Form **W-9**
(Rev. December 2011)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type
See Specific Instructions on page 2.

Name (as shown on your income tax return)
Bailit Health Purchasing, LLC.

Business name/disregarded entity name, if different from above

Check appropriate box for federal tax classification:
☐ Individual/sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☑ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ P

☐ Other (see instructions) ▶

☐ Exempt payee

Address (number, street, and apt. or suite no.)
56 Pickering Street

Requester's name and address (optional)

City, state, and ZIP code
Needham, MA 02492

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number
☐☐☐ - ☐☐ - ☐☐☐☐

Employer identification number
0 4 - 3 3 4 0 9 9 1

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here Signature of U.S. person ▶ Michael H. Bailit Date ▶ November 23, 2011

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

DEPARTMENT OF VERMONT HEALTH ACCESS

APPLICANT INFORMATION SHEET

(To be included in the proposal packet)

**NOTE: This information sheet must be included as the cover sheet of the application being submitted. Be sure to complete this form in its entirety. Please fill out and attach a fw-9 to this form signed by the duly appointed signing official for your company.

Applicant Organization: Bailit Health Purchasing, LLC.

Contact Person: Michael H. Bailit

Title: President

Mailing Address: 56 Pickering Street

Town, State, ZIP: Needham, MA 02492

Telephone: 781-453-1166 Fax #: 781-453-1167

E-mail Address: mbailit@bailit-health.com

Fiscal Agent (Organization Name): _____

FY Starts: _____ FY Ends: _____

Financial Contact Person: _____

Mailing Address: _____

Town, State, ZIP: _____

Telephone: _____ Fax #: _____

E-mail Address: _____

Federal Tax ID Number: _____

Whom should we contact if we have questions about this application?

Name Michael H. Bailit Phone Number 781-453-1166

bailit health
PURCHASING

56 Pickering Street Needham, MA 02492 T: (781)453-1166 F: (781)453-1167 www.bailit-health.com

Jason Elledge
Grants Management Specialist
Dept. of Vermont Health Access
312 Hurricane Lane, Suite 201,
Williston, VT 05495

November 28, 2011

Re: Letter of Submittal – Health Benefits Exchange Planning and Implementation
Requisition Number: 03410-103-12

Dear Jason:

Thank you for the opportunity to present Bailit Health Purchasing's proposal to continue to provide consulting services to the State of Vermont for the planning and implementation of the State's Health Benefits Exchange. Bailit is bidding to provide consulting services on Sections One through Seven of the State's RFP.

1.7.6.1. *Identifying information about your organization and any sub-contractors. Include the name of the organization, names, addresses, telephone numbers, and address of principal officers and project/program leader, and a description of the type of organization you operate.*

Bailit Health Purchasing, LLC (Bailit) is a limited liability company headquartered at 56 Pickering Street in Needham Massachusetts with a primary phone number of 781-453-1166. The principal officer of the company is Michael Bailit, who is President of the company.

The project will be led by Beth Waldman, Senior Consultant with assistance from Brendan Hogan. Beth works at and can be reached at the Needham office of Bailit listed above and Brendan works at the Vermont office which is 963 Paine Turnpike, Unit 3, Suite E, Berlin, VT 05602. The phone number for the Vermont office is (802) 522-6740.

In addition to Beth, Brendan and me, all of Bailit's senior consultants will support this effort, including: Margaret Houy, Michael Joseph, Megan Burns, Christine Hughes and Kate Bazinsky.

To provide the State of Vermont with the strongest team to perform its Health Benefits Exchange Planning and Implementation work, Bailit has brought together a large team of subcontractors to assist us with this work:

Tufts University: Amy Lischko

Burns & Associates: Peter Burns, Mark Podrazik, Steven Pawlowski, Craig Srsen and Jesse Eng

Mathematica Policy Research: Deborah Chollet, William Borden, Timothy Lake, Allison Barrett, Thomas Bell, Jill Bernstein, Suzanne Felt-Lisk, Grace Ferry, Nathan Myers, Marsha Gold and Amy Wodarek O'Reilly

Market Decisions: Curtis Mildner, Brian Robertson, Jason Maurice, Patrick Madden, Brian Brinegar, and Jennifer MacBride

Mercer Consulting/Oliver Wyman: Sheree Swanson, Sudha Shenoy, Alexander Domaszewicz, Wendy Woske, Kurt Giesa, Karen Bender, Tammy Tomczyk, and Beth Fritchen

Erica Garfin, Independent Consultant

PDI Creative: Peter Kriff, Ralph Motefusco, Patricia Brooks, Peter Bregman, Karen Fitzgerald and Toni Drowne

Caroline Earle, Independent Consultant

Global Health Payment, LLC: Robert Murray

1.7.6.2. *A detailed list of all materials and enclosures being sent in the proposal.*

Included in this proposal are all of the required documents as well as a few additional supporting documents including:

1. Rate Chart
2. Certification and Assurances
3. References
4. Insurance Certificate and Vermont Tax Certificate
5. Letter of Submittal
6. Information from the Bidder – both quality of bidder's experience and bidder's capacity
7. Assignment Matrix
8. Resumes
9. Technical proposal for Sections One through Seven

10. PDI Marketing Campaign appendix
11. Application Information Sheet
12. Summary of funds
13. Rate Chart
14. Detail of Expenses
15. Allocation of Expenses
16. Related Party Disclosure

1.7.6.3. *Any other statements you wish to convey to the State.*

Bailit appreciates the opportunity to submit this proposal as a response to the Request for Proposals from the Vermont Health Care Reform Division at the Department of Vermont Health Access. We have thoroughly enjoyed the professional working relationship we have had with the State during the planning phase of the exchange work and greatly appreciate the State considering selecting us to continue to work with the State of Vermont during this implementation phase of the work.

1.7.6.4. *Any alternative contract language you wish to propose*

Bailit does not propose using any alternative contract language.

Sincerely,

Michael H. Bailit
President

REQUEST FOR PROPOSAL
Health Benefits Exchange Planning and Evaluation

This form must be completed and submitted as part of the response for the proposal to be considered valid.

The undersigned agrees to furnish the products or services listed at the prices quoted and, unless otherwise stated by the vendor, the Terms of Sales are Net 30 days from receipt of service or invoice, whichever is later. Percentage discounts may be offered for prompt payments of invoices; however, such discounts must be in effect for a period of 30 days or more in order to be considered in making awards.

VERMONT TAX CERTIFICATE AND INSURANCE CERTIFICATE

To meet the requirements of Vermont Statute 32 V.S.A. subsection 3113, by law, no agency of the State may enter into extend or renew any contract for the provision of goods, services or real estate space with any person unless such person first certifies, under the pains and penalties of perjury, that he or she is in good standing with the Department of Taxes. A person is in good standing if no taxes are due, if the liability for any tax that may be due is on appeal, or if the person is in compliance with a payment plan approved by the Commissioner of Taxes, 32 V.S.A. subsection 3113. In signing this bid, the bidder certifies under the pains and penalties of perjury that the company/individual is in good standing with respect to, or in full compliance with a plan to pay, any and all taxes due to the State of Vermont as of the date this statement is made.

Bidder further certifies that the company/individual is in compliance with the State's insurance requirements as detailed in section 21 of the Purchasing and Contract Administration Terms and Conditions. All necessary certificates must be received prior to contract issuance. If the certificate of insurance is not received by the identified single point of contact prior to contract issuance, the State of Vermont reserves the right to select another vendor. Please reference this RFP# when submitting the certificate of insurance.

Insurance Certificate: Attached ✓ Will provide upon notification of award: ___(within 5 days)

Delivery Offered 5 Days After Notice of Award Terms of Sale _____

Quotation Valid for 90 Days _____ Date: _____

Name of Company: Bailit Health Purchasing, LLC. Telephone Number: 781-453-1166

Fed ID or SS Number: 04-3340991 Fax Number: 781-453-1167

By: Michael H Bailit Name: Michael Bailit
Signature (Bid Not Valid Unless Signed) (Type or Print)

This is NOT AN ORDER

All returned quotes and related documents must be identified with our request for quote number.

CERTIFICATIONS AND ASSURANCES

I/we make the following certificates and assurances as a required element of the bid or proposal to which it is attached, understanding that the truthfulness of the facts affirmed here and the continuing compliance with these requirements are conditions precedent to the award or continuation of the related contract(s):

1. The prices and/or cost data have been determined independently, without consultation, communication or agreement with others for the purpose of restricting competition. However, I/we may freely join with other persons or organizations for the purpose of presenting a single proposal or bid.
2. The attached proposal or bid is a firm offer for a period of 120 days following receipt, and it may be accepted by the DVHA without further negotiation (except where obviously required by lack of certainty in key terms) at any time within the 120 day period.
3. In preparing this proposal or bid, I/we have not been assisted by any current employee of the State of Vermont whose duties related (or did relate) to this proposal, bid or prospective contract, and who was assisting in other than his or her official, public capacity. Neither does such a person nor any member of his or her immediate family have any financial interest in the outcome of this proposal or bid. (Any exceptions to these assurances are described in full detail on a separate page and attached to this document).
4. I/we understand that the DVHA will not reimburse me/us for any costs incurred in the preparation of this proposal or bid. All proposals or bids become the property of DVHA.
5. I/we understand that any contract(s) awarded as a result of this RFP will incorporate terms and conditions substantially similar to those attached to the RFP. I/we certify that I/we will comply with these or substantially similar terms and conditions if selected as a Contractor.
6. I hereby certify that I have examined the accompanying RFP forms prepared by: Beth Waldman for the funding period beginning Jan 2012 and ending Sept 30, 2013 and that to the best of my knowledge and belief, the contents are true, and correct, and complete statements prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

Signature: Michael F. Pelot Date: November 23, 2011

Title: President

SUMMARY OF FUNDS

(to be included in the proposal packet)

Organization Name Bailit Health Purchasing, LLC. Fed ID # 04-3340991

Summary of Funds received during your current fiscal year
January 2011 to November 2011

Source of Funds	Contract/grant total	Briefly describe activities supported by these funds
Community Health Plan of Washington	$100,000	Bailit assisted CHPW in its response to the state of Washington's managed care procurement.
Centers for Medicare and Medicaid Services (Subcontractor to Mathematica Policy Research)	$105,000	Bailit will assist Mathematica on provide technical assistance for the 15 states that are involved in the dual eligible demonstration. As well as providing technical assistance with states involved in Medicaid health homes.
Massachusetts Division of Health Care Finance and Policy	$146,743	Bailit assisted the Massachusetts Division of Health Care Finance and Policy in supporting the Special Commission on Provider Price Reform.
Department of Vermont Health Access	$532,246	Bailit assisted the Department of Vermont Heath Access in the initial planning for Vermont's Health Benefits Exchange.
Massachusetts Department of Public Health	$146,765	Bailit is assisting the Massachusetts Bureau of Substance Abuse Services to develop an alternative delivery system and payment strategy.
National Business Coalition on Health	$80,777	Development of tools to support state purchasers of employee health benefits in applying value based purchasing practices
Massachusetts Division of Health Care Finance and Policy	$55,830	Developing a catalogue of healthcare payment arrangements in use by commercial insurers.
Vermont Agency for Human Services	$75,000	Bailit is performing legal and regulatory analysis for the State of Vermont in regards to dual eligibles.
Iowa Department of Human Services	$24,720	Bailit is facilitating a working committee on behalf of the Iowa Medicaid program to transition certain behavioral health services from fee for service to managed care.
AFL-CIO	$10,196	Authoring a brief for organized labor purchasers on value based purchasers including payment reform.

Income total	$1,277,277	

Proposal to the Department of Vermont Health Access for Health Benefits Exchange Planning and Implementation

Submitted by:

Bailit Health Purchasing, LLC
56 Pickering Street
Needham, MA 02492
November 30, 2011

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I. Introduction

Bailit Health Purchasing, LLC (Bailit) is pleased to submit our response to the Division of Vermont Health Access (DVHA) request for proposals for consultants to continue to assist the State in its efforts to implement a Health Benefits Exchange to serve individuals and small businesses in Vermont and to serve as a platform for Vermont's single payer efforts. As described within this response, Bailit leads a team of experienced consultants from a number of national and Vermont-based firms to assist the State in continuing its planning efforts and beginning to implement Vermont's Exchange. We offer a proposal on Sections One through Seven of the State's Request for Proposals.

II. Quality of Bidder Experience

Overview

Bailit and our partners bring significant experience in Vermont – both working with the State in its first phase of planning for the Exchange, and working with State health purchasing and oversight agencies on a variety of projects over several years. In addition to our experience in Vermont, the Bailit team also brings significant experience in states across the country that will be leveraged in assisting Vermont in its efforts to finalize its Exchange design and begin implementation efforts.

Bailit along with our partners, Burns & Associates (B&A), Caroline Earle, Erica Garfin, Global Health Payment, Inc., Amy Lischko, Market Decisions, Mathematica Policy Research, Mercer/Oliver Wyman, and PDI Creative, bring significant Vermont expertise along with subject matter specialization that allows our team to efficiently examine existing data and information on Vermont systems and to compare and contrast that information with other states and with federal requirements. We are able to do this because the Bailit team includes individuals and organizations with not one or two encounters with the State of Vermont's health care system and data sources but with literally hundreds of different projects over decades of combined experience working both directly for the State of Vermont and with the State and its health care partners on projects ranging from conducting the Vermont Household Health Insurance Survey (VHHIS) to negotiating the Global Commitment to Health Waiver with CMS and implementing the Catamount expansion. Our team includes individuals who have worked for fourteen years directly with BISHCA on commercial insurance issues and who have a current and intimate knowledge of the Vermont's commercial insurance market.

The Bailit team has vast experience working both directly for and with Vermont state government and with and for other state governments around the country. In fact, the team has direct experience with over 35 different state governments. The Bailit team includes:

- Brendan Hogan, a former Acting Commissioner of the Department of Disabilities, Aging and Independent Living (DAIL), with previous experience in Vermont's Medicaid program and with the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA),

- Beth Waldman, a former Medicaid Director in Massachusetts,
- Peter Burns of B&A, a former state budget director in Arizona,
- Mark Podrazik of B&A, who has consulted with DVHA since 2006 on all significant Medicaid reimbursement reform initiatives,
- Erica Garfin, a 20-year veteran health and human services planning consultant based in Vermont,
- Caroline Earle, a former Commissioner of Vermont's Department of Human Resources and an employment lawyer,
- Amy Lischko, a Tufts University Professor and nationally recognized expert in the area of Health Insurance Exchange,
- Brian Robertson of Market Decisions who has worked on the VHHIS for over ten years,
- Deborah Chollet of Mathematica who brings significant national expertise and an experienced program evaluation team,
- Peter Kriff of PDI Creative who has done significant health care marketing work in Vermont, and
- Robert Murray, of Global Health Payment, the former director of the Maryland All Payer Commission.

A sampling of our collective work within and for state government includes:

- strategic planning and policy option development including Section 1115 and home- and community-based services (HCBS) waivers and managed care programs;
- evaluation including external quality reviews, evaluations of care coordination models, surveys, and focus groups;
- federal compliance and reporting;
- budget development and analysis including the construction of models to assess the financial impact of proposed policy and rate changes at the service, provider, and consumer levels; rate-setting for HCBS for the elderly and individuals with physical disabilities, intellectual and developmental disabilities, or mental illness; inpatient and outpatient hospital services; and physician and professional services;
- development and implementation of large scale public health coverage programs;
- administrative simplification and integration efforts;
- procurement and model contract drafting;

- federal grant drafting experience;
- revenue maximization initiatives, and
- Exchange design and modeling.

We have consciously chosen to build a team that is responsive to the seven sections of the Vermont RFP that focus on the Health Benefits Exchange because we believe that Vermont will best be served by a team that can provide assistance across the sections to provide for ultimate collaboration and efficiency. Bailit's experience in Vermont and particularly in the first phase of planning for the Exchange provides the State with leadership from consultants that understand the Vermont health care system, and who understand how the different tasks need to fit together and collectively feed the Exchange planning and implementation process as the best approach to this large scope of work.

Team Experience

Bailit Health Purchasing has played a key role in the design and development of Vermont's Health Benefit Exchange to date as the lead consultant for Vermont's Health Benefits Exchange planning grant efforts. Led by **Beth Waldman**, a former Massachusetts Medicaid director who worked actively on the passage and implementation of Massachusetts' Health Care Reform law that resulted in the Commonwealth Health Insurance Connector Authority (the Massachusetts Exchange) and served as a founding Board member of the Connector, the Bailit team participated in all aspects of Vermont's Exchange planning efforts over the past year. Beth will once again lead the Bailit team and will coordinate across all of the projects within Sections One through Seven. In addition to providing project leadership, Beth will bring particular expertise to the development of a call center, program integrity, and drafting of a level 2 establishment grant under Section One; and will lead Bailit's efforts for Sections Two; Four and Five. **Brendan Hogan**, a former Acting Commissioner with the Vermont DAIL, with deep experience in Vermont state government, including employment at both DVHA and BISHCA, worked closely with Beth and Vermont officials to forward the State's Exchange planning. Brendan will work closely with Beth in the overall management of the project, and will lead Bailit's efforts for Section One, and participate actively in certain tasks within Section Two, Four and Five.

In addition to our efforts on the first phase of Exchange planning, Bailit brings significant experience and expertise from our work in Vermont and other states across the country in managing state-wide public input processes, large stakeholder meetings, interactions with state legislators, and large scale program implementations.

Bailit has a 14-year relationship with BISHCA. Over the course of the past 14 years Bailit, led by firm President, **Michael Bailit**, has successfully delivered analyses, conducted reviews, provided advice, interpreted federal policies, and assisted in aspects of commercial insurance regulation and oversight. Michael will lead Bailit's efforts under Section Three related to the certification of Qualified Health Plans (QHPs), leveraging this deep understanding of current Vermont efforts. Michael will also lead Bailit's efforts in Section Six related to the development of a quality program and rating design. Michael's long focus on improving quality and utilizing vendor performance in benefit design through value-based purchasing will be particularly helpful

in this regard. Michael will also actively participate in Section Seven, leveraging his payment reform activities in Massachusetts.

Margaret Houy will lead Bailit's efforts to assist Vermont in the development of wellness programs in Section Six. Her experience working on wellness initiatives on behalf of the City of Boston and municipalities in Massachusetts will be valuable. She will also leverage this work to support Bailit's efforts to integrate across activities in Section Five.

Bailit Senior Consultant's **Michael Joseph, Christine Hughes, Kate Bazinsky** and **Megan Burns** bring significant experience in health care policy, practice and data analysis. Each will support members of the Bailit team with research, interviews, design and drafting across the projects within the Sections.

Market Decisions is a private firm founded in 1977 that specializes in health care research and evaluation for local and state governments, insurance, and health service providers, with a particular focus on the uninsured and underinsured. Market Decisions prides itself on providing research that is accurate, thorough and compelling. Market Decisions uses several sophisticated software packages and proprietary programs to provide the most accurate and reliable data and results possible. Dr. **Brian Robertson**, Director of Research at Market Decisions, has more than 25 years of experience conducting public policy and market research. Other senior research staff has over 10 years of research-related experience.

Market Decisions has conducted health insurance research in the state of Vermont for more than 10 years. This includes large scale household health insurance surveys as well as surveys of specific populations such as the uninsured and VHAP enrollees. In additions, Market Decisions has been involved in evaluation of health care reform efforts in Vermont working with the University of New England on a Robert Wood Johnson Foundation Funded Project, the Evaluation of Vermont Health Care Reform as well as the Catamount Options Study and ESI Cost-effectiveness Study conducted on behalf of the Vermont Commission on Health Care Reform.

During the Exchange planning process, Market Decisions conducted focus groups and key informant interviews with stakeholders representing the uninsured, the underinsured, small employers and non-profit organizations to gain insights into motivations around purchasing insurance and preliminary Exchange design features. Market Decisions will leverage that work and lead Bailit's efforts under Section Three to develop and conduct consumer satisfaction surveys.

Burns and Associates (B&A) has been involved in strategic analysis and planning across all aspects of public programs—from conceptualization, financing, implementation, and subsequent evaluation. Its specialties are related to the financing of public programs and providing operational assistance in the implementation of programs. For example, **Peter Burns** has developed cost and caseload estimates for a number of Medicaid waiver submissions (AZ, LA, MS, NM, NV, OR) and developed upfront and ongoing budgets for the implementation of health care initiatives as part of the development of Nevada's strategic health plan. B&A also conducts numerous evaluations, most recently for programs serving low-income uninsured individuals not eligible for Medicaid. In the last two years, **Mark Podrazik**, a principal with B&A, evaluated

the Healthy Indiana Plan, the Healthy NY program and the Insure Oklahoma program. In these evaluations, as well as in engagements for the States of Minnesota and Pennsylvania, he conducted focus groups with insurance brokers, small businesses owners who do not offer health insurance to employees, and insurance carriers. Prior to consulting at B&A since 2008, **Stephen Pawlowski** was the Chief Financial Officer for the Arizona Department of Economic Security (ADES), a 10,000 employee, $5 billion human services agency. B&A collaborated with Bailit during the Exchange planning grant work, including development of a financial functions analysis for the Exchange, assisting in the Basic Health Plan analysis and developing the financial sustainability analysis for the Exchange. In addition to participating as part of the Bailit team in the initial planning for the Exchange, B&A has also served as technical consultant to DVHA on all provider reimbursement matters since 2006.

For this project, B&A will actively participate in Section One on the Call Center and Program Integrity projects and will lead the financial management project. B&A will also support Bailit's efforts in Section Two and Five, and will lead Bailit's efforts on payment reform in Section Seven.

Mercer (US) Inc. and Oliver Wyman are wholly-owned subsidiaries of Marsh & McLennan Companies. Oliver Wyman employees involved in this project are working as part of the Mercer team. Marsh & McLennan Companies is a public company (NYSE) with more than $10.5 billion in revenue. Mercer operates in more than 180 cities worldwide and employs more than 19,000 people worldwide. With more than 4,000 employees dedicated to health and benefits work, Mercer has the depth and breadth of staff necessary to accomplish the goals set out in your Request for Proposal (RFP). For this project, the Mercer team will draw from the Government Human Services Consulting specialty practice, the Health and Benefits clinical practice, and employees from sibling company, Oliver Wyman.

Mercer and Oliver Wyman have experience in pricing, evaluating, and managing a broad range health insurance programs -- from traditional HMO benefits programs to points of service (POS) and newer consumer driven health plans, including high deductible health plans (HDHPs) and corresponding health savings accounts (HSAs). This experience extends into prescription drug benefits and other limited service plans, stop loss policies and individual medical policies. We have developed rates for Medicaid HMOs and Medicare Advantage managed care plans, and understands the dynamics affecting government-sponsored health care.

Mercer and Oliver Wyman both are currently working on Exchange projects in several states, including Arizona, California, Connecticut, the District of Columbia, Louisiana, Massachusetts, Michigan, Nebraska and Vermont. The scope of these exchange projects have included assessing the costs of mandated benefits; reviewing the Institute of Medicine's (IOM) recommendations to HHS pertaining to essential health benefits (EHB) and the impact on states; estimating participation in the exchange; estimating the impact on premiums of reforms; identifying rules that will minimize selection; recommending how to qualify health plans for participation in the exchange; possible ancillary services that the exchange can perform to achieve financial viability.

Karen Bender, the project leader for Oliver Wyman, has served on many American Academy of Actuaries (AAA) committees that developed the "Critical Issues in Health Reform" briefs to educate policymakers on topics crucial to any effective reform. Karen and other Oliver Wyman actuaries are currently on AAA committees developing questions and suggestions to HHS regarding those components of the PPACA that are effective in the short term. These include active participation committees addressing minimum loss ratios, guarantee issue of children under nineteen, expansion of children coverage to age 26, elimination of lifetime maximums and annual maximums for essential benefits; preventive services; exchanges, and premium reviews.

During the past several years, Oliver Wyman has provided modeling including impact analyses for multiple proposed market reforms in Vermont including:

- Expanded rating bands for the individual and small group market for the Vermont Department of Banking, Insurance Securities and Health Care Administration (BISHCA);
- Tax incentives for small employers and individuals in Vermont;
- Premium subsidies for individual insurance in Vermont; and,
- Expanding a Medicaid-like program to small employers.

The impact analysis took into consideration the effect some of the proposals would have on the private health insurance market, review of cost estimates, as well as incorporating knowledge of actuarial concepts into the results provided by another consultant, and testifying before legislators regarding the results.

Oliver Wyman also assisted BISHCA in developing guidelines for the implementation of the Catamount reforms, assisted in quantifying the impact of premium assistance plans, and assisted in the pricing of the products that are being offered through the new program. Oliver Wyman continues to assist BISHCA by reviewing rate filings for Catamount and providing quantification of proposed changes to benefits and eligibility rules, including elimination of pre-existing condition waiting periods.

In 2011, Mercer/Oliver Wyman partnered with the Bailit team to provide actuarial support for Phase I of the Exchange planning. This support consisted of establishing a base line for what the impacts on the 2010 market would have been had the 2014 reforms been in effect. This involved gathering data from the commercial insurers in Vermont segregated by market segment; estimating the impact on premiums for mergers of various markets and desegregation of other markets, most notably the separation of the association market between small group and large group. This work required a thorough knowledge of the Vermont health insurance market place including its underwriting and rating rules and how reforms will impact these markets.

For this project, the Mercer/Oliver Wyman team will lead all actuarial efforts on behalf of the Bailit team, include leading Section Three projects focused on analysis of the Exchange on the outside market and the risk leveling project, and will actively participate in the benefit design of the Qualified Health Plan, including analysis of the Essential Health Benefits and the cost of

continuing Vermont state mandated benefits that may not be included in the ultimate Essential Health Benefit's package. Mercer will also actively participate in the development of a wellness program under Section Six. They will participate, as needed, on Section Seven tasks as well.

Mercer's team of consultants averages over 15 years experience in the health insurance and managed care industry. Each of the credentialed actuaries is a member of the American Academy of Actuaries and meets that body's qualification standards for rendering the types of opinions and advice that Vermont is seeking. The team also consists of highly skilled analysts that are proficient in worksheet and programming skills to support the credentialed actuaries. The team includes four individuals from Mercer Government Consulting Services and four individuals from Oliver Wyman.

Sheree Swanson, ASA, MAAA will serve as the Senior Strategy Consultant, and has worked with both state government programs and employers in the private and public sector to analyze the impact of health care reform. She has also worked with state employee benefit programs and large employers that utilize risk adjustment programs to adjust premium payments to plans and to set employee contributions. She is a member of Mercer's Health Care Exchange Work Group, and she is also the Risk Adjustment Topic Team lead for the International Association of Actuaries Health Section (IAAHS) that provides relevant information and conducts webcasts to educate actuaries and the public on this topic. Sheree will be responsible for providing direction and sharing relevant information regarding ACA's risk-leveling programs and the interface and impacts that may have on the Exchange. Sheree is currently performing a similar role for Mercer's project with the State of Arizona on its Exchange planning and implementation. **Sudha Shenoy, *FSA, MAAA, CERA*** will provide actuarial support and works currently on Exchange modeling and actuarial analysis for other state health exchanges including the District of Columbia, Nebraska, and North Carolina. She participates in many of the American Academy of Actuaries Work Groups on Exchanges and related topics. **Alexander "Sander" Domaszewicz** will provide guidance related to wellness programs. He is currently involved in health care strategy, consumer directed health care, health management, health and benefits decision support tools, web health resources, HR portals and online benefits consulting engagements. **Wendy Woske, *RN, MHA***, will provide guidance related to quality program design, and is currently assisting states in Exchange Implementation efforts, including gap analysis to address requirements necessary to define qualified health plans and quality framework under which the Exchange may operate.

From Oliver Wyman, the four individuals include **Kurt Giesa, *FSA, MAAA*** who will serve as a senior strategy consultant and has worked with two large associations on policy issues related to healthcare reform, and has worked with a number of states, including Massachusetts on health care reform. Issues Kurt has dealt with include premium rate shock that will result from compressing age bands, the impact of requiring coverage to be issued to children on a guaranteed basis, and the impact of minimum actuarial values on premiums. **Karen Bender, *FCA, ASA, MAAA*** is the lead actuary for Oliver Wyman. Karen is the Chairperson of the American Academy of Actuaries' Small Group Medical Task Force. She has worked on the earlier phase of the health benefit exchange planning work in Vermont, and has provided actuarial analysis to Vermont for over two decades. **Tammy Tomczyk, *FSA, MAAA*** will serve as a senior strategy consultant and has extensive experience working with other states in their health benefit

exchange planning work. **Beth Fritchen, *FSA, MAAA*** will serve as a senior strategy consultant and has participated in many rate hearings over her career with Oliver Wyman. She is recognized as an expert in the individual health insurance market, as well as in the Medicare supplement insurance market.

Erica Garfin has worked in Vermont's health care and social service systems for 25 years. As an independent planning consultant since 1996, she has assisted numerous state agencies, non-profit organizations, and communities to achieve their goals in health care and social services. Her areas of expertise include planning, development, and evaluation of services and programs in health and social services; strategic planning and working with groups with diverse viewpoints to set goals, identify priorities and reach decisions. Erica brings extensive expertise in qualitative research and has conducted numerous studies that have gathered stakeholder input and feedback for needs assessments, program planning and evaluation. Erica worked as part of Bailit's team during the Vermont Exchange planning phase, providing assistance in stakeholder interviews and forums, and taking minutes of Exchange Advisory Group meetings. Under this procurement, Erica will actively participate in components of Sections Two and Four, utilizing her facilitation and interviewing skills.

Amy Lischko is currently working in the states of Vermont and Washington on Exchange-related issues and has previously worked with the states of Maine, Minnesota, Rhode Island, and West Virginia directly on Exchanges. Amy is working on several projects for the Federal government related to Exchange development as well as participating on the National Association of Social Insurance's expert panel on Exchanges. Amy has over 25 years of experience conducting applied research in state health policy and health services research. She has extensive experience interpreting federal and state legislation and assisting policymakers with evaluating the impact of legislation on state programs and policies and in decision-making. Amy worked extensively as part of the Bailit team on the Vermont Exchange planning, including playing key roles in the development of a roadmap for the Exchange, the Exchange Design, and the implementation plan. Amy also led Bailit's analysis of the Basic Health Plan. In this phase of the Exchange planning and implementation, Amy will continue to be actively involved as a key Bailit partner across all sections. She will particularly focus on the Exchange evaluation and Level Two Establishment grant projects in Section One; the SHOP Exchange and the individual and employer responsibility determinations in Section Two, health plan design in Section Three, development of the Navigator program and stakeholder consultation in Section Four, program integration in Section Five, and quality program and rating design in Section Six.

Mathematica Policy Research is well known for providing data, research, and analysis to assist public- and private-sector decision makers develop informed social policy and programs. Mathematica's staff combines strong technical skills, deep substantive knowledge of institutions and policies, and an understanding of client needs. Mathematica's commitment to excellence has earned the recognition of the research and public policy communities as well as its clients. **Deborah Chollet** will lead Mathematica's team. Dr. Chollet is recognized nationally as an expert on health insurance markets and state and Federal policy to improve access to coverage. She has worked with many states (including Alabama, Minnesota, New Mexico, Pennsylvania, Rhode Island, and Washington) to project the cost and coverage impacts of Exchange-like entities; she currently co-chairs the National Academy of Social Insurance Study Panel on Health

Insurance Exchanges. As part of the Bailit team, Mathematica consultants will include policy researchers and programmer support in areas critical to the work requested – including program evaluation, modeling payment reform and developing quality measures – as well as senior members of Mathematica's Program Management Group, which assists Federal and state agencies to develop the information systems that support large program operations and evaluation.

The Mathematica team will participate in Sections One and Three, leading the Exchange evaluation and QHP plan design subtasks. In addition, the Mathematica team will support all other tasks bid, particularly with respect to modeling payment reform in Section Seven

PDI Creative is a Vermont-based marketing firm led by **Peter Kriff**. Peter has over 23 years of experience in marketing and is supported by an experienced team that will also participate in this project, including **Ralph Montefusco, Patricia Brooks, Peter Bregman, Karen Fitzgerald and Toni Drowne.**

PDI Creative has marketing experience from campaigns in Vermont for several Vermont health care campaigns, including campaigns for the Department of Disabilities, Aging and Independent Living, Department of Health, Fletcher Allen Health Care and PACE Vermont. The PDI Creative team also has experience from all over the country. The PDI Creative team will lead the Bailit team's marketing campaign under Section 4. Appendix Two provides a sample of the PDI Creative team work.

Caroline Earle is an employment lawyer practicing as the Law Office of Caroline Earle and is a former Vermont Commissioner of Human Resources. As such, she brings significant experience in Vermont state hiring processes to assist the state in development of job descriptions and hiring plans for Exchange staff, within Section One of the procurement.

Robert Murray is an economist with expertise in the development and operation of provider payment systems, health care financing, public policy development, and health care administration and management; For 18 years, Bob served as the Administrator of the nation's only All-Payer Hospital Rate Setting agency, overseeing the financing of an industry in excess of $13 billion of annual hospital revenue and an administrative budget of $100 million per year. Maryland's All-Payer Hospital Payment System is the most enduring and successful cost containment system in the United States over the past 34 years. Now consulting to other states through his firm Global Health Payment, Inc., Bob will actively participate in Bailit's efforts in Section Seven, Payment Reform.

References

The Bailit team is pleased to offer the following references of its work.

Organization/Client	Description of Work
Maine Office of Health Policy and Finance, Trish Riley, former director 15 State House Station, Augusta, Maine 04333 207-837-4815 trish@riley.net	The Bailit team provided initial strategic planning, research, analysis and facilitation in Maine's early efforts to implement health care reform (March 2010 through December 2010)
Colorado Department of Health Care Policy and Financing, Susan Mathieu, Program Manager 1570 Grant Street, Denver, CO 80203 (303) 866-3582 Susan.mathieu@state.co.us	Bailit is providing strategic consultation, waiver strategy, research, analysis and implementation assistance to Colorado as it prepares to expand coverage to Adults without Dependent Children and Persons with Disabilities (January 2010 – present)
Iowa Department of Human Services, Jennifer Vermeer, Medicaid Director 100 Army Post Road, Des Moines, IA 50315 (515) 256-4621 JVermee@dhs.state.ia.us	Bailit has worked on several projects for the Iowa Medicaid Enterprise over the last several years, including development of a behavioral health managed care carve out procurement, and facilitation of behavioral health stakeholder groups. Bailit is currently facilitating a group tasked with moving children's residential services from a fee-for-service to managed care structure. (April 2009 to present)

III. Bidder Capacity

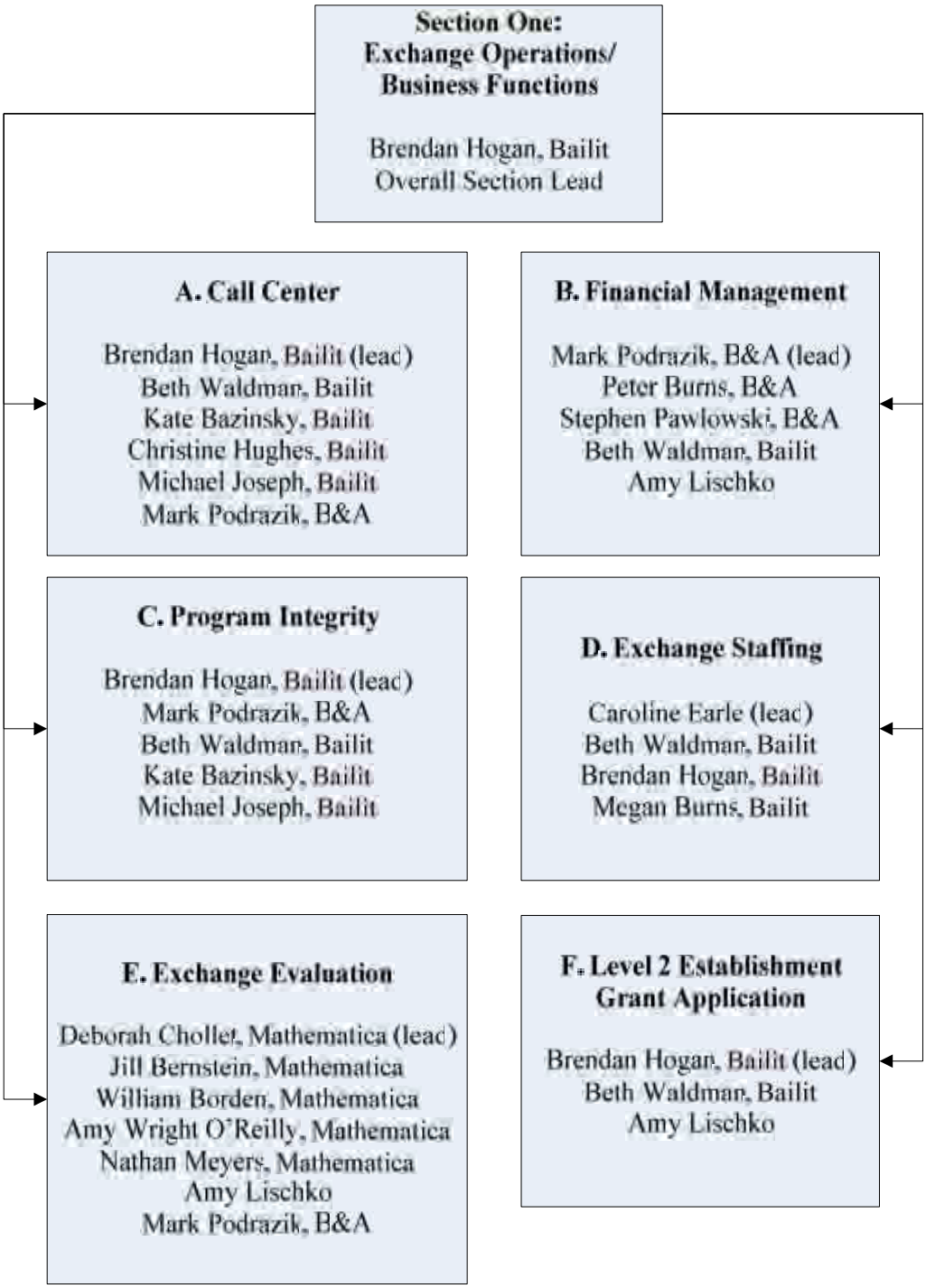
Organizational Capacity

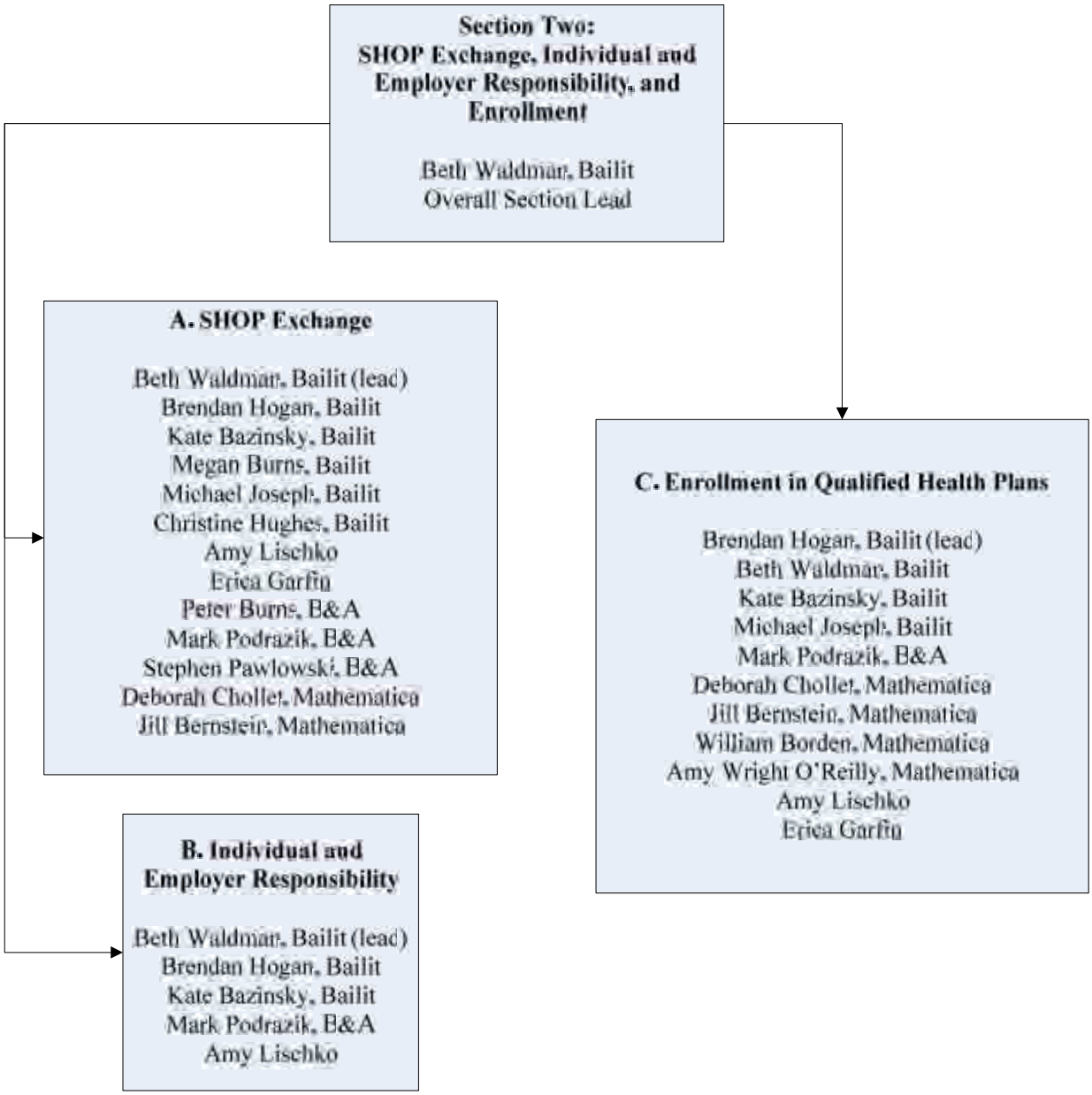
All together, Bailit Health Purchasing has assembled a team of 48 highly talented and experienced individuals across 10 entities to assist Vermont in its final design and implementation of the Health Benefits Exchange. The Bailit team was assembled to provide both the subject matter expertise needed across the wide range of topics requested in the RFP and to ensure that all tasks will be completed to meet the State's aggressive timelines. The State is ensured that the years of experience among the section leads both in Vermont and for other states on similar projects will enable our team to be very efficient as we hit the ground running. Much of the proposed team also participated in the Exchange planning project for Vermont led by Bailit. As such, we have a keen understanding of the key issues faced by the State and will not need to spend time on background research at project initiation.

Beth Waldman of Bailit will serve as the overall Project Lead. Beth brings a depth of experience in state government, hands-on work on the Exchange in Vermont and other states, and outstanding overall project management and organizational skills. Beth's general familiarity with each of the tasks within each section and subsection will allow her to provide guidance across the project as a whole and consistency across the work products. As Project Lead, Beth will help the state to effectively manage the large tasks that need to be completed for the State's Exchange to be operational by the fall of 2013. Brendan Hogan will assist Beth in the day to day management of this project. Like Beth, Brendan has worked closely with Vermont officials on the first phase of Exchange planning and brings in-depth knowledge of the State of Vermont and its stakeholders. Brendan's main responsibility related to managing the engagement will be to work closely with the team members across multiple firms to make sure that all project team members are kept informed as key decisions are made throughout the project that may relate to the specific work that they are completing. He will also be responsible for maintaining and tracking the overall project work plan that Bailit will develop with the state at project initiation. In addition to their project management roles, Beth and Brendan will also bring their subject matter expertise to Sections One through Seven.

On the following pages, we present our organizational chart for the project overall as well as for each RFP Section. An Overall Section Lead has been named for each RFP Section that our team is bidding on as well as a Section Lead for each subtask within the section. Each Section Lead was selected based on their specific expertise on the subtask and their capacity to complete the work timely. We have also built in back-up capacity by identifying other staff with relevant experience on tasks where they were not specifically assigned but would be available to assist on the task as needed.

Project Management
Beth Waldman, Bailit
Project Manager
Brendan Hogan, Bailit
Co-Project Manager
Section One:
Exchange Operations &
Business Functions
Lead: Brendan Hogan, Bailit
Section Two:
SHOP Exchange,
Individual & Employer
Responsibility, and
Enrollment
Lead: Beth Waldman, Bailit
Section Three:
Health Insurance Market
Reform
Lead: Michael Bailit, Bailit
Section Four:
Stakeholder Involvement
and Outreach/Education
Lead: Beth Waldman, Bailit
Section Five:
Program Integration
Lead: Brendan Hogan, Bailit
Section Six:
Quality & Wellness
Lead: Margaret Houy, Bailit
Section Seven: Payment
Reform
Lead: Mark Podrazik, B&A


Section One:
Exchange Operations/
Business Functions
Brendan Hogan, Bailit
Overall Section Lead
A. Call Center
Brendan Hogan, Bailit (lead)
Beth Waldman, Bailit
Kate Bazinsky, Bailit
Christine Hughes, Bailit
Michael Joseph, Bailit
Mark Podrazik, B&A
B. Financial Management
Mark Podrazik, B&A (lead)
Peter Burns, B&A
Stephen Pawlowski, B&A
Beth Waldman, Bailit
Amy Lischko
C. Program Integrity
Brendan Hogan, Bailit (lead)
Mark Podrazik, B&A
Beth Waldman, Bailit
Kate Bazinsky, Bailit
Michael Joseph, Bailit
D. Exchange Staffing
Caroline Earle (lead)
Beth Waldman, Bailit
Brendan Hogan, Bailit
Megan Burns, Bailit
E. Exchange Evaluation
Deborah Chollet, Mathematica (lead)
Jill Bernstein, Mathematica
William Borden, Mathematica
Amy Wright O'Reilly, Mathematica
Nathan Meyers, Mathematica
Amy Lischko
Mark Podrazik, B&A
F. Level 2 Establishment
Grant Application
Brendan Hogan, Bailit (lead)
Beth Waldman, Bailit
Amy Lischko


Section Two:
SHOP Exchange, Individual and Employer Responsibility, and Enrollment
Beth Waldman, Bailit
Overall Section Lead
A. SHOP Exchange
Beth Waldman, Bailit (lead)
Brendan Hogan, Bailit
Kate Bazinsky, Bailit
Megan Burns, Bailit
Michael Joseph, Bailit
Christine Hughes, Bailit
Amy Lischko
Erica Garfin
Peter Burns, B&A
Mark Podrazik, B&A
Stephen Pawlowski, B&A
Deborah Chollet, Mathematica
Jill Bernstein, Mathematica
B. Individual and Employer Responsibility
Beth Waldman, Bailit (lead)
Brendan Hogan, Bailit
Kate Bazinsky, Bailit
Mark Podrazik, B&A
Amy Lischko
C. Enrollment in Qualified Health Plans
Brendan Hogan, Bailit (lead)
Beth Waldman, Bailit
Kate Bazinsky, Bailit
Michael Joseph, Bailit
Mark Podrazik, B&A
Deborah Chollet, Mathematica
Jill Bernstein, Mathematica
William Borden, Mathematica
Amy Wright O'Reilly, Mathematica
Amy Lischko
Erica Garfin

Section Three:
Health Insurance Market Reform

Michael Bailit, Bailit
Overall Section Lead

A. Analysis of the Impact of the Exchange on the Outside Market

Karen Bender, Oliver Wyman (lead)
Kurt Gieser, Oliver Wyman
Tammy Tomczyk, Oliver Wyman
Beth Fritchen, Oliver Wyman
Michael Joseph, Bailit

B. Risk-Leveling Programs

Sheree Swanson, Mercer (lead)
Sudha Shenoy, Mercer
Wendy Woske, Mercer

C. Certification of Qualified Health Plans (QHPs)

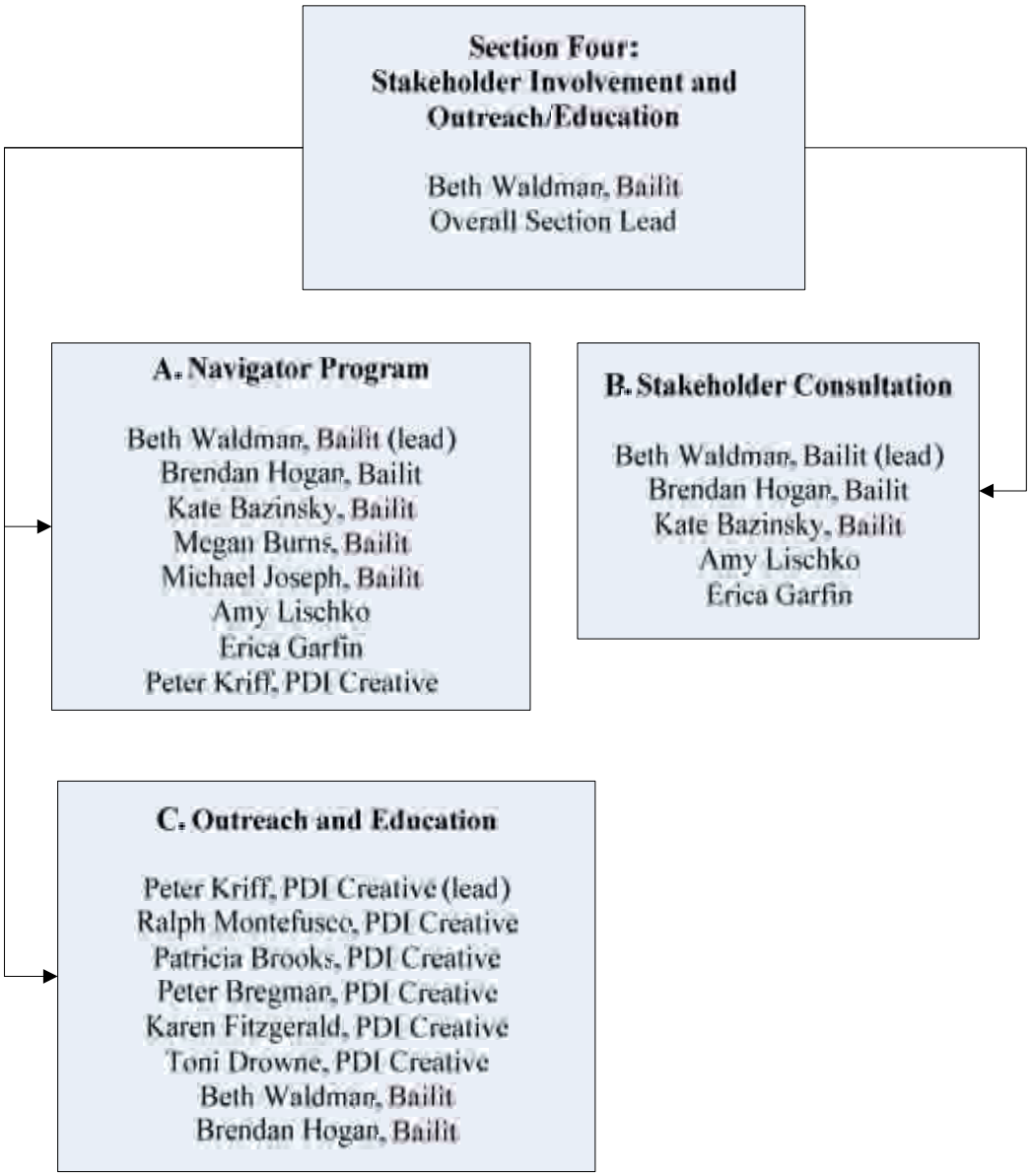
Michael Bailit, Bailit (lead)
Beth Waldman, Bailit
Marge Houy, Bailit
Kate Bazinsky, Bailit
Michael Joseph, Bailit
Megan Burns, Bailit
Sheree Swanson, Mercer
Sudha Shenoy, Mercer
Wendy Woske, Mercer
Deborah Chollet, Mathematica
Jill Bernstein, Mathematica

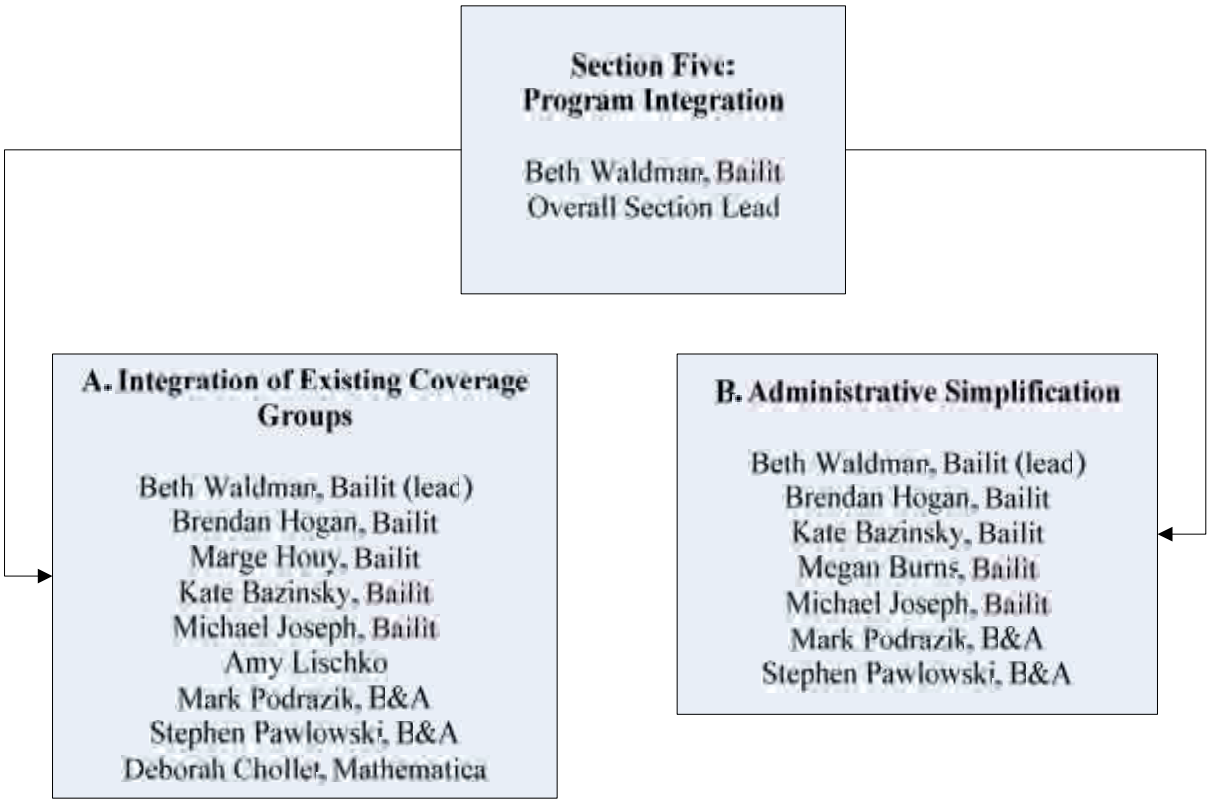
D. Consumer Satisfaction Surveys

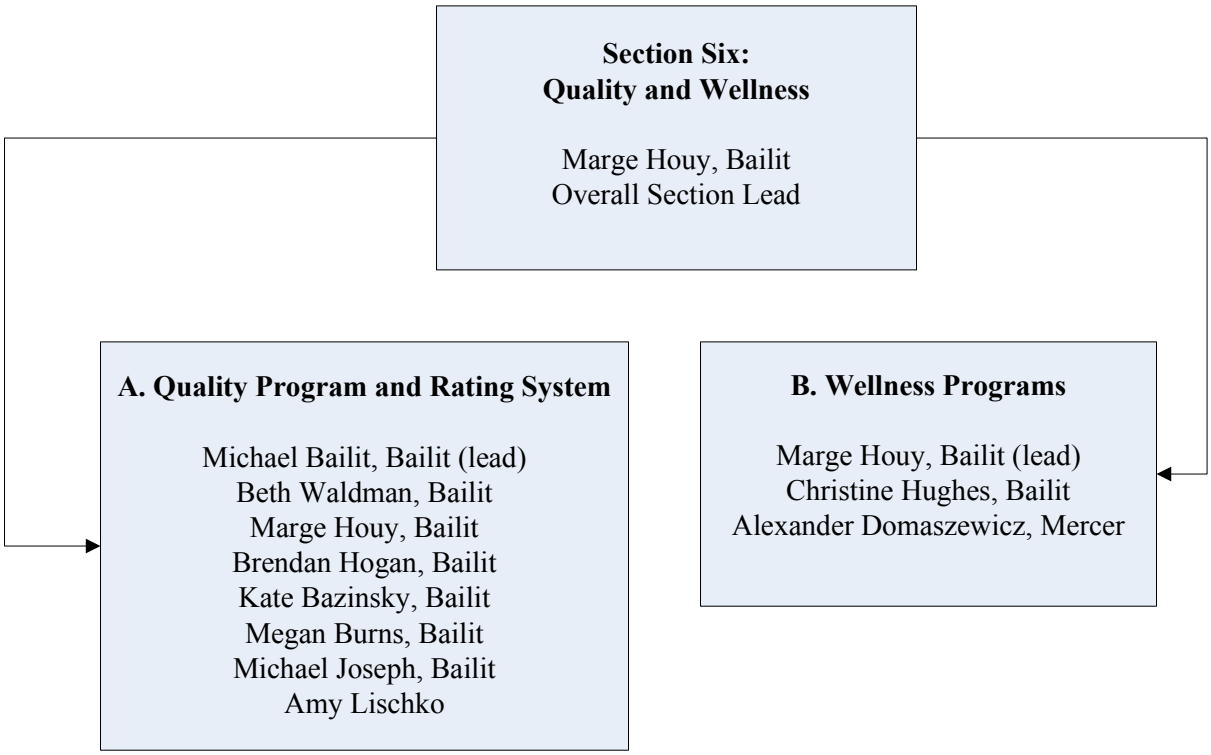
Curtis Mildner, Market Decisions (lead)
Brian Robertson, Market Decisions
Jason Maurice, Market Decisions
Patrick Madden, Market Decisions
Brian Brinegar, Market Decisions
Jennifer McBride, Market Decisions
Beth Waldman, Bailit

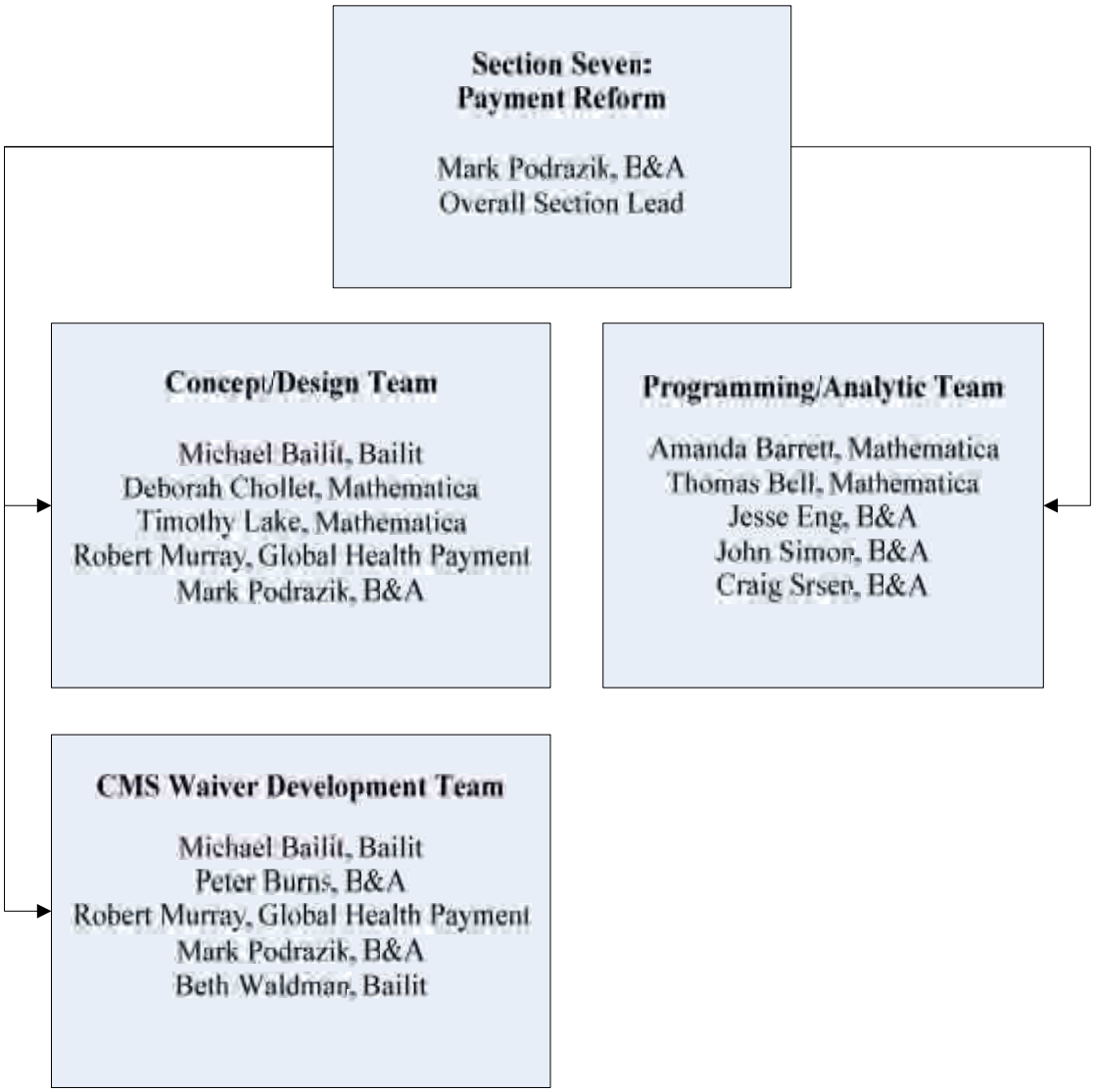
E. QHP Plan Design

Deborah Chollet, Mathematica (lead)
Allison Barrett, Mathematica
Jill Bernstein, Mathematica
Grace Ferry, Mathematica
Karen Bender, Oliver Wyman
Kurt Gieser, Oliver Wyman
Tammy Tomczyk, Oliver Wyman
Beth Fritchen, Oliver Wyman
Beth Waldman, Bailit
Brendan Hogan, Bailit


Section Four:
Stakeholder Involvement and Outreach/Education
Beth Waldman, Bailit
Overall Section Lead
A. Navigator Program
Beth Waldman, Bailit (lead)
Brendan Hogan, Bailit
Kate Bazinsky, Bailit
Megan Burns, Bailit
Michael Joseph, Bailit
Amy Lischko
Erica Garfin
Peter Kriff, PDI Creative
B. Stakeholder Consultation
Beth Waldman, Bailit (lead)
Brendan Hogan, Bailit
Kate Bazinsky, Bailit
Amy Lischko
Erica Garfin
C. Outreach and Education
Peter Kriff, PDI Creative (lead)
Ralph Montefusco, PDI Creative
Patricia Brooks, PDI Creative
Peter Bregman, PDI Creative
Karen Fitzgerald, PDI Creative
Toni Drowne, PDI Creative
Beth Waldman, Bailit
Brendan Hogan, Bailit


Section Five:
Program Integration
Beth Waldman, Bailit
Overall Section Lead
A. Integration of Existing Coverage Groups
Beth Waldman, Bailit (lead)
Brendan Hogan, Bailit
Marge Houy, Bailit
Kate Bazinsky, Bailit
Michael Joseph, Bailit
Amy Lischko
Mark Podrazik, B&A
Stephen Pawlowski, B&A
Deborah Chollet, Mathematica
B. Administrative Simplification
Beth Waldman, Bailit (lead)
Brendan Hogan, Bailit
Kate Bazinsky, Bailit
Megan Burns, Bailit
Michael Joseph, Bailit
Mark Podrazik, B&A
Stephen Pawlowski, B&A


Section Six:
Quality and Wellness
Marge Houy, Bailit
Overall Section Lead
A. Quality Program and Rating System
Michael Bailit, Bailit (lead)
Beth Waldman, Bailit
Marge Houy, Bailit
Brendan Hogan, Bailit
Kate Bazinsky, Bailit
Megan Burns, Bailit
Michael Joseph, Bailit
Amy Lischko
B. Wellness Programs
Marge Houy, Bailit (lead)
Christine Hughes, Bailit
Alexander Domaszewicz, Mercer


Section Seven:
Payment Reform
Mark Podrazik, B&A
Overall Section Lead
Concept/Design Team
Michael Bailit, Bailit
Deborah Chollet, Mathematica
Timothy Lake, Mathematica
Robert Murray, Global Health Payment
Mark Podrazik, B&A
Programming/Analytic Team
Amanda Barrett, Mathematica
Thomas Bell, Mathematica
Jesse Eng, B&A
John Simon, B&A
Craig Srsen, B&A
CMS Waiver Development Team
Michael Bailit, Bailit
Peter Burns, B&A
Robert Murray, Global Health Payment
Mark Podrazik, B&A
Beth Waldman, Bailit

Because of the tight time restrictions to complete all aspects of the project, Bailit has completed an overall assessment of the time required to complete each subtask and the ability of the proposed team members to meet their responsibilities on the tasks for which they have been assigned. In the table below, we illustrate that our proposed team is available to commit 19,000 hours over the eight-month initial contract period (through September 2012) when the work needs to be completed. We have proposed a total of 14,000 hours, meaning that our team still has 5,000 hours of capacity to complete all required tasks.

