting. DSHS shall be under no obligation to agree to any requested changes and will not consider changes to contract language or negotiate any new language not identified in response to this question.</td><td>NOT SCORED</td></tr>
<tr><td></td><td>

Exceptions to Washington State Department of Social and Health Services' RFP#2334-831

The submission of this proposal in response to the RFP may constitute Milliman's acceptance of DSHS' contract terms should the changes to the provisions below, or the addition of the new provisions below, be accepted. Milliman shall not be bound by any contract terms or obligated to perform the services described in this proposal until a mutually acceptable written agreement is signed by the parties.

The exceptions Milliman would like to discuss, as noted below, are exceptions previously granted.

<table>
<tr><th>Section</th><th>Exception</th></tr>
<tr><td>General Terms and Conditions, Section 23, pg. 8</td><td>Addition of:

a. The Contractor shall be responsible for and shall indemnify, defend, and hold DSHS harmless from any and all claims, costs, charges, penalties, demands, losses, liabilities, damages, judgements, or fines, of whatsoever kind of nature, arising out of third party claims stemming from the following in its performance of this Contract:

(1) Gross negligence, fraud, willful misconduct;
(2) Breach of Section 6 (Confidentiality);
(3) Violations of applicable law;
(4) Intellectual property infringement; or
(5) Personal injury, property damage.

b. The Contractor's duty to indemnify, defend, and hold DSHS harmless from the Indemnified Claims shall include reasonable attorney's fees, court costs, and all related expenses.

c. In the event of any claim arising from services provided by Contractor at any time, the total liability of the Contractor, its officers, directors, agents and</td></tr>
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			employees to DSHS shall not exceed five million dollars ($5,000,000). This limit applies regardless of the theory of law under which a claim is brought, including negligence, tort, contract, or otherwise. In no event shall Contractor be liable for lost profits of DSHS or any other type of incidental or consequential damages. The foregoing limitations shall not apply in the event of the gross negligence, fraud or willful misconduct of Contractor.		
		General Terms and Conditions, Section 37, pgs 12 & 13	Any capitalized terms not defined herein, but that are defined in the HIPAA Rules, shall have the same meaning as that stated in the HIPAA Rules.		
		General Terms and Conditions, Section 39(c), pg. 14	Addition of: DSHS shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule or the Security Rule if done by DSHS, except as otherwise permitted herein for purposes of Data Aggregation.		
		General Terms and Conditions, Section 39, pgs. 14 & 15	Addition of: Data Aggregation, De-Identification and Limited Data Sets. Business Associate may use PHI to provide Data Aggregation services to Covered Entity as permitted by the Privacy Rule under 45 CFR 164.504. Business Associate may de-identify PHI in accordance with the requirements of the Privacy Rule; provided that all identifiers are destroyed in accordance with this Contract, and Business Associate may create a Limited Data Set for the purpose of providing the Services, provided that Business Associate complies with its obligations under this Contract.		
		General Terms and Conditions, Section 39(f) pgs. 14 & 15	Business Associate shall report to DSHS in writing all Uses or disclosures of PHI not provided for by this Contract within three (3) business days […] The parties acknowledge and agree that this section constitutes notice by Business Associate to Covered Entity of the ongoing existence and occurrence of attempted but Unsuccessful Security Incidents (as defined below) for which no additional notice to Covered Entity shall be required. "Unsuccessful Security Incidents" shall include, but not be limited to, pings and other broadcast attacks on Business Associate's firewall, port scans, unsuccessful log-on attempts, denials of service and any combination of the above, so long as no such incident results in unauthorized access, use or disclosure of EPHI.		
		General Terms and Conditions, Section 39(k)(5) pgs. 14 & 15	Addition of: If Business Associate determines that returning or destroying the remaining PHI is infeasible, the protections of this Contract shall continue to apply to such PHI, and Business Associate shall limit further uses and disclosures of PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI. DSHS hereby acknowledges and agrees that infeasibility includes Business Associate's need to retain PHI for		

			purposes of complying with its internal archival and record retention policies and that for such retention no further notice to, or agreement by, DSHS is required. The rights and obligations of this Contract will survive termination as so required by the foregoing and for so long as Business Associate maintains the PHI.		
		General Terms and Conditions, Section 40(a)(1) pg. 15	Business Associate shall document all disclosures, except those disclosures that are exempt under 45 CFR 164.528, of PHI made by Business Associate […]		
		General Terms and Conditions, Section 40(a)(3) pg. 16	Deletion of this subsection in its entirety.		
		General Terms and Conditions, Section 40(c)(2) pg. 16	Business Associate shall make any amendments to PHI that is holds in a Designated Record […]		
		General Terms and Conditions, Section 41 pg. 16	[…] contract that contains the same or more restrictive terms, restrictions […]		
		General Terms and Conditions, Section 42 pg. 16	To the extent the Business Associate is engaged to carry out one or more […]		
		General Terms and Conditions, Section 44(b) pg. 17	[…] Business Associate will notify DSHS within three (3) business days […]		
		General Terms and Conditions, Section 44(c)	Business Associate will notify the DSHS Contact shown on the cover page of this Contract within three (3) business days by telephone […] type of Breach, origination and destination of PHI, Business Associate unit […]		
		General Terms and Conditions, Section 44(d)(1) pg. 17	[..] Business Associate bears the responsibility to reimburse DSHS for all reasonable out-of-pocket costs incurred by DSHS in notifying […]		
		General Terms and Conditions, Section 45 Pg. 17	Additional Terms: Amendment. The parties agree to take such action as is necessary to amend this Contract from time to time in order to		

			ensure compliance with the requirements of the HIPAA Rules and any other applicable law. Independent contractors. Business Associate and DSHS are independent contractors and this Agreement will not establish any relationship of partnership, joint venture, employment, franchise or agency between Business Associate and DSHS. Neither Business Associate nor DSHS will have the power to bind the other or incur obligations on the other party's behalf without the other party's prior written consent, except as otherwise expressly provided in this Contract. Entire Agreement. This Contract shall constitute the entire agreement of the parties hereto with respect to the subject matter hereof and supersedes all prior agreements, oral or written, and all other communications between the parties hereto relating to such subject matter.		
		Special Terms and Conditions, Section 5(a) pg. 19	Addition of: Contractor reserves the right to suspend its performance hereunder if any undisputed sums owed to it go unpaid for more than sixty (60) days.		
		Special Terms and Conditions, Section 6(d) pg. 20	The Contractor shall maintain of at least $1,000,000 per claim, $2,000,000 general annual aggregate for losses caused by errors and omissions [...]		
		Special Terms and Conditions, Section 8 pg. 31	Data shall be returned to DSHS or destroyed, provided the Contractor may retain one copy of any such data as is necessary to comply with applicable work product documentation standards, subject to the continued obligations contained herein.		
e	**If Bidder considers any information that is submitted as part of its Response to be proprietary, please identify the numbered pages of Bidder's Response containing such information and place the word "Proprietary" in the lower right-hand corner of each of these identified pages.**				NOT SCORED
	ANSWER: **Attachment D, Bidder Response:** pgs. 28, 37 – 38, 48 – 49, 51 **Attachment I - V:** pgs, 18-20, 22, 26-27, 34-36, 44-49, 82-83, 89, 91, 106 – 108, 112, 114-115, 125, 136 - 137, 140				

<table>
<tr><td>f</td><td>Please indicate whether you have had a contract terminated for cause or default within the past five (5) years. If so, please provide the terminating party's name, address and telephone number and provide a summary describing the alleged deficiencies in Bidder's performance, whether and how these alleged deficiencies were remedied and any other information pertinent to Bidder's position on the matter. "Termination for Cause" refers to any notice to Bidder to stop performance due to Bidder's asserted nonperformance or poor performance and the issue was either (a) not litigated; (b) litigated with a resulting determination in favor of the other party; or (c) is the subject of pending litigation.</td><td>NOT SCORED</td></tr>
<tr><td></td><td>ANSWER: No.</td><td></td></tr>
<tr><td>g</td><td>Please identify any prior contracts Bidder has entered into with the State of Washington within the past ten (10) years and identify the dates and nature of the contract and primary agency contact for each.</td><td>NOT SCORED</td></tr>
<tr><td></td><td>ANSWER:

<table>
<tr><th>DATE</th><th>DIVISION</th><th>DESCRIPTION</th><th>CONTRACT #</th></tr>
<tr><td>1/2022 - 12/2022</td><td>Washington State Health Care Authority</td><td>CCBHC program evaluation</td><td>Engrossed Substitute Senate Bill (ESSB) 5693, Section 215 (106) Report</td></tr>
<tr><td>2/2021 - 6/2021</td><td>State of Washington, Department of Commerce</td><td>Andy Hill CARE Fund performance audit</td><td>21-87101-100</td></tr>
<tr><td>8/1/18 – 6/30/19</td><td>Washington State Healthcare Authority</td><td>SAMHSA stakeholder facilitation</td><td>K2798</td></tr>
<tr><td>11/10/15 – 10/31/18</td><td>Washington State DSHS Aging & Long -Term Support Administration</td><td>PACE Rates</td><td>1532-49922</td></tr>
<tr><td>9/1/13 - 6/30/15</td><td>Washington State Office of the Attorney General</td><td>Expert Witness</td><td>Thurston County Superior Court Cause No. 12-2-02441-1