Analysis of Bailit Team Capacity

Team Member	Firm	Availability to Project (Percent of a Full Year)	Hours Available (Jan-Sept 2012)
Michael Bailit	Bailit	25%	390
Beth Waldman	Bailit	90%	1404
Brendan Hogan	Bailit	90%	1404
Marge Houy	Bailit	40%	624
Kate Bazinsky	Bailit	100%	1560
Michael Joseph	Bailit	60%	936
Christine Hughes	Bailit	50%	780
Megan Burns	Bailit	30%	468
Peter Burns	Burns & Associates	25%	390
Mark Podrazik	Burns & Associates	60%	936
Stephen Pawlowski	Burns & Associates	35%	546
Craig Srsen	Burns & Associates	30%	468
Jesse Eng	Burns & Associates	50%	780

Team Member	Firm	Availability to Project (Percent of a Full Year)	Hours Available (Jan-Sept 2012)
John Simon	Burns & Associates	50%	780
Deborah Chollet	Mathematica	35%	546
Jill Bernstein	Mathematica	25%	390
William Borden	Mathematica	10%	156
Amy Wright O'Reilly	Mathematica	40%	624
Nathan Meyers	Mathematica	10%	156
Allison Barrett	Mathematica	20%	312
Erica Garfin	Independent Consultant	40%	624
Caroline Earle	Independent Consultant	20%	312
Amy Lischko	Independent Consultant	50%	780
Peter Kriff	PDI Creative	15%	234
Robert Murray	Global Health Payment	10%	156
Sheree Swanson	Mercer	20%	312
Sudha Shoney	Mercer	20%	312
Alexander Domaszewicz	Mercer	15%	234
Wendy Woske	Mercer	10%	156
Karen Bender	Oliver Wyman	20%	312
Kurt Gieser	Oliver Wyman	10%	156

Team Member	Firm	Availability to Project (Percent of a Full Year)	Hours Available (Jan-Sept 2012)
Tammy Tomczyk	Oliver Wyman	10%	156
Beth Fritchen	Oliver Wyman	10%	156
Brian Robertson	Market Decisions	10%	156
Curtis Mildner	Market Decisions	10%	156
Jason Maurice	Market Decisions	10%	156
Patrick Madden	Market Decisions	10%	156
Peter Kriff	PDI Creative	20%	312
Ralph Montefusco	PDI Creative	20%	312
Patricia Brooks	PDI Creative	15%	234
Karen Fitzgerald	PDI Creative	15%	234
Toni Drowne	PDI Creative	15%	234
Peter Bregman	PDI Creative	15%	234

Project Management Approach

Bailit proposes to have a weekly call with DVHA's Deputy Commissioner for the Exchange (or her designee) and other key State officials to discuss progress on the overall project work plan and to tackle particular policy issues that require senior official attention. This is similar to the weekly core meetings that Bailit conducted during the initial year of Exchange planning for the State of Vermont. Brendan Hogan will be available to participate in these weekly meetings in person and Beth Waldman will participate by phone or, as necessary, in person. We will email a proposed agenda in advance of the designated time for the call each week so that the appropriate state staff will be aware of the topics to be discussed. Additionally, depending on the specific agenda topics, the Bailit Project Leads will invite other members of the Bailit team to participate in the core team meeting to present specific deliverables or discuss particular issues.

Bailit will work closely with each of its team members to ensure cross-communication and consistency across project work. In addition to Brendan's day-to-day management of the work plan with our team partners, Bailit will hold full team member meetings as necessary and will send status update emails to the team on at least a monthly basis. Bailit will also include the State on these emails. This is one way in which Bailit will ensure each team member, and in turn

the State staff, benefits from the work of other members of the team. Bailit will also set up a Sharepoint or similar internal team site so that background materials and project deliverables can be shared across the team to ensure that everyone is aware of other aspects of the project and so that duplication of effort can be avoided. When specific team members need to be aware of activities on a task where they are not assigned because of cross-cutting issues, the Bailit Project Leads will communicate directly with the team members to make sure that all relevant parties received the information timely.

Quality of Staff

As described in Section II above, the Bailit team brings an unmatched breadth and depth of experience. Our team includes seasoned consultants with significant experience in Exchange planning and design, experience implementing similar entities in other states, and a deep understanding of the Vermont health care system. Resumes for the entire Bailit team are included as Appendix One.

Ability to Meet Project Schedule

Initially, we have developed the high-level schedule shown below which illustrates our proposal to complete the tasks for each subsection at the monthly level. Upon project execution, Bailit will work with State project leads on the development of a master work plan across all project activities.

	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Q4 2012	2013
Section 1: Exchange Operations/Business Functions											
A. Call Center											
1.A.1 Review call center contract, inventory functions	x	x	x								
1.A.2 Review federal requirements for a call center	x	x									
1.A.3 Identify modifications to current call center needed				x	x	x					
1.A.4 Draft contract amendment							x	x	x		
B. Financial Management											
1.B.1 Analyze current system, build on Year 1 work		x	x	x	x	x	x				
1.B.2 Finalize Year 1 cost estimates				x	x	x	x	x			
1.B.3 Finalize a sustainability plan									x	x	
C. Program Integrity											

	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Q4 2012	2013
1.C.1 Review existing policies/procedures	x	x	x								
1.C.2 Review HHS auditing requirements	x	x	x								
1.C.3 Assess existing programs and develop a plan			x	x							
1.C.4 Develop procedures for independent unit				x	x	x					
1.C.5 Ensure functions aligned between Medicaid/Exchange							x				
D. Exchange Staffing											
1.D.1 Develop job descriptions for Exchange positions	x	x	x	x	x	x	x	x	x		
1.D.2 Recommend a management structure	x	x	x	x							
E. Exchange Evaluation											
1.E.1 Review goals and identify key indicators	x	x									
1.E.2 Inventory health care data sources		x	x	x							
1.E.3 Identify any gaps in data needed				x	x						
1.E.4 Develop a reporting template				x	x						
1.E.5 Produce a baseline data report						x	x	x	x		
F. Level 2 Establishment Grant Application											
1.F.1 Develop abstract, narrative, budget, other docs	x	x	x								

IV. Technical Proposal

The Bailit team is pleased to offer a technical proposal for seven of the eight sections within the RFP. If selected to assist Vermont across these sections, Bailit will provide overall project management and coordination services to DVHA and will ensure that our entire team of consultants has the benefit of the efforts occurring within the other pieces of work. This will allow the Bailit team to develop each sub-project with a full understanding of the many moving parts and projects that will be ongoing as part of Vermont's Exchange design and implementation. As described above, Bailit proposes a core team meeting with Bailit project leadership and senior State staff. In addition, to coordinate the team, Bailit will provide monthly all-team emails and share all deliverables across team members to ensure that the team works efficiently. Bailit will work with State leads to develop detailed work plans upon contract award that include provision of status reports on a bi-weekly or monthly basis.

Section 1: Exchange Operations/Business Functions

Bailit brings together a team of talented consultants with unparalleled experience to assist Vermont with the development of Exchange Operations and Business Functions, including the Exchange Call Center, Financial Management, Program Integrity, Exchange Staffing, Exchange Evaluation, and the Level Two Establishment Grant Application. For this section, the Bailit team includes consultants from Bailit, B&A, Mathematica, and individual consultants, Amy Lischko, Erica Garfin and Caroline Earles.

A. Call Center

Bailit is prepared to assist the State with this portion of the work based on the years of work in Medicaid programs both in Vermont and Massachusetts. Both Beth Waldman and Brendan Hogan of Bailit have interacted closely with Medicaid Call Center contractors over their years in state service and can assist Vermont also by helping to translate the federal requirements to operational requirements that the Exchange Call center will need. For example, both have had similar experience changes to call centers related to Medicare Part D implementation. Brendan was one of the lead managers for the State of Vermont during the implementation of Medicare Part D and Vermont's secondary drug program, VPharm. He worked closely with staff from the state, the MMIS contractor as well as the Vermont Health Access Member Services contractor/call center contractor to implement the necessary requirements to implement Medicare Part D. As part of the implementation plan, Brendan worked closely with the call center staff to review existing protocols and make changes as needed. The work also included coordinating efforts across the contractors (MMIS, Call Center, Pharmacy Benefit Manager) to ensure that information was being shared appropriately. In addition, Brendan actively participated in the development of new protocols developed to ensure coordination across programs occurred. For example, if someone contacted the wrong entity, they would be transferred (warm transfer) to the appropriate entity or provided the appropriate toll free number to resolve their issue.

Mark Podrazik, of B&A, also brings direct experience. Mark has direct experience in this area, completing a number of call centers in the last three years. He reviewed the call center at HP, the State of Oklahoma's fiscal agent and call center for Insure Oklahoma, a program that enables lower-income working uninsured or small businesses who hire these individuals to purchase private insurance where eligible for premium assistance. For the State of Indiana, he reviewed the call centers at the three Medicaid managed care entities serving the Medicaid program and the Healthy Indiana Plan, a program similar to Insure Oklahoma. In each of these reviews, a process "walk through" was first conducted. This "walk through" included an evaluation of typical call center functions as well as a review of acceptance of eligibility applications, premium collections, premium assistance disbursements, terminations and re-enrollments, as well as tracking of out-of-pocket expenditures due to per person annual limitations on these expenses. In the case of Insure Oklahoma, a review was conducted of both short-term solutions (by paper) and long-term solutions (automated) that were developed as program enrollment grew.

The Bailit team will utilize these experiences as it conducts the activities described in Section One, Task One, as described below.

- Review current call center contract and inventory current call center functions
- Review federal requirements for a call center that will serve both the Exchange and other publicly-funded health care programs, such as Medicaid

The Bailit team will first review Vermont's existing call center contract with MAXIMUS. In March, Bailit will review the existing contract and identify those services provided by MAXIMUS that are required in the Exchange and those services that are specific to existing state programs.

Bailit will also identify by March all federal requirements for a call center known or anticipated today based on information released thus far by the federal government through the Department of Health and Human Services. At a minimum, the Exchange call center will need to provide customer service functions. Depending on how it's organized, the Vermont call center may also be responsible for establishing enrollment procedures for individuals and small businesses. The Bailit team will utilize these criteria to develop a tool to review the existing MAXIMUS call center in May.

- Identify modifications to the current call center necessary to assure full compliance with Exchange requirements, including additional staff and technology resources

Bailit will identify modifications to the current call center necessary to assure full compliance with Exchange requirements, including additional staff and technology resources. We will deliver a report of our findings to the State by the end of July. One of the key changes in this call center amendment will be to ensure that the call center will work directly with small businesses to answer questions they might have regarding the Exchange. New training materials will need to be developed for customer service representatives at the call center to ensure that they can

respond to inquiries from this new customer group. It is anticipated that many of the functions envisioned for Vermont's Exchange call center will be similar to what our team reviewed in Oklahoma's and Indiana's programs. The Bailit team will use our experience from these reviews to itemize the operational functions and the necessary resources that will be required to fulfill these functions, including a backup plan for all key functions.

New staffing requirements may necessitate the creation of a dedicated unit for businesses within the call center. States have taken different approaches in this regard, for example one unit for individuals' requests and one for small businesses, or one unit for application questions and premium-related questions (which are usually more time consuming calls) and one unit for more general assistance calls. The staffing requirements will be one of the set of requirements necessary to run the call center. Additional call volume statistics tied to this new line of business for the call center will be developed to ensure that Exchange function is appropriately staffed.

Potential cross training of staff will be built into the requirements document so that during peak volume hours, individuals who work in other units within the call center would be able to respond to questions as they arise. Conversations will be conducted with the State to decide the level of involvement that call center staff will have in assisting customers. For example, some states have only pre-defined daytime hours while other states have enabled applicants to set a phone appointment in the evening to receive one-on-one assistance after work (this may also be considered a Navigator function, and the Bailit team will coordinate across the activities in Section Four to develop a Navigator program to ensure that the call center and Navigator operate in a complimentary manner and that their functions do not unnecessarily overlap).

Individuals who call the call center may prefer access to other forms of assistance such as email, Facebook, or Twitter applications. The requirements document will include consideration of these various contact strategies a consumer or business may desire.

- Draft an amendment to the contract with the current call center vendor

Bailit will draft an amendment to the contract with the current call center vendor that will be completed no later than September 2012. The Amendment will include the necessary requirements for the new functions of the call center. The State will want to consider performance-based incentives or holdbacks as well such as timeliness to answer calls. Our proposed team members have experience developing these requirements for RFPs and vendor contracts. We are able to assist in contract negotiations with the State, as requested, as well.

B. Financial Management

The Bailit team is proposing that each subtask specified in Section One, B of the RFP will be led by a different B&A team member who worked closely with DVHA during the planning grant engagement. B&A's Peter Burns will lead the effort to build the Exchange sustainability model,

Stephen Pawlowski will lead the task to develop the Exchange cost estimate, and Mark Podrazik will lead the Exchange financial operations development effort. Our team will be working closely together across these tasks and with other Bailit team members working on other Exchange development tasks since the identification of Exchange responsibilities and staffing will directly impact our cost estimates and sustainability plan.

- Analyze current system, building on work done in Year 1 of planning, by researching federal and state policies and requirements and identifying necessary modifications

With respect to the development of financial operations, work can commence immediately. We anticipate that since the Exchange will be housed within DVHA, the State will leverage functions already in place at DVHA and the Agency of Human Resources (AHS) and will need to develop processes to fill in any gaps in order to meet federal compliance related to Exchange governance. Our team will first meet with DVHA and AHS financial management staff to learn more about current financial operations staffing, roles and responsibilities, and methods to meet existing state and federal reporting requirements. After gathering this inventory, we will crosswalk these existing functions to the requirements that are already known to by the ACA, follow-up guidance from CMS, and Vermont's Act 48. The Bailit team will present a gap analysis of these functions and discuss with DVHA options for meeting these new requirements. After consensus has been gained on an overall approach (e.g., number of additional staff, new or changing staff responsibilities, assignment between DVHA and AHS), we will develop a more refined work plan of all processes to be developed. A key contact within the State's financial management team will be established for each work plan item so that the Bailit team can work expeditiously on each item outside of the larger financial management team.

We expect that there may be different types of deliverables required under this task with respect to revising or enhancing the State's financial reporting system processes. These may include more straightforward deliverables such as editing and refining current written policies and procedures to much more involved deliverables including operational design flows related to the collecting, disbursing, tracking and reporting of Exchange-related funds. As design flows are finalized, each flow will require corresponding written procedures to ensure conformance with federal and state accounting guidelines. Other deliverables will include the design of management reports that will be periodically delivered to CMS, the State Legislature, and the public at large on the Exchange website.

Our team expects that each of the types of deliverables described above will be iterative in nature with continual back and forth between our team and our designated state contacts. Further, we are aware that although items may be represented on the work plan, not all items will be able to be started immediately due to external limitations. For example, CMS continues to issue guidance as to expectations related to Exchange financial reporting and this will need to be factored in as the project progresses. Another item relates to SHOP functions. Our team members who will be working closely with the State on the development of the SHOP model under Section Two will keep us informed as to how the ultimate design of the SHOP may require additional SHOP-specific financial functions. There will be some joint meetings held related to these two tasks to address all cross-cutting issues. Another area where we anticipate cross-

cutting issues relates to the administrative simplification task. Bailit team members assigned to this task will work with the financial management team and vice versa to ensure that we are all moving forward on the same path.

- Finalize Year 1 cost estimates for development and operation of all Exchange functions

With respect to estimating Exchange costs, our team built the original high-level estimates and is well aware of the limitations around each component cost estimate. To the extent possible, we will first work on refining the cost estimates that are not dependent upon additional Exchange design or State decisions. Realistically, this may mean that this portion of the project may not commence until April 2012 as we await further direction on key decisions. The cost estimating team will be working closely with other Bailit team members since many of the cost estimates are dependent on other tasks in the RFP, including the ultimate composition of the Exchange staff, the size of the call center, the implementation of the Navigator program, and the outreach and education plan. In general, we expect that Stephen Pawlowski will meet with a number of State staff responsible for the Exchange functions as well as designated contractors who will perform these functions to gather more information to refine the cost estimates. The final budget will be delivered by July in an easy-to-navigate Excel format whereby assumptions will be clearly laid out that can be manipulated, as needed, by the State's Exchange staff. The file will be constructed so that State staff can adjust assumptions and the cost estimates will re-calculate based on these changes.

The greatest limitation to the cost estimating function that we anticipate is also one of the most expensive elements, namely the costs to determine eligibility under the Exchange or other state programs. As we prefaced in our initial estimates to DVHA, there are a number of methods to assess the appropriate cost allocation to the Exchange for this function, including per application costs and time and motion studies to name a few. Absent a final total cost estimate for the new VIEWS system, our team will work with the State to outline a plan for the best way to appropriately assign a cost estimate to the Exchange for this function after total costs are known. We expect that for this cost item specifically there may need to be contingency allocation plans given the uncertainty of both the total costs to implement VIEWS as well as the total number of applications that the Exchange will receive.

- Finalize a sustainability plan, including revenue and sources and amounts

Peter Burns will once again lead our team's effort in the development of the final sustainability plan. A blueprint of this plan was delivered during the planning engagement and we expect that this will continue to be refined. A number of revenue enhancing options were proposed, but we also anticipate that additional options may be considered as the Legislature convenes this year (e.g., provider taxes). We anticipate that additional work on the sustainability plan will not begin in earnest until there are enough of the other key decisions made related to Exchange design and Exchange costs, most likely around September 2012.

The work for the sustainability plan will be conducted in four phases.

Phase one will be the assembling and reviewing of the five year estimates generated in other areas of the project including: the financial management plan, the SHOP exchange, risk leveling, mandated benefits, all payer rates and the design of qualified health plans.

Phase two will develop the estimates of enrollment into the exchanges. This phase will include a literature search for information relating to participation rates, the timing of enrollment into the exchanges, as well as any information relating to the levels of plans expected to be selected by exchange participants. This phase will also include meetings with the state to adopt assumptions for estimating the exchanges' enrollment over time, and finally, to calculate the enrollment in the exchanges over the five year time period.

Phase three of this subtask will be the exploration and development of options for sustainable revenue sources. Included in this phase will be the review of the deliverables of the health care related tax study (procured under a separate RFP), a review of the Joint Fiscal Committee's documents (e.g. *FI$CAL FACT$* and *Vermont Tax Expenditures 2011 Biennial Report)* as well as discussions with the staff to understand potential qualifications and/or limitations of the information presented in those publications, the researching of revenue sources and methodologies adopted by other states in the development of their sustainability plans, and finally, meetings with the state to discuss policy options for sustainable revenue sources.

The final phase of the subtask will be the preparation of the deliverable. Prior to preparing the deliverable the ranges of potential costs of the exchange will be established as well as simple forecasts of potential revenue sources. The draft deliverable will be compiled that summarizes the relevant information collected in the prior three phases as well as recommended revenue sources for the exchanges. The draft will be shared with the state and based upon the state's review, be revised and finalized.

C. Program Integrity

The Bailit team that will be involved in this part of the work includes Brendan Hogan, Beth Waldman and Mark Podrazik. Both Brendan and Beth have had significant experience working with program integrity units in Vermont Medicaid and Massachusetts Medicaid in their previous work in State government. Mark is presently working with DVHA's Program Integrity Unit on reimbursement-related matters. Last year, he conducted an external quality review of the Program Integrity units at Indiana Medicaid's three managed care organizations and reviewed their policies and procedures as well as examined their efforts on a sample number of investigations related to both provider and member fraud and abuse.

- Review existing policies/procedures aimed at preventing waste, fraud and abuse

In February and March, our team will review policies and procedures that are aimed at preventing waste, fraud and abuse in several units across state government as well as in the private sector.

- Review HHS auditing requirements and develop/modify procedures to meet them

The Bailit team will also review HHS auditing requirements during this timeframe and develop/modify procedures to ensure compliance with Federal requirements. After the review occurs, the Bailit team will consult with State auditing staff to provide them with an update on the auditing requirements. The auditing changes may include and are not limited to the Single State Audit, Federal fund audits, program audits and audit reporting processes.

- Assess existing programs across several departments/agencies, review federal requirements, and develop a plan for enhancing existing programs and/or adding programs for the Exchange

The Bailit team will assess existing programs across several state departments/agencies, including the DVHA, the AHS, and the Attorney General's Office which runs the Medicaid Fraud and Residential Abuse Unit. Onsite interviews will occur in April. In addition, quality control functions that may exist in other units throughout state government that may have a relationship to waste, fraud and abuse will also be reviewed.

We will review federal requirements and develop a plan for enhancing existing programs by the end of April. The Bailit approach will focus on efforts to develop a centralized program integrity function within DVHA rather than creating new programs. This is consistent with the State's efforts to develop program integration and administrative simplification as described in Section Five below.

- Develop procedures for an independent, external audit, fraud detection, and reporting to HHS on efforts to prevent waste, fraud and abuse

Once a general approach is decided on by the State, our team will develop a more specific work plan of the elements that will be required to implement the recommended changes and will identify the primary State contact that we will work with to facilitate these changes. Work on these efforts will occur between April and July.

- Ensure that program integrity functions are aligned between Medicaid and the Exchange to the extent allowable under federal law

Our team will also ensure that program integrity functions are aligned between Medicaid and the Exchange to the extent allowable under federal law. This will be done by closely reviewing state and federal regulatory requirements and striving to integrate and consolidate the two sets of requirements in an effort to improve efficiency of program integrity functions. A final review will be completed in July of all policies and procedures developed in this task to ensure consistency and efficiency between Medicaid and the Exchange.

D. Exchange Staffing

Caroline Earle, the former Vermont Commissioner of Human Resources will lead this task for the Bailit team and will be assisted by Brendan Hogan, Beth Waldman and Megan Burns.

Our team is uniquely qualified to assist the State of Vermont in this task. We are well versed in creating and modifying job descriptions based on the changing needs of a state agency and is experienced in developing and reorganizing structures. Caroline most recently served as Commissioner of the Department of Human Resources, where she was responsible for administering the State of Vermont's largest workforce. This role included evaluating and pursuing human resources policies and initiatives, reviewing employment related legal and administrative strategy and decisions, selecting and administering the State of Vermont's health care benefits, and administering four collective bargaining agreements that governed the terms and conditions of employment for over 7,000 state employees.

- Develop job descriptions for Exchange-related positions and assist with administrative work resulting from the recruitment process

This newly created Exchange Division within the DVHA will need to accomplish all and/or be contract managers for all of the tasks necessary to run Vermont's Health Care Exchange in advance of January 1, 2014. The job descriptions that are developed may rely on some of the standard state job description requirements but will likely need to be adapted to meet the needs of this new division.

The Bailit Team will be able to quickly and effectively respond to the Exchange Division's hiring needs and will develop job descriptions and prepare the posting of the positions. Bailit anticipates that this work will occur over the course of this Contract, and that when a position is finalized that the goal of DVHA will be to get individuals hired as soon as possible.

- Recommend a management structure for the Exchange Division in DVHA

The Bailit team will recommend a management structure for the Exchange Division based on our understanding of the current structure within DVHA, the agency's strategic plan, and the program integration efforts taking place within the Agency of Human Services. Bailit will utilize its experience in developing and implementing new programs and units to assist DVHA in developing a management structure that allows for appropriate leveraging of existing DVHA functions but recognizes where policies and procedures are uniquely focused on the Exchange. To develop the management structure, the Bailit team will conduct a series of meetings in January and February with the Deputy Commissioner for the Exchange, or her designees to understand the management structure that most fits her and her unique skills and from there will develop a proposed management structure for review by the Exchange Director in March. Bailit will finalize the management structure in April based on feedback and will work with the Deputy Commissioner to present to other executives within DVHA and stakeholders, as requested.

E. Exchange Evaluation

The State must develop an evaluation plan for the Exchange once it is implemented. We anticipate that much of the data necessary to conduct an evaluation of the impacts of reform in Vermont are already being collected by State agencies or are available in current federal surveys. While it is possible that some additional data collection might be necessary, the project team recognizes the potential burden of additional and ongoing reporting both on the State and on

respondents. Therefore, we will seek to fully leverage data that are currently available or planned to become available, and also to prioritize indicators that are measurable with these data.

Mathematica Policy Research will lead this task, working closely with Amy Lischko and Burns and Associates (B&A), as described below. Mathematica, Amy Lischko and B&A all bring significant experience in the evaluation of large scale programs and subject matter expertise on health insurance and Exchange design.

- **Review the goals of the Exchange and identify a few key indicators under each goal**

As soon as can be arranged following award of a contract, project team leaders for this task will meet with the State to review the goals of the Exchange and identify indicators for each goal. Ideally, these indicators should reflect not only the State's near-term objectives for the Exchange, but also the State's ultimate goals for system reform—including decoupling coverage for Vermonters from the traditional employer model. Prior to the meeting, Mathematica will develop and propose a series of indicators and identify potential data sources for each indicator. Examples of indicators related to possible Exchange goals—including those articulated in Act 48, which authorizes the establishment of an Exchange within the DVHA—are summarized in Table 1 below.

Table 1. Possible Exchange Goals and Indicators

Exchange goal	Indicator
Expand access to affordable coverage	o Change in premiums for individuals and families as a percent of state median income o Employer offer and employee take up of coverage o Change in coverage of selected services
Reduce the number of uninsured and underinsured	o Adults and children with private coverage: number and percent of those not eligible for Medicare or Medicaid o Adults and children enrolled in Medicaid or Dr. Dynasaur: number and percent of those eligible
Improve access to care	o Usual source of care/personal health care provider o Delay in seeking care due to cost; unmet need for care o Use of appropriate preventive services (e.g., vaccinations, screening)

Reduce administrative cost in the insurance market	o Level and growth of private insurer administrative costs per capita and per premium dollar o Level and growth of insurance distribution costs o Extent of adverse selection in private insurance market
Contain health care costs	o Change in per capita spending for privately insured adults and children by type of service o Change in per capita spending for Medicaid adults and children by type of service
Improve efficiency in the delivery of health care services	o Change in all-cause hospital readmissions o Change in non-emergency use of hospital emergency departments
Promote health, prevention, and healthy lifestyles	o Percent of adults and children who are overweight or obese o Percent of adults who smoke
Improve the quality of care	o Change in ambulatory-sensitive hospital admissions o Change in selected (other) HEDIS measures

Source: Mathematica Policy Research.

- **Inventory health care data sources to determine how indicators will be measured**

Vermont's extensive data collection efforts provide it with a broad base of data for calculating the key indicators. Such data include federal surveys that produce statistically significant measures for Vermont—including the American Community Survey (for Chittenden county), the Behavioral Risk Factor Surveillance System, and the National Survey of Children's Health[1]—as well as disease surveillance and vital statistics systems, any special state surveys (for example, the 2005, 2008, and 2009 Vermont Household Health Insurance Surveys), and ongoing reporting systems related to the State's regulatory authority and programs.

[1]Sponsored by the Maternal and Child Health Bureau of the Health Resources and Services Administration, the 2011 National Survey of Children's Health conducts approximately 1,800 interviews in each stateregarding the physical and emotional health of children ages 0-17 and factors that may relate to well-being of children, including, parental health. In 2011, questions will be askedin some households about uninsured children in order to assess their parents' awareness of, experience with, and interest in enrolling in Medicaid and the State Children's Health Insurance Program (CHIP).

We anticipate that, in consultation with DVHA, we will identify approximately 25 indicators for measurement. Following this process, we will identify all current sources of relevant health care data, generating an inventory of agencies and current data sources as well as potential opportunities for obtaining data that may not be currently available. Working with DVHA, we will identify and contact each of the key Vermont agencies that receive data related to health insurance and program enrollment and to service delivery—including the Agency of Human Services (AHS), the Department of Banking, Insurance, Security and Health Care Administration (BISHCA), the Department of Children and Families, and the Department of Health. We will arrange a telephone meeting with program and IT staff in each agency to identify the types of data currently obtained, the specific data elements and frequency of reporting, procedures for verifying and/or cleaning the data, and time from reporting to production of data files for analysis.

We anticipate that this inventory will include not more than 12 data sources, including the surveys mentioned above as well as:

- AHS's Central Source for Measurement and Evaluation (CSME), which captures information from numerous agencies
- The Vermont Integrated Enrollment Workflow system, which is replacing ACCESS
- The Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES)
- Private insurer reporting to BISHCA

In addition, we understand that AHS is developing a Medicaid Enterprise Solution (MES), which will replace the Medicaid Management Information System (MMIS) and integrate additional clinical and administrative data sources. Although this system is still in development, the specifications for MES will yield information to inform the key indicators and, depending on the timeframe for its completion, MES might produce the data necessary for calculation of some indicators.

We anticipate that there may be multiple sources of data to measure the same indicator. If so, we will attempt to use the data source that is closest to the origin of the data in order to avoid using data that have undergone multiple transformations and therefore might introduce problems of data quality that we would need to review and assess. We will try to minimize the number of data sources used in calculations to maximize the efficiency of measuring each indicator.

- **Identify any gaps in data and propose a method for obtaining the needed data**

After finalizing the inventory, Mathematica will review the utility of each data source for measuring each indicator. The key indicators should use data reports that are stable and not subject to revision in daily operations. Our review will include an assessment of data quality (including an assessment of their source systems) to ascertain the stability and validity of the data, the frequency of data updates, the level of detail at which the data are stored, and how efficiently the system can produce timely data for the calculation of key indicators. We might

also consider the original sources of the data (for example, insurance carrier claims systems) and any transformations of the data that occur before storage in the target system.

This review will also identify data gaps that occur either because the source system does not contain the relevant data or the data are not of sufficient quality to measure the indicator reliably. In either event, we will outline a method for DVHA to obtain the relevant information. Our recommendations will consider the potential for modifying existing data systems and collection efforts, as well as any need for additional data collection. To the extent that additional data collection may be necessary, we will outline a potential process for obtaining such data and also suggest alternatives that might be possible.

- **Develop a reporting template and define a process for periodic measurement**

After completing the inventory and gaps analyses, Mathematica will create a reporting template that will detail the data elements, frequency, and calculation methods for each of the key indicators. The template will specify and define each data element required for measurement of an indicator, identify the source of the data element, and identify the frequency with which the indicator can be measured using currently available data.

- **Produce a baseline data report prior to Exchange implementation**

Finally, Mathematica will produce a baseline data report of all indicators that are measurable with data elements currently available from either survey information or sources in the health care data inventory. This report will serve as the baseline against which the State can measure change following implementation of the Exchange. Any issues that arise in production of a measure will be fully documented to ensure consistent future measurement of all indicators. In addition, the report will note the availability of data and reports documenting national levels and trends, or levels and trends in neighboring states with respect to any indicator; such information might be useful to Vermont in understanding how it compares with other states prior and subsequent to implementation of its Exchange. Mathematica will execute a data use agreement with DVHA to access, store, and use the data needed to generate the baseline data report.

F. Level Two Establishment Grant Application

- **Develop the project abstract, narrative, budget narrative, and other supporting documents for the application submittal**

Bailit is prepared to assist the state with an application to the U.S. Department of Health and Human Services, Office of Consumer and Information and Insurance Oversight for a Level Two Cooperative Agreement to Support Establishment of the State-Operated Health Insurance Exchange either in March or June of 2012 to provide funds for development and implementation of the Exchange through its first operational year. Level Two grants focus significantly on infrastructure building. The timing for the Level Two grant submission therefore will depend on Vermont's progress in designing a supporting infrastructure for the Exchange, in coordination with design needs for the Medicaid program and other health programs in the State.

Bailit team members, Brendan Hogan, Beth Waldman and Amy Lischko will assist the State of Vermont in the development, editing and production of a final draft of all materials necessary for the grant submission including the project abstract, narrative, budget narrative, and other supporting documents for the application submittal. Similar to the Level One grant, she supporting documents that are created and/or the guidance documents for the Exchange grant include and are not limited to:

A. Description of the Eleven Exchange Establishment Core Areas

B. Appendix B: Example Milestones for Exchange Establishment

C. Appendix C: IT Gap Analysis for Project Narrative

D. Appendix D: Exchange Information Technology

E. Appendix E: Guidance for Preparing a Budget Request and Narrative in Response to SF424A 77

F. Appendix F: Guidance for Preparing Budget Request By Core Area

G. Appendix G: Federal Procurement Requirements for Grantees 87

H. Appendix H: Application Check-Off List

Bailit assisted the State of Vermont with its successful application for the Level One Exchange Establishment grant recently submitted in September of 2011 and awarded on November 29, 2011, working very closely with State staff to draft sections, edit sections written by others, and compile information and documents to assist the state with the application. The Bailit team members have extensive experience with federal grant preparation in Vermont and other states. In addition, the team worked on many of the background materials that are required for the grant submission. This experience is extremely helpful as the State makes many small and large decisions while pulling together a grant application.

Section 1: Exchange Operations/Business Functions - A							
Staff Person	B. Waldman	B. Hogan	K. Bazinsky M. Burns C. Hughes M. Joseph	A. Lischko	P. Burns	M. Podrazik	Total
Fully Loaded Hourly Rate	$244	$219	$152	$230	$270	$240	
A. Call Center							
1.A.1 Review call center contract, inventory functions	40	40	220			40	$61,560
1.A.2 Review federal requirements for a call center	20	20	110			20	$30,780
1.A.3 Identify modifications to current call center needed	40	80	210			40	$68,800
1.A.4 Draft contract amendment	60	60	120			60	$60,420
1.A Subtotal	**160**	**200**	**660**	**0**	**0**	**160**	**$221,560**

Section 1: Exchange Operations/Business Functions - B						
Staff Person	B. Waldman	A. Lischko	P. Burns	M. Podrazik	S. Pawlowski	Total
Fully Loaded Hourly Rate	$244	$230	$270	$240	$220	
B. Financial Management						
1.B.1 Analyze current system, build on Year 1 work	15			160	100	$ 64,060
1.B.2 Finalize Year 1 cost estimates	15				300	$ 69,660
1.B.3 Finalize a sustainability plan	15	20	300			$ 89,260
1.B Subtotal	**45**	**20**	**300**	**160**	**400**	**$ 222,980**

Section 1: Exchange Operations/Business Functions - C					
Staff Person	B. Waldman	B. Hogan	K. Bazinsky M. Burns C. Hughes M. Joseph	M. Podrazik	Total
Fully Loaded Hourly Rate	$244	$219	$152	$240	
C. Program Integrity					
1.C.1 Review existing policies/procedures	10	20	30	10	$13,780
1.C.2 Review HHS auditing requirements	20	40	40	30	$ 26,920
1.C.3 Assess existing programs and develop a plan	20	25	60	25	$25,475
1.C.4 Develop procedures for independent unit	20	40	60	25	$ 28,760
1.C.5 Ensure functions aligned between Medicaid/Exchange	20	40		25	$19,640
1.C Subtotal	**90**	**165**	**190**	**115**	**$ 114,575**

Section 1: Exchange Operations/Business Functions -D

Staff Person	B. Waldman	B. Hogan	K. Bazinsky M. Burns C. Hughes M. Joseph	C. Earle	Total	
Fully Loaded Hourly Rate	$244	$219	$152	$175		
D. Exchange Staffing						
1.D.1 Develop job descriptions for Exchange positions		8	8	45	$	10,843
1.D.2 Recommend a management structure	8	8	8	40	$	11,920
1.D Subtotal	**8**	**16**	**16**	**85**	**$**	**22,763**

Section 1: Exchange Operations/Business Functions - E

Staff Person	A. Lischko	M. Podrazik	D. Chollet	J. Bernstein	W. Borden	A.W. O'Reilly	N. Meyers	Editor	Clerical	Total
Fully Loaded Hourly Rate	$230	$240	$347	$258	$315	$135	$103	$118	$85	
E. Exchange Evaluation										
1.E.1 Review goals and identify key indicators	4	4	24	40	18	50	20			$35,006
1.E.2 Inventory health care data sources			10	20	10	50	30			$21,603
1.E.3 Identify any gaps in data needed	4	4	20	30	10	50	20			$28,512
1.E.4 Develop a reporting template	4	4	10	30	8	50	30	8	8	$27,058
1.E.5 Produce a baseline data report	6		20	44	20	58	20	8	8	$37,483
1.E Subtotal	**18**	**12**	**84**	**164**	**66**	**258**	**120**	**16**	**16**	**$149,663**

Section 1: Exchange Operations/Business Function - F				
Staff Person	B. Waldman	B. Hogan	A. Lischko	Total
Fully Loaded Hourly Rate	$244	$219	$230	
F. Level 2 Establishment Grant Application				
1.F.1 Develop abstract, narrative, budget, other docs	25	40	40	$24,060
1.F Subtotal	**25**	**40**	**40**	**$24,060**

Section 1: Exchange Operations/Business Function - Total																
Staff Person	B. Waldman	B. Hogan	K. Bazinsky M. Burns C. Hughes M. Joseph	A. Lischko	P. Burns	M. Podrazik	S. Pawlowski	C. Earle	D. Chollet	J. Bernstein	W. Borden	A.W. O'Reilly	N. Meyers	Editor	Clerical	Total
Fully Loaded Hourly Rate	$244	$219	$152	$230	$270	$240	$220	$175	$347	$258	$315	$135	$103	$118	$ 85	
Section 1: Total	**328**	**421**	**866**	**78**	**300**	**447**	**400**	**85**	**84**	**164**	**66**	**258**	**120**	**16**	**16**	**$755,60**

Section 2: SHOP Exchange, Individual and Employer Responsibility and Enrollment

Over the past year, the Bailit team worked closely with Vermont officials to develop a framework for the SHOP Exchange which will operate as part of the Health Benefits Exchange.

Bailit will leverage its work in the planning phased and current proposed design for the SHOP Exchange to conduct the work within this section. For this effort, the Bailit team builds on our existing team (Bailit, Amy Lishcko, and B&A) and brings in the experience of Mathematica.

A. SHOP Exchange

As part of our planning grant work on behalf of the state of Vermont, Bailit worked with the state to develop an Exchange design concept that established one Exchange for both individuals and small businesses, but recognizes that these two groups may require very different approaches for success. In developing a design concept for the SHOP Exchange, Bailit first developed a set of goals for policymaker's consideration. These goals include:

- Administration simplification of the health care system;
- Maximizing the purchase of insurance through the Exchange by reducing the burden on the employer while enabling employee choice; and,
- Leveraging existing infrastructure and functions for efficiencies, including creating similar processes for the individual and SHOP Exchange as appropriate.

A key decision in the development of the SHOP Exchange is how much choice to allow small businesses and/or their employees in the selection of health plans through the Exchange. Bailit developed a continuum of options that the Exchange may offer to employers for exploration by state policymakers and the Exchange Advisory Group. The options ranged from limited choice (employer selects tier and product) to unlimited choice (employee has ability to select a product from any insurer and at any tier). Bailit developed presentations for the state's insurers as well as for the Exchange Advisory Committee to obtain specific feedback on the potential options. Stakeholders offered varied feedback with some noting that limited choice allowed for a simple process that was easily understood by employees and reduces the risk of adverse selection. Others favored providing the greatest selection of plans by employees through the Exchange, both so the Exchange adds extra value to what exists currently and to move the market towards individual choice and engagement in health.

In addition to determining what products an employer and their employee may choose from within the Exchange, the SHOP Exchange design must also include a process for attracting employers to the Exchange in the first place, including the development of a simplified enrollment process that eases a small employer's burden in offering health insurance coverage to its employees.

As a next step in finalizing the design of the SHOP Exchange, the Bailit team, led by Beth Waldman, and including Amy Lischko, Mark Podrazik, Deborah Chollet, Brendan Hogan, and senior consultants at Bailit and Mathematica, proposes the following activities:

- Conducting design meetings with employers and employees

As part of the finalization of the SHOP model, Bailit proposes conducting design meetings with employers and their employees to understand current challenges with and barriers to health coverage for small businesses. It will be important to meet with groups of employers and their employees across a range of small businesses by size, geography, industry, and whether the employer currently offers insurance. The Bailit team will conduct four sessions with employers and four sessions with employees across the state in January and February of 2012. In addition, Bailit will also hold four meetings with the state's insurers to obtain additional feedback on the SHOP model. Bailit will produce a report that includes its findings from these feedback sessions.

- Researching models in use in other states

Prior to finalizing a SHOP model for Vermont, Bailit will conduct research and interviews with other states to understand their Exchange design for small businesses, starting with meeting with officials from the Commonwealth Health Insurance Connector Authority to obtain a current understanding of how the Commonwealth Choice program works and hear about the successes and challenges Massachusetts has faced in the implementation of the program. The Bailit team will also reach out to the Connector's vendor that assists in the operation of the Commonwealth Choice program, Small Business Service Bureau Inc. (SBSB).

In addition to interviewing Massachusetts officials, Bailit will research current SHOP Exchange design in other states, including New York, New Hampshire, Washington, California, and Utah. These states are somewhat further along in their decision-making around SHOP Exchanges or already have established a small SHOP Exchange. The Bailit team will also utilize B&A's knowledge of evaluating the Healthy NY program in 2009 and 2010.

This work will occur in parallel to the design meetings being held in January and February with Vermont employers and their employees.

- Developing a proposed SHOP model

Based on the feedback the Bailit team gathers from our meetings with small employers and their employees across the state and our research on other states, Bailit will develop a revised SHOP model identifying detail on how the SHOP will function, including the enrollment process for employers, the choice of plans for the employer and its employees, and the plan selection and payment processes for employers and employees. Bailit will prepare this model for state review in March and revise it in April based on state feedback.

- Testing the proposed model with small business representatives

Upon state approval of the proposed model, Bailit will then test the proposed model with small employers to obtain additional feedback on the model to ensure that it will meet the state's goals to simplify the administration of health care and reduce employer burden, while providing employees with sufficient choice. Bailit will test the model with a different set of employer groups than those that participated in the initial design meetings. The testing of the proposed model will occur in May, and will again include a variety of employers based on size,

geography, industry, and whether currently offering health insurance. The final model will be refined based on the results of the feedback from these small business representatives. If necessary, Bailit will conduct another round of testing based on any significant revisions to the process. The final SHOP model will be delivered in June after incorporating all feedback and revisions.

- Developing cost estimates for mandatory and optional SHOP Functions

As part of Bailit's work under the Exchange planning grant, Bailit's partner, Burns and Associates, developed overall Exchange cost estimates for both mandatory and optional SHOP functions. Under that analysis, the SHOP functions are intertwined with the functions for individual purchase of coverage within the Exchange. In revising its financial functions report to focus on the SHOP Exchange, Burns will develop an allocation of costs across the individual and SHOP portions of the Exchange and will further refine costs based on the additional detail for the SHOP design to be available following the finalization and testing of the model. The cost estimates for the SHOP Exchange will be completed in July 2012.

- Developing procedures and operational processes for SHOP

Upon finalization of the SHOP design, Bailit will develop procedures and operational processes for the SHOP. We anticipate that this will include:

  - Exchange staff roles and responsibilities;
  - Employer enrollment in the SHOP Exchange;
  - Selection of health plan coverage for employees and employee role in selection (depending on amount of choice allowed within the Exchange);
  - Payment of premiums by employer to Exchange and reconciliation of changes; and,
  - Appeals and Grievances.

These procedures and processes will be developed as the SHOP Exchange is finalized, beginning in May and finalized by September 2012.

B. Individual and Employer Responsibility Determinations

The Vermont Exchange is responsible for determining both individual and employer compliance with the federal responsibility for purchasing or providing health coverage. Implementation of this administrative function of the Exchange requires the development of criteria for Exchange staff to follow in a review of an individual or employer circumstance. The Bailit team, led by Beth Waldman, and including Brendan Hogan, Kate Bazinsky, Amy Lischko and Mark Podrazik, will develop these procedures for the state through the following steps:

- Review federal guidance and regulations

As a first step, Bailit will review all federal guidance and regulations surrounding the individual mandate for insurance and an employer's responsibility to offer health coverage to its employees. In addition to looking at federal guidance, the Bailit team will review the existing procedure for

the Commonwealth Health Insurance Connector Authority in Massachusetts to review compliance with the individual mandate and will look at the plans of other states in reviewing both individual and employer responsibility through the Exchange, as available. This research will occur mainly in January and February, and will continue as additional federal guidance is released or other state models are developed. Bailit will provide an initial report detailing federal guidance in February and will update periodically during the project, if and when appropriate based on further information.

- Evaluate existing state appeals functions in Medicaid and other publicly-funded health care programs

There are several similarities between requesting an exemption from the health insurance mandate to other appeals heard by Vermont's Human Services Board today. Bailit will leverage its existing knowledge of these appeal procedures and functions and recommend whether and how they can be used to perform similar activities on behalf of the Exchange. Specifically, Bailit will review the policies and procedures for appeals within public health coverage programs, determine whether the current appeals officers have the skill level and capacity to hear these appeals, and determine what changes, if any, would be needed ensure compliance with this section of the ACA (including any changes to the systems infrastructure the supports the appeals process). This analysis will begin in February and be completed in March. The Bailit team will develop a brief report to DVHA with its recommendations for how these existing functions may be leveraged.

- Develop a detailed process to receive and evaluate exemption requests from individuals

Based on our review of federal guidance, the current procedures in Massachusetts and planned procedures in other states, combined with the results of our evaluation of the existing appeals functions within DVHA, Bailit will develop a detailed process to receive and evaluate exemption requests from individuals. The process will include the timeframes for submitting appeals, what documentation an individual needs to provide to the state, what criteria state appeals officers will use in determining compliance with the individual mandate or allowable exemption from the mandate, the training to be provided to state appeals officers for this function, timeframes for providing written determination of the exemption appeal, ability of an individual to appeal to the state/federal court, and reporting requirements to the Federal Internal Revenue Services. Bailit will present the state with a proposed detailed process in April 2012 and will revise based on state feedback in May 2012.

- Develop a process, with assistance from the state Department of Labor, to determine whether an employer is subject to a tax penalty based on the lack of an offer to employees of Minimum Essential Coverage

To the extent that determining whether an employer is subject to a tax penalty is a state responsibility, Bailit will assist the state in determining whether an employer is meeting its responsibility to provide coverage under the ACA. As with the review for individuals, the Bailit team will work with the Department of Labor to develop a process to receive and evaluate tax penalty determinations based on a comprehensive review of the federal guidance, the current

process in Massachusetts to review compliance with a minimum benefits standard, and the proposed model for other state Exchanges. In addition, Bailit will review the current appeals process at DVHA to understand whether additional capacity can be added to the current appeals functions. As part of this function, Bailit will work with the DOL to determine the appropriate reporting requirements to the federal Internal Revenue Services based on tax penalty determination. Bailit will present the state with a proposed detailed process in May 2012 and will revise based on state feedback in June 2012.

- Define reporting requirements to individuals, employers and the federal government based on decisions in these areas

Determining what, when and how the state will report information and determinations to individuals, employers and the Federal government of State activities to review potential individual or employer penalties based on non-compliance with the ACA will be an important part of the overall process. Key to the development of this will be a review of the Federal guidance regarding the State's role in individual and employer responsibility determinations and what the State is required to provide based on the ACA, implementing regulations or Federal guidance. The reporting process may require upgrades to State systems to allow for electronic transfer of information. The proposed process will include feedback from stakeholders, including individuals and employers, state officials, and federal officials on how to make the process as efficient as possible and ensure the appropriate transfer of information across all parties. Bailit will develop a proposed process in June for finalization by August 2012.

C. Enrollment in Qualified Health Plans

Act 48 anticipates that enrollment in qualified health plans being offered through the Exchange will be conducted through the Exchange for both individuals and small businesses that purchase coverage through the Exchange. Proposed Federal regulations anticipate an open enrollment period for individuals from October 2013 through February 2014. Employers will be able to enter the Exchange at any time.

As part of this task, the Bailit team, led by Brendan Hogan, will confirm that the Exchange should take on the functionality of both enrollment and premium payment for small employers and/or individual Exchange purchasers. Significant work is required to define the process for enrolling individuals and employers within the Exchange, determine how to issue consolidated bills and collect premiums from employers and individuals.

In addition to Brendan, the Bailit team for this task includes consultants from Bailit and Mathematica, as well as Amy Lischko and Erica Garfin. These Bailit team members will assist the State with the following activities in order to facilitate enrollment of individuals and businesses in qualified health plans within the Exchange:

- Evaluate the existing enrollment and premium payment processes in publicly-funded programs, including Catamount Health

The Bailit team will review the current process for enrolling and premium payment processes in Vermont today, including Catamount Health. Under Catamount Health, enrollment occurs

through DVHA's vendor, Maximus, who works closely with the two offering insurers to coordinate enrollment following an eligibility determination. The insurers then reconcile with the state in terms of monthly enrollment in the coverage. This review will be conducted in February 2012, through interviews with State and Maximus staff, and insurers to understand the current process.

- Explore and evaluate enrollment/premium payment processes in use in other states

Concurrent with its review of current enrollment and premium payment processes in Vermont, Bailit will also research processes in use in other states, and how those states plan to leverage or differentiate from their current processes for their Exchange efforts. The Bailit team will review efforts in New Hampshire, Washington, Utah and California (add others from above). We will also utilize B&A's experience evaluating the Healthy NY, Healthy Indiana and Insure Oklahoma programs in how they built these processes, all of which took a different approach. These are the same states proposed for research above for the SHOP Exchange model. Bailit will conduct this review in February and March and submit a summary report to the state in March 2012. The Bailit team will update the report over the course of the contract as more information becomes available.

- Conduct meetings with insurers and small businesses to understand potential enrollment barriers, and develop options for simplifying the enrollment/premium payment process for employers and their employees

In our initial meetings with insurers as part of the Exchange design, Bailit heard from insurers about the complexity of their billing systems and of the reconciliation process in Catamount Health. Insurers expressed some concern that the premium reconciliation process would become overly complex for employers. Bailit will continue these conversations with insurers, and also begin a dialog with small businesses to understand potential enrollment barriers. The Bailit team will design several options for the State to consider regarding the enrollment process, including premium payments that are administratively as simple as possible for employers, employees, the insurers and the Exchange. In collaboration with the State, Bailit will conduct meetings with insurers and employers in March 2012, and based on feedback will refine these options. Bailit will present a prototype enrollment and premium payment model to the state in April and will modify and finalize based on State feedback in May 2012.

- Develop proposed enrollment procedures for individuals, employers and employees

Based on the finalized design, the Bailit team will develop two sets of detailed enrollment procedures: one for individuals and one for small businesses and their employees. Each of these will detail how health plans are selected within the Exchange, where individuals and employers can obtain additional information on the health plans, and when enrollees may switch enrollment to another plan. Bailit will develop these draft procedures in May and submit them to the State in June 2012. Bailit will work with the State to finalize these procedures over the summer of 2012.

- Develop billing and premium payment procedures for employers

Based on the finalized design, Bailit will develop billing and premium payment procedures for employers. These procedures will include option for payment of premiums, timeframe for paying premiums, how the Exchange will develop a consolidated bill for an employer, a reconciliation process between employers and the Exchange for payment, and how the Exchange will reconcile payments with the insurers. Bailit will develop these draft procedures in May and submit them to the state in June 2012. Bailit will work with the state to finalize these procedures over the summer of 2012.

- Evaluate the option of allowing individuals to choose to pay premiums to the Exchange, and recommend whether the state should adopt this option

As noted above, Act 48 anticipates that the Vermont Exchange will collect premiums for both individuals and small businesses. However, at the same time, federal ACA regulations require that individuals purchasing through the Exchange have the ability to make payments directly to the health insurer. Given that individuals must be provided a choice to pay through an insurer, Vermont will need to consider whether to establish functionality for all individual payments to be made through the Exchange with an opt-out provision for individuals that select to pay directly, or whether the Exchange enrollment and premium collection processes should occur separately. Beginning in May, Bailit will consider the functionality for premium payments by the Exchange as compared to the payment by individual and the administrative effort required for both. B&A learned in its examination of other state programs that the administrative burden of collecting premiums and processes that needed to be built in post-implementation are often unanticipated. Based on Bailit's proposed reconciliation process, Bailit will analyze the administrative simplicity and cost of the payment process for individuals making payment directly to insurers rather than the costs related to maintaining different processes for enrollment and payment of premium.

Section 2: SHOP Exchange, Individual and Employer Responsibility, and Enrollment													
Staff Person	B. Waldman	B. Hogan	K. Bazinsky; M. Burns; C. Hughes; M. Joseph	A. Lischko	P. Burns	M. Prodrazik	S. Pawlowki	E. Garfin	D. Chollet	J. Bernstein	W. Borden	A.W. O'Reilly	Total
Fully Loaded Hourly Rate	$244	$219	$152	$230	$270	$240	$220	$130	$347	$258	$315	$135	
A. SHOP Exchange													
2.A.1 Conduct design meetings with employers, employees	10	30	20	10				20					$16,950
2.A.2 Research models in use in other states	10		30	10		5			10	10			$16,555
2.A.3 Develop a proposed SHOP model	35	10	20	35	10	10			15	12			$35,227
2.A.4 Test the proposed model	10	30	20	10				20	15	12			$25,257
2.A.5 Develop cost estimates	10		30	10	60		20		10				$33,373
2.A.6 Develop procedures and operational processes	15	20	50	15					10				$22,563
2.A. Subtotal	**90**	**90**	**170**	**90**	**70**	**15**	**20**	**40**	**60**	**34**	**0**	**0**	$149,924
B. Individual and Employer Responsibility Determinations													
2.B.1 Review federal guidance and regulations in this area	10	10	20	10									$9,970
2.B.2 Evaluate existing State appeals functions	20	20	20										$12,300
2.B.3 Develop a detailed process to evaluate exemptions	20	10	50										$14,670
2.B.4 Develop process for tax penalty determinations	30		50	20		20							$24,320
2.B.5 Define reporting requirements	30		40	30									$20,300
2.B. Subtotal	**110**	**40**	**180**	**60**	**0**	**20**	**0**	**0**	**0**	**0**	**0**	**0**	$81,560
C. Enrollment in Qualified Health Plans													

Section 2: SHOP Exchange, Individual and Employer Responsibility, and Enrollment													
Staff Person	B. Waldman	B. Hogan	K. Bazinsky; M. Burns; C. Hughes; M. Joseph	A. Lischko	P. Burns	M. Prodrazik	S. Pawlowki	E. Garfin	D. Chollet	J. Bernstein	W. Borden	A.W. O'Reilly	Total
2.C.1 Evaluate existing enrollment, premium pmt processes	4	16	16	4		10			4		10	15	$16,796
2.C.2 Explore other enrollment, premium pmt processes	4	5	20	4		6			4		10	15	$14,035
2.C.3 Conduct meetings with insurers, small businesses	8	20		8				20				15	$12,793
2.C.4 Develop enrollment procedures	4	20	12	4		10					16	15	$17,568
2.C.5 Develop billing/payment procedures for employers	4	10	12	4		10			8		16	15	$18,156
2.C.6 Evaluate options for individuals to pay premiums	4	10	12	4		10			8		16	15	$18,156
2.C. Subtotal	**28**	**81**	**72**	**28**	**0**	**46**	**0**	**20**	**24**	**0**	**68**	**90**	$97,502
Section 2: Total	**228**	**211**	**422**	**178**	**70**	**81**	**20**	**60**	**84**	**34**	**68**	**90**	**$328,986**

Section 3: Health Insurance Market Reform

To this section of tasks, Bailit brings together a team with deep experience in the Vermont health insurance market to assist the State with the following tasks: A) Analysis of the Impact of the Exchange on the Outside Market, B) Risk Leveling Programs, C) Certification of Qualified Health Plans (QHPs), D), Consumer Satisfaction Surveys, and E) QHP Plan Design. The Bailit team for this Section will include consultants from Bailit, Mercer/Oliver Wyman, and Market Decisions.

A. Analysis of the Impact of the Exchange on the Outside Market

The State is in the process of assessing the advantages and disadvantages for the State, employers, and individuals of various options for providing access to private insurance coverage, including the impact of the availability of supplemental insurance plans on offerings in the small group and individual market.

Oliver Wyman Actuarial Consulting has extensive knowledge of the Vermont commercial health insurance market as a result of providing actuarial consulting services to BISHCA for over twenty years. As part of the Bailit team during the Exchange planning process, Oliver Wyman recently completed a baseline analysis of how mergers of various health insurance market segments would impact the existing commercial market. This combination of historical and on-going experience coupled with recent studies enables us to best support the State in conducting any ad hoc actuarial analysis involving the assessment of various implementation and policy decisions to provide access to private insurance coverage.

We propose the following process for this task:

- Work with the State to define the statement of work for each study.
- Develop a consensus as to the scope of the study and expected deliverables.
- Create a work plan including necessary resources (such as data or the need to survey carriers, obtains data from State departments, etc.), an expected time table for deliverables and cost estimate.
- Obtain approval from the State regarding the work plan and budget (or, if necessary, develop various iterations until such approval is achieved) and commence work.
- Provide periodic status reports regarding the progress of the study.
- Submit a draft report for the State to review and offer comments.
- Finalize the report.

Based on our experience during the initial planning grant in obtaining usable data from Vermont's health insurers, in this proposal we have included 80 hours on top of the actuarial effort of 150 hours to account for a process of data cleaning and validation.

B. Risk Leveling Programs

There are a number of factors associated with the ACA that are as yet unknown. Among these are the exact structure of the risk-adjustment mechanism, the operation of the temporary reinsurance program for the individual market, and the requirements of the temporary risk corridor program to be operated by the Federal government. The introduction of these new programs in Vermont presents unique considerations due to the current community rating requirement, the significant percentage of associations in the health insurance market, and the eventual implementation of a single-payer system by 2017.

The State is requesting assistance with several activities related to the design and planning for implementation ACA's three risk-leveling programs for Vermont. Mercer Consulting will lead these tasks on behalf of the Bailit team.

- Analyze federal law and regulations to determine the requirements and limits of all three programs.

Mercer will leverage the work of its internal team of actuaries, attorneys, and policy consultants that was specifically formed to address health exchange issues. The members of that group are already working with a number of states across the country to present current requirements, monitor regulations and interpretations, and participate in the Center for Consumer Information and Insurance Oversight (CCIIO) workgroups that have been specifically set up with states to address the details of risk adjustment. We will provide a written report in March that summarizes the requirements of the Federal program as applicable to Vermont, discussing the limits of the three programs in general and depending on the Vermont-specific environment. (For example, the existence of an all-payer claims database in Vermont will mean the state can avoid the standardized data collection requirements that will apply to other states that do not have an all-payer claim database and choose to implement risk adjustment at the state level.) We will base our report on the most current regulations and guidance available at the time it is written.

- Determine if changes in state laws are needed to implement the programs

We will use the results of our analysis and report of the Federal requirements, combined with the Bailit team's collective knowledge of the current state laws in Vermont to provide an analysis of any legislative issues specific to implementing the three risk-leveling programs in Vermont. We will summarize the issues, the circumstances in Vermont's insurance market and/or Exchange model design decisions that could create issues, and the specific state laws that may require changes. Mercer/Oliver Wyman has extensive experience in quantifying the costs associated with mandated benefits and recently completed similar analyses for Connecticut and Maryland. Vermont will need to identify source(s) of funding for Vermont-mandated benefits that exceed the Essential Health Plan. Furthermore, it appears that these additional benefits would need to be excluded from any of the risk leveling programs contained in the federal reforms.

- Present program design options, with financial impacts and pros and cons of each, for the reinsurance and risk adjustment programs.

Based on our work with other states, we believe it is important to gather input from key stakeholders to best consider the options for meeting ACA's risk adjustment requirements. These stakeholders should include state insurance department officials, and carrier representatives. Most states are closely monitoring information from CCIIO on the Federal program and are seriously considering the opportunity to cede the responsibility for the risk adjustment function to the Federal government. Vermont is in a unique position, however, given its movement towards a single-payer program and may want to develop these capabilities.

Key considerations are:

(1) Will the Federal government charge a fee for serving this function and, if so, how much?

(2) How well will the Federal government's methodology work given the specific circumstances of the Vermont health insurance markets, and is there a more optimal solution with the state-based implementation based on the additional flexibility it may provide?

(3) Would the State have the needed resources to perform the risk adjustment function?

(4) What type of data will the State have access to if they cede the risk adjustment function to the Federal government?

Mercer also offers a unique breadth of knowledge and experience evaluating risk adjustment models to assist with this aspect of the project. In addition to our team of actuaries, policy analysts, and attorneys that focus on issues specific to the implementation of Exchanges, Mercer has a team consisting of actuaries, accountants, statisticians, clinicians, consultants and information technology strategists charged with keeping abreast of new developments in the field of risk adjustment. This group meets regularly with the developers of the major risk adjustment technologies – Adjusted Clinical Groupers (ACG), Chronic Disability Payment System (CDPS), Corporate Resources Group (CRG), Diagnostic Cost Group (DCG), and Episode Treatment Group (ETG) – and reviews each system for its applicability to the particular market being considered. In addition, members of this team have presented on various components of risk adjustment at major health care seminars and conferences.

The key issues for the transitional reinsurance program will be finding a non-profit entity that can serve this function for the State. Many states have been considering potential solutions and finding that they would need to look outside of their State for an entity that both meets the ACA definition to serve as a transitional reinsurer and is interested in performing this function for the temporary three year period. For example, states with high risk pools are considering using those entities since they would qualify, but it is unclear whether these states would interested in extending this function beyond their own state. States have been looking to the Federal government to provide a feasible solution that they can leverage. CCIIO is currently working on identifying an entity for the Federal solution (i.e., that would apply to states that do not

implement their own exchange), and one potential solution is that entity could also serve as a transitional reinsurer for individual states.

We believe the steps to complete this task should include meetings with insurance carriers and other stakeholders, high level modeling of potential financial impacts based on key features of the Vermont health insurance markets, and preparation of a report that summarizes stakeholder input, current knowledge of the potential opportunities to leverage Federal options, and recommends options for consideration, including their advantages and disadvantages.

- Develop an implementation plan for the chosen risk adjustment and reinsurance program models, including internal and external managerial models, required internal staffing, and cost estimates for implementing and ongoing administration.

Mercer has a detailed knowledge of what is required to implement a risk adjustment program. Mercer was a pioneer in the field of applying risk adjustment methodologies in a Medicaid environment dating back to 1995 and is a recognized leader in the application of risk adjustment to Medicaid managed care. Since then, we have assisted many states in implementing some form of risk adjustment, including Colorado, Delaware, Maryland, New Jersey, New York, Oklahoma, and Pennsylvania. Mercer assists clients with the evaluation of different risk assessment tools and implementation of payment mechanisms that incorporate health-based risk estimates.

As a result of this work, Mercer is very familiar with the models and staffing requirements for all aspects of implementing risk adjustment programs including collecting and analyzing the data, and producing and communicating results. We will use our familiarity with the various models to prepare a recommended implementation plan, assuming both an internal and external approach as options.

We will leverage our work with other states implementing Exchanges and our involvement in the CCIIO work groups to prepare a recommended implementation plan for transitional reinsurance based on Vermont's chosen approach.

These recommended implementation plans will be preliminary and subject to change based on further guidance that may be issued. They will be presented together with a written report that describes the options selected, model and staffing assumptions, and cost estimates for implementing and ongoing administration.

- Develop a process and methodology for meeting HHS' requirements for the risk corridor program.

Mercer will prepare a report to be submitted to the State in September that will cover the sequence of the three risk-leveling programs and implications, with the risk corridors being the last step in the process. The report will include the details of what will need to be done by the state, and a step-by-step process based on the information available at that time. Since this is a Federal program with formula and methodology set at the Federal level, this process will rely on the amount of guidance provided by the Federal government, or in the absence of guidance, on best estimate assumptions of how the process will work.

C. Certification of Qualified Health Plans (QHPs)

Bailit proposes an approach to certification of QHPs that will be informed by the firm's 14 years of experience assisting BISHCA with insurer regulation of managed care organizations. Bailit assisted BISHCA with implementation of its then-innovative Rule 10 quality assurance and consumer protection regulations and has supported ongoing compliance work since. In addition, Bailit supported the development of Rule 10's successor, Rule H-2009-03, and is now assisting in related compliance oversight activity. Bailit has also been certifying mental health review agents in the State for several years, an activity that could in some respects parallel the QHP certification process should the state so desire.

While the firm's prior experience with Vermont insurer regulation regarding quality provides important context and experience for QHP certification, Bailit recognizes that the Exchange will have a host of certification responsibilities that are distinct from the kinds of activities we have considered in past work. Bailit will be assisted on this task by Mercer and Mathematica.

As prescribed by the RFP, the Bailit team will commence its work in January/February by studying federal statute and regulations pertaining to QHPs and how they must operate. The firm will also study any existing State statutes and regulations beyond Rule H-2009-03 with which we are already familiar, and will develop a crosswalk analysis that identifies central points of commonality and divergence between Federal and State requirements. That analysis will be shared with State staff identified by DVHA in order that Federal requirements that extend beyond existing State insurer requirements can be discussed and the implications for regulatory activity understood.

We will concurrently acquaint ourselves with the existing BISHCA certification processes. While Bailit has extensive experience with Rule 10/Rule H-2009-03 oversight, the firm has not had direct involvement except on occasion with the rates and forms activities. In order to take advantage of such processes, it will be necessary to interview BISHCA staff to understand their operation.

Following this analytical activity, the Bailit team will begin work to develop the certification criteria. We propose that the development of the criteria be informed by three inputs:

1. State and Federal statutory and regulatory requirements;
2. a strategic consideration of the role that insurers are able to play in influencing the quality and affordability of health insurance and health care, and
3. the extent to which Vermont wishes to actively influence insurer performance over time or, alternatively, focus on ensuring basic insurer qualification.

In order to address points #2 and #3 above, Bailit proposes to prepare for and facilitate discussion with relevant State agency personnel. The discussion will provide information regarding approaches used in other states. For example, Utah has chosen to exert relatively little

influence over those insurers offered through its Exchange beyond product standardization.[2] In contrast, while its Exchange is not yet built, Rhode Island has recently taken a very active role to ensure affordability of commercial insurance policies offered within the state, requiring insurer delivery system actions intended to result in reduced commercial insurance trend rates.[3]

Informed by this discussion, in March, Bailit will begin to develop certification criteria that meet State and Federal standards. To facilitate the process both for State staff and those health insurers currently operating within the State, we propose to utilize to the extent possible existing rates and forms requirements, as well as the content of Rule H-2009-03. With respect to the later, we are aware that the Rule already contains a significant array of quality standards, including a requirement that plans participate jointly in quality improvement activities with other plans (Section 6.3 (D)). As we do so, we will seek guidance from the State in terms of the State's anticipated relationship between the QHP certification process and ongoing regulatory activity, as such information may well influence the details of the approach designed for QHP certification.

Whereas there are some pre-existing regulatory functions that can help inform the development and implementation of the certification criteria, there may be less to draw upon in terms of establishing affordability criteria. The Bailit team will draw upon its past and current work in other states to define and apply affordability criteria in this regard.

Following the development of a draft set of criteria, Bailit will consider the administrative processes for implementing the criteria, recognizing that the value of the criteria is linked to their ability to be implemented in a fashion that can be supported by the state's administrative resources. Consistent with the RFP's direction, we will seek to leverage BISHCA's process for reviewing health plans for certification. Recommended processes will consider the following:

- staff levels and technical expertise required to certify insurers;
- the process and timeline for conducting a certification review;
- the frequency of recertification, and how the scope of a recertification review should relate to the scope of initial certification reviews, and
- processes to be taken should an insurer be found to be non-compliant with certification criteria after being certified, whether as part of the recertification process or not.

Bailit proposes that the recommended criteria and processes be reviewed by State staff in May and then with interested stakeholders through informal review and consultation in anticipation of the ultimate need to use the state's existing processes for the development of regulatory requirements (e.g., review by the Legislative Committee on Administrative Rules). Feedback from State staff and stakeholders can inform worthwhile revisions.

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[2] Sabrina Corlette, Joan Alker, Joe Touschner and JoAnn Volk. "The Massachusetts and Utah Health Insurance Exchanges: Lessons Learned." Georgetown University Health Policy Institute, 2011.

[3] See www.ohic.ri.gov/Committees_HealthInsuranceAdvisoryCouncil_Affordability%20Report.php.

As a final step, Bailit will develop application documents, including questionnaires and a model contract, to support the certification and decertification processes in June through September. These documents should inform insurer applicants so that they can submit applications that are responsive to state criteria, thereby shortening the review cycle for the state and for insurers. The documents should also serve to facilitate the administrative review process for state staff so that it can be conducted efficiently and effectively.

D. Consumer Satisfaction Surveys

Bailit's team partner, Market Decisions, will lead this portion of the project. In business since 1977, Market Decisions conducts more than a hundred research assignments each year, most of which are focused in health care. They are experts in survey design, rigorous data collection protocols and complex sampling issues. Past experience has included conducting many satisfaction surveys for health insurance providers and for government entities and familiarity with national efforts, such as NCQA requirements, to standardize measurement systems. They have worked to improve satisfaction survey information so that it is understandable and useable by consumers.

The Bailit team will develop a consumer satisfaction survey during this first phase. Execution of the survey will occur in a second phase. The tasks described below will provide the State with a developed consumer satisfaction survey that includes relevant and meaningful standards and measures, and describes a sustainable process for completing the survey and publicly posting the results.

As part of the Bailit team, Market Decisions proposes to guide the State of Vermont through a process to determine what specific periodic customer satisfaction measurements will:

a. Meet the requirements of the Affordable Care Act (ACA),
b. Be most useful in aiding Vermont's efforts towards healthcare cost containment,
c. Provide useful information for consumers in evaluating competing plans, and
d. Identify poorly performing plans for remedial action by regulators and policymakers.

There are many tools available to measure various aspects of health plan performance, the most important of which is The Healthcare Effectiveness Data and Information Set (HEDIS). This tool measures performances on important dimensions of care and service. It includes approximately 75 measures across eight domains of care, which are primarily focused on three aspects of care: effectiveness, access and utilization. Some sample measurements include:

Effectiveness: *Do cardiac patients have their cholesterol under control?*

Access: *Were patients able to get an appointment with their PCP?*

Utilization: *How long was the average hospital stay for a specific chronic condition?*

Many health plans currently collect HEDIS data, making it possible to readily compare the performance of health plans in improving health. This allows plans to set improvement targets

and identify the changes that will improve HEDIS scores. HEDIS data is most useful for plans, providers and policy makers, but not necessarily consumers.

A component in HEDIS is the CAHPS® 4.0 survey; it measures health plan participant satisfaction with their care in areas such as claims processing; customer service, and getting needed care quickly. This survey focuses on patient experience with the health care they receive and with the service they receive through their health plans. It includes questions such as:

In the last 12 months, how often did your personal doctor explain things in a way that was easy to understand?

In the last 12 months, how often did your health plan's customer service give you the information or help you needed?

In addition, many health plans conduct consumer surveys that have been internally developed and conducted many years before HEDIS was developed. Market Decisions has developed and fielded many such surveys including one for the Commonwealth Health Insurance Connector Authority, for its Commonwealth Care (CommCare) program. This survey was conducted by telephone among a representative sample of policyholders and addressed satisfaction from a consumer point of view. The results of this survey are used on the Connector's website to inform and assist consumers in determining which of the health plan providers is best for them. The satisfaction surveys used by commercial insurers would provide a useful check on the completeness of other government sponsored measurement systems.

Collecting data about plan satisfaction and plan performance for use by carriers and providers is a different challenge than meeting the information needs of various constituents. For example, it is obvious that most consumers would be overwhelmed by the 75 measures in HEDIS and the more than 30 measures in CAHPS® 4.0. These surveys are thorough and complete and as such are valuable tools, but a presentation of all this data is likely more than consumers want and need. In our view, too much information is almost as bad as no information at all.

The measures must be simplified in a form is useful for consumers. Consequently, in this task the Bailit team will not only sort through measurement options, but also identify and recommend the most appropriate way to present the data – regardless of the audience – consumers, providers, insurance companies, regulators and policymakers.

Task I. Satisfaction Measurement Inventory

As part of this component of the assignment, Market Decisions will:

- Prepare a report that;
    - Summarizes ACA statutory provisions, regulations and other Federal guidance as they pertain to customer satisfaction measurement
    - Presents options for plan satisfaction measurement
    - Identifies gaps in measures
    - Projects potential costs of data collection, analysis and presentation of measures
    - Describes pros and cons of measurement approaches.

- Facilitate a meeting among stakeholders to identify measurement priories and preferences.

Task II. Consumer Needs Analysis and Fact Finding

As part of this component of the assignment, Market Decisions will:

- Inventory efforts in various states to present health plan satisfaction data to consumers.
- Interview stakeholders of different state efforts and measurement organizations to understand their perceptions of the consumer use and acceptance of the measurements used or endorsed by their programs.
- Based on the inventory and interviews, prepare a set of measurements that are most likely to be relevant and useful to consumers in Vermont.
- Objectively test measurements' usefulness in a small research study (online or one-on-one interviews) and prepare report.
- Gather facts to inform decisions for satisfaction measurement by the stakeholder group.

Task III. Satisfaction Measurement Finalization

- Summarize results of consumer research and fact finding.
- Facilitate a meeting to rate and rank options.

Task IV. Develop Specifications for Measurement

- Prepare list of measurements and specific survey questions.
- Develop specifications for how data collection is to be conducted.
- Develop specifications for how data is to be presented to consumers, policy makers, regulators, health plan providers and stakeholders.

E. QHP Plan Design

Act 48 requires the Secretary of Administration or designee to make recommendations to the appropriate committees of the general assembly, in consultation with the Green Mountain Care board, about the design a common benefit package for the Vermont health benefit Exchange.[4] This recommendation must consider whether and which of the State's current mandates will remain. The work conducted under this task will assist the Secretary in meeting this charge. The timing of this work will be dependent, in part, on release of federal guidance on the Essential Health Benefit package.

Mathematica Policy Research will lead this task, working closely with Bailit and Oliver Wyman to complete all subtasks, as described below.

[4] Act 48 further charges the secretary, when creating the common benefit package, to compare the essential benefits package defined under federal regulations implementing the ACA with Vermont's insurance mandates, consider the affordability of cost-sharing with and without the ACA's cost-sharing subsidy, and determine the feasibility and appropriate design of cost-sharing amounts for evidence-based health services with proven effectiveness.

- **Complete a comparison of State mandates to the federally defined EHB package.**

In February, the project team will review and confirm the mandate comparison list prepared by Bailit during the initial planning grant. The list includes the State's mandates and the EHB categories defined in the ACA, and identifies which mandates might be included in the EHB when Federal regulations become available and which seem unlikely to be included. The Bailit team will utilize this categorization to inform the actuarial estimates of the cost of maintaining existing mandates that are unlikely to be included in the EHB package, described below.

- **Complete an actuarial analysis of the cost to the State of maintaining existing mandates that are not included in the EHB package.**

The Institute of Medicine (IOM) report released October 7, 2011 emphasized that any EHB must provide access to services; be affordable and sustainable. The IOM recommended that the EHB contain benefits that would result in a 2014 premium for a silver level plan that would not exceed what the 2014 premium would have been had ACA not been passed. To achieve this, there is going to have to be some limitations for some benefits. One of the conclusions of the IOM report was "that Section 1302 language that says "the items and services covered within the categories," should not be read to mean that every service that is within one of the 10 categories or is covered by a typical employer plan should automatically be included within the definition of the EHB." Another conclusion is that the EHB should be based upon the typical small employer benefit plan as opposed to the typical group benefit plan. These two conclusions coupled with the upper premium limit introduce a level of uncertainty pertaining to the scope of benefits that did not exist prior to the IOM report. It is very possible the some benefits that could be classified as being included in one of the ten categories included in ACA may not be included in an EHB or, if included, may have some sort of limits. Further complicating this is the fact that HHS does not have to accept the IOM's recommendations. Therefore the whole issue of EHB and mandated benefits is undefined at this time. However decisions that State policymakers must elect pertaining to mandated benefits can have material fiscal impacts since the ACA is clear that any mandated benefit that exceeds the EHB will be the responsibility of the State. Therefore, it is important that policymakers are cognizant of the costs of retaining any and all mandates. We believe it is critical to obtain "buy in" from the carriers regarding the costs of existing mandated benefits that are not included in the EHB package since these are the entities that will be developing the ultimate rates for any benefits exceeding EHB. Because of timing issues and the fact that the EHB may not be finalized in time to provide policymakers sufficient time to begin a study of only those benefits that are not part of the EHB, we propose the following process begin in February:

- Identify those Vermont mandated benefits that have been implemented (i.e. preventive, other benefits effective September 23, 2010) or are scheduled to be implemented (women's preventive) by ACA and, by default, identify Vermont mandated benefits that have not been implemented or are not yet scheduled to be implemented by ACA (which we will refer to as the "mandates under study").

- Survey the major Vermont carriers to obtain their estimated cost for each mandate under study.

- Independently develop a cost for each mandate under study and compare these with the carriers' responses. The independent estimate coupled with the survey results will provide policymakers with a range of costs for each benefit.

- Survey the major carriers as well as major TPAs regarding the extent to which their self-funded plans (i.e. those plans not subject to compliance with Vermont mandated benefits) voluntarily cover each mandate. This will provide a means of determining the prevalence of each mandated benefit when it is not required and can serve as a proxy for the probability that a particular mandated benefit will be included in total or partially in any EHB. Prevalence will be expressed as a percentage. As an example, if a particular mandated benefit is covered by self funded plans 80% of the time, we would assume there is an 80% probability that it would be part of the EHB and a 20% probability that it would not.

- We will provide policymakers with an estimate of the impact of including each mandated benefit by using the estimates for the full costs of the mandates and the probability that a particular mandate will not be covered by the EHB. The actual costs of the mandates exceeding the EHB could be greater than those shown in these preliminary calculations. To provide policymakers with a range, we will provide the full costs of each mandate as if none were included in the EHB as well as our estimates based upon prevalence.

- Research other states to determine which states have similar mandates, whether they intend to retain or eliminate these mandates, and the research behind these decisions**.**

Using published reports of all states' mandates,[5] the Bailit team will compare Vermont's mandates with those in other states to identify approximately five states with similar mandates. The agency designated to lead implementation of Federal reform in each selected similar state will be contacted throughout the spring of 2012 to obtain information about (a) the status of discussions in the State about retaining or dropping the mandates that Vermont also currently has in place; and (b) the issues that have arisen in the course of these discussions, including stakeholder concerns, any information presented to the state regarding the medical effectiveness and cost of the mandate, and any discussions about options for funding mandates that fall outside the federal EHB package. In addition, we will identify and summarize publicly available, scientifically based evaluations of specific mandates to supplement information obtained from the selected similar states in order to assist the State in understanding the potential impacts of repealing specific state mandates.[6]

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[5] See State Health Insurance Mandates and the ACA Essential Benefits Provisions, **published July 1, 2011; material added October 31, 2011 [**available at http://www.ncsl.org/default.aspx?tabid=14227, accessed November 15, 2011]. Detailed information on state mandates is also available from the Council for Affordable Health Insurance [available at http://www.cahi.org/cahi_contents/resources/pdf/MandatesintheStates2010.pdf, accessed November 15, 2011].

[6] For example, the California Health Benefits Review Board (CHBRP) makes its analyses available to the public. Created by the California legislature to provide independent analysis of proposed health insurance benefit mandates and repeals, CHBRP is charged with analyzing the medical effectiveness, cost impacts, and public health impacts of any proposal to mandate or repeal a health insurance benefit.

The information obtained from this effort will be presented to the State by a memorandum that provides an interim project report. The report will include a matrix comparing Vermont mandates with those in other states and a detailed comparison of Vermont's mandates with those in the selected similar states. The report also will summarize the issues that have arisen in those states' policy discussions about retaining or repealing a benefit that Vermont also mandates, as well as published evaluations, if any, of the medical effectiveness, cost, and public health impacts of each benefit mandated in Vermont that is likely to fall outside the federal EHB package.

- **Identify potential funding sources for retention of State mandates.**

The Bailit team will leverage the initial financial sustainability analysis completed during the initial planning grant and any refinements to it to compile an inventory of all current sources of spending for insured and uninsured residents, including uncompensated and charity care, to identify potential opportunities to reprogram current funds that might be released as Medicaid eligibility and private coverage expand. This inventory will be produced in May and will consider both sources of funds and the level of funds, and compare the latter with the estimated cost to the State of retaining mandated benefits that are likely to fall outside the Federal EHB package.

This information will be presented in a memorandum providing a second interim project report. This report will document sources and levels of funding that currently support privately insured, public-program, and uninsured residents. It will identify possible opportunities for reprogramming funds that might be released with coverage expansions in 2014, and summarize what might be learned from other states (contacted in subtask 3, above) about the options they see for funding current mandates.

- **Inventory the most utilized benefit plans in the State and determine variations among plan designs.**

Oliver Wyman will conduct a survey of the carriers and TPAs to determine what the most common plans are in Vermont and the variations among plan designs. We will develop the survey in February and will conduct it throughout the spring to obtain the needed information. We are very familiar with the Vermont market through our work with BISHCA and have performed these types of surveys and cost analyses in our previous work. We will present the State with a summary of the most utilized benefit plans in the current market along with potential variations in benefit designs.

- **Obtain employer, employee, and individual input on potential standardized plan features.**

As the Bailit team develops potential standardized plan features, we will present these options to State officials and to the Joint Medicaid and Exchange Advisory group. In addition, the Bailit team will solicit input on the potential standardized features from employers, employees and individuals through a series of focused meetings. Prior to the meetings, the Bailit team will develop specific meeting agendas and questions to ask at each type of forum. Following the

sessions, we will draft a summary report that describes the findings from each of the sessions and highlights any particular issue that arises within the plan design.

- **Recommend one or more standardized plan designs at the silver, gold, and platinum levels and estimate the premium costs for each plan design.**

The Bailit team will consolidate the results of the various studies, including prevalence of existing benefits and inputs from consumers and policymakers to develop the benefits to be included in the Vermont market. We anticipate that this work can begin in June. Prior to developing costs, the Bailit team will present the proposed standards to the State leads and will make modifications based on their feedback. Using Oliver Wyman's proprietary pricing model, we will develop cost sharing alternatives that, based upon the available information to date pertaining to actuarial values, will reflect the silver, gold and platinum levels.

- **Provide advice and written materials as requested to support the preparation of the February 15th report to the legislature.**

The solicitation for this proposal anticipates award of a contract in mid- to late January. This timing allows little opportunity for the project team to be helpful in supporting preparation of the February 15th report to the legislature. However, our proposed budget anticipates assisting the State in response to specific needs for information or rapid-response analysis for the legislature,

Section 3: Health Insurance Market Reform

Staff Person	M. Bailit	B. Waldman	M. Houy	B. Hogan	K. Baziknsky; M. Burns, C. Hughes; M. Joseph	K. Bender; K. Giesa, T. Tomczyk, B. Fritchen	S. Swanson, S. Shenoy, W. Woske	D. Chollet	J. Bernstein	A. Barrett	G. Ferry	C. Mildner, B. Robertson	B. Brinegar	J. Maurice, P. Madden, J. McBride	Editor	Total
Fully Loaded Hourly Rate	$244	$244	$219	$219	$152	$400	$ 400	$347	$258	$143	$110	$157	$126	$ 107	$118	
A. Analysis of the Impact of the Exchange on the Outside Market																
3.A.1 Analyze follow-up issues (150 hrs actuarial work)					80	150										$72,160
3.A Subtotal	**0**	**0**	**0**	**0**	**80**	**150**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	$72,160
B. Risk-Leveling Programs																
3.B.1 Analyze federal law and regulations reqs, limits							31									$ 12,400
3.B.2 Determine if changes in state law are needed							37									$ 14,800
3.B.3 Present program design options							36									$14,400
3.B.4 Develop an implementation plan							33									$ 13,200
3.B.5 Develop a process and methodology to meet HHS reqs							32									$12,800
3.B Subtotal	**0**	**0**	**0**	**0**	**0**	**0**	**169**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	$ 67,600

Section 3: Health Insurance Market Reform																
Staff Person	M. Bailit	B. Waldman	M. Houy	B. Hogan	K. Baziknsky; M. Burns, C. Hughes; M. Joseph	K. Bender; K. Giesa, T. Tomczyk, B. Fritchen	S. Swanson, S. Shenoy, W. Woske	D. Chollet	J. Bernstein	A. Barrett	G. Ferry	C. Mildner, B. Robertson	B. Brinegar	J. Maurice, P. Madden, J. McBride	Editor	Total
C. Certification of Qualified Health Plans (QHPs)																
3.C.1 Analyze federal law and regulations for QHPs	20	5	20		40			10	10							$22,615
3.C.2 Develop certification criteria	40	4	20		60		8	30	30							$45,600
3.C.3 Develop processes and procedures	30	4	20		60		8	20	10							$34,523
3.C.4 Develop questionnaires, info requests, model contract	30	5	20		40			20								$25,945
3.C Subtotal	**120**	**18**	**80**	**0**	**200**	**0**	**16**	**80**	**50**	**0**	**0**	**0**	**0**	**0**	**0**	$128,682
D. Consumer Satisfaction Surveys																
3.D.1 Propose appropriate satisfaction standards, measures		2										40	24	40		$14,092
3.D.2 Design a consumer satisfaction survey process		2										30	24	20		$10,375
3.D.3 Develop the survey instrument		2										40	20	20		$11,443

Section 3: Health Insurance Market Reform																
Staff Person	M. Bailit	B. Waldman	M. Houy	B. Hogan	K. Baziknsky; M. Burns, C. Hughes; M. Joseph	K. Bender; K. Giesa, T. Tomczyk, B. Fritchen	S. Swanson, S. Shenoy, W. Woske	D. Chollet	J. Bernstein	A. Barrett	G. Ferry	C. Mildner, B. Robertson	B. Brinegar	J. Maurice, P. Madden, J. McBride	Editor	Total
3.D.4 Develop procedures and administrative resources		2										40	20			$ 9,298
3.D.5 Develop specs for posting the survey results		2										40	20			$9,298
3.D Subtotal	**0**	**10**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**190**	**108**	**80**	**0**	$54,506
E. QHP Plan Design																
3.E.1 Compare State mandates to federal EHB package		5		5				20		20	10					$13,220
3.E.2 Complete actuarial analysis to maintain State mandates						160										$ 64,000
3.E.3 Research other state's mandates								20		20	10					$10,905
3.E.4 Identify potential funding to retain State mandates								10		10						$ 4,902
3.E.5 Inventory variation among existing plans in the State						45		20		30	20				28	$ 34,753
3.E.6 Obtain feedback on		5		5				20		20	20					$14,321

Section 3: Health Insurance Market Reform																
Staff Person	M. Bailit	B. Waldman	M. Houy	B. Hogan	K. Baziknsky; M. Burns, C. Hughes; M. Joseph	K. Bender; K. Giesa, T. Tomczyk, B. Fritchen	S. Swanson, S. Shenoy, W. Woske	D. Chollet	J. Bernstein	A. Barrett	G. Ferry	C. Mildner, B. Robertson	B. Brinegar	J. Maurice, P. Madden, J. McBride	Editor	Total
standardized plan features																
3.E.7 Recommend silver, gold, platinum design(s)		5		5		45		30	28	32	30					$45,839
3.E.8 Advice as requested for 2/15/12 report to Legislature		5		5				10		20	10					$ 9,747
3.E Subtotal	**0**	**20**	**0**	**20**	**0**	**250**	**0**	**130**	**28**	**152**	**100**	**0**	**0**	**0**	**28**	$ 197,686
**** Sample Purchase for Section 3.D																$2,000
Section 3: Total	**120**	**48**	**80**	**20**	**280**	**400**	**185**	**210**	**78**	**152**	**100**	**190**	**108**	**80**	**28**	**$ 522,634**

Section 4. Stakeholder Involvement and Outreach/Education

Stakeholder involvement and comprehensive outreach and education are essential to the successful implementation of health reform and the Exchange. The Bailit team, led by Beth Waldman, and including Brendan Hogan, Amy Lischko, Erica Garfin, and the marketing team of PDI Creative, bring a complete skill set to meet the three tasks within this section – development of the Navigator program, stakeholder consultation, and outreach, education and marketing.

A. Navigator Program

The ACA requires states to fund Navigator Programs as part of their state Exchanges. During the Exchange planning phase, Bailit drafted a white paper that it presented to Vermont state officials and the Exchange Advisory Group focused on the role of the Navigator. Through the planning process, the state determined that it would contract with entities eligible to serve as navigators under the ACA through a competitive procurement. Bailit recommended at that time that the procurement focus on the different approaches and skills that may be necessary to provide enrollment assistance to individuals and small businesses, but that no otherwise eligible entity is precluded on bidding to serve any segment of Vermonters. In addition, there was consensus that regardless of who ultimately served as Navigators, it was essential that there be comprehensive training of Navigators.

- Develop certification criteria for Navigators, differentiating between Navigators serving individuals and those serving small businesses

- Develop a certification process for Navigators

During this next phase of the planning and implementation process, Vermont will be ready to develop certification criteria and a program certification for providing Navigator services to individuals and to small employers and their employees. Given Bailit's role in assisting the State during the first phase of planning for Navigators within the Exchange, Bailit understands the direction Vermont plans to take and will be able to efficiently and effectively develop certification criteria for Navigators that differentiate between Navigators that serve individuals and those that serve small businesses. Bailit will develop the certification criteria for the Navigator in consultation with the State and with other stakeholders, include ongoing consultation with the Joint Advisory Committee for Medicaid and the Exchange. Bailit will develop draft certification criteria by March, and will revise and finalize the criteria in April based on the feedback from the State and its stakeholders.

- Develop a training program for Navigators, including a curriculum and training materials

Once the certification criteria are finalized, Bailit will develop a certification process that Navigators must meet in order to serve within that role. A key part of that certification process will be completing an initial comprehensive training program designed specifically for Navigators that minimally will educate Navigators on:

- the ACA and health reform generally;
- the intersection of the Exchange and the State's single payer efforts;
- individual insurance mandate requirements;
- how individuals apply for coverage through the Exchange, affordability of coverage through the Exchange and when a subsidy may be available to assist in the cost;
- how the Exchange intersects with other public programs, including Medicaid, Dr. Dynasaur, VHAP, and Catamount Health;
- potential for employer penalties if don't provide coverage to employees;
- how small employers may purchase coverage on behalf of their employees through the Exchange and when a small business tax credit may be available;
- the range of options of health plans offered through the Exchange and the differences in benefits, networks and cost sharing across insurers, tiers and products;
- the open enrollment process in the first year and thereafter, including renewal requirements; and,
- the role of the ombudsman and individual and employer rights to file appeals or grievances.

In addition to providing a curriculum and materials for training Navigators on the areas described above, Bailit will also develop job aids and tools that will serve as resources for Navigators when they are meeting with individuals or small businesses.

To achieve certification, Bailit recommends that Navigators be required to show a strong understanding of the components of the ACA and their role in assisting the consumer in accessing coverage through the Exchange. The training materials will include the development of an evaluation to be completed after training to test a Navigator's understanding of the materials. Navigators will be required to score at the 90% level or above in order to provide enrollment assistance. To maintain certification, Bailit recommends that Navigators must take ongoing training classes to keep the material fresh in each Navigator's mind and to share best practices across the state. The training curriculum that Bailit develops will include ongoing training modules in addition to an initial comprehensive training. This training will be conducted in conjunction with the training developed as part of the Outreach, Education and Marketing campaign described below.

Bailit will work with the State to determine the best method or combination of methods to conduct the trainings, including a combination of online trainings and in person sessions.

- Develop the RFP and model contract

As noted above, during the planning phase, Bailit recommended and the State and Exchange Advisory Committee agreed that there should be a competitive procurement to provide Navigator services. The procurement will be open to all entities that qualify under the ACA to serve as Navigators including trade, industry and professional associations, chambers of commerce, unions, and community-based non-profit groups. Navigator entities will be required to select regions across the state or to serve statewide.

Through this task, Bailit will draft, for the state's initial review by June, and finalization in September, a Request for Proposals (RFP) and a Model Contract for qualified entities to serve as Navigators, which will include minimum qualifications to serve as Navigators, a clear description of the roles and responsibilities of the entity and its Navigators, a requirement to provide accurate information in a culturally and linguistically appropriate manner; performance measures and reporting requirements to the state, and the payment structure for the Navigator program. Because the Navigator function is being paid solely with state funds, it will be important to tie the development of the Navigator services to the financial functions analysis included in Section One above and to the financial sustainability and availability of funds that the Bailit team, led by its partner Burns & Associates, conducted during the planning stage. Bailit recommends that payment of Navigators be tied, at same level, to the entities' overall effectiveness.

The Bailit team brings strong depth in the drafting of state procurements and model contracts. Beth Waldman will lead this effort. A lawyer by training, Beth has worked on a number of state procurements during her time with the Massachusetts Medicaid program and since joining Bailit has assisted several states, including Massachusetts, Iowa, and Colorado in drafting procurements and model contracts. Other Bailit team members also bring deep experience in drafting of procurement and model contracts.

B. Stakeholder Consultation

The Bailit team provided stakeholder consultation services to the State of Vermont for the last year as part of the Health Care Exchange Planning grant process. Through this task, Bailit will continue to provide the high level of attention to detail in its support of state staff for all of the areas that are outlined in this section of the RFP. The Bailit team that will provide support for all stakeholder initiatives includes Brendan Hogan, Beth Waldman, Amy Lischko and Erica Garfin, all of whom have extensive experience in working with and gathering input from a wide variety of stakeholder groups. Examples of the work that the Bailit team has provided to the State in the past can be found on the Health Benefits Exchange website
http://dvha.vermont.gov/administration/health-benefits-exchange

The Bailit team will assist the State by developing recommendations in key areas, including basic Exchange design and numerous policy and implementation decisions, based upon input that is obtained from the Joint Advisory Committee, public forums, and discussions with stakeholder groups, including small businesses.

Joint Advisory Committee meetings

Bailit has provided support to the state for meetings of the Exchange Advisory Group throughout the Exchange Planning Grant process, and will continue to provide a high level of support for 10 additional meetings - first to the current Exchange Advisory Group, and then beginning in July to the Joint Advisory Committee. The Bailit team will provide support services for scheduling meetings, making room and logistical arrangements, preparing materials, taking minutes and providing additional administrative support as needed. The team will also work with the State staff to plan and prepare for meetings; develop agendas and PowerPoint presentations, and

briefing materials; and provide additional meeting preparation, facilitation and support services as needed.

Regional public forums and informal stakeholder meetings

The Bailit team will work with the State to plan, prepare for, and convene public forums in regions across Vermont The State may wish to achieve statewide access by convening one or more forums over Vermont Interactive Television or, may decide to convene meetings in at least six (6) selected regions of the State. Bailit will:

- Prepare a schedule that details the time, date and location of the public meetings.
- Arrange for meeting rooms and see to other meeting logistics.
- Work with the State to prepare presentations for the meetings as well as any background materials, which may be posted on the Exchange website and/or distributed at the meetings.
- Create an outreach plan for publicizing the meetings, including sending press releases to local media outlets and utilizing various stakeholder groups to spread the word through their networks.
- Work with the State to arrange for the provision of interpreters for the hearing impaired.
- Attend all meetings and provide facilitation support as needed.
- Provide summaries of all meetings.

Informal stakeholder meetings

This work is a continuation of the work that the Bailit team has done for Vermont this past year. The Bailit team worked with the State to have a series of smaller focused interviews/meetings with stakeholders to gain input from individuals/organizations as part of the planning process. These interviews/meetings included representatives from the Health Care Ombudsmen office, the Vermont Campaign for Health Care Security, Bi-State Primary Care Association, Vermont Chamber of Commerce, Vermont Insurance Agents Association, several insurance agents representing different companies, Blue Cross and Blue Shield of Vermont, CIGNA, and MVP. Bailit will continue to support the state in holding informal meetings with stakeholder groups during the coming year.

Meetings with small businesses: During this phase of the work, Bailit will assist the State in engaging the business community in discussions about the Exchange. This engagement process will be built around at least six (6) regional meetings that will be held with small businesses around the State. The meetings will be designed both to provide employers with up-to-date information and to solicit their input about the Exchange. The Bailit team will:

- Arrange for meeting rooms and see to other meeting logistics.

- Work with the State to prepare presentations for the meetings as well as any background materials, which may be posted on the Exchange website and/or distributed at the meetings.

- Work with industry groups, associations, and community groups such as the Rotary that can recruit their members to participate in the meetings.

- Attend all meetings and provide facilitation support as needed.

- Provide summaries of all meetings.

C. Outreach and Education

A successful and comprehensive outreach, education and marketing campaign that is aimed at both consumers and employers is essential for the overall success of Vermont's Health Benefits Exchange. During the initial planning for the Exchange, Bailit assisted the State in developing a high level plan for its outreach, education and marketing campaign. The plan must:

- Be organized around a set of simple messages that emphasize the State's priorities and educates both individuals and small businesses;
- Utilizes a multi-prong approach, including public education and outreach campaigns, and collaborations with State agencies, community organizations and corporate and civic organizations;
- Give special consideration to the rural nature of Vermont and the characteristics of the current uninsured population;
- Leverage and coordinate messages with the Exchange call center and Navigators; and,
- Coordinate with the marketing campaigns of the health plans that participate in the Exchange and, where possible, the business community.

- Develop a comprehensive outreach, education, and marketing campaign

As part of the initial planning in Vermont, Bailit recommended that in developing a full marketing campaign that it was essential to utilize a firm specializing in marketing to design and develop the marketing campaign based on those parameters. Bailit has partnered with PDI Creative, a Vermont-based marketing firm that has done several previous marketing projects with the State and has a deep understanding of the particular characteristics of Vermont and the State's population. Samples from previous health-focused marketing campaigns that PDI Creative has designed for the State of Vermont are included as Appendix Two.

It is important that the outreach and education component of this task be done in concert with the efforts to design a call center and Navigator program. As part of this training strategy, it will be essential to include a strategy to integrate existing "train the trainer" methods that have worked successfully in Vermont in the launch of other public health coverage programs. The training program will need to be coordinated with the overall brand. Utilizing the assistance of PDI Creative, the training materials created for state, call center, and Navigator staff can include both video and web access.

The outreach, education and marketing components must work together to provide consistent and complimentary messages about the ACA, and should include, as appropriate Vermont's single-payer efforts.

- Implement and complete the first phase of the campaign in 2012

In developing the marketing aspect of the campaign, the Bailit team, led by PDI Creative will develop a plan that engages every sector of the Vermont community. The marketing plan will be divided into five phases:

- Phase 1: Discovery – catalog of current state and insurer messages, prepare to coordinate ultimate message for the Exchange (February and March)
- Phase 2: Create overarching brand and message for the Exchange (March and April)
- Phase 3: Execute first communications for overall message (May/June)
- Phase 4: Develop strategy for more detailed and targeted marketing campaign (June through August)
- Phase 5: Ongoing tie to training program that is integrated with overall brand (ongoing)

In developing the overarching brand message, the Bailit team will develop an overall message and test on focus groups of individuals and small employers, and will also bring the message to the Joint Medicaid and Exchange Advisory Committee. Following the development of the overarching message, the Bailit team will create sub-campaigns focused on individuals and businesses and will again test these messages on focus groups. Once campaign concepts are approved, the Bailit team, led by PDI Creative will create media materials and a public relations communication plan, that may include use of speakers' bureaus, press releases, television and radio talk show appearances, blogs, meetings at service clubs, religious organizations, town meetings, and social media.

A key part of the marketing campaign will include development of website material and integrate that material with material used by the call center and Navigator organizations. Phase One of the plan, which will occur in August and September 2012, will include a statewide two month mix of web, radio, TV, newspaper and social media. At this time, the plan would also call for the execution of an ongoing public relations program.

Section 4: Stakeholder Involvement and Outreach/Education												
Staff Person	B. Waldman	B. Hogan	K. Bazinsky; M. Burns; C. Hughes; M. Joseph	A. Lischko	E. Garfin	P. Kriff	R. Montefusco	P. Brooks	P. Bregman	K. O'Connell	T. Drowne	Total
Fully Loaded Hourly Rate	$244	$219	$152	$230	$130	$100	$90	$90	$125	$90	$90	
A. Navigator Program												
4.A.1 Develop certification criteria for Navigators	40	40	80	40	30							$43,780
4.A.2 Develop certification process for Navigators	30	20	40	20								$22,380
4.A.3 Develop training program for Navigators	30	60	60	20		40						$38,180
4.A.4 Develop the RFP and model contract	50	30	80	30								$37,830
4.A Subtotal	**150**	**150**	**260**	**110**	**30**	**40**	**0**	**0**	**0**	**0**	**0**	$142,170
B. Stakeholder Consultation												
4.B.1 Develop agendas/materials for stakeholder mtgs	80	80	40	60								$56,920
4.B.2 Schedule meetings and make arrangements		30										$6,570
4.B.3 Provide minutes/summaries of the meetings	5	20		5	20							$9,350
4.B.4 Develop recommendations based on public input	80	80	40	60								$56,920
4.B Subtotal	**165**	**210**	**80**	**125**	**20**	**0**	**0**	**0**	**0**	**0**	**0**	**$129,760**
C. Outreach and Education												
4.C.1 Develop outreach, education and marketing campaign	30	30				200	70	75	50	160	110	$77,490
4.C.2 Implement and complete first phase of campaign	10	10				200	70	75	50	160	110	$68,230

Section 4: Stakeholder Involvement and Outreach/Education												
Staff Person	B. Waldman	B. Hogan	K. Bazinsky; M. Burns; C. Hughes; M. Joseph	A. Lischko	E. Garfin	P. Kriff	R. Montefusco	P. Brooks	P. Bregman	K. O'Connell	T. Drowne	Total
Fully Loaded Hourly Rate	$244	$219	$152	$230	$130	$100	$90	$90	$125	$90	$90	
4.C Subtotal	**40**	**40**	**0**	**0**	**0**	**400**	**140**	**150**	**100**	**320**	**220**	**$145,720**
Media buys for section 4												**$560,000**
Section 4: Total	**355**	**400**	**340**	**235**	**50**	**440**	**140**	**150**	**100**	**320**	**220**	**$977,650**

Section 5: Program Integration

The Bailit team is uniquely qualified to assist Vermont in its efforts to achieve integration across its health coverage programs and functions. The Bailit team brings a depth of experience in Vermont and a keen understanding of the integration of responsibilities across DVHA, BISHCA and the Department of Children and Families today and even greater intergration required with the implementation of the ACA. Moreover, the Bailit team brings national experience and understanding of health coverage programs and functions across the country that will serve Vermont well as it moves to simplify the administration of its health coverage programs.

Section Five will be led by Beth Waldman and will also include Bailit senior consultants Brendan Hogan and Marge Houy, independent consultant, Amy Lischko, Mark Podrazik and Stephen Pawloski from B&A, and Deborah Chollet from Mathematica.

A. Integration of Existing Coverage Groups

The Bailit team has a deep understanding of the eligibility processes and different requirements of the Medicaid, CHIP, and waiver requirements in place in Vermont, and also brings expertise in coverage for individuals dually eligible for Medicare and Medicaid. Bailit understands that DVHA is undertaking a strategic planning process that envisions the integration activities to be completed through this task.

- Develop a comprehensive integration strategy that includes the above-named programs and coverage options

As its first task under this project, the Bailit team will leverage the work done by DVHA to date in its development of a comprehensive integration strategy that aligns Medicaid (and other Federally funded programs), the dual eligible demonstration project, private insurance, associations and State and municipal employees coverage. The Bailit team will interview key stakeholders representing each of the programs/coverage options in order to gain a clear understanding of where there is synergy today and where there is divergence in either strategy or process. Bailit anticipates conducting these interviews in February and March. Bailit will develop and present to DVHA in April a summary of these interviews that highlights potential areas of opportunity for integration and challenges to the integration effort.

- Identify statutory changes necessary to achieve the integration strategy

Based on continued conversation with DVHA and other stakeholders, Bailit will develop a proposed strategy that prioritizes areas for integration (e.g., eligibility functions at DCF) and areas for alignment (quality, joint purchasing, particularly with state and municipal employees, as well as with associations and private insurers). As part of the strategy development, Bailit will identify statutory changes necessary to achieve the integration strategy. Bailit will provide a draft strategy to DVHA in April, and in May will present a comprehensive strategy to the Joint Medicaid and Exchange Advisory Group for feedback. Bailit anticipates that the strategy will recommend ongoing communication and alignment efforts as health reform implementation proceeds.

- Develop a plan for integrating the Exchange Division with other DVHA functions

The Bailit team will also develop specific plans for integrating the Exchange Division with other DVHA functions and for integrating the Exchange with the Medicaid eligibility function in DCF. Bailit will leverage the work completed during the Exchange planning phase on the financial functions. As part of this effort, Bailit will review the current organizational structure and functions of DVHA. This will help to identify where there is an existing function than can be leveraged and where there is a gap that needs to be filled, either directly within the Exchange Division, or as part of another unit within DVHA. The plan will identify each Exchange function, describe the full responsibilities within the function, determine whether the function can be completed by existing DVHA staff or whether additional staffing is required, either in an existing unit, or as a new function. The plan will include staff development, training and integration strategies, as well as organizational cultural activities that allow the Exchange Division to be welcomed as a new group within DVHA. Given the State and national attention on the Exchange, it may be difficult for some staff within DVHA to accept the new unit as it will be garnering more attention (good and bad) than other units within DVHA. The seamless integration of the Exchange within DVHA is essential to a successful administrative implementation of the Exchange and will require ongoing attention at the executive level from the Medicaid Director, the Exchange Director and other senior staff. Bailit anticipates working closely with this group between March and June in the development of the integration plan.

- Develop a plan for integrating the Exchange with the Medicaid eligibility function in DCF

Because the Exchange eligibility function will work closely with the Medicaid eligibility function, it is essential to have a clear plan for integrating the Exchange eligibility functions with the Medicaid eligibility functions that are currently at DCF. Through a separate process, Vermont is developing the technical infrastructure to allow the State's current eligibility system to also conduct Exchange eligibility. The plan to integrate the Exchange and Medicaid eligibility functions, therefore, will focus on the interpersonal connections between the Exchange and DCF in the implementation of this new program and how the business processes will work to best integrate the functions. We anticipate that this will be an ongoing effort throughout the Contract period. It will be important for the conversation to include other DVHA staff members who currently interact with DCF, and to leverage existing processes.

B. Administrative Simplification

The Bailit team is well-prepared to assist the state in considering how to best coordinate and simplify the many health care programs it administers. Bailit brings to this task an understanding of the potential administrative simplification efforts within the ACA and an understanding of the complexity of health coverage programs today. The Bailit team has expertise in the Medicaid and CHIP programs, and programs for the elderly and persons with disabilities, including current efforts for the dually eligible. In addition, Bailit worked closely with BISHCA and the Vermont legislature in an effort to delineate the administrative complexities for providers in billing across public and private insurers and the potential for an electronic solution.

To help Vermont determine which of the many possible efforts would result in simplification at the provider level, Bailit will assist the State as follows:

- Review past and current simplification projects in Vermont, as well as simplification efforts in other states and national research in this area

Bailit will gather information on past and current simplification projects in Vermont, including but not limited to previous efforts to simplify provider billing requirements, and the current dual eligible demonstration. Bailit will outreach to current and former state officials, the Joint Medicaid and Exchange Advisory Committee, and other stakeholders to develop a complete listing of these efforts and will catalog them to understand their purpose and outcome. In addition, Bailit will research administrative simplification processes in other states and nationally through research and outreach to organizations like the National Association of State Health Policy (NASHP), the Center for Health Care Strategies (CHCS), and the National Governor's Association (NGA). Bailit will conduct this research in February and March and will develop a catalog detailing the simplification projects, their findings and any outcomes. The catalog will be delivered to DVHA in April and will be revised based on any feedback.

- Research federal law to determine possible simplification opportunities

Bailit will review the ACA and other relevant Federal laws to determine possible simplification opportunities. As part of this research, Bailit will identify any states or organizations that are currently using any of these simplification opportunities and their progress to date. Bailit will conduct this research in February and March, and will produce a report for DVHA review in April. Bailit will revise the report and conduct any further research based on DVHA feedback.

- Poll providers to determine areas of greatest complexity from their perspective and preferences and/or priorities

Simultaneous to the cataloging of current and former simplification efforts and research on potential simplification opportunities under Federal law, Bailit will develop a survey for providers to understand what areas of the health care delivery system remains complex, where simplification would have the most impact and what their priorities are for implementation. The Bailit team will pre-test the survey to ensure provider understanding. Bailit will work with the State and provider associations to distribute this survey by mail to the greatest number of providers and to obtain a high response rate. This poll will be conducted in March 2012 and Bailit will provide a report detailing the results to the State in May. Bailit may also want to conduct key informant interviews as it may be difficult to obtain a satisfactory response rate through a survey.

- Develop an administrative simplification plan for the state, including an implementation plan and timeline that identifies any necessary state law changes and/or waivers of federal requirements, the estimated development costs to achieve the simplification strategy, and estimated long term savings.

Based on our research, the current activities and state and provider preferences for simplification activities, Bailit will develop a proposed high-level strategy for administrative simplification in May 2012. Bailit will seek feedback from the state and the appropriate stakeholder groups on the proposed strategy. Once a final strategy is approved, Bailit will develop an administrative simplification plan that describes the overall administrative simplification strategy, provides a detailed description of the project or group of projects that the state will undertake in order to implement the strategy, identifies any necessary state law changes or federal waivers necessary to implement the strategy, include a cost estimate for implementing the strategy and potential sources for those funds, and what the expected return on investment is on the project (and to whom the ROI goes). Bailit will present this proposed plan to the state in July and will finalize the plan based on feedback and further analysis by September 2012.

Section 5: Program Integration									
Staff Person	B. Waldman	B. Hogan	M. Houy	K. Bazinsky; M. Burns; C. Hughes; M. Joseph	A. Lischko	M. Prodrazik	S. Pawlowski	D. Chollet	Total
Fully Loaded Hourly Rate	$244	$219	$219	$152	$230	$240	$220	$347	
A. Integration of Existing Coverage Groups									
5.A.1 Develop comprehensive integration strategy	50	50	30	20	60	20	30	12	**$ 62,127**
5.A.2 Identify statutory changes necessary	20	10	10	30	10				**$16,120**
5.A.3 Develop plan integrating Exchange/DVHA functions	50	50	20	20	30	20	20	12	**$50,837**
5.A.4 Develop plan integrating Exchange/DCF functions	50	50		20	30			12	**$ 37,257**
5.A Subtotal	**170**	**160**	**60**	**90**	**130**	**40**	**50**	**36**	**$166,341**
B. Administrative Simplification									
5.B.1 Review previous VT, other state simplification projects	30	30		60		20	20		**$32,210**
5.B.2 Research federal law for simplification opportunities	10	10		40		10			**$13,110**
5.B.3 Poll providers on simplification preferences	10	10		30		30			**$16,390**
5.B.4 Develop an administrative simplification plan	50	50		60		30	30		**$ 46,070**
5.B Subtotal	**100**	**100**	**0**	**190**	**0**	**90**	**50**	**0**	**$107,780**
Section 5: Total	**270**	**260**	**60**	**280**	**130**	**130**	**100**	**36**	**$274,121**

Section 6: Quality and Wellness

The Bailit team brings deep experience in assessing and developing quality measurement to inform value based purchasing as well as in the development and assessment of employer wellness programs. The Bailit team for this section is led by Margaret Houy, and includes all of Bailit's senior consultants, as well as Alexander Domaszewic from Mercer Consulting.

A. Quality Program and Rating System

As described above, Bailit has assisted Vermont for the past 14 years in the definition of quality standards and the assessment of managed care organization performance relative to those standards. As part of that work, Bailit supported Vermont in its role as one of the early states to make health insurer quality performance transparent, helping BISHCA introduce Vermont Managed Health Care Plans: A Guide for Consumers in 1999.[7] Bailit assisted BISHCA with the design of this initial report and has supported the evolution of the report's design and content annually ever since. Bailit has also designed the statistical methodology and performed the report's supporting analysis every year since.

With the state anticipating that diverse populations will obtain coverage through the Exchange, there is reason to both consider BISHCA's current approach and to look beyond it. Existing Rule H-2009-03 standards were developed for a commercial insurance market. These standards do not contemplate the specific needs or characteristics of the low income populations served by the Medicaid program, nor do they consider the elderly population currently served by Medicare.

- Inventory existing quality programs and initiatives in the State

The State's desire to inventory existing quality programs within the State is well-founded. Bailit proposes to initiate this inventory in February and include both existing initiatives within Vermont as well as national best practices and other resources. Research will include a combination of interviews and consideration of published resources. Before beginning, Bailit will interview DVHA regarding any preferences it may have for the Exchange quality program and quality ratings, and any desired research avenues. Bailit recommends that its research activities consider the following:

- DVHA, DOH, BISHCA and Blueprint for Health quality standards and measures;
- Vermont Program for Quality in Health Care (VPQHC) quality initiatives, including measurement activity;
- Vermont Child Health Improvement Program (VCHIP) quality improvement activities;
- CMS' measurement sets used for transparency and performance incentive purposes for the Medicare Advantage program (the Five-Star Quality Rating System);
- federal guidance regarding Exchange quality ratings;
- NCQA Health Plan accreditation standards;
- quality standards and measures in use, or being considered, by other Exchanges;

[7] The Consumer Guide is accessible on the BISHCA website, at http://www.bishca.state.vt.us/sites/default/files/Consumer-Guide-Health-Ins.pdf

- quality standards and measures being used by best practice state Medicaid programs, and
- quality measures contained in national measurement sets, including HEDIS, NQF and the new CMS national Medicaid quality measures.
- Develop a plan for incorporating quality programs in the Exchange, including coordination with existing quality programs outside of the Exchange

Following the completion of the analysis, Bailit will provide DVHA with two memorandums. The first, which will be delivered in April, will summarize research findings and offer general recommendations for an Exchange quality program. The memorandum will address insurer quality requirements, including ongoing quality improvement activity, which will coordinate with existing and potential future state quality initiatives such as the Blueprint.

As part of this memorandum Bailit will propose a framework for quality, as any quality program (and rating system) must be predicated on clear definition of what comprises quality and how it should be assessed. Bailit recently assisted the Texas Medicaid program with defining ten core domains of health plan quality performance. Texas will use the construct as an organizing structure for assessing, and hopefully, driving improvements in quality.

The second memorandum, which will be delivered in May, will summarize research findings and offer general recommendations for an Exchange quality rating program. The objective for this memorandum, and for the first, will be to synthesize research findings and to suggest a strategic approach prior to development of more specific recommendations.

- Analyze federal guidance and regulations on quality rating

- Develop a quality rating system for the Exchange that includes federally-required quality standards, as well as any additional standards the State wishes to include

Bailit will review each memorandum with DVHA and solicit feedback. Once DVHA approves approaches for a) Exchange quality standards, and b) an Exchange rating methodology, Bailit will proceed to develop more specific recommendations. We anticipate that these recommendations will be developed in May. In developing the Exchange quality standards, Bailit will consider any quality standards that have been adopted or are being considered for certification of Qualified Health Plans to ensure necessary consistency in expectations. The resulting reports will provide a plan for incorporating quality programs in the Exchange, including coordination with existing quality programs outside of the Exchange, and an Exchange quality rating system. The quality rating system recommendations will include a method for displaying ratings that will be easily comprehended by the general public as well as a plan for rewarding plans that achieve quality goals.

In developing these work products for DVHA, Bailit will draw upon many years of work with quality standard development and assessment, quality reporting and performance incentive strategies:

1. Quality standard development and assessment: In addition to Bailit's 14 years of support of BISHCA quality assurance activity, Bailit has developed health insurer quality regulatory standards for Virginia, commercial insurer performance standards and measures for the Leapfrog Group, and crafted quality standard RFP and contract language for Medicaid managed care programs in several states, including Iowa, Massachusetts, New Jersey, New York and Texas.
2. Quality measurement requirements: In addition to Bailit's support for BISHCA's annual managed care consumer guides, Bailit has organized performance measurement sets for health plan oversight for the California, New Jersey and Texas Medicaid programs. That work has included the development of performance dashboards in two of the states (CA[8] and TX).
3. Quality incentive design: Bailit has many years of experience with the design and implementation of strategies to reward health plans for strong quality performance, be it for goal attainment, improvement in performance over time, or achievement of benchmark-level performance.[9]

Bailit proposes that the proposed quality standards and quality rating system be reviewed by State staff, and then with interested stakeholders through informal review and consultation, but in anticipation of the ultimate need to use the state's existing processes for the development of regulatory requirements (e.g., review by the Legislative Committee on Administrative Rules). Bailit will support presentation of the proposed standards and quality rating system to stakeholders, making any revisions as directed by DVHA.

- Propose a method for displaying ratings that will be easily understandable by the general public

Bailit will draw on work it has conducted previously for BISHCA and for the California Health Care Foundation that displays quality ratings or proposes how to do so. In addition, Bailit will research best practices for display of quality information. This will be included in the overall quality rating system design memorandum described above.

- Develop a plan for rewarding plans that achieve quality goals

Bailit brings a wealth of experience in developing value based purchasing strategies that reward health plans for achieving quality goals. For example, Bailit developed an algorithm for the Medi-Cal program that provides health plans that score well on quality measures to receive a greater portion of unenrolled individuals. Bailit has also developed and implemented a number of pay for performance strategies in various states, including Massachusetts, Iowa and Texas.

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[8]Bailit Health Purchasing (Waldman B and Bailit M).**"**A Medi-Cal Performance Dashboard: Practical Recommendations for a Framework and Measures"California HealthCare Foundation, Oakland, CA, January 2011.

[9] Bailit Health Purchasing (Bailit MH, Dyer MB, Joseph MS). "Incentives and Rewards Best Practices Primer: Lessons Learned From Early Pilots." The Leapfrog Group, Washington, DC, July 2006, and Bailit Health Purchasing (Dyer MB, Bailit MH), "Ensuring Quality Health Plans: A Purchaser's Toolkit for Using Incentives." National Health Care Purchasing Institute, Washington, DC, May 2002.

Bailit will leverage this expertise in the development of a plan for rewarding plans that achieve quality goals set by the Exchange. Bailit will deliver a report to the State that includes best practices and a recommendation for implementation in the Exchange context. This report will be delivered in July.

B. Wellness Programs

Scope of Work

Since a substantial program of wellness and health promotion will likely be a precondition of certification as a qualified health plan in Vermont, the State is seeking assistance in conducting background research to determine the parameters and effectiveness of existing wellness programs, including those provided by the Department of Health and programs associated with work site wellness, as well as evidence-based research, to determine what programs are effective at improving health and how such programs can be fully integrated with the Exchange. Based on the information developed, the State seeks assistance in designing a wellness program component to be included in the Exchange, including an implementation plan, timeline, and cost, and in developing an integration plan for the Exchange's wellness programs and any programs that exist outside of the Exchange. The Bailit team includes Marge Houy of Bailit and Alexander Domaszewicz of Mercer, both with significant experience in the design, implementation and evaluation of wellness programs. In addition, Christine Hughes of Bailit will provide research support.

Approach to Assisting the State

Wellness Framework

Often when people talk about wellness programs, they refer to programs that encourage healthy lifestyle choices and activities, such as developing healthful eating habits and exercising regularly. A more strategic way to consider wellness that Bailit proposes as a framework for the Vermont Exchange to consider wellness is as a stage across a continuum of patient engagement, all of which must be addressed by the certified insurers. Specifically, Bailit suggests that Vermont approach wellness from a population management framework, which would require the insurers to have the capability to assess enrollee risk and tailor interventions based on risk to promote wellness. Those with chronic conditions might be encouraged to participate in insurer disease management programs to assure that their chronic condition is maximally managed, while healthy enrollees would be encouraged to preserve their healthy condition by making healthy lifestyle choices. By adopting this framework, Vermont Exchange will be able to assure that the insurers use a comprehensive, integrated approach to maximizing enrollee well-being.

Background Research

- Research existing programs in the State and in other states, including programs designed by insurers and employers

The Bailit team will begin this task by conducting a telephone interview of the four largest health insurers in the state (BCBSVT, CIGNA, MVP and TVHP) to ascertain their existing approach to and program offerings for promoting wellness and health promotion. We anticipate these interviews will be conducted in February or March. The assessment will include a determination whether the insurer uses a population management approach, what types of incentives are offered, whether there are any studies of the effectiveness of their wellness programs.

Bailit will also interview a maximum of three insurers nationally that have developed and implemented an effectiveness wellness program based on a population management approach. One insurer that would be included in the survey would be Blue Cross and Blue Shield of Massachusetts. The other two insurers would be identified through research. These interviews will also occur in February and March.

Bailit will also collect information about what states as purchasers have done to promote wellness. For example, the states of Tennessee and Georgia have been active in the use of incentive to promote healthy lifestyles and curb the use of tobacco.

Also, Bailit will identify several large employers that have won prestigious wellness awards such as the C. Everet Koop National Health Award (http://www.sph.emory.edu/healthproject/) or the National Business Group on Health's Best Employers for Healthy Lifestyles (https://www.businessgrouphealth.org/bestemployers/index.cfm) that have successfully implemented effective wellness programs for their employees and dependents.

- Review evidence-based research on wellness programs

Bailit, working with Mercer, will conduct a literature review in March and April to identify peer-reviewed studies that have evaluated wellness programs. Reviewing the articles, Bailit will carefully assess what program elements were key to the program's effectiveness or why the program was not successful. Bailit will create a document that summaries the finding by key categories and subcategories, such as consumer engagement (financial incentives and non-financial incentives), health promotion (weight management, nutrition, exercise), wellness platforms, etc. Bailit would create a series of key words, so that the compiled information could be easily accessed. This document will be delivered to the State in May.

- Design a wellness program component to be included in the Exchange, including an implementation plan timeline, and cost

Drawing on the Bailit team's experience and expertise and the information garnered from the interviews and literature review, Bailit and Mercer will develop a series of recommendations for the Vermont Exchange staff to consider in June. The recommendations will include a set of measures that can be used to evaluate the program's effectiveness. Based on this input, Bailit will develop an effective, evidence-based wellness component for the Exchange. The documentation will include a proposed timeline and cost. Bailit will provide two rounds of refinements, based on two meetings with Vermont staff to gather input to create a final set of recommendations, timeline and cost estimates. We anticipate the wellness plan will be finalized in July.

- Develop an integration plan for the Exchange's wellness programs and any programs that exist outside of the Exchange

The Bailit team believes that program integration can best be achieved by the use of common measures to evaluate effectiveness as well as requiring transition coordination and cross program / cross health plan referrals. An integration plan will be delivered to the State in August and finalized based on State feedback. It will include developing a set of measures that the State's insurers would be asked to use to compare effectiveness across different programs. The measures should be based on nationally recognized measures of health and wellness. Possible measures include percentage of overweight and obese enrollees (BMI 25-29, and 30+) who have been effectively engaged for behavior change and selected HEDIS quality measures such as smoking cessation counseling. The measures would be selected based on the key risk factors and conditions facing Vermonters as well as the wellness program structure. The other integration aspect outlined in the plan will be around coordinating the transition of wellness program participants between the plans, including inter-plan wellness program referrals. The referral processes will also be outlined within a single plan, between the various wellness components. By developing these measures, processes and protocols, the Exchange will be establishing wellness priorities and an integrated wellness environment within the State. It will be important to coordinate this work with work being done to develop a quality strategy for the Exchange.