CMS No. 10573751</td></tr>
</table></td><td></td></tr>
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	2/2016 – 1/2017	Washington State Department of Social and Health Services (DSHS)	Feasibility Study of Policy Options to Finance Long-Term Services and Supports in the State of Washington	1634-58494	
	5/2021-12/2022	Washington State Health Care Authority	Medicaid Fee-for-Service (FFS) Hospital Rebasing	K23428.	
	7/2018-06/2023	Washington State DSHS Aging & Long-Term Support Administration	Development of Medicaid capitation rates for Program of All-inclusive Care for the Elderly (PACE) agencies	1532-49922	
	6/2023-12/2023	Washington State DSHS Aging & Long-Term Support Administration	Development of Medicaid capitation rates for Program of All-inclusive Care for the Elderly (PACE) agencies	2331-49183	
	7/2021-6/2025	Washington State Health Care Authority	Actuarial Support for Medicaid and Public Employee programs, including provide as-needed specialized actuarial and benefits services (Several work orders including tax model, Medicaid Managed Care, Medicaid Managed Care Behavioral Health Comparison rate, among others)	K4889	

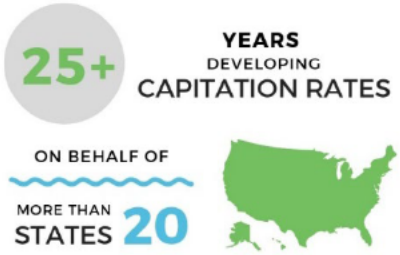
	6/2022-3/2024	Washington Department of Social and Health Services	Rate Study	2234-42497	
	07/2022-6/2026	Washington State Health Care Authority	Strategic Planning, Partnerships, Development, Delivery	K5962	
	3/2023-9/2023	Washington State Health Care Authority	Milliman working with SAO and HCA by participating in fieldwork, which will include interviews and information requests as part of a performance audit of HCA, Medicaid rate-setting process.	K6764	
	N/A	Office of the Insurance Commissioner Washington State	Project Management services	K202309	
	6/2021-6/2025	Washington Health Benefit Exchange	Provide WAHBE with senior health care policy advisors with expertise in the individual market regulatory and legislative analysis; policy analysis; program management, design and implementation; and/or data, analytic, or actuarial analysis.	HBE-503	
h	Please indicate whether Bidder has been the subject of a lawsuit or administrative proceeding alleging a failure to comply with laws relating to the types of services Bidder proposes to provide pursuant to this Competitive Solicitation. If the answer is yes, please list the nature of the allegations, docket number,				NOT SCORED

	disposition and date (if applicable) and Bidder's explanation of how it has changed its practices or operations relative to any alleged deficiencies since that proceeding was filed.	
	ANSWER: No	
i	Please describe your proposed plans for the use of Subcontractors in performing this contract, listing each Subcontractor, its proposed role and the estimated percentage of the Contract that will be performed by each Subcontractor. Please indicate whether each subcontractor self-identifies or is certified as a small business, a minority-owned business, a woman-owned business, a disadvantaged business enterprise, or a veteran-owned business. If the answer is yes, please identify the type of organization(s) and provide details of any certifications. Note that all Subcontractors must be approved by DSHS.	NOT SCORED
	ANSWER: We do not plan to use subcontractors in this solicitation.	
J	Please describe any programs, policies or activities of your organization that support human health and environmental sustainability in your business practices. If a program, policy or activity is specifically applicable to this Contract, please indicate so.	NOT SCORED
	ANSWER: At Milliman, we strive to protect people's health and financial well-being through our work, our people, and our communities. Our commitment to corporate social responsibility (CSR) has been a quiet tradition since our inception. We define corporate social responsibility as the integration of business operations and values to reflect the interests of all stakeholders in the company's policies and actions. At Milliman, we believe CSR is integral to our work, employees, communities, and environment. Milliman is committed to supporting and upholding the provision of basic human rights to all individuals globally. This commitment fits within Milliman's Mission statement that guides all our work: "Our mission is to serve our clients to protect the health and financial well-being of people everywhere." While knowing and mitigating our own environmental impact is critical, we also carry this same critical focus in the work we do with our clients and with other businesses, NGOs, and governments worldwide. We live our mission through projects and work that truly make a difference for those at the greatest risk from the effects of climate change. Examples include:	

	Industry innovation Our groundbreaking work in employee benefits has led to significant innovation in retirement planning. As the leading provider of actuarial, analytical, and data management solutions in the U.S. healthcare industry, we have played a prominent role in healthcare reform over the past decade. We have been leaders in enterprise computing since the 1960s, and that leadership continues today with products that have transformed the actuarial industry. While our name may not be a household word, our work has touched millions of individuals worldwide. **Commitment to our environment** Milliman's mission is to help our clients protect the health and financial well-being of people everywhere. There is no risk and no need for protection more dire than that of climate change on our planet. This effort first starts at home, living our mission through a strong belief that our firm's global environmental impact must be understood, monitored, comprehensively accounted for, and ultimately mitigated. Milliman has taken important steps to demonstrate our commitment to the environment: • Milliman's Sustainability and DEI Officer manages our sustainability impacts and performance. • Milliman publicly reports its carbon footprint data to the CDP (Carbon Disclosure Project). Our CDP score is available upon request by emailing socialimpact@milliman.com. • In 2021, we established a baseline for greenhouse gas (GHG) emissions and have begun the process of creating a comprehensive sustainability strategy that will include science-based carbon emission reduction targets with the goal of Net Zero. • In 2022, Milliman's Board of Directors approved our firmwide, long-term carbon mitigation strategy: Net Zero 2040. While we are in the early stages of our Net Zero journey – including target verification through SBTi – we are focused on reducing our GHG footprint by 1% annually. • In terms of water and waste reduction, Milliman offices continuously engage in local efforts to mitigate waste, often in the form of single-use plastic reduction or elimination, shifting to reusable materials and providing said materials to staff, switching to more environmentally friendly single-use materials such as compostable plates, cups, and cutlery, and reducing paper use/waste by converting to digital formats when possible. These are often driven by local office	

	Green Teams, which are set up to drive such efforts in our highly distributed structure, comprised of over 80 offices across the globe. **MicroInsurance Centre at Milliman** – The MicroInsurance Centre at Milliman is dedicated to generating access to valuable microinsurance products for the 3 billion low-income people around the world. We accomplish this by working with regulated insurers and appropriate delivery channels that efficiently provide simple, market-responsive microinsurance products. Our clients include commercial insurers, foundations, bi- and multi-lateral development agencies, regulators, and NGOs. These organizations work with us to ensure the best potential for success with their microinsurance activities. Our work with clients includes various aspects of microinsurance, from product development and training to research and advocacy. Our team has implemented microinsurance activities in more than 70 countries over the last two decades. As an example, we design crop insurance that protects Ethiopian farmers from loss of income related to climate change, and our insurance experts work to create better coverage for flood insurance. Using our deep expertise to perform risk analysis of shifting flood hazards because of climate change through advanced modeling and data innovation, we are able to provide more options and better coverage for those at risk. Through Milliman MicroAssist, one of our volunteer programs, we match the expertise of Milliman's professionals with organizations that are working globally to bring financial security to vulnerable populations. The program primarily assists organizations that serve low-income workers, especially those in informal economies who are underserved by mainstream markets. Milliman MicroAssist's mission is to help develop economic solutions that protect these populations against health, lifecycle, financial, and natural disaster risks. Milliman MicroAssist gives our recognized professionals opportunities to use their specialized skills and experience in markets that have an urgent need. We believe this application of our professionals' skills significantly extends their reach and enhances Milliman's CSR efforts. • Milliman is leading the charge in providing thought leadership and education on the topic of climate resiliency. In 2021, we held the Climate Resiliency Forum, an educational and collaborative	

	conference attended by industry leaders across multiple sectors interested in addressing climate change. • Milliman Climate Resilience Initiative (MCRI) – a coalition to unite perspectives across industry, government, academic, and not-for-profit sectors to anticipate and measure the most pressing climate risks and drive effective responses. For additional information on Milliman's social impact, please see the hyperlinks below: • 2021 Social Impact Report • Milliman Social Impact and Sustainability – Statement and Policies, September 2022	
2	**BIDDER EO 18-03 CERTIFICATION**	MAXIMUM TOTAL POINTS
EO	Are your employees required to sign, as a condition of employment, a mandatory individual arbitration clause and/or a class or collective action waiver? **Please Note:** Points for this question will be awarded to bidders who respond that they do not require these clauses and waivers. If you certify here that your employees are NOT required to sign these clauses and waivers as a condition of employment, and you are the successful bidder, a term will be added to your contract certifying this response and requiring notification to DSHS if you later require your employees to agree to these clauses or waivers during the term of the contract.	**50 Points**
	ANSWER: No	

3	BIDDER QUALIFICATIONS AND EXPERIENCE (MANAGEMENT RESPONSE)	MAXIMUM TOTAL POINTS
	MANDATORY EXPERIENCE AND QUALIFICATIONS	**800 pts**
A	Please describe the experience, skills and qualifications your organization possesses related to 5 years or more of actuarial experience with setting capitated medical, behavioral health and long-term care rates for Medicaid managed care organizations. Please include examples of specific methodology used with setting actuarial sound managed care rates specifically for Programs of All Inclusive Care for the Elderly (PACE), a fully integrated managed care program	120 pts
	ANSWER: Milliman has been a national leader in consulting to state Medicaid agencies, including work in more than 20 states for over 25 years. Currently, we have contracts with 19 state Medicaid agencies to sign and actuarially certify state Medicaid managed care capitation rates. We are a full-service firm with a deeply qualified, highly credentialed staff. We have more actuaries that specialize in Medicaid consulting than any other actuarial firm. We recognize that capitation rates are not created in a vacuum and are part of a dynamic and complex environment with managed care plans and other stakeholders. The Seattle office is the current state actuary for five Medicaid agencies (Hawai`i, Washington, Idaho, Utah, and West Virginia). In addition to these states, we are performing ad-hoc services for Medicaid agencies in Nebraska and Texas. For each of these clients and projects, we have employed innovative, customized strategies through a full-service, transparent approach with unmatched attention to detail.  Our deliverables, including managed care capitation rates, consider the specific nuances that exist in every state. We are committed to a continued focus on the State of Washington and understanding the service delivery system that supports the members. This level of service does not end with a deliverable. It is crucial that once deliverables such as capitation rates are provided that we then track the assumptions to ensure the accuracy of the rates as well as surveil the data for unanticipated changes. **Capitation Rate Setting:** Milliman has extensive knowledge and expertise in developing actuarially sound capitation rates. In fact, we are currently the certifying actuary for approximately half of all state Medicaid managed care programs that operate across the country. These programs and our experience coincide with Washington's managed care populations that include the acute care and specific programs for individuals needing long-term services and supports (LTSS).	