Section 6: Quality and Wellness								
Staff Person	M. Bailit	B. Waldman	M. Houy	B. Hogan	K. Bazinsky; M. Burns; C. Hughes; M. Joseph	A. Lischko	A. Domaszewicz	Total
Fully Loaded Hourly Rate	$244	$244	$219	$219	$152	$ 230	$500	
A. Quality Program and Rating System								
6.A.1 Inventory existing quality programs in the State	10		5	5	15			$6,910
6.A.2 Develop plan to coordinate programs in the Exchange	20	2	5	3	20	5		$11,310
6.A.3 Analyze federal guidance and regulations on rating	10				15	5		$5,870
6.A.4 Develop a quality rating system for the Exchange	20	2		2	25	5		$10,756
6.A.5 Propose a method for displaying ratings	18				15	2		$7,132
6.A.6 Develop a plan for rewarding plans that achieve goals	18		5		15			$7,767
6.A Subtotal	**96**	**4**	**15**	**10**	**105**	**17**	**0**	**$49,745**
B. Wellness Programs								
6.B.1 Research existing programs in VT, other states			46				42	$31,074
6.B.2 Review evidence-based research			6		20		5	$6,854
6.B.3 Design a wellness program component			70		76			$26,882
6.B.4 Develop integration plan for programs in/out Exchange			55		16		45	$36,977
6.B Subtotal	**0**	**0**	**177**	**0**	**112**	**0**	**92**	**$101,787**
Section 6: Subtotal	**96**	**4**	**192**	**10**	**217**	**17**	**92**	**$151,532**

Section 7: Payment Reform

The Bailit team recognizes that payment reform is an integral goal of the State of Vermont both within and outside of the context of the Exchange implementation. This unique challenge is well suited to our team of experts who have worked on numerous reimbursement projects that have included many of the goals that the State has set out for its all payer system. Bailit has put together a team that has experience with developing the high level policy considerations, the nuts and bolts of modeling these policies, and the operational experience to implement, update and monitor these policies from an information systems perspective. Our team has practical experience with Medicare, Medicaid and commercial payers and has participated in developing solutions for states that incentive quality and economic efficiencies.

The payment reform team will be managed by Mark Podrazik of Burns & Associates (B&A). Since 2006, he has served as DVHA's technical resource in the implementation of changes in Medicaid's reimbursement of inpatient hospital, outpatient hospital and professional services that are based primarily on Medicare's payment models. He also assisted the State in refining its disproportionate share payment methodology. He is currently assessing for DVHA the payment differences between Medicare, Medicaid and commercial payers for hospital and professional services. Mr. Podrazik will be assisted by the expert payment reform and quality-based incentive experience of Drs. Deborah Chollet and Timothy Lake of Mathematica Policy Research and Michael Bailit of Bailit Health Purchasing (Bailit) and the experience of developing hospital global budgets from Robert Murray of Global Health Payment. The team has five programmers/analysts from B&A and Mathematica available to work on the project immediately, all of whom are very familiar with reimbursement methodologies, fiscal agent pricing and manipulating large datasets at the service level, provider level, region level and person level. Later in the project, we may utilize our actuarial team for assistance in developing forecasts using utilization trend tables that would be developed.

The process to achieve an all payer rate setting system will involve a variety of stakeholders, will be iterative in nature, and will most likely include both short-term and long-term implementation activities. Although we are ready to start immediately, we recognize that a fundamental change like this will occur over a number of years. As such, we propose to complete the work to implement payment reform over four phases which align with the items requested in the RFP.

Phase I, which is scheduled from January through April 2012, will include the following assistance:

- Task 7.1: Assess potential approaches to implementing all payer rates by identifying the scope of rate setting methodologies to be used, and any necessary phase-in approaches that would need to be employed
- Task 7.6: Identify solutions to payment reform with potential to achieve the simultaneous goals of achieving cost reduction and quality improvement and result in an increase in overall value of care provided for the dollar expended

- Task 7.7: Explore reimbursement systems that promote a higher degree of equity, predictability, stability, and fairness in the payment of provider services

Phase II, which is scheduled from April through September 2012, will include the following:

- Task 7.2: Model the impact of implementing all payer rates within the Exchange and of applying those rates to public payers, including the identification of costs or savings to the State, to private payers, and to specific types of providers, individual institutions, or geographic areas.
- Task 7.3: Develop a plan for coordinating the all payer approach with Medicare payment policies and innovations in Medicare payment
- Task 7.4: Find solutions to this approach that are consistent with Vermont's policies related to payment reform and the political environment

Phase III, which is scheduled from October 2012 to June 2013, will include the following:

- Task 7.5: Accommodate and promote competitive approaches and solutions within an overall framework of consistent incentives, standards, and reasonable rules overseen by a regulatory authority
- Task 7.8: Insure that proposed solutions are aligned with and in conformance with the ACA and Medicaid Rules and Regulations

We also suggest adding a Phase IV, which is scheduled from July through December 2013, which will include assistance related to a task we added to the items listed in the RFP:

- Task 7.9: Assist the State with implementation tasks related to converting to an all payer rate system

The activities in these four phases were developed to prepare for a realistic implementation of the major components of an all payer rate system by January 1, 2014. As with any new system, we expect that system "fine tuning" will continue throughout 2014. Our discussion of the work we plan to complete in each phase is discussed below.

<u>Phase I</u>
At the start of work, our team will collaborate with the State to identify the key stakeholders who will participate in high-level discussions of what is envisioned for Vermont's all payer rate setting system. We will also review with these stakeholders the overall scope of our assignment and the guiding principles of the effort such as:

- Which services are being considered for all payer rates and which service types should be prioritized for introduction of all payer rates?
- Which providers will be impacted by all payer rates--e.g., all providers serving Vermonters? in-state providers only? high volume providers only? At the outset, we

would suggest that consideration be given to implement all payer rates to all providers, although the rates themselves may differ between in-state and out-of-state providers.

- Which payers will be impacted by all payer rates? We will presume that, at least initially, all payer rates that will be established will be in effect for any insurers participating in the Exchange as well as the Medicaid program and (assuming a waiver is received from CMS) the Medicare program.
- Will consideration be given to building in all payer rates that consist of methodologies that can be easily created in the relative short term that would then be amended or added to in the long term, or is it the preference to wait and implement all methodology items at once?

With this charge, we will then inventory the existing methodologies employed by all major payers in the state for the high-priority medical services defined by the State. Our team is already aware of Medicaid's and Medicare's methodologies. For commercial payers, we will conduct interviews with the health plans to gather this information. Based on our national experience, we will supplement the inventory with methodologies used in other states but not in Vermont. The inventory we will compile will consist of what may be termed "base approaches" as well as "variations" or "add-ons". For example, in the case of inpatient hospital services, "base approaches" may include use of diagnosis-related groups (DRGs), episode of care bundled rates, per diem rates, or cost reimbursement. "Variations" may include, for example, in the DRG based approach, use of different available groupers (e.g., MS-DRG used by Medicare, CHAMPUS used by the Department of Defense, All-Patient Refined (APR) used by New York Medicaid and other states). "Add-ons" may include quality-based incentives such as Medicare's recent introduction of clinical process and patient experience measures in its Value Based Purchasing (VBP) system.

Reimbursement systems can vary by medical service and become quite complex. We will subdivide our inventory across major categories of service that will include, at a minimum: inpatient hospital, outpatient hospital, primary care services, and other professional specialty services. Other ancillary medical services (e.g., laboratory) may also be considered. We will prepare the inventory in a manner that assesses multiple dimensions of each methodology, such as administrative ease, level of transparency to the public, budget predictability, the level that payments are tied to outcomes and, in the case of public programs, and the degree to which federal matching funds are assured. It is often the case that no one system meets all of these attributes.

After the inventory is completed, we will present it to the State and deliberate over the benefits and drawbacks of different reimbursement methodologies. We will discuss with stakeholders the most important attributes for each payment methodology, recognizing that the most important attributes for each service may differ. In consultation with the State, we will pare the options down from the original inventory. We recognize that final methodological decisions will not be made at this juncture and that multiple scenarios may need to be modeled. Also, decisions about reimbursement methods for some services (e.g. professional services) may yield fewer options than for other services (e.g. hospital).

Phase II

In Phase II, our team will work with the State on their priorities about which methodologies reviewed in Phase I that should be modeled for additional consideration. A work plan will be developed to create a timeline for the State to review each model or series of models that will be developed to assess the fiscal impact to provider constituencies or individual providers between the all payer rate methodology against the multiple methods in which the providers are paid today. Specific analyses that will be computed will include:

- The difference between the proposed all payer rate methodology and the current methodology across all providers (e.g., all payer rates for professional services versus Medicare's rates, or against Medicaid's rates, or against commercial rates)
- The amount that the all payer rate methodology eliminates or minimizes cost shifting across payers and, when the State is the payer, any increase or decrease in state expenditures under the all payer rate methodology
- The difference between the proposed all payer rate methodology and existing methodologies combined for specific providers (e.g., measuring the fiscal impact to a physician group practice under the all payer rate methodology versus what they are paid by commercial, Medicare and Medicaid factoring in the group's volume billed to each payer)
- The difference between the proposed all payer rate methodology and existing methodologies for a particular service by region within the state
- Where cost information can be derived (hospital services), the difference between the all payer rate methodology and the cost to deliver the service
- The extent to which the State may consider eliminating, adding or changing the provider tax structure in conjunction with a move to the all payer rate methodology

We anticipate that the work plan will be developed in a way that the review of specific methodologies will be completed separately for each category of service. For example, the fiscal impacts modeled for hospital services will be completed separately from the fiscal impacts modeled for professional services and these impacts may be delivered for review at different time. The Bailit team will use extracts from the VHCURES database, which currently includes four years of data from commercial payers and Medicaid, to model these fiscal impacts. We assume that these extracts will be made available to us in SAS, .csv or .txt format. For fiscal impacts related to hospital services, our team will utilize information collected by BISHCA on hospital margins and Medicare cost report data to derive costs for services (for Medicare claims) for consideration in developing impact estimates.

There are three limitations to our modeling known at the outset. First, we understand that services paid by Medicare are not present in the VHCURES database today. We will incorporate this data into our analysis once it is available, but this may not be until Phase III of the project. Second, the data in VHCURES has been validated and cleansed by the database contractor, but these data have yet to be used for purposes of rate setting models. Once the data are delivered, we may discover some limitations in our ability to model specific scenarios given the limitations of the data available to us in VHCURES. Lastly, given time constraints, we anticipate that the models that we develop will be static—that is, they will not anticipate provider behavioral

responses that might alter the volume of care provided. However, we will attempt to draw evidence from the health services research literature that might inform an estimate of the magnitude of dynamic effects as well.

While the team is working on developing estimates of fiscal impacts, it is likely that additional stakeholder feedback will be collected about what works and what does not work in today's systems from the perspective of providers (e.g., hospitals, State medical society, FQHCs) and insurance companies (e.g., BC/BS, MVP and CIGNA) . This stakeholder feedback, specific to types of services, will be helpful in informing State decision makers as alternative methodologies are considered. For example, conversations with hospitals may include discussing options for developing global hospital budgets. Conversations with physicians may include options for bundling payments (either with hospitals or across professional services they are currently being paid for). At the State's discretion, additional stakeholder feedback may inform the specifications of fiscal impacts.

Our team will reconvene with State representatives to review the work conducted thus far, taking into account policy considerations, fiscal considerations and stakeholder feedback. From here, we will work with the State to further refine a specific base methodology approach for each category of service. We will prioritize with the State a master timeline of the feasibility to implement each all payer rate methodology.

Phase III

After the master timeline has been approved by the State, we will develop separate work plans for Phase III that will identify the specific policy considerations, fiscal modeling, regulatory and operational changes that will be required to implement each all payer rate methodology. Once we are at this point in the process, we anticipate that "fine tuning" of the base methodologies will begin to be developed that will include incentives for reducing overall cost while increasing quality. The work plan will be divided by each rate methodology selected because we anticipate that the pace of implementation will vary by methodology. Also, some methodologies may be implemented in the short term under a basic framework while additional elements are introduced over a longer period.

As the work plan solidifies, we anticipate that a larger group of stakeholders may participate in policy and implementation discussions. In our experience, as new rate methodologies are introduced there are often two parallel tracks taking place—one track is keeping the providers impacted by the rate changes abreast of policy changes and to obtain their feedback on potential options; another track is building the systems infrastructure to accommodate the changes required for pricing under the new methodology. Our team has experience in assisting states with both of these efforts while still working on the ongoing fiscal models. With a change as significant as this, we would recommend that the State meet with both providers and systems teams early and often in the process.

To the extent necessary, another activity in Phase III will be seeking authority from CMS to implement the all payer rate methodologies ultimately developed, specifically as they would pertain to services now being paid by the Medicare and Medicaid programs. This activity would

include not only seeking any waiver authority required under the Medicaid Global Commitment waiver, but also exploring the potential for a waiver of Medicare rates. Presently, the State of Maryland is the only state in the nation to be waived from these rates since their payment structure was developed prior to Medicare's rate methodologies. In addition to our experience with rate setting activities, the Bailit team includes staff members who worked for states who submitted waiver requests as well as members who assisted states in non-traditional waiver requests to CMS. We will also utilize Robert Murray's experience in Maryland to help build Vermont's case in seeking this waiver authority. One component of CMS's review of any waiver request will be related to access to services, especially given CMS's May 2011 proposed rule for requirements to ensure sufficient access for Medicaid services. The Burns & Associates team members will leverage access reports already completed for DVHA to complete an access analysis under any all payer waiver submission to CMS.

Phase IV

Although not specifically requested in the RFP, our team is proposing a Phase IV which would include implementation activities. Once the State agrees to the final methodology for each service, a number of implementation activities must be planned, at least for services delivered by DVHA. These include the development of billing requirements, systems testing and provider education,—all required to be completed before "going live". Our team has experience with numerous rate methodology changes and can offer technical assistance in leading provider seminars, editing provider billing manuals, and working with the State's claims processor on systems price testing both pre- and post-implementation for services paid by Medicaid (and potentially Medicare). We have also built monitoring activities in place immediately post implementation as well as over the long term (i.e. annual reviews).

Estimate for Section 7: Payment Reform									
	M. Podrazik	D. Chollet	T.Lake	M. Bailit	R. Murray	B. Waldman	Programmer	Data Analyst	Total
Fully Loaded Hourly Rate	$240	$270	$270	$244	$300	$244	$200	$180	
Phase I (1/15/12 - 9/9/12) - Subtotal	**68**	**38**	**38**	**38**	**22**	**0**	**0**	**16**	**$55,592**
Meetings with State (3) and prep	36	18	18	18	18				108
Inventory existing methodologies in-state	16	16							32
Inventory other methdologies nationally			16	16					32
Compile inventory with attributes	16	4	4	4	4			16	48
Phase II (1/15/12 - 9/9/12) – Subtotal	**164**	**34**	**34**	**18**	**34**	**0**	**344**	**32**	**$146,872**
Develop work plan	6								6
Meetings with State (6, monthly Apr-Sept)	12	6	6	6	6				36
Read in and validate VHCURES data	4						16		20
Assemble and validate BISHCA data	4							16	20
Prep, lead and follow up hospital meetings (initial feedback)	15				16				31
Prep, lead and follow up physician meetings (initial feedback)	15		16						31
Prep, lead and follow up insurance meetings (initial feedback)	15	16							31
Modeling for inpatient hospital services	15						96		111
Modeling for outpatient hospital services	15						96		111
Modeling for professional services	15						96		111
Modeling for ancillary services	8						24		32
Prep deliverable of stakeholder feedback	8	4	4	4	4				24
Prep State mtg materials of models considered (4 mtgs)	32	8	8	8	8		16	16	96
Phase III (9/10/12 - 6/30/13) - Subtotal	**346**	**20**	**56**	**80**	**88**	**80**	**520**	**32**	**$278,760**
Meetings with State (12, approx. monthly)	24	12	12	12	12				72
Develop work plans for each detailed portion of project	12								12
Policy briefs on additional methodological considerations (e.g. quality incentives, global payments, global budgets)	8	8	16	16	12				60

Estimate for Section 7: Payment Reform									
	M. Podrazik	D. Chollet	T.Lake	M. Bailit	R. Murray	B. Waldman	Programmer	Data Analyst	Total
Fully Loaded Hourly Rate	$240	$270	$270	$244	$300	$244	$200	$180	
Read in and validate more recent VHCURES data							8		8
Read in and validate Medicare data							16		16
Prep, lead and follow up on provider meetings (ongoing development, assume 4 hospital, 4 professional)	64			24	40				128
Prep, lead and follow up on systems meetings (ongoing development, assume 26, weekly beginning Jan 2013)	78								78
Modeling for inpatient hospital services	24		8	8	12		120		172
Modeling for outpatient hospital services	24		8	8	12		120		172
Modeling for professional services	24		8	8			120		160
Modeling for ancillary services	12		4	4			60		80
Assist with submitting waiver request to CMS for all payer rates	60					48	60	24	192
Assist with negotiations with CMS	16					32	16	8	72
Phase IV (7/1/13 - 12/31/13) - Subtotal	**228**	**0**	**0**	**0**	**0**	**0**	**64**	**24**	**$71,840**
Meetings with State and systems team (26, weekly)	52								52
Prep and follow-up work related to systems team meetings	52								52
Assist fiscal agent(s) in developing payment logic	16						16		32
Develop system testing scenarios	8						24		32
"Grade" accurary of test cases; work with fiscal agent(s) on results	16						24		40
Prepare language for billing manuals, as requested	16								16
Prepare materials and lead provider education seminars (assume 4 sessions)	56							24	80
Build in short-term and long-term monitoring provisions	12								12

Appendices

Schedule A – Rate Chart

Schedule A - Rate Chart - Bailit Health Purchasing																
Section 1: Exchange Operations/Business Functions																
Staff Person	B.Waldman	B.Hogan	K. Bazinsky M. Burns C. Hughes M. Joseph	A.Lischko	P.Burns	M.Podrazik	S.Pawlowski	C.Earle	D.Chollet	J. Bernstein	W. Borden	A.W. O'Reilly	N. Meyers	Editor	Clerical	Total
Fully Loaded Hourly Rate	$ 244	$ 219	$ 152	$ 230	$ 270	$ 240	$ 220	$ 175	$ 347	$ 258	$ 315	$ 135	$ 103	$ 118	$ 85	
A. Call Center																
1.A.1 Review call center contract, inventory functions	40	40	220			40										$ 61,560
1.A.2 Review federal requirements for a call center	20	20	110			20										$ 30,780
1.A.3 Identify modifications to current call center needed	40	80	210			40										$ 68,800
1.A.4 Draft contract amendment	60	60	120			60										$ 60,420
1.A Subtotal	**160**	**200**	**660**	**0**	**0**	**160**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	$ 221,560
B. Financial Management																
1.B.1 Analyze current system, build on Year 1 work	15					160	100									$ 64,060
1.B.2 Finalize Year 1 cost estimates	15						300									$ 69,660
1.B.3 Finalize a sustainability plan	15			20	300											$ 89,260
1.B Subtotal	**45**	**0**	**0**	**20**	**300**	**160**	**400**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	$ 222,980
C. Program Integrity																
1.C.1 Review existing policies/procedures	10	20	30			10										$ 13,780
1.C.2 Review HHS auditing requirements	20	40	40			30										$ 26,920
1.C.3 Assess existing programs and develop a plan	20	25	60			25										$ 25,475
1.C.4 Develop procedures for independent unit	20	40	60			25										$ 28,760
1.C.5 Ensure functions aligned between Medicaid/Exchange	20	40				25										$ 19,640
1.C Subtotal	**90**	**165**	**190**	**0**	**0**	**115**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**$ 114,575**
D. Exchange Staffing																
1.D.1 Develop job descriptions for Exchange positions		8	8					45								$ 10,843
1.D.2 Recommend a management structure	8	8	8					40								$ 11,920
1.D Subtotal	**8**	**16**	**16**	**0**	**0**	**0**	**0**	**85**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**$ 22,763**
E. Exchange Evaluation																
1.E.1 Review goals and identify key indicators				4		4			24	40	18	50	20			$ 35,006
1.E.2 Inventory health care data sources									10	20	10	50	30			$ 21,603
1.E.3 Identify any gaps in data needed				4		4			20	30	10	50	20			$ 28,512
1.E.4 Develop a reporting template				4		4			10	30	8	50	30	8	8	$ 27,058
1.E.5 Produce a baseline data report				6					20	44	20	58	20	8	8	$ 37,483
1.E Subtotal	**0**	**0**	**0**	**18**	**0**	**12**	**0**	**0**	**84**	**164**	**66**	**258**	**120**	**16**	**16**	**$ 149,663**
F. Level 2 Establishment Grant Application																
1.F.1 Develop abstract, narrative, budget, other docs	25	40		40												$ 24,060
1.F Subtotal	**25**	**40**	**0**	**40**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**$ 24,060**
Section 1: Total	**328**	**421**	**866**	**78**	**300**	**447**	**400**	**85**	**84**	**164**	**66**	**258**	**120**	**16**	**16**	**$ 755,601**

Schedule A - Rate Chart - Bailit Health Purchasing																
Section 2: SHOP Exchange, Individual and Employer Responsibility, and Enrollment																
Staff Person	B. Waldman	B. Hogan	K. Bazinsky; M. Burns; C. Hughes; M. Joseph	A. Lischko	P. Burns	M. Prodrazik	S. Pawlowki	E. Garfin	D. Chollet	J. Bernstein	W. Borden	A.W. O'Reilly				
Fully Loaded Hourly Rate	$ 244	$ 219	$ 152	$ 230	$ 270	$ 240	$ 220	$ 130	$ 347	$ 258	$ 315	$ 135				
A. SHOP Exchange																
2.A.1 Conduct design meetings with employers, employees	10	30	20	10				20								$ 16,950
2.A.2 Research models in use in other states	10		30	10		5			10	10						$ 16,555
2.A.3 Develop a proposed SHOP model	35	10	20	35	10	10			15	12						$ 35,227
2.A.4 Test the proposed model	10	30	20	10				20	15	12						$ 25,257
2.A.5 Develop cost estimates	10		30	10	60		20		10							$ 33,373
2.A.6 Develop procedures and operational processes	15	20	50	15					10							$ 22,563
2.A. Subtotal	**90**	**90**	**170**	**90**	**70**	**15**	**20**	**40**	**60**	**34**	**0**	**0**	**0**	**0**	**0**	$ 149,924
B. Individual and Employer Responsibility Determinations																
2.B.1 Review federal guidance and regulations in this area	10	10	20	10												$ 9,970
2.B.2 Evaluate existing State appeals functions	20	20	20													$ 12,300
2.B.3 Develop a detailed process to evaluate exemptions	20	10	50													$ 14,670
2.B.4 Develop process for tax penalty determinations	30		50	20		20										$ 24,320
2.B.5 Define reporting requirements	30		40	30												$ 20,300
2.B. Subtotal	**110**	**40**	**180**	**60**	**0**	**20**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	$ 81,560
C. Enrollment in Qualified Health Plans																
2.C.1 Evaluate existing enrollment, premium pmt processes	4	16	16	4		10			4		10	15				$ 16,796
2.C.2 Explore other enrollment, premium pmt processes	4	5	20	4		6			4		10	15				$ 14,035
2.C.3 Conduct meetings with insurers, small businesses	8	20		8				20				15				$ 12,793
2.C.4 Develop enrollment procedures	4	20	12	4		10					16	15				$ 17,568
2.C.5 Develop billing/payment procedures for employers	4	10	12	4		10			8		16	15				$ 18,156
2.C.6 Evaluate options for individuals to pay premiums	4	10	12	4		10			8		16	15				$ 18,156
2.C. Subtotal	**28**	**81**	**72**	**28**	**0**	**46**	**0**	**20**	**24**	**0**	**68**	**90**	**0**	**0**	**0**	$ 97,502
Section 2: Total	**228**	**211**	**422**	**178**	**70**	**81**	**20**	**60**	**84**	**34**	**68**	**90**	**0**	**0**	**0**	**$ 328,986**

Schedule A - Rate Chart - Bailit Health Purchasing																
Section 3: Health Insurance Market Reform																
Staff Person	M. Bailit	B. Waldman	M. Houy	B. Hogan	K. Baziknsky; M. Burns, C. Hughes; M. Joseph	K. Bender; K. Giesa, T. Tomczyk, B. Fritchen	S. Swanson, S. Shenoy, W. Woske	D. Chollet	J. Bernstein	A. Barrett	G. Ferry	C. Mildner, B. Robertson	B. Brinegar	J. Maurice, P. Madden, J. McBride	Editor	
Fully Loaded Hourly Rate	$ 244	$ 244	$ 219	$ 219	$ 152	$ 400	$ 400	$ 347	$ 258	$ 143	$ 110	$ 157	$ 126	$ 107	$ 118	
A. Analysis of the Impact of the Exchange on the Outside Market																
3.A.1 Analyze follow-up issues (150 hrs actuarial work)					80	150										$ 72,160
3.A Subtotal	**0**	**0**	**0**	**0**	**80**	**150**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	$ 72,160
B. Risk-Leveling Programs																
3.B.1 Analyze federal law and regulations reqs, limits							31									$ 12,400
3.B.2 Determine if changes in state law are needed							37									$ 14,800
3.B.3 Present program design options							36									$ 14,400
3.B.4 Develop an implementation plan							33									$ 13,200
3.B.5 Develop a process and methodology to meet HHS reqs							32									$ 12,800
3.B Subtotal	**0**	**0**	**0**	**0**	**0**	**0**	**169**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	$ 67,600
C. Certification of Qualified Health Plans (QHPs)																
3.C.1 Analyze federal law and regulations for QHPs	20	5	20		40			10	10							$ 22,615
3.C.2 Develop certification criteria	40	4	20		60		8	30	30							$ 45,600
3.C.3 Develop processes and procedures	30	4	20		60		8	20	10							$ 34,523
3.C.4 Develop questionnaires, info requests, model contract	30	5	20		40			20								$ 25,945
3.C Subtotal	**120**	**18**	**80**	**0**	**200**	**0**	**16**	**80**	**50**	**0**	**0**	**0**	**0**	**0**	**0**	$ 128,682
D. Consumer Satisfaction Surveys																
3.D.1 Propose appropriate satisfaction standards, measures		2										40	24	40		$ 14,092
3.D.2 Design a consumer satisfaction survey process		2										30	24	20		$ 10,375
3.D.3 Develop the survey instrument		2										40	20	20		$ 11,443
3.D.4 Develop procedures and administrative resources		2										40	20			$ 9,298
3.D.5 Develop specs for posting the survey results		2										40	20			$ 9,298
3.D Subtotal	**0**	**10**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**190**	**108**	**80**	**0**	$ 54,506
E. QHP Plan Design																
3.E.1 Compare State mandates to federal EHB package		5		5				20		20	10					$ 13,220
3.E.2 Complete actuarial analysis to maintain State mandates						160										$ 64,000
3.E.3 Research other state's mandates								20		20	10					$ 10,905
3.E.4 Identify potential funding to retain State mandates								10		10						$ 4,902
3.E.5 Inventory variation among existing plans in the State						45		20		30	20				28	$ 34,753
3.E.6 Obtain feedback on standardized plan features		5		5				20		20	20					$ 14,321
3.E.7 Recommend silver, gold, platinum design(s)		5		5		45		30	28	32	30					$ 45,839
3.E.8 Advice as requested for 2/15/12 report to Legislature		5		5				10		20	10					$ 9,747
3.E Subtotal	**0**	**20**	**0**	**20**	**0**	**250**	**0**	**130**	**28**	**152**	**100**	**0**	**0**	**0**	**28**	$ 197,686
**** Sample Purchase for Section 3.D																$ 2,000
Section 3: Total	**120**	**48**	**80**	**20**	**280**	**400**	**185**	**210**	**78**	**152**	**100**	**190**	**108**	**80**	**28**	**$ 522,634**

Schedule A - Rate Chart - Bailit Health Purchasing																
Section 4: Stakeholder Involvement and Outreach/Education																
Staff Person	B. Waldman	B. Hogan	K. Bazinsky; M. Burns; C. Hughes; M. Joseph	A. Lischko	E. Garfin	P. Kriff	R. Montefusco	P. Brooks	P. Bregman	K. O'Connell	T. Drowne					
Fully Loaded Hourly Rate	$ 244	$ 219	$ 152	$ 230	$ 130	$ 100	$ 90	$ 90	$ 125	$ 90	$ 90					
A. Navigator Program																
4.A.1 Develop certification criteria for Navigators	40	40	80	40	30											$ 43,780
4.A.2 Develop certification process for Navigators	30	20	40	20												$ 22,380
4.A.3 Develop training program for Navigators	30	60	60	20		40										$ 38,180
4.A.4 Develop the RFP and model contract	50	30	80	30												$ 37,830
4.A Subtotal	**150**	**150**	**260**	**110**	**30**	**40**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	$ 142,170
B. Stakeholder Consultation																
4.B.1 Develop agendas/materials for stakeholder mtgs	80	80	40	60												$ 56,920
4.B.2 Schedule meetings and make arrangements		30														$ 6,570
4.B.3 Provide minutes/summaries of the meetings	5	20		5	20											$ 9,350
4.B.4 Develop recommendations based on public input	80	80	40	60												$ 56,920
4.B Subtotal	**165**	**210**	**80**	**125**	**20**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**$ 129,760**
C. Outreach and Education																
4.C.1 Develop outreach, education and marketing campaign	30	30				200	70	75	50	160	110					$ 77,490
4.C.2 Implement and complete first phase of campaign	10	10				200	70	75	50	160	110					$ 68,230
4.C Subtotal	**40**	**40**	**0**	**0**	**0**	**400**	**140**	**150**	**100**	**320**	**220**	**0**	**0**	**0**	**0**	**$ 145,720**
Media buys for section 4																**$ 560,000**
Section 4: Total	**355**	**400**	**340**	**235**	**50**	**440**	**140**	**150**	**100**	**320**	**220**	**0**	**0**	**0**	**0**	**$ 977,650**
*** Media buys for Section 4																
Section 5: Program Integration																
Staff Person	B. Waldman	B. Hogan	M. Houy	K. Bazinsky; M. Burns; C. Hughes; M. Joseph	A. Lischko	M. Prodrazik	S. Pawlowski	D. Chollet								
Fully Loaded Hourly Rate	$ 244	$ 219	$ 219	$ 152	$ 230	$ 240	$ 220	$ 347								
A. Integration of Existing Coverage Groups																
5.A.1 Develop comprehensive integration strategy	50	50	30	20	60	20	30	12								**$ 62,127**
5.A.2 Identify statutory changes necessary	20	10	10	30	10											**$ 16,120**
5.A.3 Develop plan integrating Exchange/DVHA functions	50	50	20	20	30	20	20	12								**$ 50,837**
5.A.4 Develop plan integrating Exchange/DCF functions	50	50		20	30			12								**$ 37,257**
5.A Subtotal	**170**	**160**	**60**	**90**	**130**	**40**	**50**	**36**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**$ 166,341**
B. Administrative Simplification																
5.B.1 Review previous VT, other state simplification projects	30	30		60		20	20									**$ 32,210**
5.B.2 Research federal law for simplification opportunities	10	10		40		10										**$ 13,110**
5.B.3 Poll providers on simplification preferences	10	10		30		30										**$ 16,390**
5.B.4 Develop an administrative simplification plan	50	50		60		30	30									**$ 46,070**
5.B Subtotal	**100**	**100**	**0**	**190**	**0**	**90**	**50**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**$ 107,780**
Section 5: Total	**270**	**260**	**60**	**280**	**130**	**130**	**100**	**36**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**$ 274,121**

Schedule A - Rate Chart - Bailit Health Purchasing																
Section 6: Quality and Wellness																
Staff Person	M. Bailit	B. Waldman	M. Houy	B. Hogan	K. Bazinsky; M. Burns; C. Hughes; M. Joseph	A. Lischko	A. Domaszewicz									
Fully Loaded Hourly Rate	$ 244	$ 244	$ 219	$ 219	$ 152	$ 230	$ 500									
A. Quality Program and Rating System																
6.A.1 Inventory existing quality programs in the State	10		5	5	15											$ 6,910
6.A.2 Develop plan to coordinate programs in the Exchange	20	2	5	3	20	5										$ 11,310
6.A.3 Analyze federal guidance and regulations on rating	10				15	5										$ 5,870
6.A.4 Develop a quality rating system for the Exchange	20	2		2	25	5										$ 10,756
6.A.5 Propose a method for displaying ratings	18				15	2										$ 7,132
6.A.6 Develop a plan for rewarding plans that achieve goals	18		5		15											$ 7,767
6.A Subtotal	**96**	**4**	**15**	**10**	**105**	**17**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**$ 49,745**
B. Wellness Programs																
6.B.1 Research existing programs in VT, other states			46				42									$ 31,074
6.B.2 Review evidence-based research			6		20		5									$ 6,854
6.B.3 Design a wellness program component			70		76											$ 26,882
6.B.4 Develop integration plan for programs in/out Exchange			55		16		45									$ 36,977
6.B Subtotal	**0**	**0**	**177**	**0**	**112**	**0**	**92**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**$ 101,787**
Section 6: Subtotal	**96**	**4**	**192**	**10**	**217**	**17**	**92**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**$ 151,532**
Section 7: Payment Reform																
	M. Podrazik	D. Chollet	T.Lake	M. Bailit	R. Murray	B. Waldman	Programmer	Data Analyst								Total
Fully Loaded Hourly Rate	$ 240	$ 270	$ 270	$ 244	$ 300	$ 244	$ 200	$ 180								
Phase I (1/15/12 - 9/9/12)	**68**	**38**	**38**	**38**	**22**	**0**	**0**	**16**								**$ 48,170**
Meetings with State (3) and prep	36	18	18	18	18											108
Inventory existing methodologies in-state	16	16														32
Inventory other methdologies nationally			16	16												32
Compile inventory with attributes	16	4	4	4	4			16								48
Phase II (1/15/12 - 9/9/12)	**164**	**34**	**34**	**18**	**34**	**0**	**344**	**32**								**$ 147,230**
Develop work plan	6															6
Meetings with State (6, monthly Apr-Sept)	12	6	6	6	6											36
Read in and validate VHCURES data	4						16									20
Assemble and validate BISHCA data	4							16								20
Prep, lead and follow up hospital meetings (initial feedback)	15				16											31
Prep, lead and follow up physician meetings (initial feedback)	15		16													31
Prep, lead and follow up insurance meetings (initial feedback)	15	16														31
Modeling for inpatient hospital services	15						96									111
Modeling for outpatient hospital services	15						96									111
Modeling for professional services	15						96									111
Modeling for ancillary services	8						24									32
Prep deliverable of stakeholder feedback	8	4	4	4	4											24
Prep State mtg materials of models considered (4 mtgs)	32	8	8	8	8		16	16								96
Phase III (9/10/12 - 6/30/13)	**346**	**20**	**56**	**80**	**88**	**80**	**520**	**32**								**$ 278,676**
Meetings with State (12, approx. monthly)	24	12	12	12	12											72
Develop work plans for each detailed portion of project	12															12
Policy briefs on additional methodological considerations (e.g. quality incentives, global payments, global budgets)	8	8	16	16	12											60
Read in and validate more recent VHCURES data							8									8
Read in and validate Medicare data							16									16
Prep, lead and follow up on provider meetings (ongoing development, assume 4 hospital, 4 professional)	64			24	40											128
Prep, lead and follow up on systems meetings (ongoing development, assume 26, weekly beginning Jan 2013)	78															78
Modeling for inpatient hospital services	24		8	8	12		120									172
Modeling for outpatient hospital services	24		8	8	12		120									172
Modeling for professional services	24		8	8			120									160
Modeling for ancillary services	12		4	4			60									80
Assist with submitting waiver request to CMS for all payer rates	60					48	60	24								192

Schedule A - Rate Chart - Bailit Health Purchasing																
Assist with negotiations with CMS	16					32	16	8								72
Phase IV (7/1/13 - 12/31/13)	**228**	**0**	**0**	**0**	**0**	**0**	**64**	**24**								**$ 73,912**
Meetings with State and systems team (26, weekly)	52															52
Prep and follow-up work related to systems team meetings	52															52
Assist fiscal agent(s) in developing payment logic	16						16									32
Develop system testing scenarios	8						24									32
"Grade" accurary of test cases; work with fiscal agent(s) on results	16						24									40
Prepare language for billing manuals, as requested	16															16
Prepare materials and lead provider education seminars (assume 4 sessions)	56							24								80
Build in short-term and long-term monitoring provisions	12															12
Total	**806**	**92**	**128**	**136**	**144**	**80**	**928**	**104**								**$ 547,988**
Total Labor																**$ 2,996,512**
Other - Media buys																**$ 560,000**
Other - Sample Purchase																**$ 2,000**
Other - Audit if Necessary (estimate)																**$ 100,000**
Total																**$ 3,658,512**

Schedule B – Detail of Expenses

In Narrative Form explain how figures for salary, benefits, phone, mileage, buildings and facilities were determined

For this response Bailit Health Purchasing and its subcontractors provide hourly rates that are fully loaded with all direct and indirect expenses including travel in the rates.

Schedule C- Allocation of Expenses

In narrative form, describe your method for allocating administrative costs

Bailit Health Purchasing allocate costs billed on a fully loaded hourly rate and do not break out profit or overhead expenses.

Schedule D – Related Party Disclosure

Please identify all related party relationships including cost purpose and approval process

Bailit Health Purchasing LLC, is a Limited Liability Corporation run by its President Michael Bailit. He is ultimately responsible for all aspects of the proposal. There are no relationships between or among Bailit and its subcontractors.

Appendix One: Team Resumes

Appendix Two: Resumes

Bailit Health Purchasing staff:

1. Michael Bailit
2. Beth Waldman
3. Brendan Hogan
4. Margaret Houy
5. Michael Joseph
6. Megan Burns
7. Christine Hughes
8. Kate Barzinsky

Subcontractors for Bailit Health Purchasing include:

1. Amy Lischko, Tufts University
2. Peter Burns, Mark Podrazik, Steven Pawlowski, Craig Srsen and Jesse Eng, Burns & Associates
3. Deborah Chollet, William Borden, Jill Bernstein, Timothy Lake, Suzanne Felt Lisk, Allison Barrett, Amy Wodarek O'Reilly, Thomas Bell, Grace Ferry, Marsha Gold and Nathan Myers, Mathematica Policy Research
4. Curtis Mildner, Brian Robertson, Jason Maurice, Patrick Madden, Brian Brinegar, Jennifer MacBride, Market Decisions
5. Sheree Swanson, Sudha Shenoy, Alexander Domaszewicz, Wendy Woske, Kurt Giesa, Karen Bender, Tammy Tomczyk and Beth Fritchen Mercer/Oliver Wyman
6. Erica Garfin, Independent Consultant
7. Peter Kriff, Ralph Motefusco, Patricia Brooks, Peter Bregman, Kim O'Connell, and Toni Drowne, PDI Creative
8. Caroline Earle, Independent Consultant
9. Robert Murray, Global Health Payment, LLC

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MICHAEL H. BAILIT

PROFESSIONAL EXPERIENCE

1997-present **BAILIT HEALTH PURCHASING, LLC** Needham, MA
President

- Since founding Bailit, has worked with over 50 state, federal, county, and purchaser coalition clients to: design new purchasing programs; structure and conduct procurements; design systems to measure, monitor, and manage contractor and provider performance, create performance incentive systems, and train client staff in the conduct of vendor management practices.
- Consulted and published widely on strategies to improve quality through the use of Value-Based Purchasing, including the use of incentives and rewards.
- Assisted Massachusetts' Special Commission on Health Care Payment to develop recommendations to reform health care payment for all Massachusetts providers.
- Assisting the Governor's Office of Health Care Reform of Pennsylvania, the Massachusetts Executive Office of Health and Human Services and the Missouri Foundation for Health in the development and implementation of statewide multi-payer initiatives to implement the Chronic Care Model and Patient-Centered Medical Home, and the Texas Health and Human Services Commission to pilot medical homes for children served by Medicaid.
- Provided or providing consultation to other medical home initiatives in Colorado, Idaho, Maine, Montana, Nebraska, Ohio, and Washington.
- Assisted The Leapfrog Group and other leading national employer organization to develop a purchaser toolkit to implement HHS Secretary Leavitt's Four Cornerstones of Value-Driven Health Care.
- Advised the Minnesota legislature on strategies for reducing health care program coverage costs without removing covered services, covered populations or cutting provider rates.
- Created quality oversight specifications for behavioral health and physical health managed care plans in Virginia and Vermont; conducting reviews over many years in Vermont.
- Led Bailit's projects assisting state agencies in Colorado, Iowa, Maine, Massachusetts, New Jersey, New York, and Texas in crafting large managed care RFPs, including the development of procurement documents, performance measures and linked financial incentives and disincentives.

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- Supported the Minnesota Long-Term Task Force as an expert consultant and as a stakeholder liaison through a widely hailed successful system change process.
- Assisted the state of Vermont with the development of a capitated, integrated acute and long-term care program for adults with disabilities and the elderly through stakeholder process facilitation and agency consultation.
- Assisted the Massachusetts Department of Developmental Services with a redesign of its rate systems for residential services, community-based day services and implementation of value-based purchasing.
- Assisted state agencies in Maryland, Michigan, New Mexico and Pennsylvania and the Center for Medicare and Medicaid Services (CMS) with strategies and preparations for organizational changes required to manage contracted HMO and behavioral health vendors.
- Analyzed performance data for program design and strategy (CA, NH, TX, VT).

1991-1997 **MASSACHUSETTS DIVISION OF MEDICAL ASSISTANCE**
Boston, MA

Assistant Commissioner, Benefit Plans (1994-1997)

- Directed the management of all of the benefit plans offered to Medicaid recipients in Massachusetts, including the Senior Care Plan, the HMO Program, the Mental Health/Substance Abuse Program, the Primary Care Clinician Plan, and CommonHealth.
- Trained and directed contractor staff to implement aggressive provider network performance profiling and management for quality improvement purposes. The resulting programs were considered to be among the best in the nation.
- Initiated and directed all new program development, including two Section 1115 waivers (one a health reform managed care expansion, the other for dual eligibles) and three grant-funded programs to develop models for better serving adults with disabilities and children with special health care needs.
- Designed and conducted a joint procurement for behavioral health services for, and with, the state mental health agency.
- Implemented HEDIS measurement with contracted HMOs and primary care case management program and developed market-tested "report cards" for Medicaid recipients to utilize when selecting managed care plans.

Director, Managed Care (1991-1994)

- Implemented Massachusetts' statewide section 1915(b) managed care waiver in 1992, including the PCC Plan, the first-in-the-nation statewide mental health substance abuse carve-out, and an expanded

HMO program, together enrolling 450,000 AFDC and disabled recipients.

- Dramatically intensified Massachusetts' HMO management efforts, creation and using purchasing specifications, improvement goals, and quality measures.
- Implemented the first contracted enrollment broker program in the country to outreach, educate, and enroll recipients into managed care plans.

1988-1991 **DIGITAL EQUIPMENT CORPORATION** Maynard, MA
Manager, Welfare Benefits Finance

- Recommended and helped implement move from indemnity to managed care.
- Designed and implemented Digital's nationally recognized quality management approach to HMO contract management.
- Participated in the HMO-employer work group design of HEDIS 1.0.

1987-1988 **STATE MUTUAL LIFE ASSURANCE COMPANY** Worcester, MA
Manager, Group Managed Care

- Developed a PPO product, the Mutual Alliance Plan, for Worcester County. Negotiated provider contracts, designed utilization management and quality management programs, and developed plan design.
- Represented State Mutual as a partner in Private Health Care Systems to develop a national network of PPOs.

1986-1987 **MEMORIAL HEALTH PLAN** Worcester, MA
Finance Manager

- Negotiated provider rates and contracts.
- Tracked plan utilization and expense to budget.

EDUCATION

1984-1986 **KELLOGG GRADUATE SCHOOL OF MANAGEMENT** Evanston, IL
NORTHWESTERN UNIVERSITY
M.B.A. in hospital and health services management, policy and marketing

1980-1984 **WESLEYAN UNIVERSITY** Middletown, CT
B.A. in religion

PUBLICATIONS

Bailit MH and Hughes C. "Key Design Elements of Shared-Savings Payment Arrangements" The Commonwealth Fund, New York, NY, August 2011.

McCue MJ and Bailit MH. "Assessing the Financial Health of Medicaid Managed Care Plans and the Quality of Patient Care They Provide" The Commonwealth Fund, New York, NY, June 2011.

Gabbay RA, Bailit MH, Mauger DT, Wagner EH and Siminerio L. "Multipayer Patient-Centered Medical Home Implementation Guided by the Chronic Care Model" *The Joint Commission Journal on Quality and Patient Safety*, Volume 37 Number 6, June 2011.

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LLanos K, Rothstein JR, Dyer MB, Bailit M. "Physician Pay-for-Performance in Medicaid: A Guide for States." Center for Health Care Strategies, Lawrenceville, NJ, March 2007.

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Bailit M and Dyer MB. "Putting Quality to Work: Rewarding Plan Performance in Medi-Cal Managed Care." California HealthCare Foundation, Oakland, CA, May 2006.

Bailit M. "As Employers Pull Their Money Out: The Failure of Health Care Cost Control." The Piper Report (piperreport.com), June 21, 2005.

Bailit M and Dyer MB. "Beyond Bankable Dollars: Establishing a Business Case for Improving Health Care." Commonwealth Fund, New York, NY, September 2004.

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Dyer MB and Bailit MH, "Are Incentives Effective in Improving the Performance of Managed Care Plans?" Center for Health Care Strategies, Lawrenceville, NJ, March 2002.

Bailit Health Purchasing and Sixth Man Consulting (Dyer MB, Bailit MH, Hughes R). "The Growing Case for Using Physician Incentives to Improve Health Care Quality." National Health Care Purchasing Institute, Washington, DC, December 2001.

Burgess LL, Bailit MH, Gray N, and Pernice C. "A Snapshot: Performance Monitoring in SCHIP Administrative Services Contracting." National Academy for State Health Policy, Portland, ME, April 2001.

Bailit MH and Kokenyesi C. "Financial Performance Incentives for Quality: The State of the Art." National Health Care Purchasing Institute Monograph, Washington, DC, September 2000.

Bailit MH and Burgess LL. "Dissecting the Carve-Out." *Behavioral Healthcare Tomorrow,* December 1999.

Kaye N and Bailit MH. "Innovations in Payment Strategies to Improve Plan Performance" in "Medicaid Managed Care: A Guide for States, 4th Edition." National Academy for State Health Policy, Portland , ME, October 1999.

Bailit MH and Burgess LL. "Competing Interests: Public Sector Behavioral Health Care." *Health Affairs* September/October 1999.

Bailit MH, Kokenyesi C, and Burgess LL. "Purchasing in a Turbulent Market: An Assessment of Medicaid Managed Care in the Mid-Atlantic States." Center for Health Care Strategies, Inc., Princeton, NJ, September 1999.

Stone E., Bailit MH, Greenberg MS, Janes GR. "Comprehensive Health Data Systems Spanning the Public-Private Divide: The Massachusetts Experience."*American Journal of Preventive Medicine* 14 (3S), 40-45, 1998.

Bailit MH. "Ominous Signs and Portents in an Era of Bliss: A Purchaser's Perspective on Health Market Trends." *Health Affairs* November/December 1997.

Bailit MH. "Why Purchasers are Interested in Physician Profiling." *Worcester Medicine* 60:8, 16-21, 1997.

Bailit MH, Burgess LL. "Group Purchasing: A Timely Strategy for State Medicaid Agencies." Paper for the Center for Health Care Strategies, Inc., Princeton, NJ, 1996.

Friedman MD, Bailit MH, Michel JO. "Vendor Management: A Model for Collaboration and Quality Improvement." *Joint Commission Journal of Quality Improvement* 21:635-645, 1995.

Jordan HS, Straus JH, Bailit MH. "Reporting and Using Health Plan Performance Information in Massachusetts." *Joint Commission Journal of Quality Improvement* 21:167-178, 1995.

Bloomberg MA, Jordan HS, Angel KO, Bailit MH, Goonan KJ, Straus JH. "Development of Clinical Indicators for Performance Measurement and Improvement: An HMO/Purchaser Collaborative Effort." *Joint Commission Journal of Quality Improvement* 19:586-595, 1993.

REFEREED LETTERS

Bailit MH. "Letter on Quality and the Medical Marketplace", *New England Journal of Medicine* 336:11, 808, 1997

REVIEWER

Academy for Health Services Research and Health Policy 2001 Annual Meeting
Health Affairs
Milbank Memorial Fund
Milbank Quarterly

BETH WALDMAN

PROFESSIONAL EXPERIENCE

2007 – present **BAILIT HEALTH PURCHASING, LLC** Needham, MA
Senior Consultant

- *Health Care Reform*: Assisting Vermont in Exchange Implementation effort, including leading Exchange design efforts; Assisting Colorado in design and implementation of early expansion for coverage of Adults without Dependent Children and eligibility expansion for working individuals with disabilities; Led initial Maine planning efforts for implementation of national health reform, including analysis of the PPACA, drafting state health plan chapter detailing implementation efforts, development of policy presentations on key aspects of reform, including design of an Exchange, impact on Medicaid and related policy decisions, and impact on Maine's insurance laws and related policy decisions.
- *Behavioral Health Care*: Providing strategic direction and drafting for managed behavioral health carve-out procurement in Massachusetts; previously led similar effort for the Iowa Medicaid Enterprise; Assisting Iowa in the transition of additional services (institutional and community based services) into the Iowa Plan through facilitation transition committees
- *Cost Containment Efforts*: Directed the Massachusetts Health Care Quality and Cost Council on its Roadmap to Cost Containment; development of payment reform readiness tool for Catalyst for Payment Reform
- *Managed Care Procurements*: Led drafting of responses to Medicaid managed care procurements for MCOs in WA, TN, WI, CT and RI.
- *Performance Measurement*: Developed a performance indicator dashboard for the California Medicaid program on behalf of the California HealthCare Foundation.
- *Eligibility Modernization*: Reviewed state of Vermont and Colorado's Medicaid eligibility and enrollment processes and issued report recommending improvements.

1994 – 2007 **EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES** Boston, MA
Medicaid Director (2003 – 2007)

- Responsible for overall administration and management of MassHealth program, with an annual budget of $8 billion and over 1 million members.
- Led complex, matrix organization with approximately 1000 employees across EOHHS and oversaw cross-agency Medicaid Management Team.
- Served as a member of the EOHHS Management Committee.

- Set policy, programmatic and purchasing goals for MassHealth program.
- Played key role in the development and implementation of the Massachusetts Health Care Reform initiative, including participating as an active member of team that created Governor's initial plan and legislation; negotiating terms of waiver amendment to implement HCR with CMS; implementing MassHealth expansions and new Commonwealth Care program; participating as a member of the Commonwealth Health Insurance Connector Authority Board (the Massachusetts Exchange); serving on cross-agency implementation team to trouble shoot across the reform; and serving as a spokesman about the reform effort both in Massachusetts and nationally.
- Provided executive leadership to major agency initiatives including implementation of Health Care Reform legislation, program integrity gap analysis and organizational restructuring, and procurement and build of a new MMIS system.
- Managed relationship with CMS, including negotiating terms of Medicaid state plan and waiver.
- Provided testimony to state legislature on annual budget request, MassHealth related bills, and oversight hearings.
- Provided executive direction in the negotiation of the *Rosie D* lawsuit on provision of services for children's behavioral health.

DIVISION OF MEDICAL ASSISTANCE
Acting Deputy Commissioner (January 2003 – September 2003)

- Managed staff responsible for the 1115 Demonstration Waiver and SCHIP program; Federal/National Policy Management; Evaluation Support; and Constituent Services (including legislation and press).
- Assisted Commissioner in overall administration of the MassHealth program, including playing a lead role in transition planning for an EOHHS reorganization.
- Continued to serve as Director, Waiver Implementation and Administration.

Director, Waiver Implementation and Administration (2001 – 2003)

- Administered the Division's 1115 Demonstration Waiver and SCHIP programs, including negotiating amendments and extensions with CMS and monitoring state and federal budget neutrality.
- Recommended and implemented major eligibility policy changes – including Insurance Partnership program and SCHIP.
- Led agency in development of and application for new waivers or amendments to current programs.
- Led major agency policy and program initiatives.

- Led evaluations of agency programs, including annual reports for the 1115 Waiver and the SCHIP program.
- Key agency contact for advocate groups.

Assistant General Counsel (1994 – 2001)

- Provided legal counsel for an 1115 waiver and SCHIP expansion - including involvement in shaping of new programs, drafting legislation and regulations for Children's Expansion, Insurance Partnership program and HIV Expansion; negotiating proposed expansions with the Health Care Financing Administration; drafting member and employer notices; procuring vendors; and troubleshooting operational issues.
- Represented Commonwealth in litigation of Medicaid actions, including oral argument before the Supreme Judicial Court.
- Advised Division's Claims Review Board on provider payment issues.
- Honors: Twice awarded Commonwealth Citation for Outstanding Performance: as member of the Pharmacy Program Plus team (2000); as member of the Insurance Partnership implementation team (1999).

1993 – 1994 **BOARD OF REGISTRATION IN MEDICINE** Boston, MA
Litigation Counsel (part-time) (1993 – 1994)

1993 - 1994 **NATHANSON & GOLDBERG** Boston, MA
Associate (part-time) (1993 – 1994)

EDUCATION

1995 – 1997 **HARVARD SCHOOL OF PUBLIC HEALTH** Boston, MA

1990 – 1993 **BOSTON COLLEGE LAW SCHOOL** Newton, MA

1986 – 1990 **UNION COLLEGE** Schenectady, NY

PUBLICATIONS

Waldman B and Nordahl K. "The ACAs Impact on Medicaid: Changes and Opportunities for MassHealth", Massachusetts Medicaid Policy Institute, July 2011.

Bailit Health Purchasing (Waldman B and Bailit M). "A Medi-Cal Performance Dashboard: Practical Recommendations for a Framework and Measures." California HealthCare Foundation, Oakland, CA, January 2011.

Waldman B. "Massachusetts Health Care Reform", *Health and Human Rights Journal*, April 2010.

Waldman B. "Covering Children and their Parents – The Massachusetts Model and Implications for National Health Reform, First Focus, December 2009.

Waldman B. “The State Children’s Health Insurance Program in Massachusetts: Achievements, Challenges and Implications for Health Reform”, Massachusetts Medicaid Policy Institute, April 2007.

BRENDAN T. HOGAN

PROFESSIONAL EXPERIENCE

2011–present **BAILIT HEALTH PURCHASING, LLC** Berlin, VT
Senior Consultant

- Assisted the State of Vermont and the State of West Virginia Medicaid Offices with writing planning grant fund applications to the Center for Medicare and Medicaid Innovation. These grant applications were in response to a request for proposals by the Centers for Medicare and Medicaid Service for states to apply for $1,000,000 18-month planning grants to work on programs that serve individuals dually eligible for both Medicare and Medicaid.
- Researched current Medicare programmatic, payment and waiver options for the State of Vermont's Governor's office, Agency of Human Services and the Department of Vermont Health Access.
- Researched current Medicaid payment and programmatic options for the delivery of services for individuals with Developmental Disabilities. Drafted recommendations for Neighborhood Health Plan of Rhode Island as it worked with the state to make changes to the delivery of services in Rhode Island.
- Providing technical assistance to Serenity Care, an Adult Day Care provider in Western Massachusetts applying to the Centers for Medicare and Medicaid Services to become a Program for All Inclusive Care for the Elderly Provider (PACE).
- Conducted interviews with many states around the country on behalf of the State of Colorado's Department of Health Care Policy and Financing. The interviews were with states to research how their respective Medicaid Buy-In programs worked for both working disabled adults and non-working disabled adults. Worked as part of a team to assist with the planning and implementation of changes to Colorado's Medicaid Buy-In program.
- Working as part of a team on State of Vermont Health Insurance Exchange planning. Primary lead for the sections of work related to integration and the status of current health insurance market. The integration work involves coordination with the State of Vermont Department of Banking, Insurance, Securities and Health Care Administration, and the Department of Vermont Health Access on documentation necessary for the state to apply for a health care exchange implementation grant.
- Wrote a Medicaid Infrastructure grant supplemental grant request for VT Vocational Rehabilitation Division and subsequently developing a work plan for connecting Medicaid

Infrastructure Grant work with Affordable Care Act work in Vermont.

2007-2011 **STATE OF VERMONT** Waterbury, VT

DEPT OF DISABILITIES, AGING & INDEPENDENT LIVING

Commissioner (2010 – 2011)

Deputy Commissioner (2007 - 2011)

- Responsible for budget preparation and legislative testimony for a Department with nearly 270 employees and a budget of over $500,000 annually.
- Provide staff supervision for eight people including four Division Managers, Division for the Blind and Visually Impaired, DBVI, Division of Disabilities and Aging Services, DDAS, Division of Licensing and Protection, DLP, and Division of Vocational Rehabilitation Business, DVR, DAIL Business office manager, Information Technology unit manager, General Council and Executive Assistant. Reported to the Agency of Human Services (AHS) Secretary.
- Responsible for Commissioner hearings, a first level of appeal for individuals disputing denials in Choices for Care 1115 LTC Medicaid Waiver, Attendant Services Program, Children's Personal Care Services, and denial of abuse allegations from Adult Protective Services.
- Member of the Governor's Health Care Cabinet – represent DAIL with other commissioners serving as the senior leadership group working to implement all aspects of health care reform in Vermont including long term care provisions and changes and opportunities including the new Medicare changes in the federal Health Care Reform law.
- Worked with the AHS Deputy Secretary on Dual Eligible effort with the Center for Health Care Strategies, specifically planning for the Vermont Agency of Human Services to be a Medicare managed care plan for all 21,000 Vermonters dually eligible for Medicare and Medicaid.
- Albany College of Pharmacy (ACP) project lead which led to the development of internships with ACP students at DAIL including 10 students starting in July 2010 providing pharmacy student review of long term care Medicaid care plans.
- Miscellaneous responsibilities including: American Recovery and Reinvestment Act contact for DAIL, Governor's Commission on Healthy Aging Commission, Legislative tracking for both state and federal legislation related to DAIL programs, Long Term Care Ombudsmen contract manager, Nursing Home and Residential Care Home lead for DAIL Vermont Medicare Beneficiaries Work Group

member. Frequently provided testimony in the Vermont Legislature on behalf of DAIL.

1999-2007 **STATE OF VERMONT, OFFICE OF VERMONT HEALTH ACCESS**
Waterbury & Williston, VT

Health Programs Integration Unit Director (2003-2007)

- Managed a unit of four staff at the state Medicaid office primarily responsible for coordination and liaison work with other departments within the Agency of Human Services and the Department of Banking, Insurance, Securities and Health Care Administration.
- Lead for the AHS Medicare modernization workgroup. Assisted with the implementation of Medicare Part D and VPharm, OVHA's secondary drug program after Medicare Part D. Frequently provided legislative testimony regarding LTC issues and Medicare D. OVHA contact person for and assisted with grant writing and/or project implementation for the following: 1115 LTC waiver, Program for All Inclusive Care for the Elderly, and Real Choices Systems Change Grants.
- Member of the following: the New England States Consortium for the Dually Eligible Initiative Work Group and the National Medicare and Medicaid Dual Eligible Technical Assistance Work Group and the Vermont Medicare Beneficiaries Work Group.
- Administrative lead for OVHA on many quality improvement projects and committees with the Department of Health and represented OVHA on the VPQHC Diabetes Collaborative. Served as the External Quality Review Organization contract manager.

Vermont Independence Project Director (2000-2003)

- Work as part of the Medicaid managed care unit. State project director for the Robert Wood Johnson Foundation Medicare Medicaid Integration Program, RWJF/MMIP grant in Vermont. Goal of this grant-funded project is to link long term care and primary/acute care service delivery systems for low-income elderly and disabled Vermonters.
- Member of the following: the New England States Consortium for the Dually Eligible Initiative workgroup & National Medicare and Medicaid Dual Eligible Technical Assistance Group and the Vermont Medicare Beneficiaries Workgroup.
- Staff assistance provided for the OVHA Quality Improvement Advisory Committee or QIAC, the QIAC primary care and behavioral health care workgroup, the RWJF Medical Home grant project, RWJF Vermont Community Depression Grant Project and the John A.

Hartford foundation Vermont Program for All-Inclusive Care for the Elderly grant project.

Social Welfare Program Consultant (1999-2000)

- Work as part of the Medicaid Managed Care Unit implementing the PCCM or Primary Care Case Management, Managed Fee-for-service Medicaid system. Assist with provider recruitment, education and training. Answered written and verbal inquiries regarding PC Plus Policies, procedures, benefits, quality improvement programs and regulations.
- Worked as part of a team on the client-provider assignment process. Assisted with the transition of Medicaid beneficiaries from contracted Medicaid Managed care plans to the PCCM program.
- Member of the Medicare Beneficiaries workgroup working on planning and outreach for individuals related to Medicare, Medicare Supplemental Insurance and Medicaid and pharmacy programs.

1997-1999 **STATE OF VERMONT** Montpelier, VT

DEPARTMENT OF BANKING, INSURANCE, SECURITIES & HEALTH CARE ADMINISTRATION

Consumer Services Specialist

- Responsible for resolving health insurance questions and complaints related to managed care and indemnity product lines. Assist with public education and outreach efforts regarding managed care policies, procedures and benefits and some assistance with implementation of Rule 10 Managed care regulations. Maintain and update health insurance brochures. Liaison work with the Health Care Ombudsmen's office staff and the Health Insurance Counseling and Assistance program staff. Assist with the development of the Medicare Beneficiaries Work Group.

1996-1997 **BLUE CROSS AND BLUE SHIELD OF VERMONT** Berlin, VT

Customer Service Representative

- Responsible for resolving subscriber, provider and group health insurance claim and benefit questions from telephone and written inquiries for both managed care and indemnity lines of business at

BCBSVT. In addition, assist members covered by Medicare supplemental policies understand the difference between Medicare and a Medicare supplemental policy. Assist members with resolving problems with the BCBS prescription drug claims and national claims systems.