The following table summarizes Milliman's Medicaid state agency capitation rate setting experience:

MILLIMAN'S MEDICAID MANAGED CARE CURRENT CAPITATION RATE SETTING EXPERIENCE

State Agency	Years of Experience	Medical Services	Behavioral Health	MLTSS	PACE
Arkansas	5 years	X	X	X	X
Florida	24 years	X	X	X	X
Hawai`i	18 years	X	X	X	
Idaho	13 years		X	X	
Illinois	25 years	X	X	X	
Indiana	23 years	X	X	X	X
Kentucky	3 years	X	X		
Louisiana	Less than 1 year	X	X		
Michigan	26 years	X	X	X	X
Minnesota	31 years	X	X	X	
Mississippi	15 years	X	X		
New Hampshire	10 years	X	X	X	
Ohio	14 years	X	X	X	X
Rhode Island	4 years	X	X		
South Carolina	15 years	X	X	X	X
Utah	13 years	X	X		
Washington	27 years	X	X		X
West Virginia	1 year	X	X		
Wisconsin	8 years	X	X	X	

	Our capitation rate setting experience spans multiple state Medicaid agency managed care contracts of comparable size and program design to Washington. Within each contract we currently hold, we provide a variety of consulting services and analysis built around managed care rate setting that include risk adjustment, plan cost reporting, budget forecasting, financial monitoring, and program strategy. Although the rate setting process applied to unique populations and specialized services generally follows Milliman's underlying methodology for Medicaid capitation rate setting, additional nuanced considerations must be made when developing the rates for these populations and service types. Based on the managed care market, covered benefits, enrolled beneficiaries, stability and credibility of the base experience data, MCO contractual administrative requirements, and program maturity, we tailor the rate setting process to appropriately align with the program for which the rates will be established, **Medical** Medical services are the commonly covered in managed care contracts. Milliman currently develops capitation rates including medical services in 18 states, including Washington, as listed in the table above. We have assisted Washington with its Medicaid program for physical health medical services since 1996. **Behavioral health** Medicaid is the single largest payer for behavioral health services in the United States. Persons with behavioral health needs are among the most vulnerable Medicaid beneficiaries with a life expectancy far below that of the United States average. This population often has significant co-morbid physical health issues that can complicate their overall treatment plan. The complexity of this illness requires a deep understanding of this population and the data to inform sound policy making when developing capitation rates. It is important to evaluate behavioral health services at a granular level for each managed care program to isolate trends in the number of persons utilizing or requiring services within specific population cohorts (e.g., persons with severe and persistent mental illness, persons with substance abuse disorder). Milliman has worked extensively with states on their behavioral health systems and has unmatched understanding of the delivery of specialty behavioral health services. In Washington, we have a deep understanding of the behavioral health service landscape as the Milliman Seattle office certifies the capitation rates for Washington, including its Apple Health Integrated Managed Care (IMC) program, Integrated Foster Care (IFC) program, and the Behavioral Health Services Only (BHSO) program. Our deep	

understanding has been fundamental in setting capitation rates for a sustainable integrated program, which has been a priority for Washington Medicaid over the past 7 years.

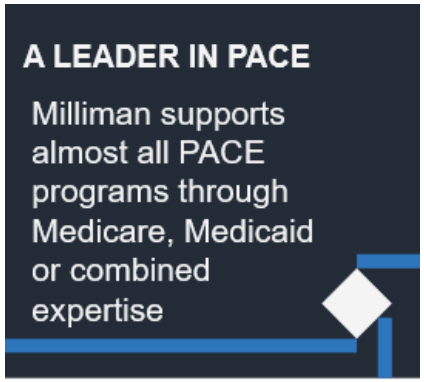
Long-term care rates

Long term supports and services (LTSS) populations are among the most vulnerable Medicaid populations, generally characterized as having met minimum criteria for long-term services and supports (LTSS) based on needing assistance with certain activities of daily living (ADLs). These services are significantly different than acute care services, and the LTSS utilization pattern can vary based on the ADL(s) where members need the most assistance. A firm understanding of the distribution of LTSS populations and service utilization across the state is necessary to develop the appropriate capitation rate cell structure and actuarial cost models that anchor the capitation rate development process. In addition, great care is needed to segment the population between non-dual and dual eligibles, as Medicare finances most acute care services for dual eligible members.

In Washington, LTSS are generally delivered through the fee-for-service program. However, we have a deep understanding of the LTSS landscape through our experience with the Community Options Program Entry System (COPES) population within the IMC program. We also have assisted Washington in developing the provider payment rates for its Health Home program which is a key care coordination program for dual eligibles.

PACE

Setting PACE capitation rates requires a deep knowledge of state-specific physical health, behavioral health, and LTSS offered under Washington's State Plan. Milliman's Seattle Health practice—which will be the primary contact for this project—has supported Washington state's Medicaid program for nearly three decades and state PACE programs managed by Aging and Long-Term Support Administration (ALTSA) for 15 years.



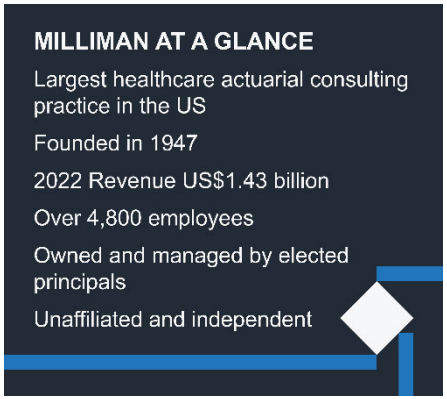
During that time, we have assisted with:

- Expansion of the PACE program from one site to six
- Expansion of managed care to disabled members in the Apple Health program

	• Expansion of managed care to foster care members in the Apple Health program • Medicaid expansion through the ACA, including conversion of the MCS program into Apple Health • Serving a key role in developing the PEBB Accountable Care Program (ACP) • Collaborating with HCA staff as well as Office of Financial Management (OFM) and Legislative staff in the development and implementation of the SEBB Program • Support for the Washington Cascade Care program • Support for the development of 90/180 day civil commitment beds • Support for the Safety Net Assessment Fund (SNAF) Seattle Health's practice developed a process for producing a risk-adjusted payment PACE capitation rate following CMS guidance and regulations while using the limited data and information available through the PACE program. Rates were developed based on FFS data for the PACE-similar population in Washington using the following methodology: 1. Identify the appropriate base data representing historical FFS medical and LTSS costs. 2. Limit the Medicaid medical and LTSS costs to the PACE-similar population and stratify by living situation (i.e., in-home, nursing facility, adult family home, or assisted living facility). 3. Adjust the base period benefit costs by applying pharmacy rebates, COVID add-on adjustments, and completion factors. 4. Project the medical and LTSS benefit costs by living situation, including the application of trend, fee schedule changes, and other program changes. 5. Risk adjust the rates and AWOP for each individual PACE organization by blending the projected costs by living situation. 6. Project and add NEMT costs. 7. Add non-benefit costs transferred from the State to the PACE organization. 8. Add the behavioral health (BH) capitation rates which are developed separately. Further detail on the methodology used for Washington PACE rate development is included in the State Fiscal Year (SFY) 2023-2024 rate certification or Attachment II.	

Milliman's Actuarial Experience

Milliman is comprised of many talented consulting actuaries, and we are committed to providing all clients with the highest quality of services. As previously indicated, Milliman has provided actuarial services to state Medicaid agencies for over 20 years – with more than 20 states in the last 5 years. We are able to exceed expectations and keep long-standing and satisfactory relationships with our clients because of the high standards we have for our staff.



Training: Milliman looks for the best and brightest professionals, recruiting actively nationwide. We hire professionals with a broad range of backgrounds and accreditations. These positions include actuaries, who are leading experts and regularly contribute to the industries they serve through research, training, working groups, and thought leadership.

Program Development for All Professionals: Milliman creates an environment that recognizes and meets our employees' personal and professional needs. Our Learning & Development team identifies opportunities for employees to advance professionally and develop consulting skills that supplement their expertise.

These programs support ongoing professional development:

- **Mentorship Program:** Senior leaders are matched with junior employees for a nine-month guided program. The program is highly sought after, with hundreds of participants in each cycle. Past participants cite benefits as diverse as learning new skills to breaking down social barriers.
- **Manager Development Program:** The Manager Development program is designed to provide a conceptual and tactical framework for successful people management. This program combines leadership attributes with daily manager skills that encompass the entire employee lifecycle.
- **Milliman Leadership Academy:** This program builds and enhances leadership skills in high achieving employees. Its structure enables participants to learn and demonstrate proven foundational leadership principles. Outside experts and leaders in the firm help participants develop skills that they'll immediately use to drive business results.

	• **Annual Health Forum:** Every year, our professionals gather for a multi-day conference to network with and learn from each other. Our sessions showcase the innovative work that we do for our clients and we have a dedicated track for Medicaid topics to provide learning and interactive opportunities to equip our professionals to be at the industry's leading edge. **The Path to Consulting Actuary:** Milliman has a comprehensive career development path for all actuaries within our firm from college graduate to Consulting Actuary. We have a formal mentorship program to guide our employees along the path, and the collaborative nature of our firm coupled with a genuine interest in developing others leads to establishing informal mentorship relationships and sharing knowledge. We have high employee retention, as many of our employees have begun their career with us and remain with us to this day. Milliman has a remarkable history of continuity in its professional staff. In fact, over the last five years, our turnover rate has been 11% among all consultants and less than 5% among principals. These percentages have not varied much throughout Milliman's history, demonstrating incredible stability in our professional staff. We attribute these factors to our professional development program, which allows multiple paths for growth. Our new hire onboarding process, ongoing training and engaging hands-on project experience for our employees, along with the high level of involvement and day-to-day interactions of the senior consultants with the staff preparing the client work ensures continuous development of our knowledge base and supports our professionals' career movement along the path to Consulting Actuary. **Certifications:** All key actuarial personnel for this project are fully qualified to provide the actuarial services required in this RFQ (Associates or Fellows of the Society of Actuaries and Membership in the American Academy of Actuaries). Not only have these actuaries attained these high standards, but they also have comprehensive and extensive experience from working in the field, with specific emphasis on Medicaid consulting. **Resources and Team Approach:** We staff each project with senior team members who hold at least 10 years of experience, assuring full understanding of the complex issues, while supporting these experts with analysts and additional consultants to provide cost-effective research and support for our clients' needs. When multiple paths might support a goal, we will queue up best practices so options can be weighed in a well-informed manner, and bring in additional experts such as operations, clinical, or finance professionals to support informed decision making. Our multidisciplinary team examines issues from numerous angles to avoid design pitfalls like settling for regulatory inflexibility, losing access to extra funding sources, or getting stuck with difficult operations. We are experts at identifying new opportunities based on the complex regulatory landscape and Washington's priorities. With a broad experience of our team working in a variety of states, both in PACE and in Medicaid, we offer insights that are not readily available from viewing national trends. Leading Medicaid reforms on the front lines,	

developing and negotiating novel waiver concepts in numerous states, we bring valuable insight into the often-unwritten regulatory limitations and policy goals of the federal government to help Washington reach its goals.

Below is a breakdown of Medicaid services our consultants have provided states over the years.

STATE	CAPITATION RATE SETTING & RISK ADJUSTMENT	ALTERNATIVE PAYMENT MODELS (APMS)	VALUE BASED PAYMENT	1115 WAIVER DEVELOPMENT & SUPPORT	FFS RATE SUPPORT	BUDGET FORECASTING & FISCAL SUPPORT
AK	X			X		X
AZ	X					
AR	X			X	X	X
FL	X		X	X		X
HI	X	X		X	X	X
ID	X		X	X	X	X
IL	X	X	X	X		
IN	X	X	X	X	X	X
IA	X			X	X	X
KY	X		X	X		X
LA	X					
MI	X		X	X		X
MN	X					
MS	X				X	X
NE					X	X

NV	X			X		X
NH	X	X		X	X	
OH	X	X	X	X	X	X
PR	X	X	X	X	X	X
RI	X	X	X	X	X	
SC	X	X		X	X	X
UT	X			X		X
VT	X			X		
WA	X	x	X	X	X	X
WI	X	X			X	
WV	X		X	X		X

Our extensive experience reaches beyond services and delves into policy work on broad range of projects, as follows:

MILLIMAN'S POLICY CONSULTING EXPERIENCE

Project Type	AK	AR	AZ	HI	ID	IN	IL	KY	LA	MI	OH	RI	SC	WA
1115 Waivers	X	X		X	X	X	X	X			X	X		
Program Design	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Legislative and Regulatory Analysis	X	X	X	X		X	X	X	X	X	X	X	X	X

1915c/HCBS Waivers														
Managed Care Program Design/Oversight				X	X	X	X		X	X	X	X		
Procurement Assistance	X				X						X	X	X	
Value Based Purchasing			X		X	X	X			X			X	
Behavioral Health Transformation	X	X		X	X				X	X			X	
CCBHC									X	X	X		X	
SDOH/Health Equity		X	X			X	X				X			
LTSS Reform					X					X	X	X		
Other HHS (child welfare, DD, Aging, Public Health)	X	X		X	X		X			X				
CMS Compliance and Reporting	X			X		X					X		X	
Stakeholder Engagement	X		X		X			X	X	X	X		X	
Pharmacy Consulting					X	X	X	X	X	X	X	X		

The table on the following pages provides additional detail for the many types of projects that Milliman regularly undertakes for our state clients in the areas of policy, finance, healthcare management, and Medicaid pharmacy consulting.

MEDICAID POLICY CONSULTING

Waiver Development, Health Care Reform, Program Development And Enhancements

- 1115, 1915, 1332, emergency waivers and state plan amendments
- Dual demonstrations/Financial alignment initiatives
- Delivery system reform and value-based payment
- High-cost drugs, premiums assistance programs, Medicare savings programs
- Managed Long-Term Services and Supports (MLTSS)
- Quality strategy
- Behavioral health transformation
- Social determinants of health

Program Conceptualization, Design, and Implementation

- Facilitation of visioning and strategic planning
- Program evaluation metrics and cost-saving initiatives
- Best practice review and gap analyses
- Value-based purchasing strategies and implementation plans
- Comparative analysis, benefit design and improvements
- Statutory/regulatory research and assessment of program impacts

Managed Care and ASO/Vendor Operational Support

- Procurement, contract evaluations, and vendor oversight programs
- Transformation and MCO integration

	• Provider collaboration models, stakeholder engagement strategies, planning new program rollouts • Care management redesign • Administrative cost modeling • Behavioral health integration • Single PBM carve out and implications • Retrospective program analysis **Proposed Team and Resources:** Milliman has a wealth of resources we can continue to provide to Washington to support your PACE work. Our holistic team of consultants are from various backgrounds and disciplines and have a shared history of collaboration and communication on similar Medicaid-focused projects. For more information on our proposed project team and key personnel, please see resumes in Attachment I for more details. **Program and Quality Management Systems:** Milliman has a strict Quality and Risk Management (QRM) policy, which guides our peer review process. This process requires a secondary review of the work performed, all deliverables, reports prepared, and overall project management. The reviewer selected is someone familiar with the project, but who has not performed significant work on the specific project. This allows for impartial review and the opportunity for additional insights. The review is structured to identify any outstanding issues that were not addressed, to ensure that the information is presented in a logical and complete manner, and to ensure that the overall quality of the work meets Milliman's high standards. This process adds an additional level of security, accuracy, and transparency for our clients.	
B	Please describe your organization's experience and expertise with the Center of Medicare and Medicaid (CMS) guidelines for the PACE rate calculations. Please provide examples that present referenced CMS guidelines and how they pertain to the PACE rate calculations that are created.	80 pts
	ANSWER: Milliman has extensive experience developing capitation rates for PACE programs in Washington and in other states. We are familiar with the nuances of establishing rates in accordance with federal regulations stipulating that payments must be less than the Amount that Would Otherwise have been Paid (AWOP). While this methodology provides an allowance to account for the frailty of PACE participants, PACE rates should not be higher than the cost of providing Medicaid coverage to this population if the PACE program did not exist.	

Milliman has assisted ALTSA in developing and certifying PACE rates compliant with CMS requirements for approximately 15 years. Through the rate setting process, Milliman complies with 42 CFR 460.182 which prescribes the requirements for Medicaid payments to PACE organizations.

The requirements include:

1. The monthly capitation amount must be less than the amount that would otherwise have been paid (the AWOP) under the State plan if the participants were not enrolled under the PACE program.
2. The monthly capitation amount must take into account the comparative frailty of PACE participants.
3. The monthly capitation amount mut be a fixed amount regardless of changes in the participant's health status.
4. The monthly capitation amount can be renegotiated on an annual basis.