1995-1996 **FLETCHER ALLEN HEALTH CARE** Burlington, VT

Patient Financial Services Representative

1992-1995 **MERCHANTS BANK** Burlington, VT

Loan Department Assistant

1982-1992 Many full time and temporary retail and data entry positions

EDUCATION

2002-2008 **ST. MICHAELS COLLEGE** Colchester, VT

Master of Science in Administration

1985-1989 **UNIVERSITY OF VERMONT** Burlington, VT

Bachelor of Arts Degree in Political Science and History

MARGARET L. HOUY

PROFESSIONAL EXPERIENCE

2002-present **BAILIT HEALTH PURCHASING, LLC** Needham, MA
Senior Consultant

- Assisting the Missouri Foundation for Health to assess Missouri primary care providers and other stakeholder readiness and interest in participating in a Medical Home initiative.
- Assisting the Texas Health and Human Services Commission to design and evaluate a Medicaid Health Home pilot designed to encourage innovative approaches to structuring practice transformation.
- Assisting the Massachusetts Executive Office of Health and Human Services to plan and implement a multi-payer Patient-Centered Medical Home initiative.
- Assisting the Pennsylvania Governor's Office of Health Care Reform to implement a consumer engagement strategy within the rollout of the Chronic Care Model across the state.
- Assisting the Massachusetts Interlocal Insurance Association with developing and implementing a strategic initiative to enhance competitive position in the municipal health insurance market through plan design innovation and data-driven approaches to managing health care costs, and with meeting the requirements of new federal and state legislative requirements.
- Assisting the City of Boston with the development and implementation of a strategy to better manage health care costs through identification of cost drivers and development and implementation of targeted programs that partner with consumers and providers.
- Assisting the Vermont Division of Health Care Administration with analysis of managed care organization quality data and development of annual consumer guide.
- Assisting the Vermont Division of Health Care Administration with compliance reviews of managed care organizations regarding state quality assurance and consumer protection requirements.
- Managed readiness review for state of Texas Foster Care Managed Care vendor and participating in readiness review for state's Integrated Case Management vendor.
- Provided project management team facilitation to a state of Vermont core planning team designing an integrated acute care and long-term care program for adults with disabilities and the elderly.
- Assisted the Massachusetts Department of Developmental Services to redesign its provider reimbursement strategy by providing conceptual and analytic support. Work included facilitation of a technical work

team and provision of project management support through tasks lists and consultation.

- Assessed the Rhode Island State Health Insurance Program for the Rhode Island Department of Elderly Affairs by identifying issues regarding leadership, organizational structure, training, outreach to hard-to-reach communities, and volunteer recruiting. Provided project management and work group facilitation.
- Assisted Minnesota with development of guide to consumer rights and responsibilities under Minnesota health care programs.
- Assisted an insurer with an assessment of enrollment barriers for its Medicare Special Needs Plan (SNP).

2000-2002 **TUFTS HEALTH PLAN** Waltham, MA
Director, Pharmacy Services

- Directed strategic departmental initiatives, including development and implementation of new benefit designs to meet market needs for 950,000 plan members, and creation and implementation of new clinical management programs in anticipation of pharmaceutical industry changes.
- Directed development of innovative patient education program that distributed patient education and safety information via written and broadcast media. Educational topics included safety information on herbal therapies, maximizing a member's pharmacy benefit, and working effectively with providers.
- Participated in development and implementation of state-of-the-art electronic prescribing pilot program for use in physicians' offices. Functionality included access to patient history maintained by the pharmacy benefit management company, formulary information and alternatives, drug utilization reviews, and electronic faxing directly to the member's pharmacy of choice. Presented pilot findings at a national health care conference.
- Managed $315 million-dollar contract with pharmacy benefit management company, including renegotiating three-year contract with savings to the plan in excess of several million dollars.
- Directed development of annual pharmacy claims budget as part of the process to develop both premiums and provider capitation amounts.
- Directed activities in support of NCQA accreditation activities of the Plan.
- Repositioned academic detailing program to leverage access to and commitment from provider risk unit leadership to realize pharmacy cost savings.

1999-2000 **Manager, Provider Unit Operations**

- Redirected department from utilization analysts to proactive consultants, targeting improvement opportunities for poor performing providers under risk contracts with the Plan.
- Developed and implemented strategy to identify poor performing risk units that were most likely to benefit from consulting services.

1995-1999 **HARVARD PILGRIM HEALTH PLAN** Quincy, MA
Director, Network Operations, 1995-1999

- Directed development and management of the provider network in territory composed of a wide range of provider organizational structures, including group practices, IPA risk units, and acute care hospitals. Provider network included both vendor and risk relationships for commercial and Medicare risk products.
- Directed development and management of the plan-wide mental health and extended care facility networks. Restructured extended care network to encourage tighter management by risk units.
- Chaired cross-functional corporate team to develop and implement new risk sharing model with individual and institutional health care providers. Estimated $10 million in savings to the plan when fully implemented.

1993-1995 **Manager, Network Development**

- Managed development and maintenance of provider network in Eastern Massachusetts for Pilgrim Health Care. Area composed of approximately 45 IPA risk units and 60 acute care hospitals engaged in risk relationships with Pilgrim Health Care.
- Participated on cross- functional corporate team responsible for the integration of Harvard Community Health Plan and Pilgrim Health Care provider network contracting strategy and operations.

1991-1993 **Project Manager**

- Negotiated and managed risk sharing and vendor relationships for Pilgrim Health Care.

1986-1989 **THE CHILDREN'S HOSPITAL** Boston, MA
Assistant General Counsel
- Provided legal advice on regulatory, patients' rights, contractual and corporate matters.

1983-1986 **NEW ENGLAND SCHOOL OF LAW** Boston, MA
Adjunct Professor
- Taught health law and contract law courses.
- Established externship program with local area law firms, hospital in-house counsel staff, and state agencies.

1980-1982 **VARNUM, RIDDERING** Grand Rapids, MI
Associate Legal Counsel

- Provided legal advice to hospital clients on regulatory, patients' rights, contractual and corporate matters.

1979-1980 **DYKEMA, GOSSETT** Detroit, MI
Associate Legal Counsel

- Provided legal advice to hospital clients on regulatory, patients' rights, contractual and corporate matters.

1969-1976 **MICHIGAN INSURANCE BUREAU** Lansing, MI
Public Policy Analyst

- Participated on new initiatives team to develop regulatory strategy requiring Michigan Blue Cross and Blue Shield to be proactive in containing health care costs for Michigan Insurance Bureau.
- Researched and documented discriminatory housing practices in local community.

EDUCATION

1997 **HARVARD SCHOOL OF PUBLIC HEALTH** Boston, MA
Certificate, Negotiation/Conflict Resolution for Health Care

1991-1994 **SIMMONS GRADUATE SCHOOL OF MANAGEMENT** Boston, MA
Masters in Business Administration

1976-1979 **THE UNIVERSITY OF MICHIGAN** Ann Arbor, MI
Juris Doctor, Magna Cum Laude

1972-1974 **THE UNIVERSITY OF MICHIGAN** Ann Arbor, MI
Masters of Public Policy

1964-1968 **PITZER COLLEGE** Claremont, CA
Bachelor of Arts

OTHER

2003-2007 **UNITED CEREBRAL PALSY OF METRO BOSTON**
Member and Chair of the Board of Directors

2002-2008 **WOMEN IN HEALTH CARE MANAGEMENT**
Steering Committee member

2001 **PHARMACY BENEFIT MANAGEMENT INSTITUTE**
Advisory Council member

1986-1994 **HARVARD COMMUNITY HEALTH PLAN INSTITUTIONAL REVIEW BOARD**
Member and Vice Chair

1982-1990 **MASSACHUSETTS BAR ASSOCIATION**
Member

1979-2005 **MICHIGAN BAR ASSOCIATION**
Member

1976-1979 **MICHIGAN BLUE CROSS AND BLUE SHIELD BOARD OF DIRECTORS**
Member

PUBLICATIONS

Slen J, Bailit M and Houy M. "Value-Based Purchasing and Consumer Engagement Strategies in State Employee Health Plans: A Purchaser Guide" AcademyHealth, Washington, DC, April 2010.

Houy M. "Value-Based Benefit Design: A Purchaser Guide", National Business Coalition on Health, September 2009.

MICHAEL S. JOSEPH

PROFESSIONAL EXPERIENCE

2005-Present **BAILIT HEALTH PURCHASING, LLC** Needham, MA
Senior Consultant

- Responsible for the analysis of data for the evaluation of the Texas Health Home pediatric medical home pilot.
- Analyzed annual managed care organization data filings, and compared plan quality performance to external benchmarks; identified key trends and opportunities for improvement for the state of Vermont.
- Researched the experience of leading pay-for-performance programs and used information to create a toolkit and primer for The Leapfrog Group.
- Co-authored the "Purchaser Guide to Value-Driven Health Care" on behalf of the Partnership for Value-driven Health Care.
- Developed a performance indicator dashboard for the California Medicaid program on behalf of the California HealthCare Foundation.
- Assisted with financial viability analysis of Massachusetts Managed Care Organizations for the Massachusetts Executive Office of Health and Human Services.
- Performed survey and statistical analysis for the Massachusetts Department of Developmental Services, worked closely with state agency staff and stakeholders, to develop a new rate system for group residential services and for certain day supports.
- Made recommendations to improve the application process for the Rhode Island Pharmaceutical Assistance to the Elderly for the Department of Elderly Affairs. This involved interviewing employees, managers and outside vendors, creating a process flow model and analyzing the effect of changes in organization structure and work flow on application through-put.
- Developed a spreadsheet tool for comparing total health insurance costs, including projected employee out-of-pocket costs, for municipalities and employees under different coverage scenarios to facilitate the renewal process for the Massachusetts Interlocal Insurance Association.
- Developed a health equity scorecard that measured the health care status and the health care environment for LA County for the Community Health Councils.

2001-2004 **Research Consultant**

- Developed market models of Medicare Supplemental Insurance market for major health insurer: assessed size of market and financial viability of markets.
- Developed a statistical algorithm to assign enrollees to HMOs based on quality measures for the state of California. This work involved testing for statistically significant differences between quality measures of competing HMOs and assigning scores based on performance.
- Conducted a statistical analysis of service and financial data in order to develop and refine a new reimbursement strategy for group residential services for the Massachusetts Department of Developmental Services. This

project included the modeling of new reimbursement formulas and examining the impact on providers.

1999-2001 **BE FREE, INC.** Marlborough, MA

Competitive Analyst

- Founded Competitive Intelligence Program.
- Developed competitive strategy and product positioning.
- Trained and supported 45 person global direct sales force on competitive objection handling and tactics.
- Created and maintained competitor profiles and product feature competitive matrix.
- Wrote regular competitive updates distributed to senior management and the sales force.
- Identified product requirements and worked with product management to incorporate features into release plan.
- Created sales tools, including sales presentations and product data sheets.

1996-1999 **AMR RESEARCH** Boston, MA

Market Research Analyst

- Co-founded Primary Research department, a new strategic direction; grew to more than $1.2 million in new revenue, exceeding expectations.
- Developed, managed, and edited Market Analysis and Review Series (MARS), an annual service focused on reporting and analyzing market share for Enterprise Applications software markets. Designed database to collect and report on market share data for MARS reports. Created marketing plan for the MARS reports.
- Advised clients, on market trends and forecasts.
- Designed, executed, and analyzed surveys on Supply Chain software adoption

1994-1996 **INTERNATIONAL DATA CORPORATION** Framingham, MA

Associate Market Analyst

- Authored reports, bulletins, and white papers on a range of topics including: The Internet, data warehousing, OLAP, and data mining.
- Forecasted market size, assessed vendor positioning and market share for software vendors in the OLAP, executive information systems, end-user query and reporting tools, and technical data analysis markets.
- Analyzed end-user survey data using SPSS; wrote survey-based research reports.
- Contributed to numerous consulting projects for established and emerging companies, including Business Objects, Fujitsu, IBM, Sagent Technologies.

1992-1994 **VOICE RECOGNITION SOFTWARE CONSULTANT** New York, NY

Beth Israel Medical Center

Kurzweil Applied Intelligence

- Provided on-site training and support for voice recognition driven pathology reporting system at Beth Israel Medical Center
- Provided pre-sales support for regional sales representatives
- Trained residents, attending physicians, and medical technologists at hospitals across the United States in the use of voice recognition systems for pathology and radiology reporting

- Developed, tested, and customized Kurzweil VoicePATH knowledge base
- Demonstrated products at trade shows and medical conferences

EDUCATION

2001-2003 **F.W. OLIN GRADUATE SCHOOL OF BUSINESS AT BABSON COLLEGE** Wellesley, MA
Master of Business Administration Degree, Magna Cum Laude, 2003

1986-1990 **BARD COLLEGE** Annandale-On-Hudson, NY
Bachelor of Arts degree in the History of Photography, 1990

PUBLICATIONS

Bailit Health Purchasing (Bailit M and Joseph M). "Purchaser Guide to Value-Driven Health Care" Partnership for Value-driven Health Care, February 2007.

Bailit Health Purchasing (Bailit MH, Dyer MB, Joseph MS). "Incentives and Rewards Best Practices Primer: Lessons Learned From Early Pilots" The Leapfrog Group, Washington, DC, July 2006.

CHRISTINE HUGHES

PROFESSIONAL EXPERIENCE

2004 to present **BAILIT HEALTH PURCHASING, LLC** Needham, MA
1999 to 2001 **Senior Consultant**

- Analyzing health plan quality of care for the Vermont Division of Health Care Administration on an ongoing basis.
- Researched strategies to improve state collection and disclosure of health quality data on behalf of the Consumer-Purchaser Disclosure Project.
- Researched and co-authored a monograph for the National Health Care Purchasing Institute regarding the state of the art in financial performance incentives for quality.
- Supported the Minnesota Long-Term Care Task Force by facilitating consumer and provider meetings and focus groups, and conducting a literature review.
- Surveyed states on selective contracting practices for long-term care on behalf of the Texas Department of Human Services.
- Facilitated focus groups and conducted interviews for the state of Kansas.
- Researched the management practices of Medicaid managed care organizations for a Center for Health Care Strategies paper.
- Performed health care market assessments of the Mid-Atlantic states for the Center for Health Care Strategies to help advise the five states on Medicaid HMO contracting strategies in the face of market changes.
- Assisted in the development of a reimbursement methodology for a Massachusetts Department of Public Health parenting support program through analysis of provider time study data.

1998-1999 **HEALTH CARE PLAN** Buffalo, NY

Director of Network Management and Contracting

- Negotiated risk-sharing contracts on behalf of Health Care Plan, one of Western NY's oldest Health Maintenance Organizations.
- Functioned as liaison with Catholic IPA during the negotiations and led an internal cross-functional team to ensure organization-wide communication. Coordinated all aspects of contract negotiation and implementation, including rate development and negotiation, operational set-up, development of medical management plan, and ongoing data and reporting requirements.
- Key member of Decision Support and Actuarial Services management team.
- Provided guidance and support toward the development of a variety of organization-wide contracting and reporting initiatives.

1997-1998 **PARTNERS COMMUNITY HEALTH CARE** Needham, MA

Network Contracting

- Negotiated a variety of contracts for PCHI, the subsidiary of Massachusetts' largest integrated delivery system, which includes Massachusetts General Hospital and Brigham and Womens' Hospital.
- Developed, implemented and monitored compliance for key elements of managed care risk contracts for a network of over 2,500 providers. Ensured contracts meet both the organization's long-term goals, as well as, the needs of a variety of affiliates (e.g.: POs, PHOs, IPAs and physician groups).
- Developed specialist physician and community hospital subcontracting strategies necessary to support network risk contracts. Ensured subcontracts enhance the integration and coordination of care delivery and appropriately align financial incentives.
- Provided staff support for two Board Committees focused on contracting.

1993-1997 **MASSACHUSETTS DIVISION OF MEDICAL ASSISTANCE** Boston, MA
Interim Director, HMO Program (1-6/1996)
Deputy Director, HMO Program (1995-1997)
Manager of Program Operations, HMO Program (1994)
Assistant Manager for Data and Reimbursement, HMO Program (1993-1994)

- Purchased over $200 million of health care coverage annually on a capitated basis from a network of HMOs on behalf of 100,000 Medicaid recipients.
- Directed the process aimed at increasing the agency and the HMO's emphasis toward serving disabled and low-income populations.
- Facilitated multiple statewide quality improvement initiatives in collaboration with health plans, industry oversight and accreditation agencies, and public and private health care purchasers.
- Assisted with rate development and negotiation, including the design of a performance-based incentive system.
- Negotiated, executed and monitored compliance for several HMO contracts, facilitated cross-functional teams, standardized performance measurement across the network, and oversaw program operations including the design and implementation of an automated interface between the state and the HMOs.

1993 **BOSTON CITY HOSPITAL** Boston, MA
Managed Care Intern

- Designed and conducted a study to determine the effect of Medicaid Managed Care on emergency room admission and billing processes. Recommended revised procedures to maximize revenue from managed care organizations and state's Medicaid program and minimize use of free care pool dollars.

EDUCATION

1991-1993 **BOSTON UNIVERSITY SCHOOL OF PUBLIC HEALTH** Boston, MA
M.P.H. with a dual concentration in health services management and health law

1980-1984 **WELLS COLLEGE** Aurora, NY
B.A. with a special academic program in Biology, Anthropology, Psychology
Schiller University, Heidelberg, West Germany semester abroad program

PUBLICATIONS

Bailit M and Hughes C. "Physician Payment Reform" in "Value-Based Purchasing Guide." National Business Coalition on Health, Washington, DC, January 2011.

Bailit Health Purchasing (Bailit M and Hughes C). "The Purchaser Guide to the Patient-centered Medical Home." Patient Centered Primary Care Collaborative, July 2008.

Bailit MH, Kokenyesi (Hughes) C, and Burgess LL. "Purchasing in a Turbulent Market: An Assessment of Medicaid Managed Care in the Mid-Atlantic States." Center for Health Care Strategies, Inc., Princeton, NJ, September 1999.

MEGAN E. BURNS

PROFESSIONAL EXPERIENCE

2011-present **BAILIT HEALTH PURCHASING, LLC** Needham, MA
Senior Consultant

- Assisting the Massachusetts Executive Office of Health and Human Services with research and staffing support for the Provider Price Commission.
- Supporting the Massachusetts Executive Office of Health and Human Services with research and staffing support for the Behavioral Health Integration Work Group as part of the Massachusetts Patient-Centered Medical Home Initiative.
- Assisting the Texas Health and Human Services Commission to implement value-based purchasing strategies for its Medicaid managed care programs.
- Assisted the National Business Coalition on Health to identify value-based purchasing strategies in use throughout state Medicaid agencies and state employee health care purchasers.

2005-2010 **UPMC HEALTH SYSTEM** Pittsburgh, PA
UPMC Rehabilitation Network
Senior Director, Rehabilitation Business Operations (2009-2010)

- Sustained a 91% occupancy rate at the IRR by directing daily operations of admissions department, including oversight of 12 pre and post-admission nurse case managers.
- Responsible for network-wide education, advocacy and strategy in response to federal regulatory changes to the IRF payment system, Medicare RAC, other third-party and payer audits.
- Directed team to enhance current electronic processes by creating a rudimentary coding product to increase Medicare payment accuracy.
- Managed a matrix relationship and oversight to all UPMC Rehabilitation IRFs existing outside of the flagship for clinical and business operations, volume, financial and quality performance.

UPMC South Side
Manager, Ambulatory Operations (2007-2009)

- Member of executive leadership team responsible for special projects during the closure of the hospital and merger with UPMC Mercy, including business development for an urgent care center and operations of merger.
- Prior to merger, provided strategic and financial consulting to operational leaders of cardiology, radiology, same day surgery and other outpatient departments.

- Managed daily operations of hospital telecommunications, physician office building and off-site leased spaces.
- Marketing and physician liaison to the active medical staff of approximately 100 employed and private physicians.

UPMC Presbyterian Shadyside
Administrative Fellow (2005-2007)

- Acting Practice Manager, Center for Liver Diseases (CLD) at UPMC Presbyterian
  - Managed the daily operations of a hospital-based sub-specialty hepatology practice with 12,000 patient visits a year, 11 physician and midlevel providers and 13 support staff.
  - Facilitated the implementation of an ambulatory electronic medical record (EpicCare) and adjusted operational workflow to achieve maximum efficiency.
- Acting Practice Manager, Midlife Health Center and Magee-Women's Hospital of UPMC
  - Managed the daily operations of a University of Pittsburgh physician gynecology, internal medicine and endocrinology practice with 5,000 patient visits a year, 4 physicians and 6 support staff.
- Project Coordinator, Magee-Women's Hospital of UPMC
  - Managed the operational component of creating a 24-bed ICU, including the equipment, staffing and construction needs.
  - Worked to create a transportation department to better manage the flow of patients throughout the hospital.
- First Year Fellow
  - Under the guidance of senior executives, participated and led numerous quality and innovation projects during five rotations in hospital operations, support services, nursing, physician services and finance.
  - Built the $6 billion revenue model for all academic and community hospitals in the UPMC system.

5-8/2004 **UNITEDHEALTH GROUP** Washington, DC
Federal Policy Graduate Intern

- Developed a business strategy to promote national long-term care policy reform.
- Researched and wrote testimony for the record of a United States House of Representatives hearing on chronic care improvement initiatives.
- Wrote policy newsletters for Evercare, a UnitedHealth Group business that focused on optimizing the health and well- being of aging, vulnerable, and chronically-ill individuals.

2001-2003 **PROGRESSIVE POLICY INSTITUTE** Washington, DC
Health, Social and Economic Policy Assistant

- Wrote bi-weekly e-newsletter on health policy issues.
- Primary researcher for Medicare and prescription drug benefit proposal.
- Participated in legislative strategy sessions on welfare and Medicare proposals.
- Primary researcher on project to assess State performance in health care.

1/5-2000 **NEW YORK STATE ASSEMBLY** Albany, NY
Legislative Analyst/Intern, Office of William L. Parment

- Drafted and analyzed legislation.
- Communicated with constituents, lobbyists and interest groups.
- Wrote press releases and budgetary articles for quarterly newsletters.

EDUCATION

2003-2005 **TERRY SANFORD INSTITUTE OF PUBLIC POLICY** Durham, NC
DUKE UNIVERSITY
Master of Public Policy, Certificate in Health Policy

1997-2001 **STATE UNIVERSITY OF NEW YORK AT CORTLAND** Cortland, NY
Bachelor of Arts in Political Science, Magna Cum Laude

PUBLICATIONS

Burns, Megan, Jeff Lemieux et al. "Medicare Reform: Don't Forget Chronic Care", PPI Backgrounder, July 2003.

Burns, Megan. *PPI's Health Policy Wire* Vol 1-Vol 11. Bi-weekly e-newsletter.

Berube, Alan, Anne Kim, Benjamin Foreman, and Megan Burns. "The Price of Paying Taxes: How Tax Preparation and Refund Loan Fees Erode the Benefits of the EITC", Brookings Institution and PPI, May 2002.

Burns, Megan. "Promoting Responsible Fatherhood: Some Promising Strategies", PPI Policy Report, March 2002.

Kim, Anne, and Megan Burns. "Economy and Welfare Caseloads" *Blueprint Magazine*, Vol 14: January 2002.

Burns, Megan. "The School Finance Reform Movement: History, Implications, and Solutions", *Journal of Public Policy and the Policy-Making Process*, Vol 2, Number 1, Fall 2000.

KATHARINE REINHALTER BAZINSKY

Professional Experience

January 2012 **Bailit Health Purchasing, LLC**

NEEDHAM, MA
Senior Consultant

2007-2010 **POLITICAL AND FINANCE DIRECTOR**
MEDFORD, MA
The Markey Committee

- Managed all political and fundraising activities for Rep. Markey throughout his 2008 and 2010 campaigns.
- Raised approximately $2.5M for Rep. Markey and $3M for other Democrats.
- Supported Rep. Markey's role as Dean of the Massachusetts delegation by coordinating political activities across all of the Massachusetts Congressional Districts.
- Developed fundraising strategies to target donors in the healthcare, energy, high tech, and small business sectors.
- Wrote an e-newsletter, maintained the campaign website, Facebook page and Twitter feed to keep thousands of constituents and national donors informed about Rep. Markey's policy positions and political work.

2004-2007 **LEGISLATIVE ASSISTANT**
WASHINGTON, DC
Office of the U.S. Representative Edward J. Markey

- Lead health policy staffer. Developed health-related legislation and amendments; wrote speeches for appearances, hearings, mark-ups, press conferences and floor debates; prepared questions for cross- examinations; made vote recommendations, wrote oversight letters, staff reports, and press releases; met with constituents and advocates and built consensus around legislation and policy ideas.
- Primary staffer on Markey legislative initiatives, including: the "Fair Access to Clinical Trials Act" (H.R. 5252), the "Pediatric Medical Device Safety and Improvement Act" (H.R. 1494), and the "Enhancing Drug Safety and Innovation Act of 2007" (H.R. 1561) all which were incorporated into the Food and Drug Administration Amendments Act of 2007 which was signed into law on September 27, 2007.
- Served in the executive director capacity for the Congressional Cystic Fibrosis Caucus and the Congressional Task Force on Alzheimer's Disease which included pursuing legislative initiatives and organizing events.
- Managed all of Rep. Markey's appropriations requests, and his Education and Transportation issues.

2003-2004 **FLOOR MONITOR & LEGISLATIVE ASSISTANT**
WASHINGTON, DC
Office of the U.S. Representative Edward J. Markey

- Managed all of Rep. Markey's appropriations requests, and created database to track request progress.
- Responsible for collecting vote recommendations from staff and ensuring that Rep. Markey knew about votes.
- Advised Rep. Markey on non-committee policy issues (Education, Judiciary, Transportation, Welfare).

2002-2003 **STAFF ASSISTANT & LEGISLATIVE ASSISTANT**
WASHINGTON, DC
Office of the U.S. Representative Edward J. Markey

- Advised Rep. Markey on non-committee policy issues (Education, Agriculture and Arts).
- Created and maintained an electronic constituent correspondence system and responded to constituent mail.

- Managed the front office, trained and supervised office interns, and maintained official Congressional website.

Education

2010-2011 **JOHNS HOPKINS BLOOMBERG SCHOOL OF PUBLIC HEALTH**
BALTIMORE, MD
Master of Public Health, Ernest Lyman and Helen Ross Stebbins Scholarship Award

1998-2002 **BATES COLLEGE**
LEWISTON, ME
Bachelor of Arts in Rhetoric and American Cultural Studies, Concentration in Educational Studies. GPA: 3.82/4.0. Honors: Summa Cum Laude; Phi Beta Kappa; Dean's List all semesters; Honors Thesis.

Publications

- Low, K.G., …**Reinhalter, K.,** et al. (2006). Effectiveness of a computer-based eating disorders prevention program at long term follow up. *Eating Disorders: The Journal of Treatment and Prevention, 14*, 17-30.
- Low, K.G., …**Reinhalter, K.**, et al. (2003). Internalization of the thin ideal, weight and body image concerns. *Social Behavior and Personality: an International Journal, 31,* 81-90.
- Dodd, A., …**Reinhalter, K.**, et al. (2000, Winter). The Challenge of Changing High Schools. *Journal of Maine Education* 16, 1: 21-27.

AMY M LISCHKO, MSPH, D.Sc.

Curriculum Vitae

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Tufts University School of Medicine
Department of Public Health and Family Medicine
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Email: amy.lischko@tufts.edu

Home Address
46 Brookside Road
Topsfield, MA 01983
Tel: 978-887-0810
Email: amltopsfield@comcast.net

PROFESSIONAL TRAINING

Education

1982	BS (Nutrition and Food Science)	University of Massachusetts at Amherst
1988	MSPH (Health Policy and Management)	University of Massachusetts at Amherst
2008	D.Sc. (Health Services Research)	Boston University

Additional Training

- Executive Leadership Training, Harvard University, Kennedy School for Government 1997.
- Quality Improvement certificate, Harvard University, 2000.

WORK EXPERIENCE

2010 – present	Associate Professor, Dept of Public Health and Community Medicine, Tufts University, School of Medicine
2007- 2010	Assistant Professor, Dept of Public Health and Family Medicine, School of Medicine at Tufts University
2005-2007	Director of Health Care Policy Massachusetts Executive Office of Health and Human Services Boston, Massachusetts
2006-2007	Commissioner, Division of Health Care Finance and Policy Boston, Massachusetts
2003-2006	Assistant Commissioner for Research and Policy, Division of Health Care Finance and Policy, Boston, Massachusetts
1996-2003	Director of Heath Systems Measurement and Improvement, Division of Health Care Finance and Policy, Boston, Massachusetts
1993-1996	Policy Manager, Long Term Care, Division of Health Care Finance and Policy, Boston, Massachusetts
1991-1993	Project Director, New England Health and Poverty Action Center, Tufts University School of Medicine, Boston Massachusetts
1989-1991	Project Director, Massachusetts Department of Public Health, Boston Massachusetts
1988-1991	Research Associate and Project Consultant, Massachusetts Eye and Ear Infirmary, Boston Massachusetts

Professional Affiliations and Board Membership

- Senior Fellow, Pioneer Institute for Public Policy, 2009 -
- State Health Reform Initiative Advisory Group, Engleberg Center for Health Care Reform, The Brookings Institution, Member 2008 - 2010
- Massachusetts Health Quality Partners (MHQP), Executive Committee and Board Member, 2008 -
- State Health Access Data Assistance Center (SHADAC), Board Member, 2001 -
- AcademyHealth member, 2003 -
- National Academy for State Health Policy, Access for the Uninsured Committee, 2004 - 2007
- Council of State Governments, Health Policy Steering Committee, 2006 – 2007
- Institutional Review Board for The Massachusetts Connector, Chair, 2009 -

ACADEMIC ACTIVITIES AND RESPONSIBILITIES

- Member of the PHPD Grievance Committee, 2007 -
- Human Resources Committee for Tufts University, 2009 -

TEACHING

Current Courses (Graduate level) at Tufts University:

- MPH/HCOM 222 Survey Research Methods and Data Management (School of Medicine, Master in Public Health)
- MPH /HCOM 215 Public Health and Health Care: Politics, Policies, and Programs (School of Medicine, Master in Public Health)
- CMPH 151/251/351 Integration of Public Health, small group co-leader
- Epidemiology and Biostatistics, Medical School, small group leader

Previous Teaching Experience

- Tufts University School of Medicine, Boston MA, Adjunct Instructor, Epidemiology and Biostatistics, 1992-2001
- Tufts University and Emerson College, Boston MA, Adjunct Instructor, Biostatistics and Epidemiology, 1996

Academic Advisor

- Academic Advisor for 8 MPH students in the Health Policy and Management concentration

RESEARCH INTEREST

My research interests are focused on increasing access to insurance and developing strategies for constraining health care costs. Before joining Tufts, I managed numerous health research and policy projects for the Commonwealth including large, federally-funded, multi-agency grants. I was one of the key authors of the adminstration's health care reform proposal. Since leaving state government, I have provided consulting services to AcademyHealth, the National Governor's Association, Centers for Medicare and Medicaid Services, and individual states including Rhode Island, West Virginia,

Minnesota, Washington, Vermont, Maine, and the US Virgin Islands around health care access and health care reform. I'm interested in bridging the gap between academic research and policymaking by making academic research more accessible to policymakers.

COMPLETED GRANTS

Using Geographic Variation to Identify and Reduce Over-treatment in Massachusetts, Edward M. Kennedy, Health Policy Scholar's grant, The Medical Foundation, Role: Principal Investigator, 2008-2011

Evaluation of Risk Selection in Market-Based State Programs, Robert Wood Johnson Foundation, State Health Access Reform Evaluation Grant, Role: Co-Principal Investigator 2009 - 2011

Massachusetts Commonwealth Health Insurance Connector: A Model for State and Federal Health Reform? The Commonwealth Fund, Role: Principal Investigator, 2008 - 2009

State Planning Grants, Health Resources and Services Administration, Roles: Co-PI 2000, PI 2003

State Coverage Initiatives Grant, Robert Wood Johnson Foundation, Role: Principal Investigator, 2002

Employee Input into Health Insurance Decisions, The Commonwealth Fund, Role: Principal Investigator, 2002

CONTRACTS

- Washington State Health Care Authority: contract to assist state with Exchange planning under ACA, 2010 –
- Census Bureau: sub-contract to assist federal government with designing survey questions related to Exchange participation.
- Vermont Department of Health Access: sub-contract to assist state with Exchange planning under ACA, 2010-
- Maine Governor's Office for Health Care Policy and Finance, sub-contract to assist state with Exchange planning under ACA, 2010
- Rhode Island, Office of the Health Insurance Commissioner: two contracts to examine a merger of individual and small group markets and feasibility of developing an insurance exchange. 2007, 2008
- West Virginia Health Care Authority: contract to assess feasibility of developing an health insurance exchange. 2007
- National Governor's Association: Work with Washington and US Virgin Islands around health care reform proposals and implementation. Author paper on exchanges for National Governor's Association annual meeting. 2007 - 2010
- Massachusetts Medical Society: Author several papers on various topics including costs, quality, and transparency of health care.in Massachusetts. 2007 - 2010
- AcademyHealth : Author papers, facilitate and participate in state policy maker meetings as consultant/advisor. 2007 - 2009
- National Academy for State Health Policy: participate as content expert in meetings for state officials, 2008 -

PUBLICATIONS

Research Articles

Lischko, A; Seddon, J.; Gragodas, E.; et al. "Evaluation of Prior Primary Malignancy as a Determinant of Uveal Melanoma - A Case Control Study." Opthalmology, 96, 12, December, 1989.

Lischko, A.; Burgess, J. Knowledge of Cost Sharing and Decisions to Seek Care, American Journal of Managed Care, April 2010.

Government Reports and Policy Publications

Lischko, A. How to Fix the Massachusetts Connector, Issue Brief, Pioneer Institute, February 2010.

Lischko, A; Manzolillo, K. Evaluation of MA Health Care Reform: Chapter 4 Cost-Effective Quality, Issue Brief, Pioneer Institute, In-press April 2010

Lischko, A. Establishing a State-Level Exchange, National Governor's Association Issue Brief, March 2010.

Lischko, A; Manzolillo, K. Evaluation of MA Health Care Reform: Chapter 3 Administrative Efficiency, Issue Brief, Pioneer Institute, March 2010

Lischko, A; Manzolillo, K. Evaluation of MA Health Care Reform: Chapter 2 Financing, Issue Brief, Pioneer Institute, February 2010

Lischko, A; Gopalsami, A. Evaluation of MA Health Care Reform: Chapter 1 Access, Issue Brief, Pioneer Institute, January 2010.

Lischko, A. Drawing Lessons: Different Results from State Health Insurance Exchanges, December 2009.

Regan, C., Robbins, A. and **Lischko, A;** *Coverage for Caregivers: Lessons from Massachusetts Health Reform*, October 2009. The Paraprofessional HealthCare Institute policy brief.

Faulkner, D.; **Lischko, A**.; Chollet, D.; Considering a Health Insurance Exchange: Lessons from the Rhode Island Experience. Academy Health, State Coverage Initiatives Program, June 2009.

Lischko, A, Bachman, S., Vangeli, A., The Massachusetts Commonwealth Health Insurance Connector: Structure and Functions, Commonwealth Fund Publication, May 28, 2009 , Volume 55

Chollet D., Liu S., Stewart K., Wellington A.,Barrett A., Kofman M., **Lischko A**., Health Insurance Exchange, Final Report, 2008. MPR Ref. No. 6392

Lischko, A. Health Care Premium Expenditures: Where Does Your Health Care Dollar Go? Massachusetts Medical Society, 2008

Lischko, A. Physician Payment Reform: A Review and Update of the Models. Massachusetts Medical Society, 2008

Lischko, A., Bieblehausen, J., Health Plan Financial Data Reporting: A Call for Transparency. Massachusetts Medical Society, 2008.

Lischko, A., Cost Sharing: Do Employees Understand Cost Sharing and Do Increases in Cost Sharing Really Have an Impact on the Utilization of Health Care Services? Dissertation, May 2008.

Lischko, A "Connectors & Exchanges: A Primer for State Officials." State Coverage Initiatives publication, September 2007.

Non-Emergent and Preventable Emergency Department Visits, FY05. An Analysis in Brief by the Division of Health Care Finance and Policy, Commonwealth of Massachusetts, February 2007.

The Use of Public Health Assistance in Massachusetts in FY06: Employers Who Have Fifty or More Employees Using MassHealth or the Uncompensated Care Pool, A report by the Division of Health Care Finance and Policy, Commonwealth of Massachusetts, February, 2006 and 2007.

Non-Emergent and Preventable Emergency Department Visits, FY04. An Analysis in Brief by the Division of Health Care Finance and Policy, Commonwealth of Massachusetts, June 2004.

Camberg, L**.; Lischko, A**.; and Brandenburg, J.; "Nursing Home Staff Turnover: Lessons from the Public Sector." VA Practitioner, 9, 6, June, 1992.

Valentine, J.; **Lischko, A**.; "A Client Record Study of the CHANCES and PACE Programs of Crittenton Hastings House." New England Health and Policy Action Center Technical Report, May, 1992.

Dreyer, P. and **Lischko, A**.; "Evaluation of the Prospective Case-Mix Reimbursement System in Nursing Homes in Massachusetts." HCFA contract # 11-C98-924/1-01, June, 1991.

Lischko, A.; "Success Stories in Troubled Times." *The Massachusetts Administrator*, 1, 4, September, 1987.

Conferences and Seminars

Maine Development Forum on Healthcare Policy, for Maine state legislators, February 2011

Webinar for National Council for State Legislatures: What Legislators Need to Know about Exchanges, June, 2010

Webinar for Connecture: State Health Insurance Exchanges, Are you Ready? September, 2010

New England States Consortium Systems Spring and Fall Meetings: Health Insurance Exchanges

National Governor's Association faculty expert on Health Insurance Exchanges

Massachusetts Health Care Reform: A Case Study. Presented to Georgia Legislators as part of a certificate program in heath care policy, Georgia State University. December, 2009.

What Can an Exchange Accomplish? Challenges and Opportunities for National Health Care

Reform, SCI Annual Summer Meeting, July 2009

Does Higher Costs equal Higher Quality? Presented at the Affordable Health Care Today forum. Boston MA, June 2008.

Health Care Reform in Massachusetts: Lessons for China. Presented at Fudang University, Shanghai, China. June 2008.

"Massachusetts Health Care Reform: A model for State-wide Coverage." presented at the National Medical Association Annual Colloquium on African American Health. March, 2008.

Connector Update: Findings from SCI Small Group Meetings, SCI Annual Summer Meeting, August, 2007

Connector Small Group Meeting, Austin TX, facilitator and presenter. June, 2007.

Connector Small Group Meeting, Washington DC, facilitator and presenter, April 2007.

Georgetown Policy Conference on National Security. Washington DC, March, 2007.

2007 Coverage Institute, Chicago IL., Faculty. September, 2007.

Health Policy Issues and Options for New York: What Can We Learn from Other States? Empire Center for New York State Policy, September, 2006.

"Health Care Reform in Massachusetts." Panel presentation at Urban Institute, April 2006.

"State Health Reform Initiatives: Are there Lessons for Federal Policymakers?" Washington, DC. Luncheon Address. November, 2006.

"Health Care Reform in Massachusetts." Panel presentation at National Health Policy Conference, Annual Meeting, Washington DC., January, 2006.

"Putting Research into Practice: A Discussion with Policy Makers." Panel discussion at AcademyHealth Spring 2005 meeting.

"Modeling Health Care Reform: What States Need to Know." Presented at AcademyHealth Workshop on Modeling, Fall, 2004.

Roman, AM., A Hauser and **A Lischko.** "Measurement of the Uninsured Population: The Massachusetts Experience." Paper presented at the annual meeting of the American Association for Public Opinion Research, May, 2002.

"Making Sense of Data." Presented at the 1995 New England Association of Homes and Services for the Aging, June, 1995.

ABSTRACTS

Lischko, A. Does Employee Understanding of Cost Sharing Matter? AcademyHealth, Research Meeting, 2007.

Lischko, A. The Impact of Cost Sharing on Middle-Income Children, AcademyHealth, Research Meeting, 2007.

Schiff, M.; Bachman, S.; Shuster, M., **Lischko, A**; "Employee Input and Health Care Cost-Containment Strategies." Presented at AcademyHealth Spring, 2003

Cai, J.; **Lischko, A.**; Schuster, M.; Bachman, S.; "Maternal Outcomes at Massachusetts Hospitals" Presented at AcademyHealth Spring, 2003.

Cai, J.; **Lischko, A.**; London, K.; "Do Medicaid Patients Use More Hospital Resources?" Presented at AcademyHealth Spring, 2002.

Schiff, M.; Cai, J.; **Lischko, A.**; Anderson, B.; "Impact of Current Premium Increases on Health Insurance Coverage in Massachusetts." Presented at AcademyHealth Spring, 2002.

Cai, J.; Wacks, C.; **Lischko, A.**; Bachman, S.; "Impact of Massachusetts Health Reform on Employer-Sponsored Health Insurance." Presented at AcademyHealth Spring, 2000.

Valentine, J.; Kulig, J., **Lischko, A.**; Hall, G.; and Mandel, L.; "Adolescent Health Promotion Strategies in the School-Based Clinic Setting." Presented at the 1993 Prevention Conference, April, 1993.

Kulig, J.; Valentine, J.; **Lischko, A.**; and Spivak, H.; "Role of Gender in the Association Between Risk Behaviors and School-Based Clinic Use." Presented at the 1993 meeting of the Society for Adolescent Medicine, March, 1993.

Valentine, J.; Kulig, J.; **Lischko, A.**; Spivak, H.; "Tracking Utilization of Comprehensive Primary Care Services by Inner City Adolescents in the School-Based Setting: Methods and Findings." Presented at the 3rd Primary Care Research Conference, January, 1993.

Dreyer, P.; Flanagan, S.; **Lischko, A.**; and Blake, E.; "Case-mix, Access and Quality: A Demonstration Project in Massachusetts Nursing Homes." Presented at the 118th Annual Meeting of the American Public Health Association, October, 1990.

Camberg, L.; **Lischko, A.**; Brandenburg, J.; "Factors Associated with Staffing Problems in Public and Private Nonprofit Nursing Homes." Presented at the 116th Annual Meeting of the American Public Health Association, November, 1988.

OTHER PROFESSIONAL ACTIVITIES

Grant Reviewer for Health and Human Services Services.. .Applications from states requesting support for establishing their Health Insurance Exchanges. August and December 2010.

Grant Reviewer for Health Services and Resources Administration (HRSA), Health and Human Services (HHS). .Applications from states requesting support for demonstration grants to increase access to health insurance, July 2009.

Grant Reviewer for American Association for the Advancement of Science (AAAS), in conjunction with the Life Sciences Discovery Fund, September 2009.

Community Member for Massachusetts Department of Public Health, Survey Research. 2008 -

Ad Hoc Reviewer for several journals, including: Health Affairs, American Journal of Managed Care, Health Services Research

Peter J. Burns, MBA
President
Burns & Associates, Inc.

Mr. Burns has over 30 years of experience in public policy, with specialties in the areas of rate setting, finance, forecasting, administration, operations, strategic planning and legislation. During his public policy career, Mr. Burns has been a senior advisor to three governors and served as a state budget director, the director of a statewide in-house management consulting office, the chief research economist for a legislative body, and a tax manager for a FORTUNE 500 corporation.

His expertise and experience extend across a wide range of state programs at various levels, from conceptualization and policy development to program planning, operations, evaluation, budgeting and accounting. For eight years prior to founding Burns & Associates in 2006, he was a Corporate Director at EP&P Consulting, Inc.

Professional Experience

Experience Specific to Budgeting and Reporting

- Provided budgeting support to the Arizona Governor as the State addresses the largest shortfalls in its history. Activities have included forecasting revenues and expenditures and developing budget reduction options, communicating with stakeholders and the media and negotiating with legislative leadership, drafting implementing legislation, and researching tax rates and systems across the country for comparison to Arizona.

- Completed a major revision to Arizona's disproportionate share methodology, including revisions based on the CMS Waiver Terms and Conditions and applicable state and federal laws, designing all reporting forms for public and private hospitals, conducting negotiations with CMS, and conducting meetings with hospitals advising them of CMS decisions and potential options

- Assisted the Arizona AHCCCS program in a review of federal Title XIX and Title XXI reimbursement claiming procedures and other initiatives to maximize federal funding under Titles XIX and XXI including identifying options for the Medicare upper payment limit, SCHIP funding, premium taxes, and modifications to CMS waivers

- While Director of the Arizona Governor's Office of Strategic Planning and Budgeting (OSPB), Mr. Burns oversaw the preparation, presentation and execution of budgets on behalf of three governors. Also directed the work of an in-house consulting office that provided consulting services and training to state agencies in the areas of strategic planning, performance measurement, and team-directed business reengineering and process improvement.

Experience Specific to Financing

- For the Nevada Legislative Committee on Health Care, Mr. Burns conducted a study of indigent health care costs in the state and the existing DSH allocation formula. Recommendations to restructuring the DSH allocation formula were adopted by the Legislature.

- Helped the Louisiana Department of Health and Hospitals develop options to maximize the utilization of the full federal DSH allotment in support of community health initiatives and coverage of the uninsured.

- Assisted six states in performing cost and caseload estimates for system reform or expansion initiatives. These estimates were utilized in submissions to CMS, in the preparation of state budget requests, and in implementation planning.

Experience Specific to Rate-Setting

- Currently assisting Georgia in developing reimbursement rates for home and community based services (HCBS) under Georgia's waivers serving individuals with developmental disabilities. The work includes an extensive survey of provider costs, wages, and productivity; developing rate models; obtaining external data sources; working with a provider stakeholder group; and conducting fiscal impact analyses.

- Provided technical assistance to the Illinois Developmental Disabilities Council to review the rates and rate methodologies that the Illinois Department of Human Services employs for Division of Developmental Disabilities contracted providers.

- Assisting the Province of Alberta in the development of a Supports Intensity Scale (SIS) informed resource allocation system for individuals with developmental disabilities.

- Led the effort for the Louisiana Office of Citizens with Developmental Disabilities in developing a Supports Intensity Scale (SIS) informed set of resource allocation guidelines for participants in the New Opportunities Waiver program.

- For the State of Louisiana, Mr. Burns also managed the development of case management rates compliant with the Interim Final Rule published by the Centers for Medicare and Medicaid Services (CMS) in December 2007. His work included a cost survey of providers, developing independent rate models based on economic and market data, fiscal forecasting and establishing 15-minute unit rate policies.

- For the State of Oregon Department of Human Services (under subcontract to HSRI), Mr. Burns assisted in the development of a rate-setting system that serves as a foundation for individual funding levels for people with developmental disabilities. This work required a provider cost survey, development of independent rate models for supported living services and employment and day programs and fiscal impact analyses.

- Currently assisting Piedmont Behavioral Health of North Carolina in evaluation and process improvement related to the PBH administration of a 1915 (b)(c) waiver for the developmentally disabled population in a five county region. To date this work has resulted in a set of proposed amendments to the Innovations waiver, the development of alternative capitation rates for consideration by the state Medicaid agency, a proposal for risk adjusted capitation rates for new participants coming off of the waiting list, and the refinement of a resource allocation cost matrix.

- For the Arizona Department of Economic Security's Division of Developmental Disabilities (DES/DDD), Mr. Burns assisted in the formulation and adoption of a legislatively mandated rate structure for both agency and independent providers. Responsibilities included developing the methodology and performing the financial analysis of the implementation costs of the rate structure, and developing strategies for implementation of the rate structure within budget constraints. Included in the financial estimates were two-year projections of caseload and utilization. Mr. Burns supervised the development of reporting systems to score clinical/environmental assessments and transform scores into unique consumer rates reflecting each individual's need.

- Mr. Burns also performed an evaluation of the appropriateness of over 40 rates paid to providers by the Arizona Department of Health Services, Division of Behavioral Health Services. His involvement included ongoing discussions with a multi-disciplinary team to review current independent rate models to modify the design to provide appropriate reimbursement for best practices. Mr. Burns also performed an analysis of the values of encounters submitted by the Regional Behavioral Health Authorities to the ADHS/DBHS that support their capitation payments.

Experience Specific to Evaluation and Planning

- Served as advisor to the Governor's office and Arizona's Medicaid program (AHCCCS) in developing a strategy to obtain a waiver of the maintenance of effort under the Accountable Care Act in order to meet a $1 billion dollar deficit. Provided options for waiver provisions to replace the existing waiver given the DHHS Secretary's recent interpretation that allows Arizona to end the waiver providing for coverage of single adults and couples.

- Performed a strategic assessment of a Maricopa county-operated Medicaid acute and long term care plan including financial performance, caseload mix, capitation rate development, medical and administrative expenses and developed future likely scenarios.

- Assisted the Nevada Legislative Counsel Bureau's Subcommittee on Health Care in developing a statewide strategic health plan. He managed this effort, which involved writing seven issue papers on facets of the plan (Medicaid coverage, private insurance coverage to small businesses, safety net provider coverage, prevention and wellness, behavioral health, medical education and workforce development, and strategic planning) and convening a summit of more than 100 stakeholders to review and make recommendations presented in the issue papers.

- Mr. Burns helped Arizona's Medicaid agency research options for expanding health insurance through private sector, public sector and public/private mechanisms.

- Evaluated reinsurance strategies used by selected MCOs in Texas' Medicaid program. The engagement entailed a review of federal and state statutes, regulations and contract requirements on reserve and bonding requirements, as well as a financial analysis of the impact of selected practices on MCO profitability and the State's Medicaid managed care capitation rates.

Experience Specific to Building Partnerships

- Assisting the Community Behavioral Health Coalition in Arizona in developing a range of options for the community behavioral health system with respect to the State's fiscal situation and the opportunities under health care reform.

- Facilitated development of the Hawaii-Arizona PMMIS Alliance (HAPA), a joint venture between Arizona and Hawaii to satisfy Hawaii's requirement for a Medicaid Management Information System.

Experience Specific to Implementation/Operations

- Assisted the New Mexico Hospitals and Health Systems Association and its partner, the Medical Assistance Division of the Human Services Department, in the implementation of the New Mexico HIFA waiver program (SCI).

- Participated in a review of claims payment system options for the Arizona Department of Economic Security (DES) to assess the feasibility of either

consolidating multiple claims processing systems within the Department into a single system or to migrate all or part of the function to a sister agency, AHCCCS.

Education & Academic Qualifications
M.B.A., Finance, Arizona State University, 1985
B.A., Political Science and Economics, Arizona State University, 1976

Professional Memberships
National Association of State Budget Officers, Past President

Mark Podrazik, M.B.A.
Principal
Burns & Associates, Inc.

Mark Podrazik has 15 years of experience in health care consulting, specializing in the operational, reimbursement, and evaluation components of public health care programs. He has managed projects for Medicaid agencies in 13 states. He co-founded Burns & Associates in 2006 and prior to this worked for another national health care consulting practice for 10 years.

Representative Accomplishments

Experience Specific to Rate-Setting

- Providing technical assistance to the Department of Vermont Health Access (DVHA) on numerous projects since November 2006 including:
  - Setting rates for physicians and other health professionals using the Medicare Resource Based Relative Value Scale (RBRVS) system.
  - Developed and refined the methodology to make disproportionate share payments to hospitals. Assist in calculating annual allotments.
  - Assisted in design and implementation of new reimbursement systems to pay for inpatient and outpatient hospital services.
  - Serve as technical resource to work with the DVHA's fiscal agent to implement new payment systems.
  - Comparing rates of pay between Medicaid, Medicare and commercial plans as the State contemplates moving to a single payer system.
  - Conducted an independent analysis of medical cost savings of the Vermont Chronic Care Initiative.
  - Built a databook that compares longitudinal utilization and expenditure trends across population cohorts and categories of service.

- Assisting the Ohio Department of Job and Family Services move to the APR-DRG grouper and rebasing the rates paid for inpatient hospital services (under subcontract to Mercer). Previously, he was the principal analyst and author of a 2006 report for ODJFS evaluating the rates paid to hospitals for inpatient and outpatient hospital services for Medicaid beneficiaries.

- Established the rebased rates paid to Ohio's state-owned homes for the developmentally disabled in 2002. This involved a comparison of the financial structure of each home and the composition and needs of the clients within the home.

- Assisted Minnesota's Medicaid program reset its physician fee-for-service rates to the Medicare RBRVS system. This engagement is a follow-up to another engagement with the State led by Mr. Podrazik in which B&A measured the

impact that rates had on member's access to services throughout the state. As part of this study, other state Medicaid rates were examined, provider availability was measured, and mail surveys were conducted of physicians and members to gain their feedback.

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

- Currently managing B&A's multi-year engagement with Rhode Island's Department of Behavioral Health, Developmental Disabilities and Hospitals (BHDDH) to redesign its program serving individuals with developmental disabilities. Phase I occurred in SFY 2011 and included redefining services, establishing a new assessment tool (Supports Intensity Scale), setting rates paid to providers, technical assistance for a new authorization system, assistance in writing new regulations, and negotiating changes to the system with CMS. Phase II, currently ongoing, includes establishing billing procedures, developing ongoing monitoring procedures, measuring expenditures against person-specific funding levels, and developing new funding levels.

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

- Principal analyst for a Nevada task force charged with developing recommendations for changing the methodology and updating rates paid to Medicaid providers who serve the developmentally disabled population and those with behavioral health needs. Developed and evaluated the results of cost survey tools administered as part of the process of refining the rates.

Experience Specific to Program Evaluation

- Project manager for B&A's engagement with Indiana's Office of Medicaid Policy and Planning since 2007 and, prior to this, with a prior firm's engagement with the OMPP from 2001 to 2006. Mr. Podrazik has managed and been the lead author on each of the deliverables that have been provided to the OMPP during this time. These have included:

  - The annual independent evaluation of Indiana's Children's Health Insurance Program (2001 to the present)
  - A Databook Monitoring Manual that tracks enrollment, utilization, access and expenditure trends (2002 to 2010)
  - The External Quality Reviews of the Hoosier Healthwise program (2005, 2007- 2011), the Care Select program (2009) and the Healthy Indiana Plan (2009-11)
  - Technical assistance in submitting Indiana's annual CMS CHIP report
  - Conducting focus studies of childhood immunization rates, children's access to primary medical providers, and a study of high utilizers in Hoosier Healthwise
  - Managed the administration of surveys to Primary Medical Providers (2009) and members enrolled in Care Select (2009).
- Managed B&A's engagement while at B&A (2009-2010) and a prior firm (2004-2005) to conduct an annual evaluation of the Healthy NY program which is offered through the New York Department of Insurance. The report which was submitted to the Legislature included results from surveys administered by B&A to members enrolled through small businesses as well as sole proprietors and small business owners. Mr. Podrazik also conducted interviews with representatives from 11 participating health plans. The report also includes a financial analysis of the costs of the reinsurance component of the program which is funded by the State and a longitudinal study of premium changes.

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

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

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

Other Health Care Consulting Experience

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

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

Education & Academic Qualifications

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

Stephen Pawlowski, M.B.A.
Senior Analyst
Burns & Associates, Inc.

Mr. Pawlowski has more than seven years of experience in human services operations and financing, budget development, and government affairs. Prior to joining B&A, Mr. Pawlowski was the Chief Financial Officer for the Arizona Department of Economic Security (ADES), a 10,000 employee, $5 billion human services agency. ADES is the state agency responsible for delivering services to individuals with developmental disabilities under contract with the single state Medicaid agency, providing non-medical home and community based services to the elderly, managing the child welfare system, operating welfare and child support programs, and administering Department of Labor-funded programs.

Mr. Pawlowski previously worked in the Arizona Governor's Office of Strategic Planning and Budgeting as a Senior Budget Analyst. In this role, he was responsible for providing cost analyses for proposed legislation and program initiatives, as well as developing funding strategies for implementation.

Professional Experience

Representative Experience Specific to Policy and Economic Analysis

- Currently assisting the state of New Mexico in developing a published rate schedule for existing and new home and community based services covered under the Division of Developmental Disabilities' (DDSD's) 1915(c) waiver extension. Services for which rates will be established include case management, residential supports (both group home and foster home-type settings), day programs, community-based activities and employment supports, and professional services (nursing, therapies, behavioral supports). Rates will reflect the cost of delivering services, considering client need, service setting, geographic area, and professional qualifications. Key activities include assisting DDSD in defining service standards and billing rules, conducting a provider survey and other special studies (conducting focus groups, studying differences between costs in different regions, and researching external data sources), providing briefings to providers, clients and policymakers, and developing fiscal analyses and implementation strategies.

- Currently assisting the State of Georgia in developing a published rate schedule for home and community based services under Georgia's two home and community based waivers serving individuals with developmental disabilities. The scope of the project includes rate development for a range of home and community based services including support coordination, group residential facilities, alternative independent residential settings, supported employment,

day activities, financial management and home/community supports. Mr. Pawlowski role is development and presentation of decision-making materials and underlying analysis for state officials as well as working with a provider stakeholder group.

- Assisted the Arizona Early Childhood Development and Health Board ("First Things First") in identifying the differences in cost between providers of different types (e.g., home-based, center-based, campus-based, etc.) at various levels of quality. Activities included designing a cost survey, providing technical assistance in the completion of the survey, and analyzing and summarizing the data to detail difference in cost categories (e.g., wages, benefits, overhead, etc.) across provider types and quality ratings.

- Updated the statewide "Children's Budget" developed in an earlier project detailing state and federal spending for children under the age of six. The children's budget includes health care programs, early intervention, services for developmentally disabled, child care, behavioral health services, etc. The project entailed inventorying all state programs to determine which serve children under six years of age, working with various state agencies to estimate spending and caseload data for these children within the target programs over a six-year period, and researching and summarizing state and federal requirements associated with the operation and funding of the programs.

- Provided analysis and implementation assistance for federal health care reform for the Louisiana Department of Health and Hospitals, including:
  - Integrating the ACA legislation and its amendments to compile a "complete, integrated" version
  - Completed a section-by-section analysis of the bill, a timeline of effective dates, and other research requests as requested
  - Organized issues to facilitate the development of Issue Committees tasked with reviewing and implementing all provisions related to a topic area (e.g. Medicaid benefits, public health programs, etc.)

- Served as day-to-day project manager for B&A's study of services available to adults with autism and related disabilities in Texas (health, home supports, socialization, employment, and residential services). The study examined services currently available and the number of adults with autism spectrum disorders now served, a gap analysis identifying those currently not served, and an analysis of the appropriateness of services that are available. In addition to the quantitative analysis of expenditures and people served with ASD through home and community based waivers, vocational rehabilitation, programs, special education, Medicaid, housing, and targeted workforce development projects, the project team conducted a statewide web based stakeholder survey, conducted numerous interviews with families and self advocates and providers, and facilitated focus groups. The study culminated in the design of three pilot

programs that meet all of the support, residential and employment needs of adults with autism.

- Led a review of reimbursement rates for home and community based services for individuals with intellectual and developmental disabilities in Illinois and supported rate-setting engagements with Missouri, North Dakota, and Rhode Island.

- Directed a $5 billion human services budget comprised of grants from four federal Departments for dozens of programs, including:
  - Long term care services for individuals with developmental disabilities
  - Early intervention
  - Eligibility determinations for Medicaid acute care
  - Child protection and child welfare
  - Employment programs funded by the federal Department of Labor as well as vocational rehabilitation services
  - Adult protection and independent living supports for the elderly
  - Benefit programs including supplemental nutrition assistance and cash assistance
  - Child support

- Served as a member of the Arizona Department of Economic Security's executive leadership team, responsible for agency coordination, strategic planning, and policy implementation.

- Participated in rate-setting projects for providers of services in the developmental disabilities program, including establishment and rebasing of independent cost models (published rates) and negotiations with providers for competitively procured services.

- Served as the liaison to the State Medicaid agency for the financial operations of the long term care program for individuals with developmental disabilities and eligibility determinations for acute care.

- Prepared ADES' annual budget request for Executive and legislative consideration. Responsibilities included forecasting changes in caseloads, costing program initiatives, preparing summary materials, and presenting to the Governor's Office, legislative committees, and stakeholders.

- Convened a workgroup to evaluate opportunities to better integrate the developmental disabilities and vocational rehabilitation programs, with the goals of increasing employment supports for individuals with developmental disabilities and maximizing the use of Rehabilitation Act dollars.

- Participated in workgroup to redesign the early intervention system. Activities included:
  - Assessing service delivery modalities

  - Setting provider rates, moving from cost-reimbursement contracts to published rates
  - Evaluating system funding and opportunities to increase revenues including increasing Medicaid's participation and implementing family cost participation

- Managed various revenue maximization initiatives; major projects included:
  - Becoming the second State in the nation to successfully claim Temporary Assistance for Needy Families (TANF) contingency funds (approximately $90 million)
  - Identifying Medicaid funding earned in previous years and devising strategy to claim these funds ($30 million)
  - Amending ADES' cost allocation plan to increase Title IV-E earnings in the child welfare system (an estimated $10-plus million annually)

- Reviewed state and federal legislation and regulations for financial implications as well as drafted legislation and amendments to implement policymakers' initiatives.

- Worked with elected officials on budget and policy issues as a registered public lobbyist

Education and Academic Qualifications

Master of Business Administration, Arizona State University, 2003
Bachelor of Science in Management, Arizona State University, 2001

Craig Srsen, M.P.P.
Supervising Programmer
Burns & Associates, Inc.

Mr. Srsen brings over ten years of experience necessary for the analysis of policy options and conducting cost-benefit and cost-effectiveness studies of those options. He is very experienced in using SAS® and other analytical tools to support rate setting and other data-intensive projects. Mr. Srsen is also very strong in policy and implementation issues for the design of reimbursement systems. Prior to joining Burns & Associates Mr. Srsen was a Managing Consultant at Navigant Consulting, Inc. and a Senior Consultant at EP&P Consulting, Inc.

Professional Experience

Representative Experience Specific to Rate Setting

- Serves as programmer/analyst in support of annual changes to the Department of Vermont Health Access's inpatient and outpatient hospital rate system updates.

- Played a central role in the analysis of assessment tools and criteria used by the North Dakota Division of Developmental Disabilities to identify individuals who are medically fragile and/or behaviorally challenged for reimbursement enhancements. In addition to the final recommendations, deliverables included an evaluation of existing systems based on quantitative analysis and input from stakeholders through focus groups and interviews; an overview of assessments used across the country; and development of detailed implementation and ongoing costs of options.

- Currently providing the technical analytic support for development of reimbursement rates for home and community supports in Georgia. The scope of the project includes rate development for a range of home and community based services including support coordination, group residential facilities, alternative independent residential settings, supported employment, day activities, financial management and home/community supports. The work includes: (1) an extensive survey of provider costs, wages, and productivity, (2) defining the unit of service, (3) development of independent rate models, (4) obtaining external data sources such as BLS for wages and fringe benefits, (5) working with provider stakeholder group and (6) conducting fiscal impact analyses.

- Assisting the Province of Alberta in the development of a Supports Intensity Scale (SIS) informed resource allocation system for individuals with developmental disabilities. Mr. Srsen developed an integrated data base of assessment, authorization and expenditures data that provide a picture of the supports they currently provide as well as to test resource allocation models.