PACE Rate Methodology

[redacted]

	The final capitation rates vary by Medicare status (Medicaid only versus dual eligible) and PACE program. The monthly capitation amounts are a fixed amount regardless of changes in a participant's health status, complying with the third requirement in 42 CFR 460.182. **Frequency** The frequency of capitation rates varies based on the needs of the state and the stability of the program. For ALTSA, we have historically typically set two-year capitation rates which are then adjusted after one-year for changes in the relative frailty of the programs and legislated fee schedule changes. During COVID-19, the rates were adjusted more frequently to account for changes in legislated funding, particularly for home- and community-based service funding from the American Rescue Plan Act of 2021. **Documentation** In addition to the above requirements, Milliman completes the CMS "Financial Review and Documentation for UPL and Rate Setting" checklist for ALTSA with each set of new capitation rates. The checklist from CMS outlines a list of requirements that CMS reviews as part of its rate review process. We complete the checklist by identifying the relevant sections of the capitation rate report that outline where each requirement is met. Milliman also reviews the PACE Medicaid Capitation Rate Setting Guide, published in December 2015, which further outlines the critical elements of rate setting that incorporate both the state development of the AWOP and the monthly capitation rates. To document compliance with all of the above requirements, Milliman provides an actuarial report which describes how the monthly capitation rates were developed, how each CMS requirement is met, and certifies that the monthly capitation rates are actuarially sound. While it is not a CMS requirement that PACE monthly capitation rates be certified as actuarially sound, CMS encourages an actuarial certification. Providing an actuarial certification strengthens the credibility of the rate development process and ensures that actuarial standards of practice (ASOPs) are followed in developing the monthly capitation rates. Relevant ASOPs include ASOP 49 "Medicaid Managed Care Capitation Rate Development and Certification" published in March 2015. Milliman also reviews the relevant sections of Washington's State Plan to ensure compliance with the expectations of the PACE program negotiated between the State and CMS.	
C	Please describe your organization's years of experience with PACE rate negotiations and preparing rate analysis documentation to provide for rates review and approval by CMS. Please provide examples of specific communications (draft rate letters, etc).	120 pts

ANSWER:

Milliman has assisted states in PACE rate negotiations and preparing rate analysis documentation since the PACE program's inception in 1997. Milliman supports almost all PACE programs nationwide through Medicare, Medicaid or combined expertise. Specifically, Milliman assisted in preparing rate analyses and developing and documenting PACE capitation rates, including the ensuing negotiations with CMS, in the following states:

- Arkansas: 2018 to present
- Indiana: 2000 to present
- Florida: 2008 to present
- Michigan: 1997 to present
- Nebraska: 2010 to 2012
- Ohio: 2015 to present
- South Carolina: 2008 to present
- Washington: 1997 to present
- Wisconsin: 2000 to 2005; 2015 to present

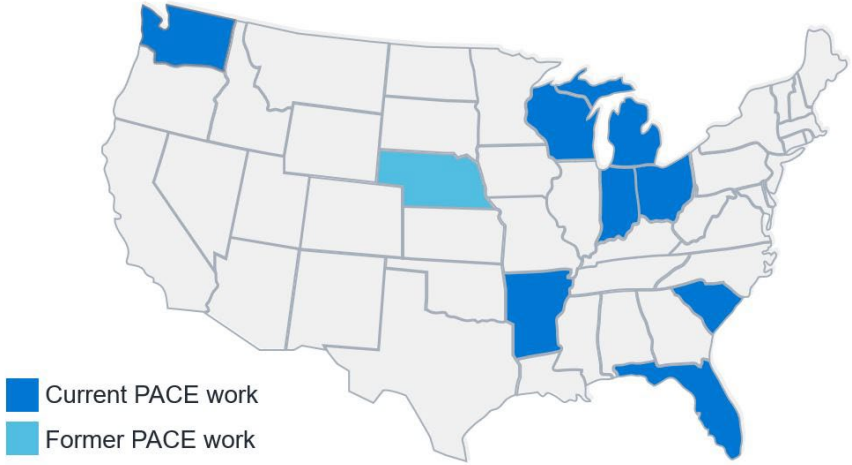


Figure 1: States where Milliman assists with PACE work

For each of the above states, we have provided any necessary assistance to the State and CMS for developing and documenting the capitation rates. As described in the prior response, our rate report documents the approach used for developing capitation rates and compliance with CMS requirements. We have included our most recent report for the Washington State PACE programs as Attachment II. We have also included our responses to the CMS Guide as Attachment III and our most recent CMS rate questions and responses as Attachment IV.

Attachments II and III – the report and the guide – are submitted as part of the initial rate package to CMS. Attachment IV documents our work with CMS to answer any questions about the results or methodology. When warranted, we have also held calls with CMS including its subcontracted actuaries to address any questions that are easier to discuss live.

D	Please describe your organization's actuarial staff's experience in analyzing data to develop and calculate capitated medical rates for PACE programs and managed care models. Please include their experience of working with the CMS guidelines for the PACE rate calculations.	120 pts
	ANSWER: Milliman supports almost all PACE programs through Medicare, Medicaid or combined expertise. Our staff has extensive experience analyzing data to develop and calculate capitated medical rates for PACE programs and managed care models. For the last 15 years, Milliman's Seattle Health practice has supported the Washington PACE programs managed by ALTSA. Our long history with the State of Washington has provided us with an extensive understanding of the current landscape in Washington as well as existing access to detailed claims data required for PACE capitation rate setting. As mentioned previously, in our work for PACE we have helped with: • Expansion of the PACE program from one site to six • Expansion of managed care to disabled members in the Apple Health program • Expansion of managed care to foster care members in the Apple Health program • Medicaid expansion through the ACA, including conversion of the MCS program into Apple Health • Serving a key role in developing the PEBB Accountable Care Program (ACP) • Collaborating with HCA staff as well as Office of Financial Management (OFM) and Legislative staff in the development and implementation of the SEBB Program • Support for the Washington Cascade Care program • Support for the development of 90/180 day civil commitment beds • Support for the Safety Net Assessment Fund (SNAF) Milliman staff currently set PACE rates in eight states. For this engagement, we are proposing the following team: • Annie Hallum, FSA, MAAA: Primary Contact for administration and contract management • Nick Johnson, FSA, MAAA: Alternative Contact for administration and contract management • Justin Birrell, FSA, MAAA: Subject Matter Expert for program history	

	• Daniel Gerber, ASA, MAAA: Project Manager • Kelly Backes, FSA, MAAA: External Peer Reviewer With Milliman's deep Medicaid experience nationwide and in Washington, we have extensive resources available to adapt to the project needs as they arise and add additional staff. We also have deep understanding and experience with the data to run the project efficiently. **Annie Hallum** has approximately 13 years of experience analyzing data and developing capitation rates. She has worked with data from State of Washington and its managed care organizations since she joined Milliman in 2009. She has certified PACE capitation rates in Washington and Wyoming. She has also developed capitation rates for other managed care programs in Hawai'i, Nevada, Utah, Vermont, Washington, and West Virginia. **Nick Johnson** has 14 years of actuarial experience, primarily working with Medicare Advantage organizations (MAOs), state Medicaid agencies, and Medicaid managed care organizations (MCOs). He has extensive experience with programs for dual eligible populations through work with MAOs offering D-SNPs, Medicaid capitation rate setting for MLTSS and integrated programs for dual eligible beneficiaries, and PACE organizations. He has certified or reviewed Washington's PACE capitation rates since 2017. **Justin Birrell** has nearly 30 years of actuarial experience, most of that time focused on Medicaid related work. This has involved work for states including Florida, Hawai'i, Idaho, Nevada, Utah, Washington, West Virginia, and Vermont, as well as non-state clients where he has supported Medicaid populations in Kentucky, Arizona, Georgia, Massachusetts, New Mexico, and the District of Columbia. He has worked on a variety of projects, including medical, long-term care, behavioral health, transportation, disease management, procurement, healthcare reform, and other state-specific analyses. **Daniel Gerber** has six years of experience analyzing data and developing capitation rates, primarily working with state Medicaid agencies, federal government agencies, and Medicare Advantage organizations. He has worked with data from State of Washington and its managed care organizations since 2018. He has also developed capitation rates and performed related analyses for other managed care programs in Nevada, Washington, and West Virginia. **Kelly Backes** has more than 20 years of actuarial experience and eight years of development of Upper Payment Limits for the PACE population, including peer review for Washington and its PACE population since 2021. Please see Attachment I for the full resumes of the proposed team.	

	We are committed to maintaining our national reputation for integrity and high-quality work. As part of this process, we use peer review from another Milliman office to align best practices across Milliman practices and Medicaid programs. We ensure the highest quality results through internal control procedures, resulting in capitation rates that are as accurate as possible for the populations and benefits covered under a Medicaid managed care program. All work is peer reviewed by other professionals before being sent to clients. Our actuarial credentialing process goes beyond the Society of Actuaries, requiring individuals to demonstrate competency through experience, technical knowledge, and high sensitivity to quality before being granted authority to sign deliverables. Kelly Backes will provide an extra level of external peer review as our external peer reviewer.	
E	Please describe your organization's years of experience working with Medicaid medical and behavioral health benefits. Please include specifically reference Medicaid medical and behavioral health benefits and how their inclusion would impact setting actuarial sound rates for PACE.	80 pts
	ANSWER: With more than 70 years of experience in the actuarial field and more than 40 years specifically in the Medicaid market, we have more years of experience as an organization than any other major actuarial organization in the country. In Washington specifically, we have more than 27 years of Medicaid experience. In the Seattle Health practice, we currently have 18 Principals and 120 actuaries and analysts who are part of a larger worldwide network of more than 4,000 staff members, with 500 who are qualified FSA actuaries and consultants. Our work processes and expertise have extensively shaped the field over the last seven decades, and we are committed to continuing that trend in the best interests of all key stakeholders. Beyond our years in the Medicaid space, Milliman currently has contracts with 19 state and territorial Medicaid agencies to sign and actuarially certify state Medicaid managed care capitation rates, as displayed in the map in Figure 2 below.	