- Assisted Piedmont Behavioral Health, a managed behavioral health organization in North Carolina, in the development of a Supports Intensity Scale (SIS) informed resource allocation system for individuals with developmental disabilities. The project included analyses of expenditure and provider rate information.
- Assisted the Missouri Division of Developmental Disabilities in the analysis of a potential Supports Intensity Scale (SIS) informed resource allocation system for individuals with developmental disabilities. The project is currently on hold but work to date has included analyses of expenditure and provider rate information.

- Assisted the State of Louisiana in rate-setting for the Office of Citizens with Developmental Disabilities including analysis of claims and cost survey data.

- Managed Navigant Consulting's engagement with the Arizona Department of Economic Security Developmental Disabilities Division in the rebasing of its home and community based services rates for long-term care. Assisted in rebasing rates for in-home companionship and habilitation services, nursing, music therapy and home health aides. Used original data collection and publicly-available data sources to reevaluate the core assumptions underlying the Division's rate models. Assisted in the complete redesign of the Division's nursing and long-term respite models.

- Conducted numerous quantitative analyses to assist Arizona's Department of Economic Security, Division of Developmental Disabilities in setting reimbursement rates for home and community based services. Calculated payments to providers for a retroactive rate increase and provided ad-hoc fiscal forecasting. Thoroughly analyzed and cleaned the Division's claims payment data, matching it against data from other agencies, and analyzed service usage at a variety of levels.

- Assisted in the redesign of the reimbursement system for Ohio's developmental disabilities program home and community based services (HCBS). Designed and developed SAS programs to analyze the quality of the provider cost and utilization data. Designed multivariate regressions and discriminant function analyses using cost data, rate data and assessment data that Ohio collected for HCBS. The project developed a model that places individual clients in a funding range that serves as a budget to develop the individual's service plan and models various options for computing the actual statewide provider rates. Ohio implemented the model as a part of a new HCBS waiver.

- Provided technical support to community providers submitting cost data to the Ohio Department of Mental Retardation and Developmental Disabilities. The Department used cost surveys in electronic format to collect cost information from a variety of supported living and residential community providers in an effort to better understand the market cost of long-term support services. The survey achieved a high response rate and allowed Ohio to collect data from providers that had not previously submitted their cost data.

- Managed the project team preparing a report on Medicaid home and community based services rate adequacy for the Idaho Department of Health and Welfare. The report compared Idaho's HCBS rates to rates of five comparable states and compared Idaho's service descriptions and provider qualifications for selected services to those of the other states. Wrote a Study and Operations Manual for Department staff to assist in conducting future analyses.
- Assisted the Department of Vermont Health Access in moving to a Resource-Based Relative Value Scale for physician payments and an update to their prospective outpatient hospital reimbursement system.

- Recently completed the rebasing of the Arizona Health Care Cost Containment System's (AHCCCS) prospective outpatient hospital reimbursement system. The prospective outpatient hospital reimbursement system is based in part on the ambulatory payment classification system used by the Medicare Outpatient Prospective Payment System (OPPS). Both encounter data and cost report data were updated in the rebasing. Mr. Srsen also participated in the original development of the system in 2005.

- Assisted the Georgia Department of Community Health in the rebasing of its Medicaid inpatient hospital reimbursement rates. Cleaned and evaluated claims data to transition to a new Diagnosis Related Group (DRG) grouper and to balance the rates for budget neutrality.

- Calculated the allocation of Disproportionate Share Hospital funds to public and private hospitals in Arizona for multiple years.

- Programmed a new data process for calculating Medicaid Disproportionate Share Hospital allocations to hospitals for the Arizona Health Care Cost Containment System (AHCCCS). The system collects and incorporates data from several sources, including electronic hospital cost reports, AHCCCS claims and encounters data, and hospital financial transaction data. The Centers for Medicare and Medicaid Services required the new process as part of AHCCCS' waiver renewal.

- Assisted the Arizona Health Care Cost Containment System in designing and conducting a fiscal impact analysis using claims and encounter data to assess the payment neutrality of the new outpatient hospital fee schedule over the old payment system in its first year of operation. Examined the impact by hospital, hospital type and service category and found the new payment system was paying within predicted parameters.

- Assisted the Ohio Department of Job and Family Services' Medicaid program in determining appropriate capital reimbursement for nursing facilities. Developed a fair rental value model of capital reimbursement.

- Assisted the Arizona Department of Health Services, Division of Behavioral Health Services in several rate setting and retroactive payment projects. Developed independent, "bottom-up" rate models, conducted quantitative analysis of paid claims and matched data from other state agencies.

Representative Experience Specific to Evaluations

- Analyzed person-level data for utilization and expenditure trends for two focus studies for Indiana's State Children's Health Insurance Program (SCHIP). The first study analyzed the diagnosis and treatment of children with asthma, and the second analyzed the nature and frequency of well-child visits to physicians. Indiana used the analysis to evaluate its success in meeting its performance goals in these areas.

- Developed the annual SCHIP Monitoring Manual for the State of Indiana. The manual is a part of the performance monitoring of Indiana's SCHIP program and consists of 75 enrollment and utilization reports.

- Developed SAS programs to analyze health care reform initiative microsimulation data for Illinois. The programs cleaned and compiled the simulated data and created formatted reports of cost and coverage estimates for several proposed components of health care reform.

- Assisted the Pennsylvania Governor's Office with development of a comprehensive health care reform proposal. Produced cost and coverage estimates for several components of Medicaid expansion.

- Prepared an annual report that analyzed and reported inpatient and outpatient hospital costs and payments for Ohio's Medicaid program. The report measures changes in cost coverage over a five-year period by Ohio hospital peer groups, compares hospital cost inflation with broader state and national trends and evaluates the effectiveness of changes in payment policy. State Medicaid staff and counsel use the report for a variety of purposes.

- Analyzed and reported on Ohio's Medicaid reimbursement methodology for nursing facilities. Analyzed nursing facility cost components and the

distribution of costs by geographic area. Developed a cost coverage analysis and compared Ohio's demographic and economic factors in the nursing facility industry to those of other states. The Department's General Counsel continues to use this data to support various objectives.

- Assisted Oklahoma in researching the adequacy and availability of pediatric health care services to prepare for litigation brought against the State. Analyzed the population and distribution of general and family practitioners in the state in support of on-going litigation in the State.

- Assisted the project team at the National Academy of Public Administration in analyzing and evaluating the research, demonstration and strategic planning needs of the Centers for Medicare and Medicaid Services (CMS). This project clarified the functional role of CMS' Office of Strategic Planning.

Education & Academic Qualifications

M.P.P. Public Policy, Georgetown University, 2001
B.A., Political Science, Winona State University, 1994

Jesse A. Eng
SAS Programmer
Burns & Associates, Inc.

Jesse Eng has over seven years of experience in programming and data analysis. Before joining Burns & Associates in early 2009, he worked for American Express as a programmer and data analyst developing skills in financial analysis, predictive modeling and quantitative analysis. Prior to this, he worked for the North Dakota Department of Transportation.

Representative Accomplishments

- Built programs to analyze longitudinal utilization and expenditure trends for a databook for the Department of Vermont Health Access.

- Lead programmer on B&A's engagements to assist the Minnesota and Vermont Medicaid programs convert to the Medicare Resource Based Relative Value Scale (RBRVS) system for professional services.

- Analyzed person-level data among 19 discrete populations over five years in support of B&A's analysis of medical savings in the Vermont Medicaid Chronic Care Initiative, a care management program for high utilizers.

- Provides programming and analysis for the annual B&A evaluation of Indiana's Children's Health Insurance Program, the annual External Quality Review of Indiana's managed care plans, and the databook delivered to the Office of Medicaid Policy and Planning to analyze trends in its managed care programs.

- Provides programming and analytical support for the Arizona Department of Economic Security, Division of Developmental Disabilities (DES/DDD) as part of a monthly budget report delivered to the Division to identify data trends.

- Analyst on B&A's engagement to conduct an annual evaluation of the Healthy New York program. Developed programs to scrub datasets received from 11 health plans and developed stratification methodology for three different surveys that are part of the evaluation.

- While at American Express, provided data, programming and statistical support in the implementation of two new predictive models used to support cost savings. Also wrote SAS programs to increase overall process efficiencies.

- Created a Microsoft Access reporting tool in VBA used by the North Dakota Department of Transportation for doing analytics on the weight, speed, and time of day of trucks on the highway system. Also re-wrote Basic programs into Visual Basic 6.0 to improve efficiency and system compatibility.

Education & Academic Qualifications
B.S., Computer Science, North Dakota State University, 2004

Mathematica Staff Qualifications

Deborah Chollet (Ph.D., Economics, Syracuse University) is a senior fellow at Mathematica Policy Research. Dr. Chollet conducts research on private health insurance coverage, markets, provider payments, and regulation—including health insurance exchanges, employer-sponsored health plans for workers and retirees, individual health insurance, and high risk health insurance programs. Chollet directed Mathematica's work measuring health care cost trends in Massachusetts and projecting health care spending in Minnesota, and currently leads Mathematica's participation in a team of experts providing technical assistance to the Center for Consumer Information and Insurance Oversight (CCIIO) to support the development of policy and regulation affecting health insurance exchanges under the Affordable Care Act (ACA). Under grants from the Robert Wood Johnson Foundation and the New York State Health Foundation, she recently led projects, respectively, evaluating risk selection in Massachusetts' Commonwealth Care program to expand individual coverage (a potential model for a Basic Health Plan under the ACA), and modeling the potential impacts of hospital payment incentives to reduce costly readmissions in New York State.

Dr. Chollet has assisted many states—including Alabama, Maine, Massachusetts, Minnesota, New Mexico, Rhode Island, and Washington State—in understanding the implications of health reforms, including the development of health insurance exchanges. Recently, for example:

- In Alabama, under subcontract to LMI, Dr. Chollet directed recent analyses of insurance coverage, underinsurance, and the individual and small group health insurance markets to support deliberations of the state's Health Insurance Exchange Study Commission. The reports submitted to the Commission identified the number and relative health status of individuals who would be eligible to participate in the Exchange or who would become newly eligible for Medicaid.
- For the Office of the Insurance Commissioner in Washington State, Dr Chollet led a research team evaluating the impact of association health plans on the community-rated small group market. In prior work for the Health Care Authority (HCA), Dr. Chollet led a research team assisting in the design state's Health Insurance Partnership program (an exchange-like program offering coverage to low-wage small businesses) and modeling likely enrollment in the program. She has also analyzed five alternative proposals—including a health insurance exchange and a universal state reinsurance program—for the State Legislature, reporting on the coverage and cost implications of each proposal. Currently, Dr. Chollet provides technical assistance to the HCA on various issues related to the development of the state's health insurance exchange under the ACA.
- For Rhode Island, Dr. Chollet led research measuring the cost of the uninsured, current sources of funding, and options for reprogramming private and public funds to help finance expanded coverage.

Dr. Chollet served on the Massachusetts commission to evaluate the impacts of merging the small group and individual markets, and currently serves on the national advisory committee of the California Health Benefits Review Program (CHBRP), which responds to requests from the state legislature to conduct independent analysis of the medical, financial, and public health impacts of proposed health insurance benefit mandates and repeals. In addition, she co-chairs the National Academy of Social Insurance Study Panel on Health Insurance Exchanges.

William S. Borden (Ph.D., History, University of Wisconsin) is the director of Mathematica's Performance Management Group. He has 30 years of experience in systems analysis, documentation, and design; program evaluation managing large technical projects; and synthesizing technical information from complex federal data systems. Currently, Dr. Borden directs a project for CCIIO on the design, development, and use of a new Multidimensional Insurance Data Analytics

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System to support implementation of health insurance exchanges. In addition, as a part of a Master Data Management (MDM) effort at the Centers for Medicare and Medicaid Services (CMS), he is working to implement an Enterprise Master Person Index (EMPI) for Medicare, Medicaid and CHIP that will uniquely identify beneficiaries and providers for these programs in all states.

Dr. Borden has a detailed understanding of the challenges that states and managed care organizations face in reporting eligibility, claims and encounter data to CMS. For example:

- For CMS, Dr. Borden directed an assessment of the completeness, accuracy and timeliness of Medicaid and CHIP data and developed recommendations to improve its processing. He provides ongoing technical assistance to Medicaid and CHIP Business Information Solutions Council (MACBIS) information management strategy to develop an enterprise system to collect, store, and analyze Medicaid and CHIP program policies and administrative data.
- For the Medicaid Statistical Information System, Dr. Borden oversaw revisions to the MSIS 2010 data dictionary to incorporate new data element specifications; the dictionary will be used in a state pilot to ascertain whether state Medicaid programs are able to report an enhanced data set through the MSIS process.
- For the Disabled and Elderly Health Programs group within the Center for Medicaid, CHIP, and Survey & Certification, Dr. Borden led the design and specifications for a Decision Support System to integrate multiple data sources (such as MSIS, MAX, Medicare claims and eligibility records, waiver applications, and state plan amendment data) and provide a business intelligence interface for CMS staff. He conducted a detailed requirements analysis to identify stakeholder needs, designed detailed data specifications, and developed a conceptual system design.

Dr. Borden has designed and implemented rigorous, standardized state reporting, performance measurement, data collection and data validation systems for programs such as Unemployment Insurance, the Workforce Investment Act, the U.S. Employment Service, the Senior Community Service and Employment Program, and the Vocational Rehabilitation Program. For these programs he developed analytical models to classify each reportable claims and services transaction to make it easier to report and validate the state data and mapped each state's internal data to the national models to ensure data consistency. He has conducted numerous multi-state pilot tests and technical workgroups and provided on-site training and technical assistance in every state, including Vermont.

Jill Bernstein (Ph.D., Sociology, Columbia University) is a senior researcher at Mathematica. Dr. Bernstein's work focuses primarily on health care financing policy issues—including private health insurance, cost-sharing, and access to care, as well as Medicare program and policy issues, and health care reform. Dr. Bernstein recently co-authored a policy analysis of regional variation in Medicare spending for the Center for Studying Health System Change. With Dr. Chollet, she co-directs Mathematica's participation on a team of experts providing technical assistance to CCIIO on a range of health reform implementation topics—including state regulation of private insurance entities such as association health plans and multiple employer welfare arrangements. Before joining Mathematica, Dr. Bernstein was the research director of the Citizens' Health Care Working Group (established by the Congress in 2003 to produce recommendations on ways to expand private insurance coverage) and a principal policy advisor at MedPAC, where her work focused on Medicare managed care organization and markets, benefit design, supplemental insurance, physician private-sector purchasing strategies, and beneficiary access to care. Dr. Bernstein also served in senior research positions at the National Academy of Social Insurance, directing quantitative and qualitative research and managing panels of national experts exploring Medicare capitation, markets, and

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beneficiary choice; the Agency for Health Care Policy and Research (now AHRQ); the Public Policy Institute at AARP; and the Physician Payment Review Commission.

Timothy Lake (Ph.D., Health Services Research, Johns Hopkins University) is an associate director and senior researcher at Mathematica Policy Research. Dr. Lake has 15 years of health policy research experience, with specific expertise in payment reforms and measures of quality and access. Dr. Lake provided extensive support to CMS in designing the Medicare Accountable Care Organization shared savings program, and he is currently advising the Department of Defense in designing provider payment incentives to support a medical home intervention in the TRICARE program. With Dr. Chollet, Dr. Lake recently participated on a technical assistance team providing staff support to the Massachusetts Special Committee on the Healthcare Payment System and analyzing the potential for payment reforms in New York State to reduce all-payer hospital readmissions. Dr Lake also has substantial experience with research and policy analysis of health insurance design and consumer choice (especially with respect to enrollment in Medicare Advantage plans and Medicaid), as well as uses of quality measures in consumer decision making. He directed work supporting the initial phase of CMS's assessment of factors associated with Medicare Advantage enrollment and disenrollment, and led parts of Mathematica's evaluation of the Healthy Indiana Plan (a Medicaid 1115 waiver demonstration program). Dr. Lake is also familiar with health insurance and the health care environment in Vermont, having led site visits throughout the states and case studies of implementation to evaluate Vermont's mental health and substance abuse parity reforms for SAMSHA.

Suzanne Felt-Lisk (M.P.A., State University of New York at Albany) is a senior health researcher at Mathematica with 20 years of relevant experience. Ms. Felt-Lisk's recent work has focused on quality of care as it relates to hospitals, physician practices, and health plans. She currently leads the formative evaluation of the DHHS Partnership for Patients initiative; she is responsible for tracking progress on all facets of program implementation and patient safety outcomes, and recommending program improvements. Ms. Felt-Lisk has studied health plan quality measures, publishing on the public availability of HEDIS measures for Medicaid managed care, and analyzing patterns in health plans' HEDIS scores for the Medicaid population. She is also familiar with programs that incentivize quality: she led the Local Initiative Rewarding Results Collaborative Demonstration evaluation, which examined a pay-for-performance program for Medicaid managed care; and the implementation analysis for the evaluation of the Medicare Care Management Performance demonstration for CMS, which incentivized small-to-medium sized primary care practices on quality measures. In earlier work, Ms. Felt-Lisk led a study identifying characteristics of high-quality health plans (for The Commonwealth Fund). She currently participates on the National Committee for Quality Assurance's Standards Committee.

Allison Barrett (M.A., Economics, The George Washington University) is a researcher at Mathematica with experience modeling the potential effects of health insurance exchanges and other state insurance market reforms on health insurance coverage, program enrollment, and health care spending. Working with Drs. Chollet and Lake, Ms. Barrett helped lead Mathematica's analysis of the potential for payment reforms in New York State to reduce rates of readmission and payer cost, developing a microsimulation model of hospital behavior in response to changes in payment. She has worked with Dr. Chollet to model state health insurance reforms in Minnesota, Washington, and New Mexico, and with other Mathematica researchers to model health programs that would low-income children and families in Illinois. Also with Dr. Chollet, Ms. Barrett has estimated the drivers of privately insured health care cost growth in Massachusetts and investigated risk selection in the Massachusetts CommCare program, a program similar to a Basic Health Program under the ACA. In projects for CMS and AARP, she has identified facilitators and barriers to public program

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enrollment, and examined state variation in application processes for the Medicare Part D low-income subsidy (LIS), suggesting improvements to increase enrollment among eligible seniors.

Amy Wodarek O'Reilly (M.P.A., Public Administration, Ohio State University) is a senior program analyst at Mathematica. Ms. Wodarek O'Reilly has substantial experience in assessing the completeness, accuracy, and timeliness of Medicaid and CHIP data and identifying ways to improve data collection and processing in order to produce more timely and accurate reports of program performance and outcomes, better informing program decisions. She has substantive knowledge of the reporting capabilities of state eligibility systems, data warehouses, performance reporting systems, data validation, and data quality. Currently Ms. Wodarek O'Reilly is reviewing state Enterprise Master Person Indexes (EMPI) activities to develop and EMPI for Medicare, Medicaid and CHIP beneficiaries and providers in support of CMS's Master Data Management (MDM) initiative. She was instrumental in the development of a conceptual data model of Medicaid and CHIP data, which will be used to develop a CMS enterprise system, including data on state program policies (such a state plan, state plan amendments, waiver documents) and state-reported eligibility and claims data, and is mapping state data to the model to identify implications for the development of CMS's enterprise system.

Thomas Bell (M.B.A. Wake Forest University) is a principal program analyst at Mathematica Policy Research. Mr. Bell has ten years of experience in using public health care databases to model and study a wide range of state and federal health reforms. He has worked extensively with the American Community Survey state sample data; health insurer filed data compiled by the National Association of Insurance Commissioners; Medicare, Medicaid, and private insurer claims data; state All Payer Claims Databases; hospital discharge data, and state-sponsored survey data; as well as national databases such as the Medical Expenditure Panel Survey (Household and Insurance Components) and the Current Population Survey Annual Social and Economic Supplement (formerly known as March Supplement). Mr. Bell has used these data to model population and outcomes of state insurance reforms; measure the size and characteristics of sub-populations such as people with disabilities and the uninsured; and analyzed access to care and cost trends. Mr. Bell experience includes work for the states of Alabama, Illinois, Maryland, Minnesota, New Mexico, New York, and Rhode Island.

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Mathematica Resumes

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MATHEMATICA
Policy Research

Deborah Chollet
Senior Fellow

Education

1979	Ph.D., Economics, Maxwell School of Citizenship and Public Affairs, Syracuse University
1972	B.S., Economics, University of Missouri at St. Louis

Positions

2000 -	Mathematica Policy Research
1994 - 2000	Vice President, Alpha Center, Washington, DC
1990 - 1994	Georgia State University, Atlanta, GA
1992 - 1994	Director, Center for Risk Management and Insurance Research, and Associate Professor, Risk Management and Insurance
1990 - 1992	Associate Director, Center for Risk Management and Insurance Research, and Associate Professor, Risk Management and Insurance
1989 - 1990	Executive Director, Advisory Council on Social Security, U.S. Department of Health and Human Services, Washington, DC
1982 - 1990	Senior Research Associate, Employee Benefit Research Institute, Washington, DC
1980 - 1981	Senior Research Fellow, National Center for Health Services Research, U.S. Department of Health and Human Services, Rockville, MD
1977 - 1980	Assistant Professor of Economics, Temple University, Philadelphia, PA

Experience

Mathematica

Project Director and Principal Investigator, Insurance and Coverage Technical Assistance (2011 -). Under subcontract to NORC, Mathematica is assisting the Center for Consumer Information and Insurance Oversight (CCIIO) to understand state insurance oversight of health insurance products and the populations eligible and likely to enroll in state health insurance exchanges. CCIIO's concerns about health insurance markets include not only currently insured small groups, but also the implications of extending the definition of small groups to include groups of 2-100 lives, and the potential for insured and self-insured association plans and MEWAs to undermine the exchange and small group markets. For this aspect of the project, Mathematica is cataloging state regulation that defines reinsurance attachment points for small groups and that governs association plans and MEWAs under current law, collaborating with researchers at Georgetown University.

Project Director and Principal Investigator, Planning for Alabama's Health Benefit Exchange (2011 -). Under subcontract to LMI, Mathematica is working with the Alabama Department of Insurance to plan the state's Health Insurance Exchange under the ACA. Mathematica analyzed Alabama's uninsured and underinsured populations and Alabama's health insurance market. Both analyses informed the ongoing policy development process that LMI is facilitating in Alabama as well as the actuarial modeling being conducted by another subcontractor to the project. Mathematica's analyses were presented in two reports to the Insurance Commissioner and the Governor's Health Insurance Exchange Study Commission. Chollet participated in planning and conducting a full-day educational retreat for the Study Commission and continues to provide technical assistance to LMI and the Health Insurance Exchange Study Commission.

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Project Director and Principal Investigator, **Analysis of Massachusetts Health Care Provider and Health Care Payer Cost Trends (2009 -).** Mathematica is conducting the analytic work to develop Massachusetts' annual health care cost trends reports for the Division of Health Care Finance and Policy (DHCFP), as required in statute. These reports are based on analysis of multiple years of enrollment and private claims data from the largest 6 to 10 carriers in Massachusetts, Medicare, and Medicaid. In addition, Mathematica and its subcontractor, Oliver Wyman Actuarial, draft the content and conduct analysis of DHCFP's special surveys of carriers' premium trends and provider payment methods, present findings at DHCFP's stakeholder hearings, and review the DHCFP's final report and recommendations.

Project Director and Principal Investigator, Establishing Health Care Spending Projections and Certifying Actual Health Care Spending in Minnesota (2008 -). For the Minnesota Department of Health (MDH), Mathematica is projecting Minnesota health care spending through 2018 and collaborating with Watson Wyatt Worldwide, which, under subcontract to Mathematica, certifies Minnesota's annual estimates of residents' total health care spending. In the first year of the project, Mathematica also offered detailed recommendations to improve the methods that MDH currently uses to estimate historical health care spending for Minnesota residents.

Project Director and Principal Investigator, Health Insurance Market Performance Analysis (2011). For the Washington State Office of the Insurance Commissioner (OIC), Mathematica analyzed the state's association health plan (AHP) market—including AHPs and state-certified multiple-employer welfare arrangements (MEWAs), whether insured or self-insured. The analysis relied on AHP and small-group data reported to the OIC in response to a 2011 data call, 2006-2010 health carrier annual statements reflecting insured individual and group business in Washington State, April 2010 health carrier statements reporting fully insured AHPs and MEWAs, and self-insured MEWA's 2009-2010 reporting to the U.S. Department of Labor. The analysis (1) documented the magnitude of AHP and MEWA enrollment in Washington State, relative to the magnitude of the small-group and total group markets; (2) compared average premiums and medical losses per member per month in each market and trends in both measures from 2005 to 2008; and (3) summarized the reasons that Washington State might be concerned about the self-insured AHPs and MEWAs under the Patient Protection and Affordable Care Act (ACA), and (4) suggested opportunities for improved monitoring of changes in small-group enrollment in these plans. Mathematica's report was presented to the OIC and state legislature to assist in the development of policy and regulation governing the state's health insurance exchange under the ACA.

Project Director and Coprincipal Investigator, Rehospitalization in New York State and Implications for Avoidable Cost (2009 - 2011). To address the gap in knowledge about the frequency and cost of hospital readmissions in New York State, Mathematica is estimating the potential saving that might result from targeted interventions such as hospital procedures to reduce infection rates and improve discharge protocols. The study identifies geographic areas, conditions, and patient cohorts in New York with high rates of readmissions, reviews current payment reforms and care interventions that show promise for reducing hospital readmissions, and estimates the potential savings in New York State from incentive payment systems intended to reduce high risk-adjusted readmission rates, including pay-for-performance and episode-based payment reforms. The study is based on analysis of linked hospital discharge data for all adults admitted to a hospital in New York State from 2006 to 2008.

Project Director and Principal Investigator, Evaluation of Risk Selection in Market-Based State Programs (2008 - 2011). Under a grant from the Robert Wood Johnson Foundation (RWJF), Mathematica is evaluating risk selection in Massachusetts' Commonwealth Care program to understand the extent of risk selection and whether it has changed over time. In addition, Mathematica is developing an issue brief describing the information that states need to anticipate and monitor adverse risk selection in public programs that subsidize private coverage, to help make these programs sustainable. The evaluation also will explore the risk implications of the federal health reform law's tax credit approach to subsidizing private insurance (which pools risk for subsidized and unsubsidized individuals) versus the more conventional public program model adopted in Massachusetts (which segments these populations). For states that retain a separate basic health program for low-income residents under the federal reform law, the evaluation will help program administrators anticipate sources of risk selection, evaluate the impact on program costs, and design programs to avert risk selection and improve sustainability.

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Project Director and Principal Investigator, Study of Rhode Island's Uninsured (2009 - 2010). Mathematica projected the number of uninsured Rhode Islanders in 2010, the costs of their care, and the likely cost of care if they were insured. The report identifies sources of payment using survey and administrative data, and explores opportunities for reprogramming federal and state funds to cover the cost of expanding coverage in Rhode Island. Mathematica presented the results of this analysis to a meeting of stakeholders to launch a series of stakeholder discussions cochaired by the lieutenant governor and health insurance commissioner.

Project Director and Principal Investigator, Research and Analytic Support to the Massachusetts Special Commission on the Health Care Payment System (2009). Mathematica collaborated with Bailit Health Purchasing to provide technical and facilitation support to the Massachusetts DHCFP and the Special Commission on the Health Care Payment System. The project team prepared a briefing book for Commission members on models for health payment reform, conducted background research for the Commission, facilitated Commission and subcommittee meetings, and prepared the final report containing the Commission's recommendations.

Project Director and Principal Investigator, HealthHub Rhode Island Planning Project (2008 - 2009). The Rhode Island Affordable Health Insurance initiative was an effort by the governor's administration through its Office of the Health Insurance Commissioner, the lieutenant governor and other stakeholders to develop strategies and initiatives to address the decline in private insurance coverage and the rising cost of health insurance in Rhode Island. Collaborating with consultants in Rhode Island and Massachusetts, Mathematica helped developed the outlines of an exchange (or "health hub") as both a mechanism for purchasing individual coverage and a policy-setting entity in Rhode Island. In consultation with state leaders and key stakeholders, the project team confirmed the goals of a health hub to organize the market, support the transition to individual purchasing, and provide a location for subsidies; identified a business model including primary functions and how a health hub should work; identified the target populations eligible to purchase health insurance through the hub; considered the need for individual or employer mandates and made a recommendation; and recommended how the hub should interface with the existing health insurance market. The project resulted in recommendations to the lieutenant governor, summarized in an Issue Brief for RWJF's SCI Program.

Project Director and Principal Investigator, Analytic Support for Washington Citizens' Work Group on Health Care (2008 - 2009). For the Washington State Legislature, Mathematica conducted economic analysis of four health care reform proposals. To evaluate and compare the potential impacts of each reform proposal, Mathematica developed a modeling approach and baseline data set, simulated the implementation impacts on private and public health care coverage and expenditures, and conducted economic impact and actuarial analyses. In addition, Mathematica developed a series of research syntheses to support a common understanding of the programmatic factors of each proposal that could contribute to specific desirable outcomes, including improved population health, good medical outcomes, evidence-based practice, and the development of medical homes. Mathematica presented the results of the analysis in separate sessions of the State Senate and House of Representatives authorizing committees.

Project Director and Principal Investigator, Washington State Health Insurance Partnership (HIP) Board Studies (2008 - 2009). Mathematica simulated enrollment in, and the cost of, the HIP as a single and exclusive market for small groups and individuals, with common health plan options and rating based on pooled experience. Mathematica developed detailed specifications of HIP rules and policies as indicated by the HIP Board; modeled the impacts of the HIP on small-group and individual coverage, cost, and financing; and assessed unintended impacts on the association health plan market, which accounts for approximately half of all insured small groups in Washington state.

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Director and Principal Investigator, CareFirst's Community Benefit in the Washington, DC National Capital Area, I, II, and III (2004 - 2009). Mathematica examined the capacity of CareFirst to provide community benefit. In the initial phase, Mathematica investigated whether and how General Health and Medical Services, Inc. (GHMSI), CareFirst's affiliate in the District of Columbia might expand its community benefit mission in the national capital area. In the second phase of the project, Mathematica provided follow-up analyses of CareFirst's proposed community benefit plan; a decision framework for allocating community benefit funds; and technical assistance to the DC Appleseed Center for Law and Justice (a nonprofit public interest advocacy organization), the City Council, and Office of the Mayor of the District of Columbia. In the third phase, Mathematica updated earlier estimates of financial capacity and provided technical assistance to DC Appleseed, as the City Council and the Department of Insurance, Securities and Banking (DISB) considered policy options for expanding health insurance coverage and improving public health in the District of Columbia. Subsequent to enactment of the Medical Insurance Empowerment Act of 2008, which requires the insurance commissioner to review GHMSI's surplus in light of the company's obligation to "engage in community health reinvestment to the maximum feasible extent consistent financial soundness and efficiency," Mathematica continued to offer technical assistance to DC Appleseed, the City Council, and DISB.

Project Director and Principal Investigator, Maryland State Health Expenditure Accounts (SHEA) I and II (2002 - 2009). Mathematica provided technical leadership and support for the estimation of SHEA private health insurance and out-of-pocket expenditures, by type of service and geographic area, under subcontract to Social and Scientific Systems, Inc. In cooperation with other subcontractors, Mathematica developed and drafted the annual SHEA report of the Maryland Health Care Commission (MHCC) and, collaborating with MHCC staff, prepared an annual "Spotlight on Maryland" report on health insurance administrative cost.

Project Director and Principal Investigator, Minnesota Health Insurance Exchange Study (2007 - 2008). Mathematica assessed the potential impacts of major health insurance reforms that might accompany the development of a statewide health insurance exchange to serve the individual and small group markets in Minnesota. The reforms included a proposed requirement that employers establish Section 125 plans, which Minnesota subsequently enacted. Mathematica provided technical assistance to the Minnesota commissioner of health to identify alternative designs for the exchange and estimated participation, costs, and fiscal impacts under each reform. In addition, Mathematica collaborated with regulatory and implementation experts at Georgetown University and in Massachusetts to identify and review legal, administrative, and operational issues associated with developing an exchange.

Project Director and Principal Investigator, Hospital Cost, Financial Performance, and Cost Shifting in West Virginia (2006 - 2008). Mathematica estimated general acute care hospital cost shifting to private payers, simulated the effects on general hospital margins of improved cost and revenue management, and explored reasons for the pervasive financial distress of critical access hospitals in the state. This project contributed to a more systematic understanding of the financial performance of general acute care and critical access hospitals in West Virginia and the extent to which these hospitals shift costs among payers.

Project Director and Principal Investigator, Health Coverage for New Mexicans Committee (2007). This project continued Mathematica's work for the Legislative Council Service (LCS) (an agency of the New Mexico legislature) and the Health Coverage for New Mexicans Committee (HCNMC) appointed by the governor and the legislative leadership. Mathematica provided technical assistance and microsimulation modeling of additional HCNMC recommendations as well as various other initiatives that included the creation of a health care authority, extensive private insurance reforms, an individual insurance mandate, an employer "play or pay" mandate, development of larger insurance risk pools, and various initiatives to improve access and quality and constrain cost. In addition, Mathematica assisted the LCS to determine what coordination and technical assistance would be required, and also made presentations to legislative interim committees and other groups as requested.

Project Director and Principal Investigator, Quantitative and Comparative Analysis of Reform Options in New Mexico (2006 - 2007). Mathematica supported the work of HCNMC, appointed by the governor of New Mexico. Specifically, Mathematica provided technical assistance to the Committee in understanding options and refining three reform strategies intended to achieve universal coverage, and modeled the coverage and cost impacts of each. Subcontractors to the project were Social and Scientific Systems; Actuarial Research Corporation; and the University of New Mexico's Bureau of Business and Economic Research, Institute of Public Law, and the Institute for Public Health.

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Project Director and Principal Investigator, Options for Expanding Coverage in Missouri (2006 - 2007). In cooperation with the State Health Access Data Assistance Center at the University of Minnesota, Mathematica developed reform concepts and policy options for the Missouri State Planning Grant Policy Work Group to expand health insurance coverage in the state. Mathematica developed coverage and cost estimates of the potential effects on coverage and the state's fiscal exposure if Missouri were to develop a subsidized small-group health insurance product offered through the state employee health plan to small firms that do not offer health benefits to their workers.

Senior Adviser and Project Director, Medical Specialty Centers Study for the Wyoming Healthcare Commission (2006 - 2007). Collaborating with the Center for Studying Health Systems Change (HSC), Mathematica developed information about the actual and potential effects in Wyoming of new general hospitals and medical specialty centers. At present, no specialty hospitals are located in Wyoming, but several have located at the border of neighboring states. The project team developed a detailed review of the literature, conducted semi-structured interviews with key informants in the Wyoming health care market, and developed supporting data and analyses of the financial impacts of niche hospitals on general hospitals. The project produced a report to the Wyoming state legislature.

Principal Investigator, Assessment of Health Care Access Strategies, Illinois Adequate Health Care Task Force (2006 - 2007). Working with Navigant Consulting and Milliman, Mathematica developed a comprehensive strategy to cover all Illinois residents and provided overall guidance for Mathematica's role on a project team to assist a state-appointed task force in identifying the strategy to ensure that every Illinois resident has access to affordable, quality health care. The project team analyzed and reported on current levels of health care access in the state, developed criteria for evaluating competing access proposals, estimated and compared the cost and coverage outcomes of each, and proposed a "best" strategy for achieving the state's access goals.

Project Director and Principal Investigator, Design Options for Estimating Price and Income Elasticities for the Demand for Health Services and Insurance Products (2005 - 2007). This project was conducted for the U.S. Department of Health and Human Services (DHHS), Assistant Secretary for Planning and Evaluation (ASPE). Mathematica investigated available estimates of the price and income elasticity of demand for health insurance products and health services to support development of options for updating and/or improving these estimates. Mathematica also developed a critical assessment of the research literature and conducted discussions with key stakeholders, developed a research design to improve on and/or update available estimates of price elasticity, and developed an analysis of non-price factors that have affected enrollment in recent or ongoing state and community programs intended to provide health coverage to the uninsured.

Project Director and Principal Investigator, Statewide Strategic Plan to Address the Accessibility, Affordability, and the Quality of Health Care in Pennsylvania (2005 - 2007). Under subcontract to EP&P consulting, Mathematica supported the Governor's Office of Health Care Reform for the Statewide Strategic Plan to Address the Accessibility, Affordability, and the Quality of Health Care in Pennsylvania. Mathematica provided technical assistance to the Governor's Office of Health Care Reform, developed a compendium of state initiatives to expand employer-based coverage, identified options for retaining and increasing employer-based health care coverage in Pennsylvania, analyzed health care drivers and the net cost of health insurance in Pennsylvania, analyzed health insurance regulation in Pennsylvania and selected comparison states, and offered policy suggestions for reducing the cost of coverage. Finally, Mathematica developed and delivered to the Governor's Office a series of simple models to analyze the coverage impacts and costs of policy options to expand coverage, regulate insurance, and lower coverage cost.

Senior Consultant, Analysis of Transition Events in Health Insurance Coverage (2004 - 2007). Mathematica updated and expanded on existing research measuring transitions in health insurance coverage for the population as a whole and for key subpopulations, and to address important methodological problems for improving the information available to develop sound health policy. The project used the most recent data from the Survey of Income and Program Participation.

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Project Director and Principal Investigator, Financial Impact and Analysis of Niche Hospitals on General Hospitals in Texas (2005 - 2006). Conducted for the Texas Department of State Health Services, Mathematica analyzed issues related to the development of physician-owned specialty hospitals in the state, including the financial impact of niche hospitals on general hospitals in Texas and physician-owner referral behaviors that could bolster these impacts. The project team produced a detailed review of the literature, conducted interviews with key informants in the Texas health care market, and developed quantitative analyses. The project team, including Mathematica's sister company HSC, worked with the Department to develop a report to the state legislature as mandated in statute.

Director and Principal Investigator, Analyses for Insurance Directions for Every Alabamian Project (2005). Mathematica estimated the costs and benefits to Alabama employers and residents of obtaining coverage for workers and their families. Mathematica statistically matched the 2003 Alabama Health Care Access and Insurance Survey with the Medical Expenditure Panel Survey (MEPS), calibrating the MEPS national spending estimates to Alabama.

Senior Consultant, Medicare Advantage (MA) Stabilization Fund (2004 - 2005). In this project for DHHS, ASPE, Mathematica developed a microsimulation analysis of the effect of the MA stabilization fund in attracting and retaining regional preferred provider organizations (PPOs) under the Medicare Modernization Act of 2003. Mathematica built a microsimulation model to estimate regional and national PPO entry, retention, and exit under a range of MA stabilization fund payments.

Director and Principal Investigator, Economic and Actuarial Analyses for Maine, Implementation (2003 - 2005). Mathematica supported the development and implementation of the DirigoChoice health program in Maine, with funding from Maine's State Health Planning Grant project and the Maine Governor's Office of Health Policy and Finance. DirigoChoice is a state program that provides subsidized health insurance and other health benefits to small-group employees and non-Medicare individuals in Maine. The project entailed development of improved-precision projections of enrollment in the program, consultation with Watson Wyatt Worldwide to develop program benefits and actuarial cost estimates, microsimulation modeling of alternative subsidy and benefit designs, development of methods to estimate total health care spending in Maine, and technical assistance to the Governor's Office of Health Policy and Finance.

Director and Principal Investigator, Economic and Market Analysis for the Indiana State Planning Grant (2004). Mathematica developed a summary of the health care marketplace in Indiana, identifying trends that affect employer-based health insurance and health care cost-drivers. The project resulted in a series of reports and a summary report. This project was intended to give policymakers a better understanding of the key market issues that contribute to increasing health care costs in Indiana and the growing number of uninsured.

Director and Principal Investigator, Making Coverage for the Uninsured: The Role of Community Initiatives (2003 - 2004). With support from the Commonwealth Fund, Mathematica worked with Georgia State University's Health Policy Center to develop case studies of community-based systems of free or discounted health care services for the uninsured in five communities (Wichita, Kansas; Paris, Arkansas; Milwaukee, Wisconsin; Olympia, Washington; and Forsyth, Georgia). The study examined the effectiveness, cost effectiveness, and efficiency of community efforts to increase coverage or access; factors that enhance or challenge their sustainability and expansion; lessons for their replication; and cooperation with the state and state programs to close gaps in funding and access.

Project Director and Principal Investigator, Maryland State Healthcare Expenditure Accounts 2001 and State Health Expenditure Accounts 2002 (2002 - 2003). Under subcontract to Social and Scientific Systems, Mathematica developed methods for estimating the private insurance components of the annual SHEA and analysis for MHCC's annual SHEA report. In a related special task, Mathematica provided technical support to improve MHCC's methods for projecting nursing home utilization in Maryland.

Project Director and Principal Investigator, Economic and Actuarial Analyses to Support Maine's State Health Planning Grant (2002 - 2003). Mathematica developed cost and economic impact estimates to support the Maine Governor's legislative initiative to ensure access to affordable coverage for all individuals and businesses in Maine.

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Project Director and Principal Investigator, Public Strategies to Ensure High-Risk Individuals (2000 - 2003). Mathematica produced a series of reports for The Commonwealth Fund describing and comparing state high-risk pools. In addition, Mathematica estimated the impact of alternative regulatory strategies to facilitate private health insurance for high-risk individuals without group coverage.

Project Director and Principal Investigator, Feasibility of a Single-Payer System in Maine (2002). Mathematica developed a microsimulation analysis of the costs, financing requirements, and economic impact of a single-payer health care financing system, and provided technical assistance to the Maine Health Security and Health Systems Board to support the Board and report to the Maine Legislature. Mathematica's analysis indicated that a single-payer system in Maine was economically feasible, although a number of important questions would need to be resolved—including how or whether such a system could integrate Medicare financing.

Project Director and Principal Investigator, Evaluation Design for the Covering Kids and Families Program (2001 - 2002). Mathematica designed a major program evaluation for RWJF, in cooperation with The Urban Institute and Health Management Associates. The design team subsequently was awarded the evaluation contract.

Alpha Center/AcademyHealth

As **Vice President (1994 - 2000),** developed, conducted, and managed sponsored research on health insurance coverage and markets, conversion of nonprofit hospitals to for-profit status, and Medicare supplemental insurance regulation, and provided technical assistance to state governments on private and public health care financing programs and strategies. Developed and conducted intensive workshops for senior state officials and legislators on selected topics, including health insurance markets and the development and use of integrated health information systems. Coordinated, directed, and produced technical assistance products and participated on research and technical assistance teams with other private research and consulting organizations.

Georgia State University

As **Director (1992 - 1994)** and **Associate Director (1990 - 1992)** of the Center for Risk Management and Insurance Research, developed and coordinated faculty research grant proposals on the theory and domestic and international practice of health care financing; life insurance; employee benefits; and automobile, property, and professional liability insurance. Managed state interagency discussions and prepared major proposals to fund staff work for the governor's health care reform initiative.

As **Associate Professor of Risk Management and Insurance (1990 - 1994),** developed and taught undergraduate courses and graduate seminars in employee benefits and health care financing. Advised departmental and nondepartmental doctoral students on curricula and participated on dissertation committees. Developed liaison relationships with Georgia State University's Institute of Health Administration and School of Health Professions, and Emory University's School of Public Health, serving as guest lecturer, developing joint training proposals, and conducting cooperative management of graduate assistantships.

U.S. Department of Health and Human Services

As **Executive Director (1989 - 1990)** of DHHS's Advisory Council on Society Security, developed and managed all staff work for the quadrennial council on matters related to the status of the Social Security Old Age and Survivor's Insurance and Hospital Insurance and Supplemental Medical Insurance trust funds. Developed informational briefings, secured and worked with consultants and expert advisers, and advised members on matters of process and policy related to the Council's authorizing mandate from the secretary.

As **Senior Research Fellow (1980 - 1981)** in the National Center for Health Services Research, worked with the intramural long-term care research team to develop analyses of long-term care financing and the use of formal and informal services. Served frequently as a reviewer for the Center's extramural research program and as a member of the department-wide strategic reorganization team.

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Employee Benefit Research Institute

As **Senior Research Associate (1982 - 1990),** developed, managed, and conducted research on private health insurance and on employee and retiree health benefits and financing. Initiated an ongoing series of chartbooks and analyses of the uninsured population. Developed monographs and issue briefs on employee and retiree health benefits and developed and presented conference papers and congressional testimony.

Temple University

As **Assistant Professor of Economics (1977 - 1980),** developed and taught undergraduate and graduate courses in microeconomics, macroeconomics, and income distribution. Developed and taught the MBA microeconomics service course for the Department of Health Administration. Served on and subsequently chaired the department's undergraduate curriculum committee.

Papers and Publications

Journal Articles and Other Peer-Reviewed Publications

Chollet, Deborah, and Allison Barrett. "Individual Health Coverage." In *Covering Health Issues,* 5th edition. Washington, DC: The Alliance for Health Reform, 2010.

Chollet, Deborah. "How Temporary Insurance for High-Risk Individuals May Play Out Under Health Reform." *Health Affairs,* vol. 29, no. 6, June 2010, pp. 1164-1167.

Faulkner, Deborah, Amy Lischko, and Deborah Chollet. "Considering a Health Insurance Exchange: Lessons from the Rhode Island Experience." SCI Issue Brief, The Robert Wood Johnson Foundation's State Coverage Initiatives Program. Washington, DC: The Robert Wood Johnson Foundation, June 2009.

Chollet, Deborah. "Insurance: Restructuring of Private Markets Likely as Public Programs Expand." In *Futurescan 2008*. Chicago: Society for Healthcare Strategy and Market Development and American College of Healthcare Executives/Health Administration Press, 2008, pp. 20-24.

Minyard, Karen, Deborah Chollet, Laurie Felland, Lindsey Lonergan, Chris Parker, Tina Anderson-Smith, Claudia Lacson, and Jaclyn Wong. "Lessons from Local Access Initiatives: Contributions and Challenges." New York: The Commonwealth Fund, August 14, 2007.

Chollet, Deborah. "Nonprofit Health Care and Insurance: Protecting the Public Interest." *Inquiry Web Special,* January 2007.

Chollet, Deborah, and Carolyn Watts. "Pooling and Reinsurance in Washington State Health Insurance Markets." *Journal of Insurance Regulation,* vol. 24, no. 2, winter 2005, pp. 81-92.

Chollet, Deborah. "Insuring the Uninsured: Finding the Road to Success." *Frontiers of Health Services Management,* vol. 21, no. 4, summer 2005, pp. 17-28.

Cohn, Donald, Enrique Martinez Vidal, and Deborah Chollet. "More Answers on Reinsurance." The Robert Wood Johnson Foundation's State Coverage Initiatives Program. *In Focus,* vol. 6, no. 2, June 2005.

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1995 - 1996	"Conversion of Hospitals and Health Plans to For-Profit Status: A Preliminary Investigation of Community Issues." The Commonwealth Fund.
1995 - 1996	"Enrollment and Utilization Across Medicare Supplemental Plans." Center for Health Economics Research.
1994 - 1996	"The Cost of Informal Caregiving: Implications for Private Long-Term Care Insurance and Public Policy." Retirement Research Institute.
1992 - 1995	"Defining a Minimum Health Insurance Benefit." Robert Wood Johnson Foundation.
1993 - 1994	"Issues in Developing a Standardized Health Benefit." Health Care Financing Administration.

Professional Activities

2009 -	Cochair, Study Panel on Health Insurance Exchanges, National Academy of Social Insurance
2006 -	Board of Trustees, DC Appleseed Center for Law and Justice.
2006 -	Editorial Advisory Board, *Journal of Insurance Regulation*
2004 -	National Advisory Council for the California Health Benefits Review Program, State of California
1995 -	Editorial Advisory Board, *Journal of Insurance Issues*
1988 -	Editorial Advisory Board, *Benefits Quarterly*
2006 - 2007	Commissioner, Massachusetts Commission to Study the Impact of Merging the Massachusetts Nongroup and Small Group Health Insurance Markets (designated by Speaker of the House Salvatore F. DiMasi)
2000 - 2003	Member, Study Panel on Medicare and Markets, National Academy of Social Insurance
1996	Consultant, Ministry of Finance, Government of Croatia, in cooperation with the World Bank Public Sector Adjustment Loan Program
1993 - 1994	Expert Adviser to the Governor's Commission on Health Care, State of Georgia
1992 - 1994	Advisory Panel, Office of Technology Assessment, U.S. Congress: Technology, Insurance and the Health Care System
1989 - 1994	Technical Adviser, Robert Wood Johnson Foundation
1992 - 1994	Health Care Data Program
1990 - 1994	Health Care Financing and Organization Program
1989 - 1992	Health Care for the Uninsured Program
1993	Member, Research Advisory Council, Georgia Children's Initiative, by invitation from the Governor of Georgia
1991 - 1992	Technical Adviser, National Institutes of Health, Human Genome Project, Task Force on Ethical, Legal and Social Implications

1991 U.S. Delegate, US-USSR Leadership Conference, Health Care Commission, Moscow and St. Petersburg

Professional Affiliations

Founding Member, National Academy of Social Insurance
AcademyHealth

Occasional Reviewer

American Journal of Managed Care

Benefits Quarterly

Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services

Congressional Research Service, U.S. Congress

Health Affairs

Health Services Research

Inquiry

Journal of Insurance Issues

Medical Care

National Academy of Science, Institute of Medicine

National Academy of Social Insurance

Health Care Financing and Organization program, The Robert Wood Johnson Foundation

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MATHEMATICA
Policy Research

William S. Borden
Director, Performance Management Group

Education

1996	Certified Software Quality Engineer, American Society for Quality
1981	Ph.D., American History, University of Wisconsin-Madison
1976	M.A., American History, University of Wisconsin-Madison
1973	B.A., Sociology and Political Science, Livingston College, Rutgers University

Positions

1979 -	Mathematica Policy Research
1998 -	Director, Performance Management Group
1998 -	Senior Fellow
1990 - 1998	Project Director
1988 - 1989	Senior Program Analyst
1984 - 1988	Program Analyst
1981 - 1983	Survey Associate
1979 - 1981	Survey Assistant
1977 - 1978	Systems Researcher, Capitol Text Management

Experience

Mathematica

Director, Performance Management Group (1998 -). Manage a group of 20 professional staff who design and operate state and federal performance management systems. These systems are currently being used by every state and more than 50 grantees to perform all performance reporting and data quality and analysis tasks for all major federal job training programs and the Unemployment Insurance (UI) Program for the U.S. Department of Labor (DOL), Employment and Training Administration (ETA), the Rehabilitation Services Administration (RSA), Office of Planning, Evaluation and Policy Development, U.S. Department of Education, the Food and Nutrition Service (FNS), the U.S. Department of Agriculture (USDA), Office on Disability, the U.S. Department of Health and Human Services (DHHS), the Centers for Medicare & Medicaid Services (CMS), and numerous state governments.

Project Director, Multidimensional Information Data Analytics System (2011 -). Oversee a project to design, develop, and utilize a new Multidimensional Information Data Analytics System (MIDAS) supporting implementation of the Health Insurance Exchanges within CMS. The project involves three major components: data integration, the data warehouse, and multidimensional analytics. At its full capacity, MIDAS will be a comprehensive clinical health insurance exchange data warehouse that facilitates access to and analysis of data from a variety of modern sources and formats, and will enable collation of that data with other sources of information. MIDAS will be interoperable with other data sources and will include protocols for secure and reliable data storage and access, as well as analytic tools for data comparison and analysis. Mathematica is participating in this project with other partner organizations.

Task Leader, Research and Evaluation of the Money Follows the Person Demonstration Grants and Technical Support to Centers for Medicaid and State Operations (2011 -). Oversee two tasks under this project. Coordinate the development of CMS's Medicaid and Children's Health Insurance Program (CHIP) conceptual data model and develop technical alternatives to collecting claims and encounter data to ensure that CMS has sufficient data to analyze program operations and investigate program integrity issues. Design methods for classifying data quality issues in a standardized and structured format. This work supports CMS's Medicaid and CHIP Business Information Solutions Council information management strategy to develop an enterprise system to collect, store, and analyze Medicaid and CHIP program policies and administrative data.

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Task Leader, Rehabilitation Services Administration Redesign of State Vocational Rehabilitation Data Collection Forms (2008 -). Manage project to redesign three data collection and reporting instruments for RSA. Mathematica is gathering knowledge and revising the current reporting system used by State Vocational Rehabilitation agencies to report case performance and fiscal data to the federal RSA.

Technical Adviser, Performance Standards and Reporting for Supplemental Nutrition Assistance Program (SNAP) Modernization Initiatives (2008 -). Oversee study to identify how states are measuring performance of activities that have recently been implemented to improve access to SNAP, cost efficiency, accuracy, and customer service. This project for USDA, FNS will create a conceptual framework for measuring performance of SNAP modernization activities, describe the details of each state's SNAP performance measures and standards, provide detailed results of those measures for each state, and assess the pros and cons of applying alternative performance measures and standards across states.

Project Director, Technical Design of a Temporary Assistance for Needy Families (TANF) Performance Management System (2006 -). Manage system testing, including the preparation of comprehensive test data, test reports, and user documentation. Under direct contracts with two states, Mathematica is designing and testing performance management systems to enable states to manage their TANF work participation rates and other federal reporting responsibilities. Mathematica is developing and maintaining a data model to calculate and analyze the work participation rate, including detailed programming specifications, data quality specifications (edit tests), and specifications for reports, federal files, and user displays.

Project Director, Department of Work and Pensions (DWP), United Kingdom (2006 -). Conduct an alternatives analysis of ways in which the DWP, UK can improve performance measurement of the Pathways to Work programme, a welfare-to-work program for people with disabilities in the UK.

Project Director, Performance Reporting and Administrative Support for the Centers for Medicare & Medicaid Services Medicaid Grant Initiatives (2006 -). Lead all project activities and deliverables including a baseline assessment of each grant covered by the contract, development of an approach to ongoing qualitative assessment of grantee reports, design of specifications for the Performance Monitoring Report and the Targeted Follow-Up Report, and technical assistance to grantees. Mathematica, in collaboration with Ascellon Corporation, is assisting CMS, Disabled and Elderly Health Programs Group (DEHPG) and the Office of Acquisition and Grants Management in managing several grant programs established through the New Freedom and Ticket to Work (TTW) initiatives. The programs covered by this project include Medicaid Infrastructure Grants (MIG), Real Choice Systems Change grants, and Direct Service Workers grants. Mathematica is currently conducting a pilot to examine the data quality and performance reporting capabilities and challenges of states with MIG grants. Mathematica visited four states, prepared state profiles and a summary report, and presented findings at the 2008 CMS MIG/Demonstration to Maintain Independence in Employment Conference.

Project Director, Senior Community Service Employment Program (SCSEP) Performance Management Software Technical Assistance (2003 -). Direct staff who provide technical assistance to 75 grantees and 900 subgrantees on the use of SCSEP web-based data collection and performance measurement systems. Develop requirements for system enhancements and technical documentation to assist program grantees. Oversee all systems specifications, user documentation, systems acceptance testing, and coordination with third party systems developer. Under a related project, oversaw development of a desktop data collection and reporting system that enabled more than 900 SCSEP grantees and subgrantees to capture and report all the elements required to generate the SCSEP quarterly performance reports. Developed performance measurement and reporting specifications and provided training to grantees and subgrantees on the use of the system.

Project Director, Unemployment Insurance Data Validation Implementation (1999 -). Oversee implementation of the UI data validation methodology developed by Mathematica under an earlier project. Developed data validation and reporting software to calculate and validate 1,500 federal reporting elements; train federal and state staff to use the methodology and automated tools to validate federal reports submitted by the states. The training is conducted using a training package developed by Mathematica. As followup to the training, Mathematica is providing technical assistance to states that are implementing the methodology. In addition, under direct contracts with 16 states, Mathematica is conducting independent verification and validation (IV&V) of state UI benefits and tax data systems. IV&V tasks include reviewing state validation instructions, manuals, and validation files; conducting independent data element validation; and providing training and technical assistance. Mathematica assesses all state validation products against federal standards and issues certification once the assessment is complete.

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Task Leader, National Medicaid Statistical Information System (MSIS) (2011). Oversaw two tasks under this project. Led in the development of the automated front-end MSIS data quality and validation process. Oversaw designing and composing specifications for the front-end validation business rules, including pass, fail, and warning thresholds. Planned proposed workflow of the state-submitted MSIS files for the new front-end validation processing, including referencing external look-up tables and crosswalks. Coordinated the rapid production of user-friendly diagnostic reports from the results of all front-end data quality and validation business rule checks.

Adviser, Medicaid Statistical Information System (2011). Managed the revisions to the MSIS data dictionary, which reconciles the MSIS 2010 version with the proposed MSIS Plus files, and incorporated limited data requirements. The revised MSIS data dictionary will be used in a pilot project to assess the ability of state Medicaid programs to extract additional data needed to assess the enrollment and expenditures of the Medicaid and CHIP programs.

Task Leader, Ticket to Work Initiatives, Project Year 3 (2010 - 2011). Provided ongoing consultation to CMS on the design and planning for an enterprise system and improvements to the processing of state Medicaid and CHIP data. Identified alternative approaches to improve the production and processing of state Medicaid data submitted through MSIS. Outlined a definitional framework to analyze Medicaid data. This project involved designing an implementation strategy to improve the completeness, accuracy, timeliness, and processing of state Medicaid data, developing a Medicaid and CHIP conceptual data model, and documenting data and functional needs of all CMS staff using Medicaid data, including the Center for Medicaid, CHIP, and Survey & Certification, the Center for Innovation and Strategic Planning, and the Center for Program Integrity.

Task Leader, Ticket to Work Initiatives, Project Year 2 (2009 - 2010). Conducted source file analysis and stakeholder interviews to develop detailed user requirements and a conceptual design for a Decision Support System (DSS) for DEHPG and potentially other groups within CMS. Determined data, functional, and other specifications that software vendors will use to implement DSS. This project for CMS identified all administrative data sources DEHPG uses to manage large grant programs, Medicaid waiver programs, and state plan amendments; outlined an approach to increase analytic abilities; and developed system specifications for the development of a DSS, which would be comprised of an integrated database of Medicaid and Medicare claims data, as well as other sources, and business intelligence tools for reporting and analytics.

Task Leader, Evaluation and Technical Assistance: Ticket to Work Initiatives, Project Year 1 (2008 - 2009). Developed a comprehensive information management plan for CMS DEHPG. This project identifies all administrative data sources DEHPG uses to manage large grant programs, Medicaid waiver programs, and state plan amendments; outlines an approach to increase analytic abilities; and develops system specifications to be used for the development of a DSS.

Project Director, Employment and Training Administration Performance Reporting and Validation Initiative (1998 - 2009). Assisted DOL, ETA in reporting, performance measurement, and data validation across all ETA programs. Oversaw development of detailed specifications for calculating performance measures, conducting state and regional training on performance measures, and directing analyses comparing various calculation methodologies. Also oversaw development and testing of reporting and validation software for several ETA programs based on these specifications. Programs include the Employment Service, Workforce Investment Act, Welfare-to-Work, National Farmworker Jobs Program, and Trade Adjustment Assistance programs. Oversaw provision of technical assistance to states using the software applications for reporting and data validation. Oversaw all systems specifications, user documentation, systems acceptance testing, and coordination with third-party systems developer. The project conducted an analysis of current programs, including data requirements, reporting systems, data validation systems, and performance standards, as well as assisting ETA's key program staff to better understand the concepts of performance measurement and data validation and how they should be applied to ETA programs.

Project Director, Assessment of Computer Matching in the Food Stamp Program (FSP) (1998 - 2002). Managed the development of a data collection instrument, procedures, and census of state FSP offices for their computer matching activities. Coauthored final report on findings from the census. The project included extensive telephone interviews with key computer matching staff in each state to obtain information on the use of various database matching systems for detection of fraud and abuse.

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Task Director, Study of a National Database for Federal Means-Tested Public Assistance Programs (1999 - 2000). Coauthored a report to Congress concerning the feasibility of a national database to track food stamp recipients, to satisfy a congressional mandate to FNS. Oversaw report sections related to technical feasibility, and analysis of a similar study commissioned by DHHS.

Project Director, Unemployment Insurance Data Validation Pilot Test and Pre-Implementation Training (1997 - 1999). Managed analytic and technical assistance activities in development of pilot-test and pre-implementation training of benefits and employer contribution data validation methodology for state and federal UI staff. Updated data validation handbooks and coordinated with prime contractor on conversion of data validation handbooks to training program. Conducted and analyzed benefits pilot tests in three states. Conducted training for states and federal UI staff on validation methodology.

Project Director, Performance Measurement Review and Unemployment Insurance Data Validation Project, New Hampshire Department of Employment Security (1993 - 1997). Conducted an evaluation of a new system to evaluate the performance of State Employment Security Agencies (SESAs) in providing payments, adjudications, and appeals to UI claimants. Oversaw and analyzed the development of system-generated performance data in six pilot states. Coauthored final evaluation report with analysis of performance outcomes and recommendations for national implementation. Developed state-specific data validation design to perform quality control on data reports submitted to DOL, UI Service by 53 SESAs. Provided on-site technical assistance, collected benefits system and federal reporting systems documentation, and tested validation software design. Developed state-specific benefits data validation handbooks and reporting software logic. Designed a state-specific data validation model and evaluated a pilot test for validating UI employer contribution reports. Led the development of 53 state-specific tax data validation handbooks.

Pensions and Employee Benefits

Project Director, Direct Filing Entity (DFE) Database Design and Data Entry (1997 - 2001). Provided support to the Pension and Welfare Benefits Administration (PWBA) to develop comprehensive statistics on the private pension plan universe and to analyze compliance with the Employee Retirement Income Security Act (ERISA) reporting requirements. Oversaw processing of DFE data to create a database covering Master Trusts, Common and Collective Trusts, 103-12 Investment Entities, and Pooled Separate Accounts. Managed design of a DFE processing system that allocated plan year DFE and "other" assets reported by plans from DFE primary and "other" lines to primary investment lines on the Form 5500 balance sheet. For plan year 1994, project team directly identified primary investment categories for 65.4 percent of the $936 billion in plan assets invested in DFEs, and used statistical imputation to identify the remaining 34.6 percent. For plan year 1996, project team directly identified 75 percent of the $1.3 trillion in plan assets invested in DFEs, and used statistical imputation to identify the remaining 25 percent.

Project Director, Assist Pension and Welfare Benefits Administration in the Analysis of Form 5500 Series Filer Burden (1998 - 1999). Managed the development of a data collection and analysis methodology to update the estimate of Form 5500 filer burden. Coordinated data collection, which included convening a panel of technical experts, conducting in-depth qualitative interviews, and data analysis. Wrote final report for the Office of Management and Budget including discussion of methodology, baseline findings, and analysis of the change in burden between filing years.

Project Director, Employee Retirement Income Security Act Filing Acceptance System (EFAST) (1997 - 1999). Managed development of requirements for EFAST for DOL, PWBA. Evaluated vendor proposals and designed functional requirements and cost estimation methods. Negotiated detailed system requirements from four federal agencies and system quality assurance and quality control. EFAST is a technologically advanced system that replaced the labor-intensive Internal Revenue Service (IRS) procedures for processing Form 5500 Series reports.

Project Director, Employee Retirement Income Security Act Computer Targeting Design Project (1988 - 1997). Designed a computer targeting methodology for PWBA to use 5500 Series data to detect plans in violation of ERISA. Developed program specifications to implement the targeting methodology on the ERISA Information System. Conducted a statistical analysis of the targeting programs for plan years 1988 and 1992 and made recommendations for revising the quality control capabilities of the programs.

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Project Director, Employee Retirement Income Security Act Access System Design and Acceptance Testing Project (1988 - 1997). Designed the user interface for a microcomputer database management system application to retrieve and display ERISA data in PWBA field offices. Managed the development of program specifications and systems acceptance testing and training phases, including the redesign of the ERISA Access System and Update Subsystem logic. Coordinated the systems acceptance testing of various components of the ERISA Information System. Conducted training and developed user manuals and system maintenance guides. Analyzed the number and quality of hits generated, to determine the effectiveness of various targeting programs in detecting plans most likely to have committed some fiduciary violation.

Project Director, Employee Retirement Income Security Act Edit System Design and Development Project (1987 - 1997). Created a data dictionary of all 5500 Series data elements required by the PWBA. Designed a comprehensive series of quality control edit tests to generate correspondence to plan sponsors in order to correct inconsistent or incomplete data. Served as principal liaison between DOL and IRS for the database creation by IRS, and wrote a booklet explaining how all 5500 Series forms should be completed. Designed and implemented a methodology for reviewing the accuracy of IRS processing of 5500 Series data according to PWBA specifications. Coordinated redesign of the processing specifications for plan years 1989 to 1995. Designed and implemented a quality control system for detecting and measuring errors in the identification of 5500 filings. Supervised research of plans participating in DFEs that may have been in violation of reporting requirements.

Project Director, Employee Retirement Income Security Act, Filing Acceptance System Conceptual Design Project (1995 - 1996). Coauthored paper for PWBA, DOL, on justification for seeking to create a new ERISA data processing system outside the IRS. Designed a model to calculate operations cost of the system, by form and function. Managed development of detailed functional requirements.

Expert Witness, Various U.S. Tax Court Petitioners vs. Commissioner of Internal Revenue (1991 - 1992). Provided expert testimony to support the IRS in two U.S. Tax Court cases involving tax court petitioners. Developed expert witness report on the actuarial assumptions used by various actuaries on defined benefit plans from 1984 to 1987, based on data from Schedule B, Form 5500. Produced two rebuttal reports that analyzed methodological flaws in expert witness reports presented by the petitioners.

Project Director, Employee Retirement Income Security Act Research Database Project (1984 - 1992). Designed procedures and managed data processing and editing tasks on a project for PWBA to create a research database of pension and welfare data as reported on Form 5500 for plan years 1981 to 1990. Oversaw quality control editing procedures, including reconciliation of all asset and income and expense data, and coding of actuarial data and the portfolio distribution of plan assets invested in master trust accounts. For plan years 1988 to 1989, designed and implemented a multilevel portfolio distribution system that allocates assets, income, and expenses among DFEs. For plan year 1988, designed and implemented a process to code and analyze all real estate assets held by pension plans. For plan years 1989 to 1990, designed and implemented a system for detecting DFE reporting deficiencies and for computer generating correspondence to filers of DFEs to correct the deficiencies. For a special analysis captured and analyzed all welfare benefits offered by 20,000 plans and assessed how the plans funded the benefits.

Project Director, New Jersey Rooming and Boarding Home Coding Project, New Jersey Bureau of Rooming and Boarding House Standards (1985 - 1986). Directed a project to process data from 3,700 folders that contained all data on rooming and boarding homes in the state. Oversaw all project activities, including budgeting, budget monitoring, coding design, training materials, and training.

Project Manager/Survey Director, Home Banking Interchange (1985 - 1986). Managed all data collection activities in waves 3 and 4, including instrument design, on a market research project on home banking systems for ADP Telephone Computing Service. Also moderated market research focus groups and designed recruitment materials and survey instruments.

Manager and Information Analyst, Litigation Support Coding Project (1983 - 1984). Managed coding and quality control activities, supervising approximately 140 staff members in coding 78,000 lengthy business documents. Developed training materials, trained staff members, served as client liaison, and authorized all coding policy decisions. Also led an extensive database-cleaning effort that involved 400,000 unique personal and organizational names and geographic locations.

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Other

Field Coordinator, Simplified Application Evaluation (1982 - 1983). Hired and trained field interviewers for a survey of 2,000 recipients of Aid to Families with Dependent Children (AFDC) and food stamps for USDA, FNS to assess the effects of integrating and simplifying food stamp application procedures and benefit calculations for AFDC and Supplemental Security Income (SSI) recipients.

Survey Manager, Study of Undocumented Aliens in New York City Hospitals (1982). Managed the field staff in six New York City hospitals in a data collection effort to determine the cost to New York City of providing health care to undocumented aliens. Served as liaison between senior hospital administrators and project staff and participated in database cleaning and analysis (including the coding of medical diagnoses) using the ICD-9 classification system. Coauthored the final report submitted to the New York City Law Department.

Field Coordinator, National Long Term Care Demonstration (1981 - 1982). Hired, trained, and supervised field staff in four sites of a national survey of 10,000 elderly disabled individuals in a study sponsored by DHHS to assess the effects of a case-management intervention to provide community-based care to frail elderly people.

Survey Manager, Food Intake Survey, National Food Stamp Cashout Demonstration (1980 - 1981). Managed a pioneering 24-hour dietary recall telephone survey with 2,500 elderly SSI recipients for FNS. Developed survey procedures, hired and trained survey staff, and supervised the data reduction process.

Analyst, Study of Retirement Policies (1980). Managed the case study component of a national evaluation of mandatory retirement legislation for DOL. Participated in the research design and collection of data from personnel directors of 30 corporations, including AT&T, General Motors, Coca-Cola, and IBM, on personnel practices and labor force composition.

Interviewer, Study of Highway Safety Countermeasures (1979 - 1980). Served as computer-assisted telephone interviewing interviewer and executive interviewer for a national study of public and special interest group opinion on traffic legislation for the National Highway Traffic Safety Administration, U.S. Department of Transportation. Interviewed 30 senior state, corporate, and public interest group officials in three states. Contributed to the final report.

Capitol Text Management

As **Systems Researcher (1977 - 1978),** researched and designed a proposed computerized bill drafting and printing system for state legislatures.

Papers and Publications

Borden, William. "The Challenge of Measuring Performance." In The Workforce Investment Act, Implementation Experiences and Evaluation Findings, edited by D.J. Besharov and P.H. Cottingham. Kalamazoo, MI: Upjohn Institute, 2011.

Borden, William S., Cheryl Camillo, Stephen Kuncaitis, Nathan Myers, Megan Reilly, Cara Weiss, and Amy Wodarek O'Reilly. "Revised Medicaid Statistical Information System: Data Dictionary." Washington, DC: Mathematica Policy Research, April 29, 2011.

Borden, William S., Cheryl A. Camillo, Matthew Potts, Megan Reilly, Cara Weiss, and Amy Wodarek O'Reilly. "Improving the Completeness, Accuracy, and Timeliness of Medicaid Data." Report submitted to the Centers for Medicare & Medicaid Services, Disabled and Elderly Health Programs Group. Princeton, NJ: Mathematica Policy Research, July 13, 2010.

Borden, William S., Cheryl A. Camillo, Megan C. Davis, Henry T. Ireys, Matthew Potts, Megan Reilly, Cara Weiss, and Amy Wodarek O'Reilly. "Medicaid Decision Support System User Requirements and Data Specifications." Report submitted to the Centers for Medicare & Medicaid Services, Disabled and Elderly Health Programs Group. Princeton, NJ: Mathematica Policy Research, January 22, 2010.

Borden, William S., Brandon Kyler, Amy Wodarek O'Reilly, Michael Kerachsky, and Gail Eulenstein. "New York Department of Labor Final UI Benefits and Tax IV & V Report." Princeton, NJ: Mathematica Policy Research, March 2009.

Borden, William S., Brandon Kyler, Amy Wodarek O'Reilly, Michael Kerachsky, and Gail Eulenstein. "District of Columbia Department of Employment Services Final UI Benefits and Tax IV & V Report." Princeton, NJ: Mathematica Policy Research, March 2009.

Borden, William S., Brandon Kyler, Amy Wodarek O'Reilly, Michael Kerachsky, and Gail Eulenstein. "Georgia Department of Labor Final UI Benefits and Tax IV&V Report." Princeton, NJ: Mathematica Policy Research, March 31, 2009.

Borden, William S., Henry T. Ireys, and Amy Wodarek O'Reilly. "Building a Decision Support System for the Disabled and Elderly Health Programs Group: Phase 1, An Information Management Plan." Princeton, NJ: Mathematica Policy Research, February 2009.

Borden, William, and Amy Wodarek O'Reilly. "Ability of MIG Grantees to Report on Program Participation and Outcomes for People with Disabilities: Findings from Four State Site Visits." Princeton, NJ: Mathematica Policy Research, July 18, 2008.

Borden, William S., Thomas Armington, Kevin Conway, Shelly Craig, Terry Cram, Minsong Kim, Jonathan Ladinsky, Tim Liao, Alexander Millar, Matthew Potts, Larry Vittoriano, and Christopher Wilt. "SPARQ Version 3.2 Case Management, Reporting, and Validation Software." Princeton, NJ: Mathematica Policy Research, February 8, 2008.

Borden, William S., Kevin Conway, Shelly Craig, Terry Cram, Amy Wodarek O'Reilly, and Yingying Xu. "SCSEP Data Validation Handbook." Princeton, NJ: Mathematica Policy Research, February 6, 2008.

Borden, William S., Grace F. Roemer, and Amy W. O'Reilly. "MIG Performance and Outcome Data Quality Pilot: State Site Visit Protocol." Princeton, NJ: Mathematica Policy Research, January 24, 2008.

Borden, William S., Kevin Conway, Brandon Kyler, and Amy Wodarek O'Reilly. "Kansas Department of Labor UI Benefits Data Validation IV&V Certification: Final Report." Princeton, NJ: Mathematica Policy Research, January 18, 2008.

Borden, William S., Kevin Conway, Brandon Kyler, and Amy Wodarek O'Reilly. "Rhode Island Department of Labor and Training UI Data Validation IV&V Certification: Final Report." Princeton, NJ: Mathematica Policy Research, January 14, 2008.

Borden, William S., Kevin Conway, Brandon Kyler, and Amy Wodarek O'Reilly. "Texas Workforce Commission UI Benefits Data Validation IV&V Certification: Final Report." Princeton, NJ: Mathematica Policy Research, September 27, 2007.

Borden, William S., Kevin Conway, Brandon Kyler, and Ryan Miller. "Ohio Department of Job and Family Services UI Benefits Data Validation Report." Princeton, NJ: Mathematica Policy Research. May 11, 2007.

Borden, William S., Grace F. Roemer, Yingying Xu, and Tim Liao. "Modeling MIG Goals and Accomplishments." Princeton, NJ: Mathematica Policy Research, January 31, 2007.

Borden, William S., Grace F. Roemer, and Brandon N. Kyler. "Revised ET 406 Data Preparation Handbook: ETA 9002 Report and VETS 200 Report." Princeton, NJ: Mathematica Policy Research, March 2, 2006.

Borden, William S., Grace F. Roemer, and Gail Kohn. "Comparison of Data Validation Software Calculations and UI Required Report Calculations." Princeton, NJ: Mathematica Policy Research, March 3, 2004.

Ladinsky, Jonathan, William S. Borden, and Matthew T. Werner. "OATELS Performance Measurement and Validation Design." Final report. Princeton, NJ: Mathematica Policy Research, February 12, 2004.

Borden, William S., Grace F. Roemer, Michelle J. Van Noy, and Todd Anderson. "UI Performs Final Report." Princeton, NJ: Mathematica Policy Research, November 30, 2003.

Ruben-Urm, Robbi L., and William S. Borden. "UI Benefits Data Validation Handbook (Generic Portions)." Princeton, NJ: Mathematica Policy Research, October 3, 2003.

Borden, William S., and Jonathan Ladinsky. "State Program Data Validation Training Presentation." Washington, DC: Mathematica Policy Research, June 4, 2003.

Borden, William S., Brandon N. Kyler, Nakis Evgeniou, and Robbi L. Ruben-Urm. "UI Benefits Data Validation Software Version 1.5 and Software Users Guide." Princeton, NJ: Mathematica Policy Research, April 4, 2003.

Borden, William S. "Data Validation State Program Training—Utah." Princeton, NJ: Mathematica Policy Research, March 25, 2003.

Borden, William S., Grace F. Roemer, Jonathan Ladinsky, Brandon N. Kyler, Robbi L. Ruben-Urm, Matthew T. Werner, and Nakis Evgeniou. "Welfare to Work Version 1.3 Validation Software, Technical Guidance and User Guide." Princeton, NJ: Mathematica Policy Research, February 13, 2003.

Borden, William S., and Grace F. Roemer. "ETA Validation/Reporting Technical Assistance Assessment." Princeton, NJ: Mathematica Policy Research, December 30, 2002.

Borden, William S., and Charter Oak Group, LLC. "Challenges in Collecting Information on Costs and Services." Final report. Princeton, NJ: Mathematica Policy Research, October 31, 2002.

Borden, William S., and Robbi L. Ruben-Urm. "An Assessment of Computer Matching in the Food Stamp Program." Princeton, NJ: Mathematica Policy Research, January 5, 2002.

Borden, William S., Grace F. Roemer, and Brandon N. Kyler. "Revised ET 406 Data Preparation Handbook: ETA 9002 and VETS 200." Princeton, NJ: Mathematica Policy Research, November 1, 2001.

Borden, William S., and Grace F. Roemer. "Revised Youth Opportunity (YO) Program Reporting and Performance Specifications." Princeton, NJ: Mathematica Policy Research, October 30, 2001.

Borden, William S., Tony Nastek, and Grace Farrell Roemer."1996 Pension Plan and DFE Files." Princeton, NJ: Mathematica Policy Research, September 15, 2001.

Borden, William S., Grace F. Roemer, Brandon N. Kyler, and Robbi L. Ruben-Urm. "DOL ETA Validation Requirements Assessment." Princeton, NJ: Mathematica Policy Research, April 17, 2001.

Borden, William S. "YO MIS Acceptance Test Results." Princeton, NJ: Mathematica Policy Research, January 31, 2001.

Borden, William S., Tony Nastek, and Grace Farrell Roemer. "1994 Pension Plan and DFE Files." Princeton, NJ: Mathematica Policy Research, September 27, 2000.

Borden, William S., and Grace F. Roemer. "Training and Employment Guidance Letter Attachment C: Guidance for Calculating WIA Core Measures." Princeton, NJ: Mathematica Policy Research, March 6, 2000.

Borden, William S., Matthew Haynes, and Grace Farrell Roemer. "Calculating Workforce Investment Act Performance Measurement Indicators." Revised report. Princeton, NJ: Mathematica Policy Research, March 3, 2000.

Borden, William S., Matthew Haynes, Edward Hoke, and Christopher Tallman. "EFAST Deliverables 9-31 Review Binder." Princeton, NJ: Mathematica Policy Research, December 11, 1999.

Borden, William S., Grace F. Roemer, and Robbi L. Ruben-Urm. "The Workforce Investment Act of 1998: Performance Measurement and Data Integrity Issues—Draft Final Report." Princeton, NJ: Mathematica Policy Research, October 29, 1999.

Borden, William S., John Adams, Matthew Haynes, Edward Hoke, Myles Maxfield, Marianne Musone, Tony Nastek, Tom Schrader, Bruce Silver, Chris Tallman, and John Scott Williams. "ERISA Filing Acceptance System (EFAST): Base Period Strengths, Weakness, and Risks of Two Vendors." Princeton, NJ: Mathematica Policy Research, August 23, 1999.

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Borden, William S. "The Pacific Alliance: The United States and Japanese Trade Recovery, 1947-1954." Ph.D. dissertation. Madison, WI: University of Wisconsin-Madison, 1981.

Borden, William S. "The United States and Japanese Trade Recovery, 1950-1952." Paper presented at the MacArthur Memorial Conference on the Occupation of Japan, 1978. Published in the conference proceedings.

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Presentations

Borden, William S. "Evaluation and Performance Management of Job Training Programs: What Can the European Social Fund Learn from the WIA Experience?" Presentation at the Center for International Policy Exchanges Conference, Washington, DC, November 7, 2009.

Borden, William S., and Amy Wodarek O'Reilly. "State Data Capacity to Report on MIG Progress." Presentation at the Medicaid Infrastructure Grant/Demonstration to Maintain Independence and Employment Summit: Melding Data and Policy, New Orleans, April 22, 2008.

Borden, William S. "Native American Program Data Validation." Presentation at the Midwest Native American Employment and Training Conference, New Orleans, September 23, 2003.

Borden, William S., and Jonathan Ladinsky. "State Program Data Validation Training." Presentation at the Midwest Native American Employment and Training Conference, New Orleans, June 4, 2003.

Borden, William S. "The National Perspective on Measuring System Success." Presentation at the One Step Conference, Anaheim, CA, August 2002.

Hoke, Edward W., and William S. Borden. "ERISA Filing Acceptance System (EFAST) Technical Requirements." Pre-proposal conference presentation. U.S. Department of Labor, Washington, DC, November 12, 1997.

Borden, William S. "The United States and Japan in Southeast Asia, 1947-1954." Paper presented at the Amherst International Conference on the Occupation of Japan, 1980.

Professional Membership

American Society for Quality

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MATHEMATICA
Policy Research

Jill Bernstein
Senior Researcher

Education

1980	Ph.D., Sociology, Columbia University
1976	M.Phil, Columbia University
1975	M.A., Columbia University
1973	B.A., Sociology, magna cum laude, Carleton College

Positions

2011 -	Mathematica Policy Research
2010 - 2011	Senior Policy Analyst, Center for Studying Health System Change, Washington, DC
2006 - 2010	Consultant, Silver Spring, MD
2006	Research Director, The Citizens' Health Care Working Group, Bethesda, MD
2002 - 2006	Research Director/Principal Policy Analyst, Medicare Payment Advisory Commission, Washington, DC
2001 - 2002	Senior Policy Adviser, Public Policy Institute, AARP, Washington, DC
1997 - 2001	Director of Health Policy Studies, National Academy of Social Insurance, Washington, DC
1990 - 1996	Agency for Health Care Policy and Research, Rockville MD
1990 - 1996	Branch Chief for Program Policy, Research Development and Evaluation
1993 - 1996	Deputy Director, Office of Program Evaluation
1988 - 1990	Senior Analyst, Physician Payment Review Commission, Washington, DC
1983 - 1988	Project Manager, Program Evaluation and Methodology Division, U.S. General Accounting Office, Washington, DC
1980 - 1983	Senior Social Scientist, Advanced Technology, Inc., Reston, VA
1976 - 1979	Assistant Project Director, Graduate School of Business, Columbia University, New York, NY

Experience

Center for Studying Health System Change (HSC)

As **Senior Policy Analyst (2010 - 2011),** directed projects focused on public and private sector health policy issues including insurance coverage and benefit design, market variations in health care spending and use of health services, and payment policy. Also participated in the design of HSC policy studies addressing health care reform and implementation.

Consultant

As **Consultant (2006 - 2010),** performed consulting services for private and public sector organizations on policy-relevant health care issues of coverage, costs, quality, and access to care. Conducted research syntheses, policy syntheses and policy analysis, health services research project development and management, and evaluation studies. Clients included Harvard Medical School, Department of Health Care Policy; Economic Systems, Inc.; National Academy of Public Administration/National Academy of Social Insurance (NASI); Paraprofessional Health Care Institute; AcademyHealth; Robert Wood Johnson Foundation Changes in Health Care Organization & Financing program; Kleimann Communication Group, Inc.; and Mathematica.

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The Citizens' Health Care Working Group

As **Research Director (2006),** directed staff research and coordinated with the Working Group in all stages of the production of the congressionally mandated Health Care Report to the American people. Coordinated staff work supporting the Working Group's efforts to develop policy recommendations submitted to the president and the Congress in September 2006. Performed analytic work including the development of policy syntheses, and the analysis of the quantitative and qualitative data from community meetings, hearings, multiple structured and open-ended on-line and paper polls; written narratives; and secondary data sources for use by the Working Group in developing its recommendations "Health Care That Works for All Americans: Dialogue With the American People."

Medicare Payment Advisory Commission (MedPAC)

As **Research Director/Principal Policy Analyst (2002 - 2006),** conducted policy research and analysis on Medicare topics including Medicare benefits, Medigap and employer-sponsored supplemental insurance, and Medicare Advantage, beneficiary costs of care, out-of-pocket liability, and access to care. Examined physician payment issues including private sector purchasing strategies and practice expenses issues associated with payment for nonphysician practitioners. Provided technical and administrative support to the director and deputy on MedPAC research contracts, recruited and screened job applicants, and mentored research assistants.

Public Policy Institute, AARP

As **Senior Policy Adviser (2001 - 2002),** planned and conducted original research projects on health care expenditures, Medicare reform, and health care organization and management. Reviewed and analyzed legislative proposals and draft testimony. Made presentations within AARP and to external organizations on research and policy topics. Provided guidance to staff on technical and methodological issues in research design and data analysis and mentored junior staff.

National Academy of Social Insurance

As **Director of Health Policy Studies (1997 - 2001),** served as coprincipal investigator for Medicare research projects, including NASI's multiyear project, Making Medicare Restructuring Work: Policy Decisions for the Next Decade, and projects exploring Medicare and managed care and the experiences of Medicare beneficiaries with HIV/AIDS in California. Planned and conducted original quantitative research, focus groups, and surveys and arranged for the commissioning of research and policy analyses, worked with panel chairs to recruit research and policy experts from throughout the United States to serve on panels, and drafted research syntheses and papers for peer-reviewed publications. Directed staff work for three expert study panels (Capitation and Choice in Medicare, Medicare's Larger Social Role, and Medicare and Markets) and for the NASI Medicare Steering Committee. Provided technical support to other NASI Medicare study panels, supervised junior staff and interns, worked with senior staff on health and income security issues associated with other NASI work, and planned policy conferences. Provided briefings and coordinated communications on health policy and research matters to NASI members; the health services research community; congressional staff; and staff from the U.S. Department of Health and Human Services, Office of the Secretary and Health Care Financing Administration (HCFS).

Agency for Health Care Policy and Research (AHCPR)

As **Branch Chief for Program Policy, Research Development and Evaluation (1990 - 1996),** managed professional and administrative staff. Actively contributed to planning and research development; drafted and reviewed policy papers, reports, and analyses of program issues, and statements of AHCPR research priorities; and organized conferences and workshops on program initiatives. Conducted program reviews, recruited staff, supported the director and the Office of the Administrator at meetings, and represented AHCPR on senior-level workgroups convened by the U.S. Department of Health and Human Services and other agencies such as the U.S. General Accounting Office (GAO). Served on the department-wide Medicaid 1115 Demonstration Waiver Review Group and coordinated with the Health Care Financing Agency (HCFA) on AHCPR review of Medicaid managed care waiver proposals. Served as the general program issues contact for AHCPR's Small Project Grant Program. Provided technical assistance in the development of congressional testimony and budget presentations and provided planning assistance to extramural research staff. Provided policy and technical oversight to all agency-wide evaluation projects, and served as Associate Director (Acting), in the Center for Outcomes and Effectiveness Research from 1995 to 1996.

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As **Deputy Director (1993 - 1996),** coordinated office work involving agency-wide planning, evaluation, and policy implementation activities.

Physician Payment Review Commission (PPRC)

As **Senior Analyst (1988 - 1990),** conducted policy research and policy development focused on beneficiary issues; served on the Technical Advisory Committee convened to plan Medicare's Medicare Current Beneficiary Survey; and served as project officer for the PPRC Survey of Medicare Beneficiaries addressing beneficiaries' experience with and understanding of Medicare insurance provisions. Oversaw staff work leading to PPRC recommendations related to quality and utilization review and to policies for reforming Medicare assignment policies in conjunction with a broader program of physician payment reform. Coordinated PPRC staff work on organizational and administrative issues related to the development of national and subnational volume performance standards for Medicare physician services; the adequacy and equity of Medicaid physician payment; and issues related to beneficiary protection, Medicare assignment policies; and the financial burdens associated with medical care.

U.S. General Accounting Office

As **Project Manager (1983 -1988),** conducted evaluations of federal health care programs including a quantitative model of the effectiveness of the Medicare Peer Review Organizations in assuring the quality of care provided to Medicare beneficiaries; an evaluation of medical care quality assessment and quality assurance programs conducted in all parts of the Medicare program; and an assessment of HCFA efforts to develop information on the effects of the Medicare prospective payment system for inpatient hospital care on the use, cost, and quality of posthospital subacute care services. Served as a consultant on a GAO study examining hospital discharge planners' experiences placing Medicare patients in appropriate posthospital care and an analysis of catastrophic health insurance legislative proposals. Participated in a study of financing, utilization, and quality issues in Medicaid nursing home services. Planned and coordinated inter-Divisional GAO health care projects.

Advanced Technology, Inc.

As **Senior Social Scientist (1980 - 1983),** managed data analysis for a multiyear, multicomponent evaluation and redesign of quality control systems in the Pell Grant program conducted under a contract from the U.S. Department of Education, Office of Student Financial Aid.

Columbia University

As **Assistant Project Director (1976 - 1979),** completed research and drafted study report for the U.S. Department of Labor study of alternative work schedules (flexible and compressed workweeks). Served as a research assistant for a project evaluating the effects of automation on union structure, contract provisions, and workers' decisions to retire in the New York City printing industry. Supervised interviewers for a study designed to evaluate the effectiveness of government decentralization on the delivery of community services (initiated at the Bureau of Applied Social Research, Columbia University).

Papers and Publications

Bernstein, Jill, James D. Reschovsky, and Chapin White. "Geographic Variations in Health Care: Changing Policy Directions. NIHCR Policy Analysis no. 4. Washington, DC: National Institute for Health Care Reform, April 2011.

Bernstein, Jill. "The Elusive Benefits of Chronic Care Management." *Archives of Internal Medicine,* vol. 171, no. 5, March 2011, pp. 7-8.

Bernstein, Jill. "Recognizing Destabilization in the Individual Health Insurance Market." Robert Wood Johnson Foundation, Changes in Health Care Financing & Organization Issue Brief. *AcademyHealth,* online article, July 2010.

Bernstein, Jill, Deborah Chollet, Deborah Peikes, and G. Gregory Peterson. "Medical Homes: Will They Improve Primary Care?" Reforming Health Care, Issue Brief no. 6. Princeton, NJ: Mathematica Policy Research, May 2010.

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Bernstein, Jill, Deborah Chollet, and G. Gregory Peterson. "Disease Management: Does It Work?" Reforming Health Care, Issue Brief no. 4. Princeton, NJ: Mathematica Policy Research, May 2010.

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Bernstein, Jill, and Robert D. Reischauer (eds.). "Restructuring Medicare: Next Steps." Report of the National Academy of Social Insurance Medicare Steering Committee. Washington, DC: National Academy of Social Insurance, January 2000.

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Bernstein, Jill, and Joseph Newhouse (eds.). "Structuring Medicare Choices." Final Report of the Study Panel on Medicare Capitation and Choice. Washington, DC: National Academy of Social Insurance, April 1998.

Bernstein, Jill. "Clinical Practice Guidelines: Applications and Implications" Presentation to the National Health Lawyers Association Annual Meeting, April 1994. In *National Health Lawyers Association Health Law* on CD ROM, 1996.

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Rice, Thomas, and Jill Bernstein. "Volume Performance Standards: Can They Control Growth in Medicare Services?" *The Milbank Quarterly,* vol. 68, no. 3, 1990, pp. 295-319.

Van Gelder, Susan, and Jill Bernstein. "Home Health Care in the Era of Prospective Payment: Some Early Evidence and Some Thoughts About the Future." *Pride Institute Journal of Long Term Home Health Care,* vol. 6, no. 1, winter 1986, pp. 3-16.

Bernstein, Amy B., and Jill Bernstein. "Data on Home Health Care Services in the United States: What We Know and What We Need to Find Out." *International Journal of Technology Assessment in Health Care,* vol. 1, no. 2, 1985, pp. 451-462.

Bernstein, Jill, and Nathalie S. Friedman. "The Union in Transition." In *Printers Face Automation: The Impact of Technology on Work and Retirement Among Skilled Craftsmen,* edited by Theresa Rogers and Nathalie Friedman. Boston: Lexington Health, 1980.

Presentations

Bernstein, Jill. "Public Views of Health System Reform." Presentation at the Health Care Coverage Symposium, Arlin M. Adams Center for Law and Society, Selinsgrove, PA, March 26, 2009.

Jill Bernstein. "Guideline-Based Quality Measures." Presentation to the Leadership Conference, Health Standards and Quality Bureau, Health Care Financing Administration, Baltimore, July 27, 1994.

Bernstein, Jill, and Jean Slutsky. "Improving Quality of Care: The Development and Uses of Clinical Practice Guidelines and Medical Review Criteria." Presentation at the Agency for Health Care Policy and Research User Liaison Program Workshop for Senior State Officials, "Medical Effectiveness Research, Clinical Practice Guidelines and Practice Pattern Profiling: Implications for State Government," December 1993 and July 1994.

Bernstein, Jill, Barbara Else, Sandra Robinson, and Stephen King. "Quality Assurance/Quality Improvement in Federal Health Care Programs." Conference paper presented at the American Medical Review Research Center Annual Research Symposium, Crystal City, VA, November 1992.

Bernstein, Jill. "Identifying Data Sources and Their Uses: Medicare Part B Payment Data." Presentation at the National Working Forum on Outcomes Data and Quality of Care, American Medical Review Research Association Annual Research Symposium, Outcomes, Evaluation and Effectiveness in the 1990s, Atlanta, November 1, 1989.

Bernstein, Jill. "Expenditure Targets: Drastic Physician Payment Reform?" Presentation at the Part B Alert Conference, Washington, DC, October 1989.

Bernstein, Jill, and Roger Straw. "Evaluating the Effects of PPS on Long-Term Care: The Federal Role." Presentation at the American Public Health Association Annual Meeting, Washington, DC, November 18, 1985.

Professional Activities

1996 -	Ad hoc reviews *Medicare Care;* occasional reviews for other journals, including *Health Services Research, Health Affairs*
1992 - 2009	Editorial Board, *Medical Care Research & Review*

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MATHEMATICA
Policy Research

Timothy Lake

Associate Director of Health Research and Senior Researcher

Education

2000	Ph.D., Health Services Research, School of Hygiene and Public Health, The Johns Hopkins University
1991	M.P.P., Public Policy, University of Michigan
1987	B.A., American Studies, cum laude, Amherst College

Positions

1991 -	Mathematica Policy Research
2011 -	Associate Director of Health Research
2007 - 2010	DC Health Analyst Supervisor
2004 -	Senior Researcher
1996 - 2004	Health Researcher
1991 - 1996	Research Analyst
1987 - 1989	Project Analyst, Center for Cost-Effective Care, Brigham and Women's Hospital, Boston, MA

Experience

Mathematica

Project Director, Design of a Medicare Access Monitoring System (2010 -). Provide technical assistance and consultation to Kennell and Associates in designing a claims-based, access-to-care monitoring system for Medicare beneficiaries, as part of a project for the Centers for Medicare & Medicaid Services (CMS).

Senior Researcher, Federal Facilitation of the Patient Centered Medical Home (PCMH) Model (2010 -). Assist with analysis and writing white papers on PCMH and its relation to accountable care organizations (ACOs) and the concept of a medical neighborhood.

Project Director, Case Studies of Accountable Care Organizations and Independent Practice Associations (2009 -). Direct a project in collaboration with the Center for Studying Health System Change (HSC) to conduct 12 to 16 case studies of provider organizations that serve as potential models for ACOs and/or are facilitating adoption and use of health information technology for care improvement purposes. This project is funded by the National Institute for Health Care Reform.

Coprincipal Investigator, Strategies for Reducing Hospital Readmissions in New York State (2009 -). Conduct a study for the New York State Health Foundation to identify and simulate the effects of payment and clinical intervention strategies to reduce rates of hospital readmissions in the state of New York.

Task Leader, Evaluation of the Healthy Indiana Plan (2009 -). Lead or advise on tasks for an evaluation for the state of Indiana of a program to expand Medicaid coverage to Indiana residents. Tasks include an assessment of the first year of implementation of the program and a claims data analysis of use and cost of services during the first year.

Task Leader, Development of Resource Use Reports for Medicare Fee-for-Service Claims (2008 -). Led a task to develop utilization and cost-of-service category statistics in Medicare cost and quality feedback reports to physicians. Lead a task to provide technical support to CMS in the design of a Medicare ACO program.

Project Director, Disparities in Preventable Hospitalizations Among Maryland Medicare Beneficiaries (2008 -). Lead a project sponsored by the Maryland Health Care Commission to generate hospitalization rates for ambulatory care sensitive conditions among fee-for-service Medicare beneficiaries living in Maryland. The project examines differences in hospitalization rates according to beneficiaries' racial, socioeconomic, and geographic characteristics.

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Task Leader, Defining and Identifying Efficient Medicaid Spending in United States (2008 - 2010). Oversaw identification and analysis of state-level quality measures for a project for the U.S. Department of Health and Human Services (DHHS), Office of the Assistant Secretary for Planning and Evaluation, to assess the efficiency of state Medicaid programs nationwide.

Project Director, Analysis of Medicare Advantage (MA) Enrollment and Disenrollment (2008 - 2009). Directed a project under a subcontract with L&M Policy Research for CMS to examine factors affecting Medicare beneficiaries' enrollment and disenrollment from MA plans.

Deputy Project Director, Development of Physician and Other Clinician Quality Measures (2007 - 2008). Led a project team including two subcontractors—the American Medical Association and the National Committee for Quality Assurance—to develop and test additional physician and other clinician quality measures in support of the Physician Quality Reporting Initiative (PQRI) sponsored by CMS.

Principal Investigator, Evaluation of the Agency for Healthcare Research and Quality (AHRQ) Grant-Supported Research on Health Care Costs, Productivity, and Market Forces (2006 - 2008). Led an analysis of the effects of AHRQ grants supporting research on health care costs and market forces for AHRQ. This study involved document review, convening an expert panel, and conducting case study interviews with grantees and experts in the field.

Project Director, Site Visit Study of Private Health Plans' Use of Efficiency and Quality Measures (2007). Collaborated with Medicare Payment Advisory Commission (MedPAC) staff to conduct site visits to four health plans and affiliated physician groups to understand their experiences with use of quality measures and episode group-based efficiency measures in provider network arrangements. Led writing of the final report.

Senior Researcher, Develop Strategies for the Physician Voluntary Reporting Program (PVRP) Validation Methodology, Cost Estimates, and Impact on Underserved Areas (2006 - 2007). Performed qualitative interviewing and analysis, reviewed literature, and convened an expert panel meeting. Participated in a task for PVRP (now known as PQRI) to explore the challenges of performance reporting and potential pay-for-performance approaches for physicians who treat vulnerable or underserved populations.

Task Leader, Development of Physician Quality Measures (2006 - 2007). Led a task to assess operational issues associated with physician practices participating in PVRP. Led discussions with physician practices to examine how they report quality measures on Medicare claims, and what issues they faced, in this study for CMS.

Senior Researcher, Evaluation of Medicare Advantage Special Needs Plans (SNPs) (2005 - 2007). Conducted health plan site visits for the implementation analysis for the evaluation of SNPs for Medicare beneficiaries in managed care who are also eligible for Medicaid, have chronic or disabling conditions, or are permanent nursing home residents. Mathematica provided an overview of all plans operating in 2006, and in-depth descriptions of a subset of plans, to inform CMS's decision to extend the plans beyond 2008.

Project Director, Study of What Constitutes a Viable, High-Quality Provider Network in TRICARE (2004 - 2006). Led a study for the U.S. Department of Defense (DoD) to assess issues related to the adequacy of the civilian provider network and access to care for TRICARE beneficiaries. Submitted a final report to DoD and briefed senior management at the TRICARE Management Activity on study findings. The study included a literature review, interviews with DoD and health plan contractor staff, and analysis of TRICARE survey and administrative data.

Senior Researcher, Setting Future Directions: Evaluating Efforts by the Consumer Assessment of Healthcare Providers and Systems (CAHPS) and Survey User Network Projects to Measure and Report on Health Care Quality (2004 - 2006). Conducted a literature review of recent studies of the use of quality information for consumer decision making and quality improvement activities, with a focus on CAHPS survey-based reporting efforts. Assisted in identification and review of models of public-private partnerships applicable to strategic planning efforts within AHRQ.

Task Leader, Medicare Quality Monitoring System (2002 - 2006). Produced measures of hospitalizations for ambulatory-care-sensitive conditions and quality of care for diabetes using Medicare claims data from 1992 to 2001, led task to calculate mortality rates and relative risk of mortality associated with diabetes from 1992 to 2003, and conducted an analysis of the use and cost of diagnostic imaging services from 1999 to 2004. Analyzed patient health status information submitted on physician claims for anticancer chemotherapy services in 2005 as part of a large-scale quality monitoring project for CMS.

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Deputy Project Director, Evaluation of the California HealthCare Foundation (CHCF) Quality Measurement and Reporting Projects (2002 - 2006). Led the telephone interviewing task, and interviewed/profiled organizations, including Medicare + Choice ([M+C] now MA) plans, hospitals, and nursing homes for a study of a multifaceted, quality-reporting initiative in California. Led a second round of interviews with stakeholders and leaders involved in national quality measurement and reporting activities to assess how California's efforts fit with national and other state-level efforts.

Senior Researcher, Diabetes Control and Quality of Care Measurement for the State of Maryland (2004 - 2005). Contributed to the design and analysis of diabetes quality of care measures using Medicare claims data. Served as acting project director at the conclusion of the project, and briefed Maryland officials on the results of the study for a project sponsored by the state of Maryland.

Task Leader, Evaluation of California's Mental Health Parity Law (2001 - 2005). Oversaw a case study task for an evaluation of the mental parity law in California. Led site visits to three California communities to interview mental health providers, county mental health agencies, consumer advocates, and other stakeholders. Conducted telephone interviews with health plan executives for this study sponsored by DHHS, Substance Abuse & Mental Health Services Administration (SAMHSA).

Principal Investigator, Targeted Survey on Access to Physician Services Among Medicare Beneficiaries (2002 - 2004). Conducted analysis of a targeted Medicare beneficiary survey conducted in 2003 and 2004, which used selected Medicare CAHPS questionnaire items. Conducted analysis of existing Medicare CAHPS fee-for-service data and other data sources for selection of areas that were most likely to be experiencing Medicare physician access problems following cuts in Medicare physician payments. Led analysis and report writing on two reports for this CMS-sponsored project.

Researcher, Evaluation of the Program for Elders in Managed Care (2002 - 2004). Synthesized findings on outcomes associated with multiple demonstration projects that were testing new care management and disease management approaches for coordinating services to frail elders in California. The study was sponsored by CHCF.

Deputy Project Director, Lessons from Medicare + Choice (2001 - 2002). Led an analysis of factors relating to health plan withdrawals from the Medicare program from 1999 to 2001. Collaborated on an analysis of the lessons from California's experience with M+C. This project was sponsored by the Henry J. Kaiser Family Foundation.

Project Director, Snapshot Study of California's Mental Health Parity Law (2001 - 2002). Directed a study of the implementation of California's parity law during the first year, sponsored by CHCF. Interviewed key stakeholders about their experiences with the new law.

Researcher, Evaluation of the Effects of the Vermont Parity Act (1999 - 2002). Led a site visit to Vermont and drafted the case study chapter in the final report. This project, sponsored by DHHS, SAMHSA, assessed the effects of Vermont's mental health/substance abuse parity law on utilization, access, and spending.

Task Leader, Design of an Evaluation of California's Mental Health Parity Law (2000 - 2001). Led efforts to develop the background information necessary for designing a mental health parity law for a project sponsored by DHHS, SAMHSA. Conducted a site visit to northern California to obtain perspectives of key stakeholders on important research questions, methods for conducting an evaluation, and implementation issues relevant to the evaluation design.

Researcher, Medicare + Choice Monitoring and Evaluation System (2000 - 2001). Conducted an analysis of Medicare CAHPS and Health Plan Employer Data and Information Set data to understand how performance of M+C organizations changed over time in 69 metropolitan areas. The analysis was part of the development and implementation of a monitoring system for the M+C system, under a project sponsored by CMS.

Researcher, Community Tracking Study (CTS) Site Visits (2000 - 2001). Participated in site visits to three communities to study health system changes. Collected information on health care providers. Led an analysis of trends in hospital-physician relationships. The study, conducted by HSC, was sponsored by the Robert Wood Johnson Foundation (RWJF).

Task Leader, Review of Health Plans' Selection and Payment of Providers (1998 - 2000). Led analysis of national survey data on health plans' provider contracting practices. Conducted a literature review of previous research. The study was sponsored by MedPAC.

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Researcher, Study of the Effects of Health Maintenance Organizations (HMOs) on Access to Care, Satisfaction, and Use of Services (1997 - 1999). Collaborated with research staff from HSC to assess the effects of HMOs on health care services. Led the analysis of effects on satisfaction with care. The analysis, funded by RWJF, used data from the CTS Household Survey.

Researcher, Evaluation of the Medicare Choices Demonstration (1997). Designed the implementation analysis and led site visits for an evaluation of the Medicare Choices demonstration, sponsored by DHHS, Health Care Financing Administration (HCFA). The demonstration tested whether new forms of managed care can be applied to the Medicare program, as well as the effects of several new payment arrangements between HCFA and health plans participating in the demonstration.

Analyst, Evaluation of Implementation of the Ambulatory Patient Groups Payment System (1995 - 1997). Served as an analyst on a project for DHHS, HCFA to assess efforts by the Iowa Medicaid program and two commercial insurers to implement a new outpatient payment system. Assisted with the development of an evaluation design report. Conducted site visits. Conducted telephone interviews with health plan managers about other methods used for outpatient payment. Authored paper on findings from interviews.

Analyst, Study of Evolving Health Care Markets and Medicare (1994 - 1996). Provided analytic support on a project to assist the Physician Payment Review Commission (PPRC) in planning a study of changing health markets and the implications for Medicare. Oversaw logistics and budgeting for expert panel meeting to advise commission staff on key research issues related to the Medicare market.

Project Manager and Analyst, Study of Arrangements Between Managed Care Organizations and Physicians (1993 - 1996). Participated in the development and analysis of a national survey of 108 managed care plans about the arrangements they make with physicians. Designed and conducted an analysis of variation in managed care practices across different U.S. markets. Assisted with a literature synthesis of managed care arrangements. Handled planning and logistics for two expert advisory panel meetings. Conducted a site visit to obtain survey response details. Monitored project costs and progress on this project for PPRC.

Principal Investigator and Project Manager, Study of Delaware's Health Insurance Reforms (1994 - 1995). Conducted site visits and telephone interviews with health insurance executives and other key parties in Delaware to assess anticipated effects of recent state health insurance market reforms. Organized and attended four focus group discussions with small employers to assess their awareness of, and opinions about, the reforms in a project for the Delaware Health Care Commission. Conducted site visits to collect information on health benefits, premiums, and marketing activities. Coauthored reports and briefed the commission.

Analyst, Evaluation of the Essential Access Community Hospital (EACH)/Rural Primary Care Hospital (RPCH) Program (1992 - 1995). Conducted hospital site visits and interviewed state officials. Developed hospital payment simulation model and conducted analyses of hospital cost report and claims data. Served as an analyst on a project sponsored by DHHS, HCFA to evaluate the impact of establishing networks of EACH hospitals and limited-licensure RPCHs on the delivery and cost of rural health care.

Analyst, Study of Health Maintenance Organization Primary Care Practitioner Staffing Patterns (1993 - 1994). Conducted site visits to four HMOs to learn how they design and implement strategies for development of their primary care networks, for this project for DHHS, Health Resources and Services Administration (HRSA). Wrote summaries of information gathered at each HMO.

Project Manager and Analyst, Evaluation of the Medicare Physician Preferred Provider Organization (PPO) Demonstration (1992 - 1994). Provided analytic and management support on a project sponsored by DHHS, HCFA to evaluate demonstration Medicare PPOs. Drafted sections of a final report on implementation issues at the demonstration sites. Monitored monthly project progress and research costs.

Project Manager and Analyst, Design of an All-Payer System of Price and Utilization Controls for the State of Minnesota (1993). Provided analytic and management support on a project to assist the state of Minnesota in designing a regulated all-payer system as part of its health reform strategy. Interviewed staff from state government, insurers, and trade associations about experiences with health care payment systems. Wrote a chapter on system governance in a recommendations report. Monitored project costs and progress.

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Analyst, Cost Implications of Managed Competition (1993). Conducted a literature review for U.S. Healthcare to examine the potential cost effects of managed competition. Reviewed the research literature on price elasticities of demand for health insurance and health care services and on cost differences between different health care delivery and financing systems.

Analyst, Review and Analysis of Health Care Cost-Containment Efforts and Impact on Cost, Quality, and Access to Health Care (1993). Conducted a literature review of the effects of Medicare hospital and physician payment reform on the health care system. Helped draft a background paper to support meetings between senior U.S. Public Health Service (PHS) and DHHS, HCFA officials and experts in health care policy.

Analyst, Municipal Health Services Program (MHSP) Evaluation (1992 - 1993). Coordinated with HCFA staff and staff at Medicare Part B carriers to collect and process claims data in order to construct an analysis file for comparing the experience of MHSP users with a comparison group. Drafted sections of the final report. This research project was sponsored by DHHS, PHS, HCFA to estimate the impact of Medicare waivers for MHSP health centers on Medicare expenditures and the quality of care.

Analyst, Assessing the Completeness of No-Pay Billing Data on Medicare Health Maintenance Organization Enrollees (1991 - 1992). Oversaw data analysis and programming to compare hospitalization rates represented by no-pay billing data with rates calculated from other sources, including HMO records and survey information collected by Mathematica. Drafted a final report. This project for DHHS, PHS, HCFA assessed the completeness and representativeness of no-pay billing data submitted by hospitals for the care of Medicare HMO enrollees.

Analyst, Evaluation Design for the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, Title I and Title II Grant Programs (1991). Reviewed and summarized issues presented in reports and journal articles as part of an analysis of data linkage and confidentiality issues relevant to the Ryan White program. Drafted a technical assistance document that described data linkage and confidentiality issues. Provided research support on a project sponsored by DHHS, HRSA to develop an evaluation design for Titles I and II of the Ryan White CARE Act.

Brigham and Women's Hospital

As **Project Analyst (1987 - 1989)** for the Center for Cost-Effective Care, managed a patient database for the hospital, generating written and statistical reports that summarized utilization statistics for all inpatient clinical services. Conducted analyses of hospital utilization trends, providing analytic support for hospital cost-containment efforts. Prepared market-share analyses based on the characteristics of patients in the Boston area.

Papers and Publications

Journal Articles

O'Neil, Sasigant So, Timothy Lake, Angela Merrill, Ander Wilson, David Mann, and Linda Bartnyska. "Racial Disparities in Hospitalizations for Ambulatory Care Sensitive Conditions." *American Journal of Preventive Medicine,* vol 38, no. 4, April 2010, pp. 381-388.

Rosenbach, Margo, Timothy Lake, Susan Williams, and Jeffrey Buck. "Implementation of Mental Health Parity: Lessons from California." *Psychiatric Services,* vol. 60, no. 12, December 2009, pp. 1589-1594.

Gold, Marsha, Timothy Lake, William E. Black, and Mark Smith. "Challenges in Improving Care for High-Risk Seniors in Medicare: Lessons and Observations from Past Demonstrations." *Health Affairs,* Web Exclusive, April 26, 2005.

Casalino, Lawrence, Kelly Devers, Timothy Lake, Marie Reed, and Jeffrey Stoddard. "Benefits of and Barriers to Large Medical Group Practice in the United States." *Archives of Internal Medicine,* vol. 163, no. 16, September 8, 2003, pp. 1958-1964.

Lake, Timothy, Kelly Devers, Linda Brewster, and Lawrence Casalino. "Something Old, Something New: Recent Developments in Hospital-Physician Relationships." *Health Services Research,* vol. 38, no. 1, part 2, February 2003, pp. 471-488.

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Devers, Kelly J., Lawrence P. Casalino, Liza S. Rudell, Jeffrey J. Stoddard, Linda R. Brewster, and Timothy K. Lake. "Hospitals' Negotiating Leverage with Health Plans: How and Why Has It Changed?" *Health Services Research,* vol. 38, no. 1, part 2, February 2003, pp. 419-446.

Hurley, Robert, Joy Grossman, Timothy Lake, and Lawrence Casalino. "A Longitudinal Perspective on Health Plan-Provider Risk Contracting." *Health Affairs,* July/August 2002.

Gold, Marsha R., Timothy Lake, Robert Hurley, and Michael Sinclair. "Financial Risk Sharing with Providers in Health Maintenance Organizations, 1999." *Inquiry,* vol. 39, no. 1, spring 2002, pp. 34-44.

Lake, Timothy, Marsha Gold, and Robert Hurley. "HMO Provider Networks in Medicare+Choice: Comparing Medicare and Commercial Lines of Business." *Managed Care Quarterly,* vol. 9, no. 4, autumn 2001, pp. 16-22.

Gold, Marsha R., Robert Hurley, and Timothy Lake. "Provider Organizations at Risk: A Profile of Major Risk-Bearing Intermediaries, 1999." *Health Affairs,* March/April 2001.

Lake, Timothy. "Do HMOs Make a Difference? Consumer Assessments of Health Care." *Inquiry,* vol. 36, no. 1, winter 1999/2000, pp. 411-418.

Lake, Timothy. "Current Trends in Health Plan Payment Methods for the Facility Costs of Outpatient Services." *Journal of Health Care Finance,* vol. 25, no. 2, winter 1998, pp. 1-8.

Gold, Marsha, Robert Hurley, Timothy Lake, Todd Ensor, and Robert Berenson. "A National Survey of the Arrangements Managed Care Plans Make with Physicians." *New England Journal of Medicine,* vol. 333, no. 25, December 21, 1995.

Gold, Marsha, Lyle Nelson, Timothy Lake, Robert Hurley, and Robert Berenson. "Behind the Curve: A Critical Assessment of How Little Is Known About Arrangements Between Managed Care Plans and Physicians." *Medical Care Research and Review,* vol. 52, no. 3, September 1995.

Gold, Marsha, Karyen Chu, Suzanne Felt, Mary Harrington, and Timothy Lake. "Research on the Effects of Selected Health Care Cost-Containment Efforts Involving Price Controls: 1971 to the Present." *Health Care Financing Review,* vol. 14, no. 3, spring 1993.

Briefs

Lake, Timothy K., Tricia Collins Higgins, and Paul Ginsburg. "Fostering Health Information Technology in Small Physician Practices: Lessons from Independent Practice Associations." Research Brief no. 5. Washington, DC: National Institute for Healthcare Reform, June 2011.

Taylor, Erin Fries, Timothy Lake, Jessica Nysenbaum, Greg Peterson, and David Meyers. "Coordinating Care in the Medical Neighborhood: Critical Components and Available Mechanisms." AHRQ Publication No. 1100-64. Rockville, MD: Agency for Healthcare Research and Quality, June 2011.

Lake, Timothy, Kate Stewart, and Paul Ginsburg. "Lessons from the Field: Making Accountable Care Organizations Real." Research Brief no. 2. Washington DC: National Institute for Health Care Reform. January 2011.

Lake, Timothy, Vivian Byrd, and Seema Verma. "Healthy Indiana Plan: Lessons for Health Reform." Issue Brief no. 1. Washington DC: Mathematica Policy Research, January 2011.

Myers, David, Debbie Peikes, Janice Genevro, Greg Peterson, Erin Taylor, Timothy Lake, Kim Smith, and Kevin Grumbach. "Roles of Patient-Centered Medical Homes and Accountable Care Organizations in Coordinating Care." AHRQ Publication No. 11-M005-EF. Rockville, MD: Agency for Healthcare Research and Quality, December 2010.

Esposito, Dominick, Arnold Chen, Margaret Gerteis, and Timothy Lake. "Using Comparative Effectiveness Research: Information Alone Won't Lead to Successful Health Care Reform." Topics in Health Care Effectiveness, Issue Brief no. 2. Princeton, NJ: Mathematica Policy Research, December 2010.

Barrett, Allison, and Timothy Lake. "Provider Payment: Trends and Methods in the Massachusetts Health Care System." Publication number 10-43-HCF-02. Boston: Division of Health Care Finance and Policy, February 2010.

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Pham, Hoangmai, Paul Ginsburg, Timothy Lake, and Myles Maxfield. "Episode-Based Payments: Charting a Course for Health Care Payment Reform." Policy Analysis no. 1. Washington DC: National Institute for Health Care Reform, January 2010.

O'Neil, So, Angela Merrill, Ander Wilson, and Timothy Lake. "Differences in Hospitalizations for Ambulatory Care Sensitive Conditions for Maryland Medicare Beneficiaries." Spotlight on Disparities. Baltimore: Maryland Health Care Commission, December 2008.

Stevens, Beth, Timothy Lake, and Erin Fries Taylor. "Improving Health Care Quality Reporting: Lessons from the California HealthCare Foundation." Issue Brief. Oakland, CA: California HealthCare Foundation, December 2006.

Katz, Aaron, Robert Hurley, Leslie Jackson, Timothy Lake, Ashley Short, and James Reschovsky. "Insurers Consolidate, Hospitals Struggle Financially." Community report for Syracuse, New York. Washington, DC: Center for Studying Health System Change, winter 2001.

Rosenbach, Margo, and Timothy Lake. "Mental Health and Substance Abuse Parity in Vermont: What Did We Learn?" Issue Brief no. 1. Washington, DC: Mathematica Policy Research, September 2001.

Katz, Aaron, Robert Hurley, Leslie Jackson, Timothy Lake, Ashley Short, Paul Ginsburg, and Joy Grossman. "HMO Model Shaken but Remains Intact." Community report for Orange County, California. Washington DC: Center for Studying Health System Change, summer 2001.

Short, Ashley, Glen Mays, and Timothy Lake. "Provider Network Instability: Implications for Choice, Costs, and Continuity of Care." Issue Brief no. 39. Washington, DC: Center for Studying Health System Change, June 2001.

Katz, Aaron, Robert Hurley, Leslie Jackson, Ashley Short, Lee Hargraves, and Timothy Lake. "Provider Systems Thrive in Robust Economy." Community report for Indianapolis, Indiana. Washington, DC: Center for Studying Health System Change, fall 2000.

Reschovsky, James D., Peter Kemper, Ha T. Tu, Timothy Lake, and Holly J. Wong. "Do HMOs Make a Difference? Comparing Access, Service Use, and Satisfaction Between Consumers in HMOs and Non-HMOs." Issue Brief no. 28. Washington, DC: Center for Studying Health System Change, March 2000.

Lake, Timothy, and Robert St. Peter. "Payment Arrangements and Financial Incentives for Physicians." Data Bulletin: Results from the Community Tracking Study. Washington, DC: Center for Studying Health System Change, fall 1997.

Reports

Chollet, Deborah, Allison Barrett, and Timothy Lake. "Reducing Hospital Readmissions in New York State: A Simulation Analysis of Alternative Payment Incentives." Report to the New York State Health Foundation. Washington, DC: Mathematica Policy Research, July 2011.

Lipson, Debra, Margaret Colby, Tim Lake, Su Liu, and Sarah Turchin. "Value for the Money Spent? Exploring the Relationship Between Medicaid Costs and Quality." Report submitted to the U.S. Department of Health and Human Services, Office of the Assistant Secretary of Planning and Evaluation. Washington, DC: Mathematica Policy Research, August 2010.

Colby, Margaret, Timothy Lake, Vivian Byrd, Cynthia Collier, and Carol Irvin. "First Annual Report to the Office of Medicaid Policy and Planning: Evaluation of the Healthy Indiana Plan." Report submitted to the Indiana Office of Medicaid Policy and Planning. Washington DC: Mathematica Policy Research, December 2009.

Lake, Timothy, Ellen Singer, Greg Peterson, Stephanie Peterson, and Emma Ernst. "Assessing Potential Refinements to Cost of Service Categories in Medicare Value Reports." Draft report submitted to the Centers for Medicare & Medicaid Services. Washington DC: Mathematica Policy Research, October 13, 2009.

Chollet, Deborah, Bob Schmitz, Timothy Lake, Michael Bailit, and Margaret Houy. "Recommendations of the Massachusetts Special Commission on Health Care Payment System." Document No. PR09-45b. Boston: Division of Health Care Finance and Policy, July 2009.

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Pham, Hoangmai, Genna Cohen, Elizabeth November, Paul Ginsburg, Timothy Lake, Christopher Tompkins, Joy Grossman, and Myles Maxfield. "Concept Paper on Defining Accountable Care Entities for Medicare Payment and Performance Measurement." Draft report submitted to the Centers for Medicare & Medicaid Services. Washington DC: Mathematica Policy Research, May 29, 2009.

O'Neil, So, Angela Merrill, Ander Wilson, and Timothy Lake. "Assessment of Disparities in Potentially Avoidable Hospitalizations for Maryland Medicare Beneficiaries." Report submitted to the Maryland Health Care Commission. Washington DC: Mathematica Policy Research. December 2008.

Gold, Marsha, Timothy Lake, Kate Stewart, Tara Krissik, and Kirsten Barrett. "Evaluation of Effectiveness of AHRQ's Grant-Supported Research on Healthcare Costs, Productivity, Organization, and Market Forces." Final report. Washington, DC: Mathematica Policy Research, December 8, 2008.

Croghan, Thomas, Stephanie Peterson, Timothy Lake, Leslie Conwell, Myles Maxfield, Karen Kmetik, Shannon Sims, Philip Renner, and Sepheen Byron. "Clinician Measures Project: Final Report." Report submitted to the Centers for Medicare & Medicaid Services. Washington DC: Mathematica Policy Research, September 18, 2008.

Ainbinder, Alisa, Barbara Hoffman, Tiffany Waits, Katherine Burnett, and Timothy Lake. "Clinician Measures Formative Testing Results." Draft report submitted to the Centers for Medicare & Medicaid Services. Washington, DC: Mathematica Policy Research, July 25, 2008.

Kim, Jung, Melanie Au, Nancy Duda, and Timothy Lake. "Operation and Usability Analysis of 2007 PQRI Measures." Draft report submitted to the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. Washington, DC: Mathematica Policy Research, June 16, 2008.

Gold, Marsha, and Timothy Lake. "Evaluation of the Effectiveness of AHRQ's Grant Supported Research on Health Care Costs, Productivity, Organization, and Market Forces: Phase II Design Plan." Report submitted to the Agency for Healthcare Research and Quality. Washington, DC: Mathematica Policy Research, November 2007.

Gold, Marsha, Tara Krissik, and Timothy Lake. "Evaluation of the Effectiveness of AHRQ's Grant Supported Research on Health Care Costs, Productivity, Organization, and Market Forces: November 2007 Interim Report." Report submitted to the Agency for Healthcare Research and Quality. Washington DC: Mathematica Policy Research, November 2007.

Lake, Timothy, Margaret Colby, and Stephanie Peterson. "Health Plans' Use of Physician Resource Use and Quality Measures." Report submitted to the Medicare Payment Advisory Commission. Washington DC: Mathematica Policy Research, October 2007.

Pham, Hoangmai, Erin Fries Taylor, Timothy Lake, Stephanie Peterson, and Melanie Au. "DiSH Physician Participation in Performance Reporting and Pay-For-Performance: Findings from an Environmental Scan and Literature Review." Working paper. Washington DC: Mathematica Policy Research, November 2006.

Lake, Timothy, Sibyl Day, David Kennell, Stephanie Peterson, and Gilbert Gimm. "A Review of TRICARE Network Adequacy Oversight Activities Across the Military Health System." Report submitted to the U.S. Department of Defense, TRICARE Management Activity. Washington, DC: Mathematica Policy Research, September 2006.

Stevens, Beth, Timothy Lake, Erin Fries Taylor, Jennifer Coughlan, and Sheila Hoag. "Evaluation of the Second Phase of the California HealthCare Foundation's Quality Measurement and Reporting Projects." Report submitted to the California HealthCare Foundation. Princeton, NJ: Mathematica Policy Research, March 2006.

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MATHEMATICA
Policy Research

Suzanne Felt-Lisk
Senior Health Researcher

Education

1987	M.P.A., Nelson A. Rockefeller College of Public Affairs and Policy, State University of New York at Albany
1985	B.A., Economics, State University of New York at Binghamton

Positions

1991 -	Mathematica Policy Research
1996 -	Senior Health Researcher
1992 - 1996	Health Researcher
1991	Research Analyst
1987 - 1990	U.S. General Accounting Office, Washington, DC Project Manager, National and Public Health Issues Group Assistant Project Manager, National and Public Health Issues Group Research Analyst, Health Care Quality Assurance Group and Defense Health Systems Group
1986 - 1987	Graduate Intern, Nelson A. Rockefeller College of Public Affairs and Policy, Albany, NY

Experience

Mathematica

Formative Evaluation Director, Evaluation Activity in Support of Partnership for Patients (PfP) (2011 -). As lead for the formative evaluation of the Partnership for Patients program funded by CMS, work closely with the program staff to track program progress, explore issues that arise, and suggest program improvements to assist the program in meeting its goals of reducing 9 areas of hospital-based harms by 40% and readmissions by 20% by the end of 2013. Responsible for producing monthly and annual formative feedback reports to CMS with succinct indicators of program progress, based on a robust set of data streams implemented by the evaluation team including direct observation, a national survey of hospital quality improvement directors, a learning activities survey of participants, site visits, focus groups, and review of contractors' deliverables.

Project Director and Coprincipal Investigator, Synthesis Reports for Grants and Cooperative Agreements for Transforming Healthcare Quality Through Information Technology (THQIT) (2009 -). Lead project for Agency for Healthcare Research and Quality (AHRQ) to synthesize results across the 118 THQIT planning, implementation, and value grantees funded by AHRQ for a diverse set of health information technology (health IT) projects. Work in partnership with Geisinger Health System leadership and staff. Convened and cohosted technical expert panel representing health IT professionals, clinicians, and researchers. Oversaw literature reviews and development of grantee surveys, and oversaw and contributed to a report featuring eight health IT quality improvement stories based on grantee reports to AHRQ and followup with the principal investigators. The project's final report will synthesize across the literature, survey results, and follow-up interviews with a subset of grantees.