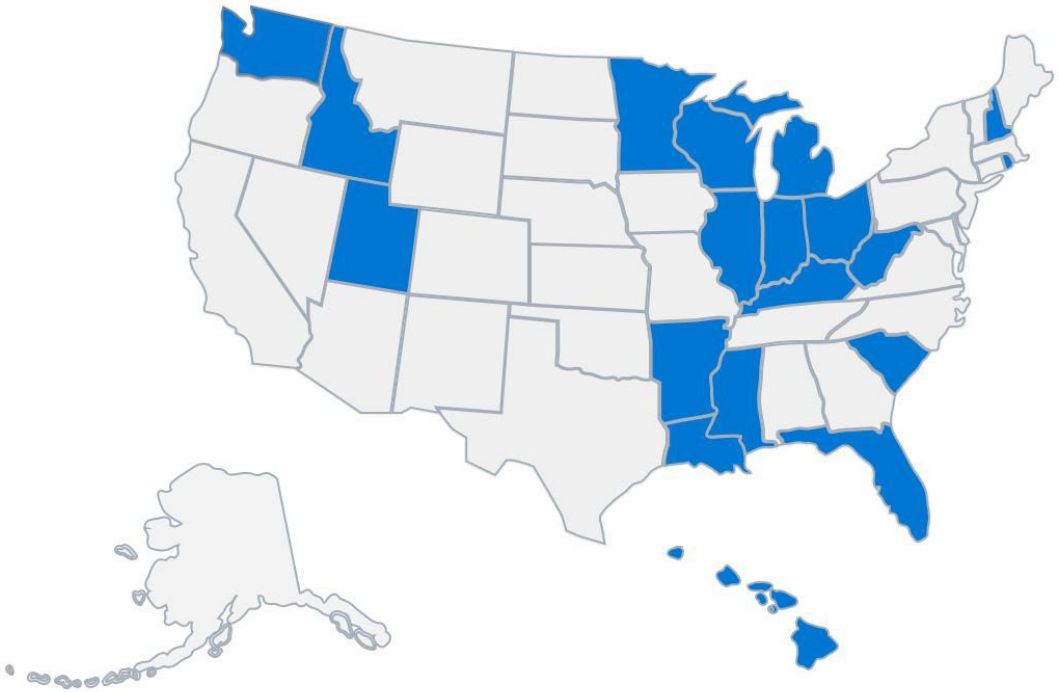


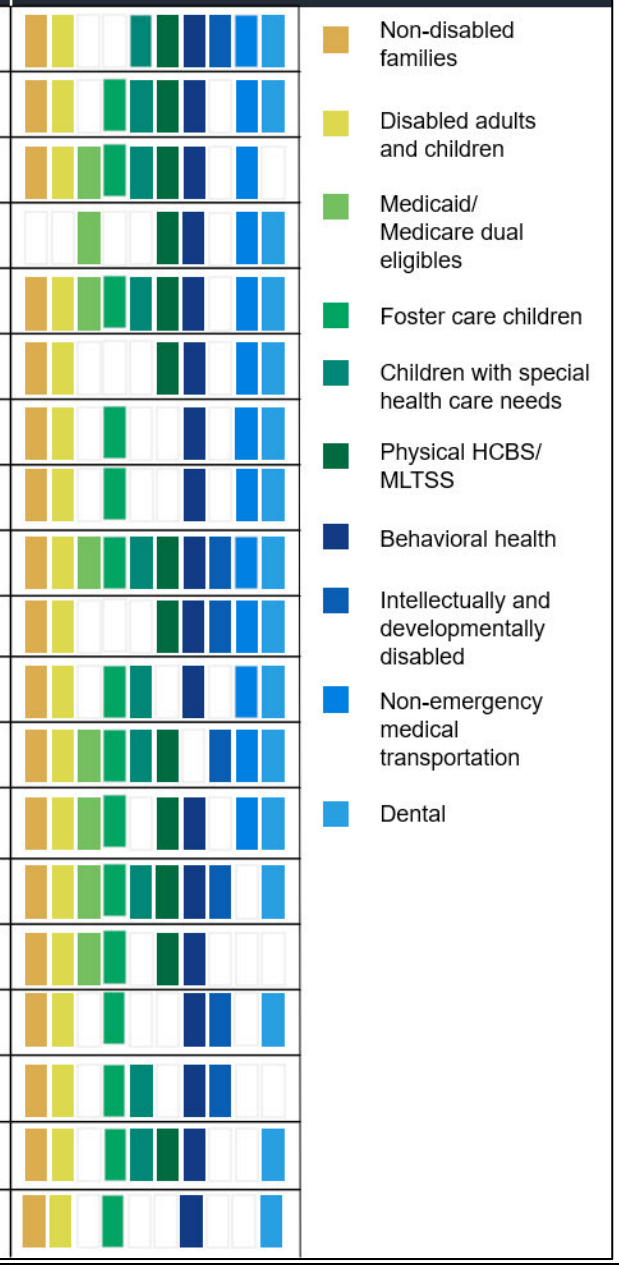
Figure 2: Current states Milliman certifies Medicaid rates for

The Seattle office alone is the current state actuary for five Medicaid agencies (Hawai`i, Washington, Idaho, Utah, and West Virginia). In addition to these states, we perform ad-hoc services for Medicaid agencies in Nebraska and Texas. For each of these clients and projects, we have employed innovative, customized strategies through a full-service, transparent approach with unmatched attention to detail.

The diversity of our experience provides our clients with a one-stop solution for financial analysis of the Medicaid program including:

	• Support for managed care programs covering a variety of different benefit packages, including acute medical, pharmacy, behavioral health, long-term care, dental, vision, and non-emergency transportation plans. • Developing adjustments to reflect the impact of proposed policy and legislative changes on existing and prospective capitation rates. • Understanding the challenges associated with providing healthcare to Medicaid populations including access to services, provider reimbursement levels, and outreach to persons with disabilities or complex medical needs. The following chart below outlines the states where we are the current actuary of record, along with the number of enrollees and the managed care cohorts and services covered by the capitation rate certifications.	

State	Active Since	Number of Enrollees	Managed Care Cohorts and Services
AR	2018	1,000,000	
FL	1999	4,600,000	
HI	2005	400,000	
ID	2010	400,000	
IL	1998	3,600,000	
IN	2000	1,800,000	
KY	2020	1,500,000	
LA	2023	1,400,000	
MI	1997	2,900,000	
MN	1992	1,300,000	
MS	2008	760,000	
NH	2013	230,000	
OH	2015	3,200,000	
RI	2019	300,000	
SC	2008	1,200,000	
UT	2010	500,000	
WA	1996	2,100,000	
WI	2015	1,300,000	
WV	2022	600,000	



	Federal regulations require that PACE organizations assume full financial risk for all the health care services enrollees need. Therefore, the Medicaid rates must encompass the full array of potential services received by enrollees under the Medicaid state plan. We understand that the PACE rates are an integrated rate and need to consider both the expected medical and behavioral health costs. This is particularly true for the non-dually eligible population where Medicaid is still the primary payer for most medical services. For members who are dually eligible for Medicaid and Medicare, the behavioral health costs along with Medicaid covered services that are not covered by Medicare (like diapers and certain prescription drugs) are the primary non-LTSS costs to the State for the PACE eligible members. Therefore, PACE rate development requires a deep understanding of both medical, behavioral health, and integrated services.	
F	Please describe your organization's years of experience using PACE eligibility requirements and understanding of specific PACE demographics to be included as variables when creating PACE rates. Please provide specific examples (documents, spreadsheets, etc) representing this experience.	40 pts
	ANSWER: Milliman has assisted states in reviewing PACE eligibility requirements and understanding PACE demographics since the PACE program's inception in 1997. In particular, Milliman has assisted the following states in analyzing PACE eligibles: • Arkansas: 2018 to present • Indiana: 2000 to present • Florida: 2008 to present • Michigan: 1997 to present • Nebraska: 2010 to 2012 • Ohio: 2015 to present • South Carolina: 2008 to present • Washington: 1997 to present • Wisconsin: 2000 to 2005; 2015 to present [redacted]	

	[redacted]	
	DESIRED EXPERIENCE AND QUALIFICATIONS	
M	Please describe your organization's years of experience working with WA State Medicaid medical and behavioral health benefits. Please include specifically reference WA state Medicaid medical and behavioral health benefits and how their inclusion would impact setting actuarial sound managed care rates for PACE.	120 pts
	ANSWER: Milliman has provided actuarial consulting services for the state of Washington since 1996, serving multiple agencies over this tenure: the Washington Health Care Authority (HCA), the Department of Social and Health Services (DSHS), and the Washington State Aging and Long-Term Support Administration (ALTSA). The managed Medicaid programs in Washington have approximately 2.1 million enrollees. The State of Washington covers most TANF, CHIP, foster care, disabled, and Medicaid expansion clients through managed care. Milliman assists the State with data validation and analyses, monitoring of health plan performance, health care trend analyses, capitation rate setting, risk adjustment, CMS documentation, and various policy analyses. With Milliman's assistance, the program has continued to provide broad access to care while maintaining reasonable cost controls. We have assisted with numerous policy analyses and procurements and have been an active and involved member of their team throughout our tenure. We have assisted in several procurements and transitions of members from FFS to managed care, as well as Medicaid expansion and a statewide integration of behavioral health and physical health. Over the years, rate setting has included the following programs:	

	• MMIP and WMIP – Two fully integrated programs for dually eligible members. • Healthy Options – A program that primarily included pregnant women and children. This program includes a risk pool for high-cost birth events. • General Assistance Unemployable – This program ultimately became part of Medicaid expansion. Prior to expansion, we set rates and computed shared savings for this program, including many homeless and those with severe behavioral health issues. • Medicaid expansion – We developed rates and unique risk mitigation strategies for this program. • Health Home – We compute provider payment rates for this program, which is key to the managed FFS program for dually eligible members. • Foster Care – Milliman assisted in the procurement and continued support including rate setting for this program. • State Option for ACA members – Currently we are supporting the state in the development of a state option for members getting care through the exchange. • PACE – Milliman has assisted to develop, certify and negotiate PACE rates with regional PACE organizations. In addition, Milliman has assisted Washington with the following projects: • Budget neutral risk adjustment factor development for acute care and LTSS populations • Forecasting and legislative modeling support • State-directed payment pre-print consulting • Waiver application projections	

	Our long history with the State of Washington has provided us with a detailed understanding of the current physical health and behavioral health services landscape in Washington as well as existing access to detailed claims data required for PACE capitation rate setting. PACE capitation rates are impacted by the Medicaid medical and behavioral health benefits in many ways. The most obvious way is that the PACE capitation rates must be less than the amount that would have otherwise been paid under the State Plan. Therefore, setting PACE capitation rates requires a deep knowledge of state-specific physical health, behavioral health, and LTSS offered under Washington's State Plan. Members of our proposed PACE team have experience with Apple Health which assists us in many additional ways, including but not limited to: • We know which services are provided by the managed care organizations and which services are covered FFS through our deep understanding of the Apple Health Integrated Managed Care (IMC) and Behavioral Health Services Only (BHSO) claims data and contracts. • We maintain detailed eligibility and claims databases through our work for HCA which serve as the basis for PACE rate development. This allows us to be more efficient and avoid duplicating work for PACE capitation rate development. • We understand utilization and unit cost trends inherent in medical and behavioral health services for Washington's PACE-similar population (particularly COPES enrollees) from our work in developing and certifying the Apple Health IMC and BHSO rates. • We keep abreast of legislative changes impacting the Apple Health IMC and BHSO programs via our work for HCA and PEBB. This allows us to understand expected program changes that should be considered in PACE rate development.	
N	Please describe your understanding of and experience with WA state LTSS delivery system that represents expertise of the WA state specific services and impact on how PACE rates are created.	120 pts
	ANSWER: Milliman has supported Washington programs including LTSS for nearly 20 years. In 2005 Washington launched the Medicare-Medicaid Integration Project (MMIP) to integrate medical and long-term care and financing for dual eligible seniors in two counties. Through the pilot program, dual eligible seniors in King and Pierce counties could	

	enroll in both Evercare's Medicaid contracted state plan (MMIP) and its Medicare Advantage Special Needs Plan, for Medicare and Medicaid long-term care supports and services. Washington also began the Washington Medicaid Integration Partnership (WMIP) a voluntary managed care pilot project in Snohomish County. WMIP was designed to improve care for disabled Medicaid clients who are 21 years of age or older by coordinating services that in the past have been provided through separate treatment systems. This included, like PACE, medical, pharmacy, behavioral health and LTSS services. Justin Birrell led the team that developed rates and the structure for these programs to integrate aged, blind and disabled members both eligible for Medicare and Medicaid-Only members and Medicaid-Only members for these programs. This work required an understanding of all the agencies supporting these programs including LTSS. Because these were small pilot programs, it was necessary to leverage broader Washington data for these populations and adjust the rates for the risk of those in the program. We worked with ALTSA and RDA to develop risk adjustment models for these programs. Ultimately the key to LTSS risk adjustment was use of the data from the Comprehensive Assessment Reporting Evaluation (CARE) tool. Over a number of years, we developed different risk models for Washington LTSS leveraging this tool, including the methods used currently for PACE. Milliman understands that the Washington state LTSS delivery system is mostly fee-for-service, excluding its six current PACE programs. However, PACE rates include all Medicaid covered services, including medical, behavioral health, pharmacy, transportation, and LTSS. For the non-dual eligible population, this requires an understanding of the entire Washington state Medicaid delivery system in order to develop both the capitation rates and the amount that would have otherwise been paid (AWOP). We discuss our understanding of the nursing facility eligible population and our approach to each type of Medicaid covered service separately below. **PACE Eligible Population Background** The eligible population for the PACE program is Medicaid-eligible (including dually eligible) members residing in Washington state ages 55 and older, who are aged, blind, disabled, or presumptive SSI, at a nursing home level of care. The most common approach to Medicaid capitation rate development is to rely on membership and claims experience from the population actually enrolled in the managed care program. However, the Washington State PACE programs are unable to submit reliable claims data at this time. Therefore, we rely on the development of a "PACE-similar population" using membership and claims data from the membership not enrolled in PACE. To do so requires familiarity with both the physical health services typically provided by the Washington State Health Care Authority (HCA) and LTSS provided by ALTSA.	

	Furthermore, approximately 91% of Washington's existing PACE members (as of CY 2022) are dually eligible for Medicare and Medicaid. The remaining 9% are either non-dually eligible or are not fully dual eligible. This means we must take a different approach to rate development for each of the two populations and must consider changes in the Medicare program that would impact Medicaid costs (such as expanded Medicare coverage of opioid treatment services in 2020). Given these constraints, we develop rates separately by PACE program (which are delineated by organization and county) and dually eligible versus Medicaid only. We also identify the components of rates payable by HCA versus ALTSA to assist Washington's internal budget processes. **Medical Services** For non-dually eligible individuals, we identify the historical medical costs of a similar population from the fee-for-service (FFS) population and their medical claims data. However, we also consider that many of Washington's non-dual eligible population are covered by one of Washington's Medicaid waivers, particularly the Community Options Program Entry System (COPES) waiver. As part of the medical rate development, we must consider that the remaining nursing home eligible FFS population in Washington is small. We therefore use the COPES managed care medical costs as a reasonableness check in developing the medical costs for non-dual eligibles under age 65. Members of Milliman's proposed project team – particularly Annie Hallum and Daniel Gerber – help develop the capitation rates for the Apple Health program, including the COPES managed care capitation rates. As such, Milliman has the expertise in the existing program and is aware of COPES program changes that would impact the PACE AWOP or rates. This expertise is particularly helpful in understanding medical cost changes from the base period costs used in rate development to the projected rate period. For dually eligible individuals, we similarly rely on the historical costs of a similar FFS population. However, it is much easier to identify a similar population given most dually eligible Washington State Medicaid members are not enrolled in Apple Health for their medical benefits. Furthermore, the medical costs typically only represent Medicaid cost sharing for Medicare benefits and costs for a limited set of services that are Medicaid covered, but not Medicare covered (such as adult diapers). We use the historical FFS data and our knowledge of the Washington State Medicaid program to identify Medicaid-covered services and project costs. **Pharmacy Services**	

	Similar to the medical services, pharmacy services are primarily Medicare-covered for dually eligible individuals or covered under Apple Health managed care for most non-dually eligible nursing facility level of care individuals. We approach rate setting for these populations similar to the medical services, with limited exceptions: • We request pharmacy rebate information from the State to estimate pharmacy rebate recoveries that must be accounted for in the AWOP development. • We develop separate add-on components to the PACE rates for high-cost drugs that would typically be excluded from the Apple Health Managed Care rates for non-dual eligibles (particularly Hepatitis C). **Behavioral Health Services** Behavioral health services for both dually eligible and non-dually eligible PACE eligible members are covered under Apple Health managed care. For our AWOP and rate development, we rely on the behavioral health capitation rates set by Milliman (including members of the proposed Washington PACE project team) as both the AWOP and the behavioral health capitation rates used for PACE rate development. Our deep understanding of the Apple Health rate development allows us to certify that these rates are appropriate for use in PACE rate development. In particular, we identify the regional Apple Health behavioral rates for the following categories in PACE rate development: • Apple Health Behavioral Health Services Only (BHSO) Non-Disabled Adult • Apple Health BHSO Disabled Adult • Apple Health Integrated Managed Care (IMC) Newly Eligible **Long-Term Services and Supports (LTSS)** LTSS is paid almost entirely FFS in Washington, outside of the PACE programs. Therefore, for both the dually eligible and non-dually eligible populations, we rely on FFS claims data to develop the PACE AWOP and capitation rates. However, while most LTSS is covered by Medicaid, there are some services that are not Medicaid covered services. These services must be excluded from the PACE AWOP and capitation rate development. We rely on functional recipient aid category (RAC) codes to identify Medicaid covered services. We also consider the patient's contribution to the capitation rate – namely the patient participation amount. Consistent with CMS guidance, rates are gross of patient participation. We composite patient participation costs to include in rate development and present this information separately in the report, rather than as part of the medical costs. The patient participation included in the rates is the sum of three P1 fields: room and board amount, third party resource amount, and participation amount.	

	For LTSS, we also consider significant changes to the program for each PACE rate setting cycle. For example, we recently adjusted rates to incorporate the implementation of the Consumer Direct Care Network Washington (CDWA) in early 2022. We also adjust the LTSS components of rates annually for legislated fee schedule changes. **Transportation** Non-emergency Transportation services are provided to Washington Medicaid enrollees on a FFS basis, but through another vendor who does not submit their claims data to the state's encounter warehouse (ProviderOne). As such, we rely on high-level summaries of trips and costs from the third-party vendor and from the PACE programs to develop the transportation component of the PACE AWOP and capitation rates.	

	BIDDER's SOLUTION AND PROPOSED APPROACH (TECHNICAL RESPONSE)	MAXIMUM TOTAL POINTS - 280
A	Please describe your organization's years of experience of compiling and analyzing medical, behavioral health and long-term care data necessary to set an actuarially sound rate for PACE. Please provide examples of how the data is compiled and explanations related to the analysis used to create the actuarially sound PACE rates.	120 pts
	ANSWER: Milliman has assisted states in compiling and analyzing medical, behavioral health, and long-term care data necessary to set actuarially sound rates for PACE since the PACE program's inception in 1997. In particular, Milliman has assisted the following states in analyzing data to develop and calculate PACE rates: • Arkansas: 2018 to present • Indiana: 2000 to present • Florida: 2008 to present • Michigan: 1997 to present • Nebraska: 2010 to 2012 • Ohio: 2015 to present • South Carolina: 2008 to present	

	• Washington: 1997 to present • Wisconsin: 2000 to 2005; 2015 to present In order to compile the data and develop the data into actuarial rates, we use the following process: Step 1: Provide ALTSA with a data request identifying the data needed for rate development Step 2: Identify a PACE-similar population Step 3: Project historical costs to the rating period Step 4: Develop rate letters and PowerPoints for explaining the PACE rates **Step 1: Provide the Department with a Data Request** The first step of our rate development is requesting the necessary data from the State. The data requests includes four parts, identified separately by the entity responsible for providing the data. We request data from the PACE organization to review enrollment history and projections, financial data, and any other data they can supply to support rate development (transportation data, claims data, etc.). We request CARE assessment data and patient participation data from HCA. We also request information from ALTSA to identify eligible members and services, LTSS per cap reports, transportation data, expected nursing facility and HCBS rates, and information related to expected policy changes. A key item not listed above is the detailed claims and enrollment data used to develop the capitation rates. Our Apple Health managed care capitation rate development team receives ProviderOne (P1) extracts monthly from HCA which included detailed enrollment and claims data for all managed care and FFS Medicaid members. The Apple Health team maintains this dataset in a format where the data is readily for available for our use for PACE rate development. Therefore, our PACE rate development team is able to streamline our data request and processing. **Step 2: Identify the PACE-Similar Population** Using the detailed claims and enrollment data from P1 and the CARE assessment data from HCA, we develop rates using FFS members as a PACE-similar population. We use a comprehensive membership	

	eligibility file for all Washington Medicaid members as well as further historical data. We identify the PACE-similar population as the Medicaid eligible population with the following exclusions: • Members under the age of 55 are excluded. • Dually eligible members who are not entitled to Medicaid Services (QMB-only, QDWI, SLMB-only and QI-1) are excluded. These are identified as members with dual eligibility indicators "01," "03," "05," or "06." • Members who are enrolled with a managed care program covering physical health services, including PACE, are excluded. Note that although many COPES members are enrolled in managed care, we use the managed care data as a reasonableness check instead of the underlying data for capitation rates due to compatibility issues. • Members who are not in a nursing home and do not require a nursing home level of care are excluded. "Nursing home level of care" is determined using the member's CARE assessment and historical claims. • Members with certain eligibility RAC codes are excluded when it is determined that those RAC codes indicated the member is inconsistent with the PACE population. **Step 3: Project Historical Costs to the Rating Period** After compiling the historical claims data and limiting the PACE-similar population, we make adjustments for the following: • We apply completion factors for claims that have been incurred but not paid • We adjust pharmacy costs for anticipated rebates due to the State • We apply geographic unit cost adjustments to address data credibility issues in certain PACE counties. • We apply trend rates which vary for Medicaid only versus dually eligible rate cells and by service type (e.g., inpatient, outpatient, in-home, etc.).	

	• We adjust for changes to the program (such as implementation of CDWA). • We adjust for fee schedule changes including, but not limited to, one-time COVID add-ons funded through ARPA funds, legislated appropriations, and other regular fee schedule changes. • We apply risk adjustment to ensure rates are appropriate for the relative risk and age of each individual PACE program. For example, we develop a projection of the expected nursing home versus community distribution of each PACE program and adjust rates accordingly. • We add administrative costs to the AWOP (transferred care management only) and the capitation rates (care management and other admin and risk management costs). • We add behavioral health rates equal to the appropriate BHSO and IMC capitation rates. • We add a Hepatitis C add-on rate for members who receive a Hepatitis C prescription in the month. **Step 4: Develop rate letters and PowerPoints for Explaining the PACE Rates** We provide the State and CMS with a detailed rate certification and responses to CMS checklist. This documentation helps explain the data requested, adjustments to the data, and the overall rate development methodology. We also provide individual rate letters for each PACE organization so they can understand how their rates were developed without receiving proprietary information from another organization. Finally, we provide a PowerPoint presentation and schedule a meeting to discuss the PowerPoint with the PACE organizations so that everyone understands the creation of the actuarially sound PACE rates. We have included our State Fiscal Year 2023-2024 rate report for the Washington State PACE programs as Attachment II. We have also included our responses to the CMS Guide for the same period as Attachment III and the accompanying PowerPoint for the PACE Organizations as Attachment V.	
B	Please describe your organization's years of incorporating the complex Long Term Services and Supports (LTSS) delivery system into their setting actuarial sound managed care rates for PACE. Please include in the examples specific LTSS references and how they would be used/calculated in setting the PACE rates.	80 pts
	ANSWER:	

	Milliman has incorporated the complex LTSS delivery system into actuarially sound managed care capitation rates for PACE since the PACE program's inception in 1997. In particular, Milliman has assisted the following states in incorporating LTSS into PACE capitation rates: • Arkansas: 2018 to present • Indiana: 2000 to present • Florida: 2008 to present • Michigan: 1997 to present • Nebraska: 2010 to 2012 • Ohio: 2015 to present • South Carolina: 2008 to present • Washington: 1997 to present • Wisconsin: 2000 to 2005; 2015 to present For Washington ALTSA, our methodology for incorporating LTSS into the PACE capitation rates continues to evolve with changes to the LTSS landscape. Below we highlight three specific examples of how we have considered the complex LTSS landscape in the capitation rates below. 	

	[redacted] [redacted] **ARPA Fund Distribution** Beginning with the American Rescue Plan Act of 2021, Washington began allocating significant funding investitures in its HCBS services, including LTSS and behavioral health. However, the rates were partly funded through COVID-19 add-in amounts embedded in FFS payments and partly allocated through funding to the PACE organizations. We needed to account for the complexity of the funding allocations to make sure the PACE rates included the anticipated amount of funding. Our understanding of the landscape allowed us to adjust our PACE rates every six months appropriately for added funds. We also understood the changes on the behavioral health side as Milliman certifies the behavioral health rates for IMC and BHSO. This integrated understanding of the Washington State Medicaid landscape allows for quick adoption of new program changes and flexibility in implementation.	
C	Please describe your organization's experience with calculating PACE rates in accordance with 42 CFR 460.182 "Medicaid monthly capitation payment amounts must be less than the amount that would otherwise have been paid under the State plan if the participants were not enrolled under the PACE program".	80 pts
	ANSWER:	

	Milliman has assisted states in calculating PACE rates in accordance with 42 CFR 460.182 since the PACE program's inception in 1997. In particular, Milliman has assisted the following states in developing CMS compliant PACE rates: • Arkansas: 2018 to present • Indiana: 2000 to present • Florida: 2008 to present • Michigan: 1997 to present • Nebraska: 2010 to 2012 • Ohio: 2015 to present • South Carolina: 2008 to present • Washington: 1997 to present • Wisconsin: 2000 to 2005; 2015 to present Milliman has assisted ALTSA in developing and certifying PACE rates compliant with CMS requirements for approximately 15 years. Through the rate setting process, Milliman complies with 42 CFR 460.182 which prescribes the requirements for Medicaid payments to PACE organizations. The requirements include: 1. The monthly capitation amount must be less than the amount that would otherwise have been paid (the AWOP) under the State plan if the participants were not enrolled under the PACE program. 2. The monthly capitation amount must take into account the comparative frailty of PACE participants. 3. The monthly capitation amount must be a fixed amount regardless of changes in the participant's health status. 4. The monthly capitation amount can be renegotiated on an annual basis. There are multiple ways to demonstrate that PACE rates satisfy the first requirement, that monthly capitation rates are lower than the AWOP. In some states, for example, the AWOP can be tied to managed LTSS (MLTSS) capitation rates. Historically, Milliman has used State Plan data for Washington as the basis for both capitation rate development and AWOP estimates due to the lack of MLTSS program and the lack of encounter data from PACE organizations. This data is limited to the costs and utilization of other Washington Medicaid members who could enroll in PACE (i.e., they are Medicaid-eligible members	

	residing in Washington sages 55 and older, who are aged, blind, disabled, or presumptive SSI, at a nursing home level of care). For services other than behavioral health services covered under the Apple Health Integrated Managed Care (IMC) or Behavioral Health Services Only (BHSO) program, the data represents fee-for-service data for the PACE eligible population. For behavioral health services, both the AWOP and the certified capitation rates rely on the BHSO capitation rates certified by Milliman. [redacted]	