Coprincipal Investigator, Evaluation of the Electronic Health Records Demonstration (2008 -). Oversee analysis of implementation of this Centers for Medicare & Medicaid Services (CMS) demonstration to encourage small- to medium-sized physician practices to adopt and better use electronic health records to improve care quality. Developed site visit protocols and telephone discussion guides for use with physician practice personnel including physicians, nurses, and administrative personnel. Worked collaboratively with CMS, the U.S. Department of Health and Human Services (DHHS), Assistant Secretary for Planning and Evaluation (ASPE) staff, and another CMS contractor to develop a method for composite scoring of physician practices' use of health IT based on their responses to the Office Systems Survey (OSS). Oversaw and conducted site visits to small-to-medium-sized physician practices to learn about their care management and health IT use. Prepared a report on demonstration implementation in the first year, based on the site visits and first year OSS results.

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Coprincipal Investigator, Evaluation of the Quality Improvement Program Eighth and Ninth Scopes of Work (2008 - 2011). Led design and implementation of qualitative analyses, including literature reviews, surveys of Quality Improvement Organizations (QIOs) and providers, site visits, and analysis of program infrastructure. Worked with subcontractor as well as Mathematica staff to accomplish tasks. Led analysis and reporting on national surveys of hospitals and nursing homes as well as a survey of QIO directors and theme leaders. Organized and hosted listening sessions with experts on selected health care topics to provide input to CMS planning for the program's future. Conducted two week-long site visits to QIOs and the community health leaders and providers they worked with. Worked with quantitative lead to develop summary of findings synthesizing quantitative and qualitative analyses.

Task Leader, Implementation Analysis, Evaluation of the Medicare Care Management Performance Demonstration (2007 -). Lead study of the implementation of this CMS/Medicare pay-for-performance program for solo and small group practices. Designed site visit protocols to probe practices' implementation of health IT and care management processes and their use of quality data as well as their experience with the demonstration. Oversaw two rounds of site visits to 32 physician practices in four states and participated in both rounds of visits to 16 practices. Lead-authored a first-year and final report to CMS on program implementation and practices' operational responses to the demonstration and published a corresponding article.

Project Director (2008 - 2009), Deputy Director (2005 - 2008), Medicare Health Support (MHS), formerly Chronic Care Improvement Program, Performance Monitoring System (2005 - 2009). Worked with CMS, National Committee for Quality Assurance, and more than a dozen internal staff to develop and operate the performance monitoring system for CMS's MHS. Recommended data reporting requirements for sites that balance the need for critical performance data with feasibility and cost concerns and explained and defended those requirements to the sites. Designed and oversaw implementation of quarterly monitoring reports to the eight sites and CMS, advised CMS on policy issues associated with performance measurement, reviewed sites' data collection plans and the cooperative agreement protocol documents that govern reporting, oversaw liability calculations to determine if participating organizations met performance guarantees, and designed final quality summaries to report end-of-program results. MHS is a disease management program for Medicare beneficiaries with congestive heart failure or diabetes operated through cooperative agreements with eight organizations.

Project Director, Evaluation of the National Resource Center for Health Information Technology (NRC) (2007 - 2008). Led a short-term evaluation of the NRC for AHRQ, which involved designing and leading telephone and in-person discussions with 71 stakeholders including health IT grantees, senior managers and relevant key staff from AHRQ, the Health Resources and Services Administration (HRSA), CMS, the Office of the National Coordinator for Health IT, leaders in the health IT field, NRC staff and subcontractors, national and local hospital associations, physician specialty societies, Medicare QIO staff, and primary care associations. Convened an expert panel of health IT leaders from safety net and rural providers. Contributed to design of an email satisfaction survey of nearly 5,000 NRC website users. Led analysis and final report, which included recommendations for strengthening the program. Briefed the AHRQ director and senior agency leadership.

Project Director, Assessing Business Plan Options for Financing Clinical Pharmacy Services in Safety Net Settings (2007 - 2008). Developed policy options for HRSA and others to advance the use of clinical pharmacy services (such as medication therapy management) in safety net settings. Convened a national stakeholders meeting of 21 organizations including pharmaceutical and safety net stakeholder groups. Worked with two pharmacist consultants and Mathematica systems staff to develop an interactive, web-based financial planning tool to help safety net providers plan clinical pharmacy services. Led selected interviews with safety net providers who had successfully sustained clinical pharmacy services. Guided a literature review of the evidence for clinical and cost effects. Briefed HRSA officials and prepared final report under tight deadlines.

Project Director, Evaluation of Local Initiative Rewarding Results Collaborative Demonstration (2003 - 2006). Directed an evaluation of a demonstration by eight Medicaid-dominated health plans to improve quality of care by strengthening financial and nonfinancial provider incentives. Oversaw process and impact analysis, with two rounds of stakeholder interviews, and comparative descriptive analysis of provider- and plan-level quality indicators. The evaluation was funded by the Center for Health Care Strategies, Inc. (CHCS), which administered the demonstration with a grant from the California HealthCare Foundation (CHCF).

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Project Director, Analysis of Medicaid Managed Care Plans (2004 - 2005). Tracked the types of Medicaid managed care plans participating in Medicaid, drawing on data from CMS and InterStudy supplemented by staff research, for the Kaiser Family Foundation. Analyzed the extent to which Health Plan Employer Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems data are publicly available for Medicaid managed care plans and presented a preliminary analysis of selected HEDIS measures by type of plans using the available data. This extended the database and analysis through 2004 and provided a new analysis of the trend in enrollment of beneficiaries with disabilities, aged beneficiaries, and the dually eligible population in full-risk plans.

Task Leader and Deputy Project Director, Evaluation of the Development Process of the National Healthcare Quality Report (NHQR) and Analysis of the National Healthcare Quality Report (NHQR) and National Healthcare Disparities Report (NHDR) Products (2003 - 2005). Obtained and synthesized feedback from experts on AHQR's plans for the 2004 NHQR and NHDR under a very tight time frame. Prepared a report and briefed agency officials. Convened two expert panels, one on use of aggregate measures in reporting on quality and one on summarizing disparities in the NHDR.

Task Leader, Evaluation of the National Voluntary Hospital Reporting Initiative (2003 - 2005). Led several tasks to study hospital reporting of quality data to CMS and transformational change in hospitals, for CMS, under a subcontract through the Delmarva Foundation for Medical Care. Developed discussion protocols, managed the interview process with staff at 30 hospitals to provide feedback to CMS under a tight time frame, drafted the report, and briefed agency officials. Designed a national survey of hospitals on the impact of public reporting. Led case studies of 6 hospitals advanced in transformational change efforts, including protocol design, the site visit process, and the related report. Conducted discussions with 30 hospitals participating in the Premier Hospital Quality Incentive Demonstration. Prepared related issue briefs based on the survey results on hospital IT and on pay-for-performance, led two related reports and a journal article, and contributed to several other related reports and a second journal article.

Project Director, Evaluation of the Clinical Pharmacy Demonstration Projects (2002 - 2005). Directed an evaluation for HRSA of grant-funded demonstration projects aimed at improving access to comprehensive pharmacy services for low-income populations and thus improving health care outcomes. Analyzed pharmacist-led disease management of diabetes in low-income patients. Briefed HRSA officials and presented results at a national conference. Evaluation included qualitative analysis and analysis of data on patient outcomes, pharmacy services provided, and financial information that was mandated for all grantees, as well as comparison data from HEDIS for the Medicaid population and HRSA's uniform data set.

Senior Adviser, Effective Use of Quality-Related Provider Incentives in Medicaid Managed Care (2003 - 2004). Advised a project for CHCS to explore how health plans that serve Medicaid are using provider incentives to improve quality of care. Conducted a case study of the Neighborhood Health Plan of Rhode Island's program, and contributed to study design and report-writing. Project included telephone interviews with about 40 health plans nationally that reported in a previous survey that they use financial incentives to improve quality, and case studies of selected plans with incentive programs that appear particularly effective.

Project Director, Accessibility of Specialty Services for California's Uninsured (2002 - 2004). Directed a project for CHCF to study how and how well the uninsured in California are able to access specialty services. Designed a survey for medical directors of Federally Qualified Health Centers in California about their patients' ability to access specialty services and a survey of referral hospital outpatient departments on their policies and availability regarding service to the uninsured. Also oversaw case studies of selected communities. Led final report and related issue brief.

Team Leader, Policy/Safety Net Team, Round 4 Site Visits, Community Tracking Study (2002 - 2004). Led one of four research teams and one of four site visit teams. Developed research topics, including analysis plans and interview protocols; oversaw site-visit planning and set-up; conducted site visits; and wrote an issue brief and two community reports. The project, funded by the Robert Wood Johnson Foundation (RWJF) through the Center for Studying Health System Change (HSC), involved site visits to 12 communities tracked.

Project Director, Private Physicians' Role in the Safety Net: A Study of Ascension Health Affiliated Physicians in Austin, Texas (2002 - 2003). Directed a project for Ascension Health that collects detailed survey and administrative data on private specialist physicians' service to the uninsured in one market, in order to develop a methodology that can be used more broadly to better understand the largely unrecognized role that private physicians play in serving the uninsured.

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Project Director, Privacy Issues in Managed Care for Mental Health and Substance Abuse (2001 - 2002). Directed a project for DHHS, ASPE to examine privacy issues in the transfer of information between providers of mental health and substance abuse services and managed care payers. Performed and oversaw interviews with mental health and substance abuse treatment stakeholders (clinicians, managed care organizations [MCOs], related trade associations, and advocates), collected related documentation, and analyzed and reported results.

Researcher, Medicaid/State Children's Health Insurance Program Managed Care Plan Survey (2000 - 2002). Developed a questionnaire on quality of care initiatives in health plans serving Medicaid, which was administered as part of a larger health plan survey effort funded by the Henry J. Kaiser Family Foundation. Analyzed the results and wrote the relevant report chapter; contributed to a related journal article.

Team Member, Health Plans Team, Round 3 Site Visits, Community Tracking Study (2000 - 2001). Led analysis of how care management is changing in health plans and published a related journal article. Participated in site visits to three communities that are part of this large, longitudinal study of health system change.

Project Director, Study of Health Plans Serving Medicaid (2000 - 2001). Directed a project to analyze current patterns and trends in health plans' service to Medicaid, for the Henry J. Kaiser Family Foundation's Commission on Medicaid and the Uninsured (updating and expanding previous work). Guided database development, analyzed national trends, analyzed the relationship between selected HEDIS quality indicators for Medicaid for 1998 and plan type or participation status, and led a related report and paper.

Project Director, Safety Net Provider Capacity for Care to Low-Income Uninsured Patients (1999 - 2001). Led a study for HRSA on the changing capacity of safety net providers in five cities. Led study design, site visits, data analysis, and report-writing. Prepared a related journal article. The study also sought to advance policymakers' ability to monitor capacity of the safety net by exploring useful ways of collecting comparable information on local safety nets from national and local data sources.

Project Director, Chartbook on Medicaid Special Needs Populations (1999 - 2000). Led analysis of nonelderly Medicaid beneficiaries with chronic or disabling conditions, using the Health Care Financing Administration (HCFA) State Medicaid Research File data for four states. Led final report, which described the study population's diagnoses, service use, and cost, primarily through graphics. The report analysis, for CHCS, became a core piece of a chartbook on Medicaid special needs populations, published and widely disseminated by CHCS, with funding from RWJF.

Project Director, Study to Improve States' Ability to Assess the Adequacy of Managed Care Organizations' Provider Networks (1998 - 2000). Led development of a technical assistance tool for states to help them better assess the adequacy of MCOs' provider networks when they enroll the Social Security Income (SSI)-eligible Medicaid population and those needing behavioral health services into capitated Medicaid managed care programs.

Project Director and Principal Investigator, Health Plan Practices Associated with High Performance on Selected Health Plan Employer Data and Information Set Indicators (1998 - 2000). Led a study for the Commonwealth Fund, in collaboration with Lawrence Kleinman, M.D., to facilitate improvement in quality of care by describing health plan practices associated with high performance on HEDIS clinical quality measures. Performed overall project direction, designed the site visit protocol, oversaw health plan recruitment into the study, supervised implementation, led six of the visits, and led the final report. Presented results at several conferences. The project involved site visits to 10 health maintenance organizations (HMOs) that were identified by Mathematica as outstanding nationally based on their HEDIS scores.

Project Director, Role of Medicaid-Only Plans in the Medicaid Managed Care Market (1998 - 1999). Directed this project, funded by the Henry J. Kaiser Family Foundation, that explored the role of Medicaid-only plans in the Medicaid managed care market. Oversaw development of a national profile of Medicaid-only plans, then analyzed Medicaid-only plans in 15 states for a more in-depth analysis. Data sources include state Medicaid agencies, enrollment data by plan, InterStudy data, the Area Resource File (ARF), and Mathematica's own contacts with plans and other researchers. Topics analyzed included ownership type, financial viability, service to the SSI population, and enrollment patterns relative to competing commercial-based plans.

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Project Director, Study of Commercial Plans' Participation in Medicaid (1998). Analyzed the trends in commercial plans' participation in Medicaid nationally through mid-1997, and in high-volume Medicaid managed care states through mid-1998, with funding from the Henry J. Kaiser Family Foundation. Presented findings to policymakers at conferences and developed an issue brief that was widely disseminated by the Henry J. Kaiser Family Foundation in spring and summer 1999.

Researcher, Analysis of Community Health Center (CHC) User/Visit Surveys (1997 - 1998). Analyzed the care experience of adults with diabetes who use community health centers as their regular source of care compared with others with diabetes, as part of a project funded by HRSA. Performed bivariate and multivariate analyses to describe the patient profile of diabetics who use CHCs, describe the consistency of care for diabetics in CHCs relative to nationally accepted guidelines, and assess how being cared for at a CHC affects various health outcomes for diabetics. Data sources were the 1994 National Health Interview Survey, the National Hospital Ambulatory Medical Care Survey, and the CHC user and visit surveys.

Principal Investigator, Experience and Consequences of Medicaid Managed Care for Rural Populations (1996 - 1998). Led a study of rural Medicaid managed care on a project for the Agency for Health Care Policy and Research, working with staff at the University of North Carolina Sheps Center. Led most project activities, including advisory committee meetings, design of the case studies and process for the state calls, and analysis and writing on project findings. The project conducted semi-structured telephone interviews to Medicaid policymakers in all 50 states, focused on how the state has implemented Medicaid managed care in rural areas, and if not, why not. These were followed by case studies of 10 states to identify lessons learned to date.

Project Director, Study of Health Maintenance Organizations Serving Medicaid and Medicare Beneficiaries (1996 - 1997). Led an analysis for HSC to describe the types of HMOs serving Medicaid and Medicare and how this changed between 1993 and 1996. Led development of a database that merged Medicaid and Medicare enrollment data from HCFA with HMO industry directories from the American Association of Health Plans and InterStudy. The merged data for each year were matched across time to create a more comprehensive database of all full-risk health plans than was previously available. Author of analysis of the types of full-risk health plans serving Medicaid in 1996 and the changes since 1993.

Project Director, Implementation of Ambulatory Patient Groups (APG) by Public and Private Payers (1996 - 1997). Directed a project for HCFA to study other payers' implementation of APG payment systems in order to support HCFA's plans for implementing such a system. APG-based payment systems, which are applied to hospital outpatient care and ambulatory surgery centers, are a prospective payment system with clinically related groups analogous to diagnostic related groups for inpatient services. Project involved site visits to two private payers with experience implementing APGs, telephone interviews with many private payers in some stage of implementation, and telephone interviews with payers who are not implementing APGs, to find out how they control hospital outpatient and ambulatory surgery costs.

Project Director, Study of Health Maintenance Organization Staffing Strategies in Underserved Areas (1995 - 1997). Directed a study, for HRSA, to examine how HMOs staff medical and special services in inner-city and rural areas, and how these strategies affect communities' access to care. Led preparation of final report and a stand-alone executive summary, which was widely disseminated. The study conducted site visits to 14 HMOs that have high Medicaid enrollment and are located in eight states with recent growth in Medicaid managed care. Visits included selected community health centers in the HMOs' service areas.

Project Director and Researcher, Evaluation of the Medicaid Managed Care Quality Assurance Reform Initiative State Demonstrations (1993 - 1996). Directed a project, for the Henry J. Kaiser Family Foundation, to develop insights into oversight of managed care quality at state, health plan, and provider levels and to provide feedback for improving the quality assurance guidelines set by HCFA. Prepared two interim reports on implementation of the Quality Assurance Reform Initiative system, was lead author on the final evaluation report, and presented study findings to personnel from managed care organizations, the Foundation, and HCFA. Also participated in collection and analysis of selected measures from HEDIS and contributed to the related report. The study involved three rounds of intensive site visits to states, health plans, advocates, and other stakeholders, as well as data collection and analysis of hospital discharge data.

Author, Ensuring and Improving the Quality of Care in a Managed Care Environment (1995). Prepared a monograph to provide directors of state health departments with information on current quality improvement initiatives, health plans' perspectives on quality initiatives, and how the state health department might work to improve quality in this environment, for the Association of State and Territorial Health Officials.

Task Leader, Support to the Center for Studying Health System Change (1995). Led a collaborative effort to design the process analysis component for a longitudinal study of health system change. The project drew on the process analysis experience of senior Mathematica researchers and a panel of reviewers to create a design reflecting the state of the art for visiting multiple sites and analyzing information from them.

Project Director, Evaluation of Organizational Changes in Academic Health Center (AHC)-Affiliated Teaching Hospitals in Competitive Markets (1994 - 1995). Directed a short-term project funded by the Office of the Assistant Secretary for Health, U.S. Public Health Service (PHS), to explore organizational changes in teaching hospitals affiliated with AHCs and to assess the effect of such changes on hospital training programs, research activities supported by federal funds, and indigent care to the extent that this is a core part of the AHCs' mission. The project conducted case studies of four AHCs and synthesized the study findings in a final report.

Project Director, Health Maintenance Organization Primary Care Practitioner Staffing Patterns (1993 - 1995). Directed a project for HRSA to provide information on HMO primary care staffing issues based on site visits to 23 HMOs nationwide. Led site visits to interview senior plan officials on these issues, supervised the work of five analysts and researchers. Prepared the report on study findings and briefed senior officials at DHHS. The project team explored primary care staffing issues, including recruiting for primary care, how HMOs decide on the number of primary care providers, the appropriate mix and use of primary care providers, training such providers, and how service to low-income populations affects staffing needs.

Researcher, Evaluation of the Essential Access Community Hospital Program (1991 - 1995). Analyzed a program sponsored by HCFA to develop an alternative hospital model for rural communities and to encourage the formation of rural health networks in order to strengthen the service delivery system. Conducted site visits to states and hospitals. Interviewed state officials, clinicians, health service administrators, and community leaders. Designed and tested data collection instruments mailed to the 49 grantee hospitals to obtain detailed operational and environmental data for assessing program impact. Participated in policy briefings of senior HCFA and Senate policymakers and prepared reports.

Principal Investigator, Cost-Containment Measures for Physician and Other Services (1992 - 1994). Directed a project for HCFA to design, implement, and analyze a national survey of state Medicaid agencies to assess the prevalence and characteristics of their utilization management efforts. Conducted a literature review of utilization management in state Medicaid programs. Analyzed state findings on and opinions of the impact of utilization management efforts on Medicaid costs, quality of care, and access to care.

Researcher, Study to Recommend Design for a Regulated All-Payer System for the State of Minnesota (1993). Led several tasks on a project funded by the Minnesota Department of Health to develop an all-payer health care system that controls costs, protects quality of care, and recognizes the needs of rural communities. Drafted the initial system design based on literature and input from expert consultants.

Researcher, Review and Analysis of Past Health Care Cost-Containment Efforts and Impact on Cost, Quality, and Access to Health Care (1993). Reviewed the literature on the impacts of state rate-setting programs and drafted a background paper to support policy meetings between senior PHS and HCFA policymakers and other high-level experts. This work was funded by the PHS.

Member, Technical Assistance Team, Field Test and Assessment of Data Systems for Reporting Activities Under the Ryan White CARE Act, Part III (1992). Prepared a guide for providers of AIDS services on handling confidential patient information, after conducting a literature review and holding discussions with experts on confidentiality issues for a task on a HRSA project. Also prepared a parallel guide for state and local agencies receiving grant funds under this program. The purpose of the larger project was to assist HRSA in developing and implementing a reporting system for AIDS providers receiving program funds.

Member, Case Studies Team, Rural Health Care Transition Grants Evaluation (1991 - 1992). Conducted and prepared summaries of site visits (involving more than 50 on-site interviews) to assess the implementation and impacts of grants on eight rural hospitals participating in a HCFA project to improve the financial viability of rural hospitals. Interviewed hospital grantees by telephone.

Task Leader, Rural Health Outreach and State Offices of Rural Health Grant Program Support (1991). Directed a project to provide technical and analytic support to HRSA in awarding grants under these two programs. Also provided post-award descriptive analyses of grantees.

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Analyst, Interventions to Reduce Drug-Related Events Among Community-Resident Elderly Medicare and Medicaid Patients (1991). Analyzed existing knowledge about adverse drug reactions through a literature review and telephone interviews. Developed strategies HCFA could use to reduce adverse drug reactions and documented this analysis in a report on this study.

U.S. General Accounting Office

As **Project Manager, Assistant Project Manager,** and **Research Analyst (1987 - 1990),** participated in the following projects:

Causes and Consequences of Rural Hospital Closures. Coordinated the work of seven team members to prepare a final report to Congress on the causes and consequences of rural hospital closures. Led an investigation of the role of Medicare payment in closures, the impact of closures on local economies, and the financial symptoms that precede closure. Integrated site visit results and quantitative analysis to draw conclusions and develop recommendations for policy. Used several national databases, including HCFA's Healthcare Cost Report Information System, the American Hospital Association Annual Surveys and closure files, and the ARF.

Federal, State, and Hospital-Based Strategies that Assist Rural Hospitals. Designed and implemented methodologies for evaluating the financial impact and administration of HCFA's Sole Community Hospital Provision. Summarized the constraints and challenges for rural hospitals and performed a comparative analysis of financially successful and distressed rural hospitals with fewer than 100 beds.

Patients' Satisfaction with Care at Selected Military Hospitals. Designed and implemented a mail survey of 3,300 inpatients and outpatients at nine military hospitals to assess their satisfaction with care. Also conducted site visits to each facility.

Initiatives in Hospital Risk Management. Compared state laws and regulations on hospital risk management/quality assurance. Performed site visits to three states to ascertain their program implementation experience. Visited and interviewed selected experts in the field representing the Joint Commission, hospitals, the research community, risk management firms, and insurers.

Impact of Proposed CHAMPUS DRG System. Developed an estimate of the impact on hospital payments of the military's CHAMPUS program, using a proposed DRG system that differed from the system established by Medicare.

Nelson A. Rockefeller College of Public Affairs and Policy

As **Graduate Intern (1987)** for the Rockefeller Institute of Government, researched and wrote chapters on the functioning of the legislature, intergovernmental relations, auditing and internal controls, and contracting and purchasing in a handbook on New York State government disseminated to state managers.

As **Graduate Intern (1986)** for the Center for Women in Government, assisted in quantitative research on factors associated with higher wages. Also assisted in developing and testing training exercises to teach job evaluation.

Papers and Publications

Journal Articles and Book Chapters

Felt-Lisk, Suzanne M., Lorraine Johnson, Christopher G. Fleming, Rachel J. Shapiro, and Brenda Natzke. "Toward Understanding EHR Use in Small Physician Practices." *Health Care Financing Review,* vol. 31, no. 1, 2009, pp. 11-22.

Felt-Lisk, Suzanne M., Kirsten A. Barrett, and Rebecca Nyman. "Toward Transparency: Public Reporting of Quality Information on Medicaid Health Plans." *Health Care Financing Review,* vol. 28, no. 3, 2007, pp. 5-16.

Laschober, Mary A., Myles Maxfield, Suzanne M. Felt-Lisk, and David J. Miranda. "Hospital Response to Public Reporting of Quality Indicators." *Health Care Financing Review,* vol. 28, no. 3, spring 2007, pp. 61-76.

Felt-Lisk, Suzanne M., Gilbert Gimm, and Stephanie Peterson. "Making Pay-for-Performance Work in Medicaid." *Health Affairs,* vol. 26, no. 4, 2007, pp. w516-w527.

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Felt-Lisk, Suzanne M., and Marsha R. Gold. "Do Quality Improvement Strategies for Medicaid Enrollees Differ in Medicaid Dominant versus Commercial Managed Care Organizations?" *American Journal of Managed Care,* vol. 9, no. 12, December 2003.

Felt-Lisk, Suzanne M., Megan McHugh, and Embry M. Howell. "Monitoring Local Safety Net Providers: Do They Have Adequate Capacity to Meet the Needs of Low-Income Uninsured Populations?" *Health Affairs,* vol. 21, no. 3, September/October 2002.

Felt-Lisk, Suzanne M., and Glen P. Mays. "Back to the Drawing Board: New Directions in Health Plans' Care Management Strategies." *Health Affairs,* vol. 21, no. 3, September/October 2002.

Felt-Lisk, Suzanne M. "Monitoring Quality in Medicaid Managed Care: Accomplishments and Challenges at the Year 2000." *Journal of Urban Health,* vol. 77, no. 4, December 2000.

Felt-Lisk, Suzanne M. "Tools for Monitoring Quality for Vulnerable Populations." In *Access to Health Care: Promises and Prospects for Non-Elderly Low-Income Americans,* edited by Diane Rowland, Marsha Lillie-Blanton, Sara Rosenbaum, and Rose Marie Martinez. Washington, DC: The Henry J. Kaiser Family Foundation, 1999.

Fasciano, Nancy J., Suzanne M. Felt-Lisk, Thomas C. Ricketts, and Benjamin Popkin. "Preparing Rural Communities for Managed Care: Lessons Learned." *Journal of Rural Health,* vol. 15, no. 1, winter 1999.

Felt-Lisk, Suzanne M., Pam Silberman, Sheila Hoag, and Rebecca Slifkin. "Medicaid Managed Care in Rural Areas: A Ten-State Follow-Up Study." *Health Affairs,* March/April 1999.

Slifkin, Rebecca, Sheila Hoag, Pam Silberman, Suzanne M. Felt-Lisk, and Benjamin Popkin. "Medicaid Managed Care Programs Operating in Rural Areas: A Fifty State Overview." *Health Affairs,* November/December 1998.

Felt-Lisk, Suzanne M. "How HMOs Structure Primary Care Delivery." *Managed Care Quarterly,* vol. 4, no. 4, autumn 1996, pp. 96-105. Reprinted in *Managed Care Essentials: A Book of Readings.* Chicago: Health Administration Press, 2000. Also reprinted in *Contemporary Managed Care: Readings in Structure, Operations, and Public Policy.* Chicago: Health Administration Press, 1998.

Felt-Lisk, Suzanne M., and Sara Yang. "Changes in Health Plans Serving Medicaid, 1993-1996." *Health Affairs,* September/October 1997. Reprinted in *Contemporary Managed Care: Readings in Structure, Operations, and Public Policy.* Chicago: Health Administration Press, 1998.

Felt-Lisk, Suzanne M., and Robert F. St. Peter. "Quality Assurance for Medicaid Managed Care." *Health Affairs,* May/June 1997.

Kemper, Peter, David Blumenthal, Janet M. Corrigan, Peter J. Cunningham, Suzanne M. Felt-Lisk, Joy M. Grossman, Linda T. Kohn, Charles E. Metcalf, Robert F. St. Peter, Richard C. Strouse, and Paul B. Ginsburg. "The Design of the Community Tracking Study: A Longitudinal Study of Health System Change and Its Effects on People." *Inquiry,* vol. 33, no. 2, summer 1996, pp. 195-206.

Gold, Marsha R., and Suzanne M. Felt-Lisk. "Reconciling Practice and Theory: Challenges in Monitoring Medicaid Managed-Care Quality." *Health Care Financing Review,* vol. 16, no. 4, summer 1995.

Gold, Marsha R., Karyen Chu, Suzanne M. Felt-Lisk, Mary E. Harrington-Naud, and Timothy K. Lake. "Research on the Effects of Selected Health Care Cost-Containment Efforts Involving Price Controls: 1971 to the Present." *Health Care Financing Review,* spring 1993.

Lillie-Blanton, Marsha, Suzanne M. Felt-Lisk, Patrick Redmon, Steven Renn, Steve Machlin, and Elizabeth Wennar. "Rural and Urban Hospital Closures, 1985-88: Operating and Environmental Characteristics that Affect Risk." *Inquiry,* vol. 29, no. 3, fall 1992.

Reports

Felt-Lisk, Suzanne, Lauren Smith, Sarah Croake, Suzanne Witmer, Martha Kovac, Andrew Clarkwest, Brittany English, and Kirsten Barrett. "Interim Qualitative Assessment of the Ninth Scope of Work QIO Program." Executive Summary, Volume I: 9th SOW QIO Program Experience: QIOs, Volume II: 9th SOW Program Experience: Hospitals and Nursing Homes. Submitted to the Centers for Medicare & Medicaid Services. Washington, DC: Mathematica Policy Research, March 2011.

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Felt-Lisk, Suzanne, Christopher Fleming, and Brenda Natzke. "Medicare Care Management Performance Demonstration: Final Report on Implementation and Changes in Practices' Use of Health IT and Care Management, 2008-2010." Submitted to Centers for Medicare & Medicaid Services. Washington, DC: Mathematica Policy Research, March 2011.

Felt-Lisk, Suzanne, Tricia Higgins, Jenna Libersky, and Christopher Fleming. "Considerations in Designing a Population Health Management Program for TRICARE." Submitted to the TRICARE Management Activity. Washington, DC: Mathematica Policy Research, January 2011.

Felt-Lisk, Suzanne, Rachel Shapiro, Christopher Fleming, Brenda Natzke, Allison Barrett, and Grace Anglin. "Electronic Health Records Demonstration Evaluation: Implementation Report 2010. Final Report." Washington, DC: Mathematica Policy Research, January 20, 2011.

Au, Melanie, Suzanne Felt-Lisk, Grace Anglin, and Andrew Clarkwest. "Using Health IT: Eight Quality Improvement Stories." AHRQ Publication no. 10-0102. Rockville, MD: Agency for Healthcare Research and Quality, September 2010.

Felt-Lisk, Suzanne, Melanie Au, and Patricia Collins Higgins. "Health Information Exchange: The Role of Safety-Net Providers." Trends in Health Informatics, Issue Brief no. 5. Washington, DC: Mathematica Policy Research, June 2009.

Felt-Lisk, Suzanne M., Christopher Fleming, Brenda Natzke, and Rachel J. Shapiro. "Using Payment Incentives to Improve Care for the Chronically Ill in Medicare: First Year Implementation of the Medicare Care Management Performance Demonstration (MCMP)." Washington, DC: Mathematica Policy Research, March 4, 2009.

Gold, Marsha R., and Suzanne M. Felt-Lisk. "Using Physician Payment Reform to Enhance System Performance." Policy Brief. Washington, DC: Mathematica Policy Research, December 2008.

Felt-Lisk, Suzanne M., Todd Sorensen, Zandra Glenn, Margaret Colby, and Christopher Fleming. "Report to HRSA: Opportunities to Advance Clinical Pharmacy Services in Safety-Net Settings." Submitted to the Health Resources and Services Administration. Washington, DC: Mathematica Policy Research, January 14, 2008.

Felt-Lisk, Suzanne M., Margaret Gerteis, Melanie Au, and Sarah Davis. "Evaluation of the National Resource Center for Health Information Technology (NRC): Final Report." Submitted to the Agency for Healthcare Research and Quality. Washington, DC: Mathematica Policy Research, January 4, 2008.

Felt-Lisk, Suzanne M., and Mary A. Laschober. "Pay for Performance: Are Hospitals Ready and Willing?" Trends in Health Care Quality Issue Brief no. 4. Princeton, NJ: Mathematica Policy Research, November 2006.

Felt-Lisk, Suzanne M., Gilbert Gimm, and Stephanie Peterson. "Evaluation of the Local Initiative Rewarding Results Collaborative Demonstrations: Final Report." Washington, DC: Mathematica Policy Research, October 2006.

Felt-Lisk, Suzanne M. "New Hospital Information Technology: Is It Helping to Improve Quality?" Trends in Health Care Quality Issue Brief no. 3. Princeton, NJ: Mathematica Policy Research, May 2006.

Laschober, Mary A., Myles Maxfield, Meredith Lee, Martha D. Kovac, Frank Potter, and Suzanne M. Felt-Lisk. "Hospital Responses to Public Reporting of Quality Data to CMS: 2005 Survey of Hospitals." Washington, DC: Mathematica Policy Research, October 2005.

Felt-Lisk, Suzanne M., Myles Maxfield, Meredith Lee, Sarah Davis, and Lindsay Harris. "Crossing the Quality Chasm Via Transformational Change." Washington, DC: Mathematica Policy Research, October 28, 2005.

Felt-Lisk, Suzanne M., and Fabrice Smieliauskas. "Evaluation of the Local Initiative Rewarding Results Collaborative Demonstrations: Interim Report." Washington, DC: Mathematica Policy Research, August 12, 2005.

Felt-Lisk, Suzanne M., Bridget Lavin, and Marsha R. Gold. "Aggregate Quality Measures for the National Healthcare Quality Report. Summary of Technical Advisory Panel Meetings May/June 2005." Draft report. Washington, DC: Mathematica Policy Research, July 2005.

Felland, Laurie E., Suzanne M. Felt-Lisk, and Megan McHugh. "Health Care Access for Low-Income People: Significant Safety Net Gaps Remain." Issue Brief no. 84. Washington, DC: Center for Studying Health System Change, June 2004.

Felt-Lisk, Suzanne M., Megan McHugh, and Melissa Thomas. "Examining Access to Specialty Care for California's Uninsured: Full Report." Oakland, CA: California HealthCare Foundation, June 2004.

Felt-Lisk, Suzanne M., and Megan McHugh. "Health Insurance: Examining Access to Care for California's Uninsured." Issue Brief. Oakland, CA: California HealthCare Foundation, May 2004.

Felt-Lisk, Suzanne M., Meredith Lee, and Myles Maxfield. "Hospitals' Early Experience with the National Voluntary Hospital Reporting Initiative." Washington, DC: Mathematica Policy Research, May 5, 2004.

Felt-Lisk, Suzanne M. "Expert Reactions to Working Plans for the 2004 NHQR/NHDR." Submitted to the Agency for Healthcare Research and Quality. Washington, DC: Mathematica Policy Research, April 2004.

Felt-Lisk, Suzanne M., and Jon B. Christianson. "Intense Competition and Rising Costs Dominate Cleveland's Health Care Market." Community Report no. 2. Washington, DC: Center for Studying Health System Change, winter 2003.

Felt-Lisk, Suzanne M., Jon B. Christianson, and Linda R. Brewster. "Market Developments Signal Cost Hikes in Greenville." Community Report no. 6. Washington, DC: Center for Studying Health System Change, spring 2003.

Felt-Lisk, Suzanne M. "Helping Eligible Medicare Beneficiaries Access Medicaid: Lessons from SCHIP." Monitoring Medicare + Choice Operational Insights no. 9. Washington, DC: Mathematica Policy Research, September 2002.

Gold, Marsha R., Jessica Mittler, Debra A. Draper, Suzanne M. Felt-Lisk, Julie Ingels, and Michael D. Sinclair. "Medicaid and SCHIP Managed Care: Plan Participation, Provider Networks, and Quality Improvement." Final report submitted to the Henry J. Kaiser Family Foundation. Washington, DC: Mathematica Policy Research, January 2002.

Felt-Lisk, Suzanne M., Rebecca Dodge, and Megan McHugh. "Trends in Health Plans Serving Medicaid—2000 Data Update." Washington, DC: The Henry J. Kaiser Family Foundation, November 2001.

Felt-Lisk, Suzanne M., Megan McHugh, and Embry M. Howell. "Study of Safety Net Provider Capacity to Care for Low-Income Uninsured Patients." Washington, DC: Mathematica Policy Research, September 2001.

Felt-Lisk, Suzanne M., Jessica Mittler, and Amanda Cassidy. "Ensuring Special Needs Populations' Access to Providers in Managed Care Networks: A Technical Assistance and Self-Assessment Tool for State Medicaid Agencies." Informed Purchasing Series. Hamilton, NJ: Center for Health Care Strategies, Inc., January 2001.

Felt-Lisk, Suzanne M., and Lawrence C. Kleinman. "Effective Clinical Practices in Managed Care: Findings from Ten Case Studies." Field report. New York: The Commonwealth Fund, November 2000.

Felt-Lisk, Suzanne M., Mei-Ling Mason, Margo L. Rosenbach, and Susan M. Allen. "Analysis of Nonelderly Medicaid Beneficiaries with Chronic or Disabling Conditions." Final report submitted to Center for Health Care Strategies, Inc., April 2000. Analysis published in *"The Faces of Medicaid: The Complexities of Caring for People with Chronic Care and Disabilities."* Princeton, NJ: Center for Health Care Strategies, Inc., October 2000.

Felt-Lisk, Suzanne M., Hilary Frazer, Elizabeth Langer, Jessica Mittler, and Cheryl Young. "Effective Clinical Practices in Managed Care: Ten Case Studies." Case Study Reports. Washington, DC: Mathematica Policy Research, August 2000.

Felt-Lisk, Suzanne M. "The Characteristics and Roles of Medicaid-Dominated Managed Care Plans." Issue Brief. Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, February 2000.

Felt-Lisk, Suzanne M. "The Changing Medicaid Managed Care Market: Trends in Commercial Plans' Participation." Issue Brief. Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, May 1999.

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Fasciano, Nancy J., and Suzanne M. Felt-Lisk. "Toward a Prospective Payment System for Outpatient Services: Implementation of APGs by State Medicaid Agencies and Private Payers." Report submitted to the U.S. Department of Health and Human Services, Health Care Financing Administration. Washington, DC: Mathematica Policy Research, November 1997.

Felt-Lisk, Suzanne M., Mary E. Harrington-Naud, and Anna Aizer. "Availability of Primary Care Services Under Medicaid Managed Care: How 14 Health Plans Provide Access and the Experiences of 23 Safety Net Providers and Their Communities." Washington, DC: Mathematica Policy Research, August 1997. Executive Summary reprinted in *1999 Medicaid Managed Care Sourcebook,* New York: Faulkner & Gray, 1999.

Felt-Lisk, Suzanne M., and Robert F. St. Peter. "The Quality Assurance Reform Initiative (QARI) Demonstration for Medicaid Managed Care: Final Evaluation Report." Washington, DC: Henry J. Kaiser Family Foundation, November 1996.

Aizer, Anna, Suzanne M. Felt-Lisk, and Lyle Nelson. "Experience in Collecting Selected HEDIS 2.0 Measures for the Medicaid Population." Washington, DC: Henry J. Kaiser Family Foundation, May 1996.

Felt-Lisk, Suzanne M. "Ensuring and Improving the Quality of Care in a Managed Care Environment." Washington, DC: Association of State and Territorial Health Officials, November 1995.

Felt-Lisk, Suzanne M., Julianne Howell, and Karyen Chu. "How Academic Health Centers Are Changing in Response to the Market: A Synthesis of Four Case Studies." Washington, DC: Mathematica Policy Research, August 1995. (Appendixes containing the case study reports are bound separately.)

Felt-Lisk, Suzanne M. "The First Twenty Months of the Quality Assurance Reform Initiative (QARI) Demonstrations for Medicaid Managed Care." Interim Evaluation Report. Washington, DC: Mathematica Policy Research, March 1995.

Wright, George, Suzanne M. Felt-Lisk, Anthony Wellever, Timothy K. Lake, and Stephen Sweetland. "Limited-Service Hospital Pioneers: Challenges and Successes of the Essential Access Community Hospital/Rural Primary Care Hospital (EACH-RPCH) Program and Medical Assistance Facility (MAF) Demonstration." Submitted to the Health Care Financing Administration. Washington, DC: Mathematica Policy Research, March 1995.

Felt-Lisk, Suzanne M., Hilary Frazer, and Marsha R. Gold. "HMO Primary Care Staffing Patterns and Processes: A Cross-Site Analysis of 23 HMOs." Washington, DC: Mathematica Policy Research, December 1994.

Felt-Lisk, Suzanne M., and Marsha R. Gold. "First Annual Evaluation Report on the Demonstration of a Quality Improvement System for Medicaid Managed Care (QARI)." Washington, DC: Mathematica Policy Research, April 1994.

Frazer, Hilary, Karyen Chu, and Suzanne M. Felt-Lisk. "Ambulatory Surgery, Preadmission Testing, and Same-Day Surgery: State Medicaid Programs' Experience and Findings from the Literature." Report submitted to the U.S. Department of Health and Human Services, Health Care Financing Administration. Washington, DC: Mathematica Policy Research, February 1994.

Gold, Marsha R., Myles Maxfield, and Suzanne M. Felt-Lisk. "Design of the All-Payer System in Minnesota: Recommendations and Implementation Strategies." Report submitted to the Minnesota Department of Health. Washington, DC: Mathematica Policy Research, December 1993.

Gold, Marsha R., and Suzanne M. Felt-Lisk. "State Hospital Rate-Setting Programs: Research on Effects and Potential Lessons." Paper submitted to the U.S. Public Health Service. Washington, DC: Mathematica Policy Research, April 1993.

Felt-Lisk, Suzanne M., and Karyen Chu. "Cost-Containment Measures in State Medicaid Programs: A Literature Summary." Report submitted to the U.S. Department of Health and Human Services, Health Care Financing Administration. Washington, DC: Mathematica Policy Research, September 1992.

Felt-Lisk, Suzanne M., and George Wright. "Diversity in States' Early Implementation of the EACH Program." Report submitted to the U.S. Department of Health and Human Services, Health Care Financing Administration. Washington, DC: Mathematica Policy Research, 1992.

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Felt-Lisk, Suzanne M., and David J. Edson. "Protecting the Confidentiality of HIV-Related Information: A Guide for Providers." Guide submitted to the U.S. Department of Health and Human Services, Health Care Financing Administration. Washington, DC: Mathematica Policy Research, 1992.

Felt-Lisk, Suzanne M., and David J. Edson. "Protecting the Confidentiality of HIV-Related Information Under the Uniform Reporting System: A Guide for State and Local Agencies Receiving Ryan White CARE Act Grants." Report submitted to the U.S. Department of Health and Human Services, Health Care Financing Administration. Washington, DC: Mathematica Policy Research, 1992.

Felt-Lisk, Suzanne M., George Wright, and Anthony Wellever. "EACH Program Evaluation: State Site Visit Reports on Early Implementation." Report submitted to the U.S. Department of Health and Human Services, Health Care Financing Administration. Washington, DC: Mathematica Policy Research, 1992.

Thornton, Craig, Suzanne M. Felt-Lisk, Marilyn Pajk, Joseph Scavone, Carl Serrato, Knight Steel, and Mary K. Willian. "Interventions to Reduce Drug-Related Reactions Among Community-Resident Elderly Medicare and Medicaid Patients." Report submitted to the U.S. Department of Health and Human Services, Health Care Financing Administration. Princeton, NJ: Mathematica Policy Research, 1991.

U.S. General Accounting Office. "Rural Hospitals: Federal Efforts Should Target Areas Where Closures Would Threaten Access to Care." GAO/HRD-91-41. Washington, DC: U.S. General Accounting Office, February 1991 (major contributor).

U.S. General Accounting Office. "Rural Hospitals: Factors that Affect Risk of Closure." GAO/HRD-90-134. Washington, DC: U.S. General Accounting Office, June 1990 (major contributor).

U.S. General Accounting Office. "Rural Hospitals: Federal Leadership and Targeted Programs Needed." GAO/HRD-90-67. Washington, DC: U.S. General Accounting Office, June 1990 (major contributor).

U.S. General Accounting Office. "Defense Health Care: Patients' Views on the Care They Received." GAO/HRD-89-137. Washington, DC: U.S. General Accounting Office, September 1989 (major contributor).

U.S. General Accounting Office. "Health Care: Initiatives in Hospital Risk Management." GAO/HRD-89-79. Washington, DC: U.S. General Accounting Office, July 1989 (major contributor).

Felt-Lisk, Suzanne M. Chapters 5, 6, 7, and 9. In *Governing the Empire State, An Insider's Guide*. Albany: State of New York Management Resources Project, Rockefeller Institute of Government, 1988.

Presentations

Felt-Lisk, Suzanne M. "Factors Influencing EHR Use in Small Practices: Case Studies in Four States." Presented at the AcademyHealth Annual Meeting, Chicago, June 28, 2009.

Felt-Lisk, Suzanne M. "Pay-for-Performance Lessons from Experience." Presented to the Massachusetts Special Commission on Payment Reform, Boston, February 6, 2009.

Felt-Lisk, Suzanne M. "Examining Access to Specialty Care for California's Uninsured." Presented at the AcademyHealth Annual Meeting, San Diego, June 7, 2004.

Felt-Lisk, Suzanne M. "Back to the Drawing Board: Recent Changes in Health Plans' Care Management Strategies." Presented at the Academy for Health Services Research and Health Policy Annual Meeting, Washington, DC, June 24, 2002.

Felt-Lisk, Suzanne M. "GAO's Rural Hospital Studies: Patient Care Location Preferences Before Closure and Implications for Policy." Paper presented at the American Public Health Association Annual Meeting, Atlanta, November 1991.

Professional Memberships

2011 - American Evaluation Association

2009 - Quality Interest Group Advisory Committee, AcademyHealth

2002 - National Committee for Quality Assurance Standards Committee

Reviewer

Health Affairs
Health Care Financing Review
American Journal of Managed Care
Journal for the Poor and Underserved
Journal of Health Politics, Policy and Law

Awards and Honors

2002 Research paper abstract selected as one of 21 outstanding abstracts from nearly 1,000 abstracts submitted for peer review to the Academy for Health Services Research and Health Policy's Annual Research Meeting.

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MATHEMATICA
Policy Research

Allison Barrett
Researcher

Education

2009	M.A., Economics, George Washington University
2004	B.A., Mathematics and Sociology, Grinnell College

Positions

2004 -	Mathematica Policy Research
2010 -	Researcher
2006 - 2010	Research Analyst
2004 - 2006	Research Assistant/Programmer
2003 - 2004	Statistics Tutor, Grinnell College, Grinnell, IA
2003	Research Intern, Institute for Women's Policy Research, Washington, DC

Experience

Mathematica

Researcher, Enhancing the Adoption of Comparative Effectiveness Research in the Treatment of Serious Mental Illness in Medicaid (2010 -). Conducted literature review on the factors that influence state Medicaid agencies to adopt evidence-based practices to treat beneficiaries with serious mental illness. Authored report on the use of the Medicaid Analytic eXtract (MAX) data to identify beneficiaries with schizophrenia and bipolar disorder and their receipt of evidence-based practices. This project, funded by the Office of the Assistant Secretary for Planning and Evaluation, will use MAX data to identify the combinations of benefit design, payment, and organizational arrangements that best support the use of evidence-based practices for the severely and persistently mentally ill population in Medicaid.

Analyst (2009 - 2010), Researcher (2010 -), Analysis of Health Care Provider and Health Care Payer Costs and Cost Trends (2009 -). Drafted analysis plan and wrote programming specifications for an analysis of private payer claims data, including an analysis that decomposed total changes in medical expenditures into changes in price, quantity, and intensity of services. Led evaluation of data quality of medical claims data submitted by each commercial carrier in Massachusetts. Led analysis of a survey of the methods used by carriers to pay providers. This project will provide the analytic and technical support to develop Massachusetts' annual health care cost trends reports for the Division of Health Care Finance and Policy, as required by statute.

Analyst (2008 - 2010), Researcher (2010 -), Evaluation of Risk Selection in Market-Based State Programs (2008 -). Led analysis of CommCare claims and eligibility data to determine enrollees' demographic characteristics and average service use and costs. Wrote sections of the final report. This project, funded by the Robert Wood Johnson Foundation, evaluated the extent of risk selection in Massachusetts' Commonwealth Care program initially and over time, and compared program risk and cost to the commercial individual market in the state.

Analyst, Evaluation of the Electronic Health Records (EHRs) Demonstration (2008 -). Coordinated site visits and data collection for interviews with small physician practices participating in the demonstration. Wrote sections of the site visit report. This project will evaluate the effect of a demonstration by the Centers for Medicare & Medicaid Services (CMS) to encourage small- to medium-sized physician practices to adopt and better use EHRs to improve care quality.

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Analyst (2009 - 2010), Researcher (2010 - 2011), Rehospitalization in New York State and Implications for Avoidable Cost (2009 - 2011). Conducted literature review of care interventions that show promise for reducing avoidable hospital readmission and created estimates of the per-discharge cost of implementing most promising interventions. Wrote sections of the analysis plan and created programming specification to identify readmissions in the discharge data, assign each readmission to an index hospitalization, and calculate readmission rates for each hospital. Wrote sections of the final report. This project will address the knowledge gap in the frequency and cost of avoidable hospital readmissions in New York using hospital discharge data for all adults admitted to a New York hospital between 2006 and 2008. The study identifies geographic areas, conditions, and patient cohorts in New York with high rates of avoidable readmissions; reviews current payment reforms and care interventions; and estimates the potential savings in New York from adopting payment reforms that induce hospitals to adopt evidence-based interventions reducing readmission rates.

Analyst, Study of Rhode Island's Uninsured (2009 - 2010). Used survey and administrative data to identify the sources and amount of local, state, and federal funding used to provide uncompensated care to the uninsured in the state and wrote sections of the final report. This project, funded by The Rhode Island Foundation, estimated the number of uninsured Rhode Islanders in 2010, the costs of their care, and the likely cost of care if they were insured and explored opportunities for reprogramming existing federal and state funds to cover the cost of expanding coverage in Rhode Island.

Analyst, Analytic Support for Washington Citizens' Work Group on Health Care (2008 - 2009). Developed the economic impact analysis for several health market reform proposals using Bureau of Economic Analysis multipliers. Funded by the Washington State Legislature, this project used microsimulation modeling to evaluate the potential implementation impacts of five alternative proposals for major health reform.

Analyst and Task Leader (2007 - 2009), Analyst and Project Manager (2005 - 2007), Medicaid Mental Health Services—Program and Analytic Reports (2005 - 2009). Led team of programmers and project staff in the creation of state-by-state MAX tables describing the service use and expenditures for fee-for-service Medicaid beneficiaries with mental health or substance abuse diagnoses in 2003. Coordinated an expert panel soliciting feedback from state Medicaid agency staff, state mental health agency staff, and mental health advocacy organizations on proposed analysis of Medicaid mental health service use and expenditures. Created summary measures and explanatory cover page about the quality and completeness of each state's MAX data. Coauthored a chartbook aimed at a nontechnical audience about the findings. Worked with research team to conduct and write up telephone interviews of 51 state Medicaid agency directors. Led analysis of the quantitative survey results and wrote sections of the final report. This project will help the Substance Abuse & Mental Health Services Administration better understand mental health service use and expenditures in state Medicaid programs.

Analyst, Affordability Proposal for the State of Minnesota (2008). Assisted with the development of a microsimulation model to estimate changes in health insurance coverage and public and private expenditures under a proposed subsidy for low-income workers to purchase employer-based insurance. Funded by the Minnesota Department of Health (MDH), this project provided technical assistance to MDH in developing a proposal to the state legislature to make health care affordable for individuals and workers at or below 300 percent of the federal poverty level.

Analyst, Microsimulation of Health Care Coverage Options in Illinois (2008). Wrote SAS program for a microsimulation model of policy changes in public programs and the individual and group markets in Illinois. Conducted simulations on tight turnaround schedule for client and summarized results. This project provides cost and coverage estimates to the Illinois Department of Healthcare and Family Services in support of the state's health care reform efforts, using a microsimulation model that estimates the impact of proposed health coverage programs five years into the future.

Analyst and Internal Project Director, Updated Analysis of Medicaid Managed Care (2007 - 2008). Used CMS, InterStudy, and telephone and internet research to update the Mathematica/Henry J. Kaiser Family Foundation (KFF) database of all full-risk Medicaid managed care plans in the nation in 2006. Created descriptive tables analyzing changes in the types of plans serving the Medicaid market. Used Medicaid Statistical Information System data to analyze statewide enrollment patterns among the elderly and disabled and National Committee for Quality Assurance data on Health Plan Employer Data and Information Set (HEDIS) plan performance quality measures to investigate quality of care by plan type. This project, funded by KFF, updates previous analyses on the types of fully capitated managed care plans serving Medicaid.

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Analyst and Internal Project Director, Managed Care in the State Children's Health Insurance Program (SCHIP): Enrollment and Plan Characteristics (2007 - 2008). Constructed a plan-level database of all full-risk managed care organizations (MCOs) serving the SCHIP market in 2007, using the biannual SCHIP enrollment survey conducted by the Kaiser Commission on Medicaid and the Uninsured and a Mathematica database of MCOs serving Medicaid enrollees. Created tables documenting the characteristics of MCO plans serving SCHIP enrollees and wrote a summary report. This project for KFF analyzed trends in SCHIP enrollment and the types of managed care plans serving SCHIP enrollees.

Analyst and Project Manager, Long-Term Care (LTC) in New York State (2007). Coordinated site visit and data collection for interviews, gathered and synthesized documents for the literature review, analyzed interview data, and wrote sections of the final report. Under contract with AARP, this project provided a strategic policy analysis of long-term care issues and priorities in New York State through a review of the relevant literature and interviews with key stakeholders in the LTC system.

Analyst and Project Manager, Enrollment Processes for the Medicare Part D Low-Income Subsidy (LIS): Challenges and Opportunities (2006 - 2007). Scheduled and wrote up interviews with key staff in the Social Security Administration, state Medicaid offices, and local advocacy organizations conducting outreach. Assisted with interview data analysis and writing of the final report. Under contract with AARP, this project identified the factors that promote or impede the enrollment of low-income Medicare beneficiaries into the Medicare Part D LIS and Medicare Savings Programs (MSP) and produces recommendations to ease LIS enrollment and increase MSP enrollment.

Analyst, Best Practices for Enrolling Low-Income Beneficiaries into the Medicare Prescription Drug Benefit Program (2005 - 2007). Coordinated survey of all state Medicaid, State Health Insurance Assistance Program, and State Pharmaceutical Assistance Program agencies about outreach activities; drafted an application for Office of Management and Budget approval; researched respondent universe; conducted follow-up phone calls and emails; cleaned data; and analyzed responses. Used results of state survey to assist project team in identifying state agencies as candidates for site visits. Scheduled and wrote up interviews with expert stakeholders, assisted with beneficiary focus groups, and created monthly tables tracking LIS enrollment from CMS administrative data. This project provides CMS with description and analysis of national, state, and local efforts in educating and enrolling low-income beneficiaries into the LIS for Medicare Part D benefits and will identify best practices.

Analyst, Update Food Stamp Program Quality Control (FSPQC) Database and QC Minimodel (2006). Updated the FSPQC database and the QC Minimodel routines that use FSPQC data to simulate the Food Stamp Program (FSP) participant population for U.S. Department of Agriculture (USDA), Food and Nutrition Service (FNS). Refined model specifications and operating parameters, wrote code for new waiver and demonstration projects, analyzed model output, and updated technical documentation.

Research Assistant/Programmer, Identify Trends in Food Stamp Program Eligibility and Participation Rates (2006). Conducted analyses of FSP participation rates based on March Current Population Survey (CPS) and FSPQC data for USDA, FNS. Examined the changes in participation rates over time and assessed differences in rates across subgroups. Wrote final report presenting FSP participation rate trends and described legislative and economic impacts on FSP. Conducted in-depth analysis of the New Immigrant Survey to estimate the number of FSP-eligible immigrants whose sponsors might be subject to income deeming under new FSP rules.

Task Leader, Quick-Response Analyses of Food Stamp Program Issues (2005 - 2006). Conducted quick-turnaround simulations and analyses for the USDA, FNS to estimate the distributional and cost impacts of proposed FSP reforms. Discussed and refined requests with FNS analysts, translated the policy questions into an analysis plan, developed computer specifications, ensured the quality of the resulting estimates, and interpreted and communicated the results to FNS analysts and policymakers. Conducted analyses using the March CPS, Survey of Income and Program Participation (SIPP), and FSPQC databases and the QC Minimodel, MATH® CPS model, and the MATH® SIPP model.

Analyst and Project Manager, Analysis of Medicaid Managed Care Plans (2004 - 2006). Created database of all Medicaid MCOs operating in each state, produced tables analyzing different plan types, and wrote sections of the final report. Researched the availability of publicly reported Consumer Assessment of Healthcare Providers and Systems and HEDIS data on state Medicaid websites and conducted statistical analysis of quality data based on plan characteristics. This project, funded by KFF, examined the availability of publicly reported data on Medicaid managed care plans and how states are using the data for payment updates and health plan incentives.

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Research Assistant/Programmer and Project Manager, Sources of Variation in Food Stamp Participation Rates (2004 - 2006). Researched and assembled state policy and economic data, merged FSPQC and CPS data to predict household-level FSP participation, and created SAS programs to estimate standardized state rates. Under contract with USDA, Economic Research Service, this project used a two-stage multivariate technique to examine the variation across states in the rates at which people participate in the FSP.

Research Assistant/Programmer, Evaluation of Three Models Designed to Increase Participation of Eligible Elderly in the Food Stamp Program (2004). Updated programs that converted case record extract files from six states and created a master analysis file for each state, created SAS and Stata code to estimate regression models that identified the impacts of the demonstrations, and produced Excel tables of the results. Wrote programs to conduct significance tests and created tables and graphs presenting results. This project evaluated six demonstrations funded by USDA to increase FSP participation rates among the eligible elderly.

Grinnell College

As **Statistics Tutor (2003 - 2004)** in the Math Department, tutored students one-on-one and was a teaching assistant in an introductory-level statistics class.

Institute for Women's Policy Research

As **Research Intern (2003),** coauthored a literature review on women and civic activism, including analysis of national election study data using SPSS. Created descriptive statistics from an econometric model of a proposed paid family and medical leave program in the state of Illinois.

Papers, Publications, and Presentations

Chollet, Deborah, Allison Barrett, and Amy Lischko. "Selection in Massachusetts' Commonwealth Care Program: Lessons for State Basic Health Plans." Final report submitted to the Robert Wood Johnson State Health Access Reform Evaluation (SHARE) program. Washington, DC: Mathematica Policy Research, August 2011.

Chollet, Deborah, Allison Barrett, and Timothy Lake. "Reducing Hospital Readmissions in New York State: A Simulation Analysis of Alternative Payment Incentives." Report to the New York State Health Foundation. Washington, DC: Mathematica Policy Research, July 2011.

Chollet, Deborah, Allison Barrett, and Amy Lischko. "Selection in Massachusetts's Commonwealth Care Program: Lessons for State Basic Health Programs." Presentation at the AcademyHealth Annual Research Meeting, Seattle, June 12, 2011.

Barrett, Allison, Jonathan D. Brown, and Emily Caffery. "Strategies for Using Medicaid Analytic Extract Data to Study the Receipt of Evidence-Based Practices for Schizophrenia and Bipolar Disorder." Final report submitted to the U.S. Department of Health and Human Services, Assistant Secretary of Planning and Evaluation. Washington, DC: Mathematica Policy Research, May 11, 2011.

Felt-Lisk, Suzanne, Rachel Shapiro, Christopher Fleming, Brenda Natzke, Allison Barrett, and Grace Anglin. "Electronic Health Records Demonstration Evaluation: Implementation Report 2010. Final Report." Washington, DC: Mathematica Policy Research, January 20, 2011.

Ireys, Henry T., Allison Barrett, James M. Verdier, Ann Bagchi, Carol Irvin, Christine Yip, Jeffrey A. Buck, and Judith Teich. "Mental Health and Substance Abuse Services in Medicaid, 2003: Charts and State Tables." DHHS Publication no. (SMA) 10-4608. Rockville, MD: Substance Abuse & Mental Health Services Administration, Center for Mental Health Services, 2010.

Chollet, Deborah, Allison Barrett, and Bill Erwin. "Individual Health Coverage." In *Covering Health Issues,* 5th edition. Washington, DC: The Alliance for Health Reform, 2010.

Ireys, Henry, Allison Barrett, Jeffrey Buck, Thomas Croghan, Melanie Au, and Judith Teich. "Medicaid Beneficiaries Using Mental Health or Substance Abuse Services in Fee-for-Service Plans in 13 States, 2003." *Psychiatric Services,* vol. 61, September 2010, pp. 871-877.

Pavetti, LaDonna, Michelle K. Derr, Jacqueline Kauff, and Allison Barrett. "Mental Health Conditions and Service Use Among Welfare and Disability Program Participants Enrolled in Fee-for-Service Medicaid." *Psychiatric Services,* vol. 61, May 2010, pp. 495-499.

Chollet, Deborah, Jeffrey Ballou, Allison Barrett, and Thomas Bell. "Study of Rhode Island's Uninsured: Current Costs and Future Opportunities." Report submitted to The Rhode Island Foundation. Washington, DC: Mathematica Policy Research, March 2010.

Barrett, Allison, and Timothy Lake. "Provider Payment: Trends and Methods in the Massachusetts Health Care System." Publication no. 10-43-HCF-02. Boston: Division of Health Care Finance and Policy, February 2010.

Chollet, Deborah, Su Liu, Allison Barrett, Kate Stewart, and Thomas Bell. "Massachusetts Health Care Cost Trends: Health Spending Trends for Privately Insured 2006-2008." Publication no. 10-43-HCF-08. Boston: Division of Health Care Finance and Policy, February 2010.

Chollet, Deborah, Jeffrey Ballou, Alison Wellington, Thomas Bell, Allison Barrett, Gregory Peterson, and Stephanie Peterson. "Analytic Support for Washington Citizens' Work Group on Health Care: Evaluation of Health Care Reform Proposals." Report to the Washington State Legislature. Washington, DC: Mathematica Policy Research, 2009.

Chollet, Deborah, Kate Stewart, and Allison Barrett. "Analysis of Minnesota Affordability Proposal: Final Revised Report." Report submitted to the Minnesota Department of Health. Washington, DC: Mathematica Policy Research, December 2008.

Verdier, James, and Allison Barrett. "How Medicaid Agencies Administer Mental Health Services: Results from a 50-State Survey." *Psychiatric Services,* vol. 59, no. 10, October 2008, pp. 1203-1206.

Chollet, Deborah, Su Liu, Kate Stewart, Alison Wellington, Allison Barrett, Mila Kofman, and Amy M. Lischko. "Final Report: Health Insurance Exchange Study." Report submitted to the Minnesota Department of Health. Washington, DC: Mathematica Policy Research, March 2008.

Verdier, James, Allison Barrett, and Sarah Davis. "Administration of Mental Health Services by Medicaid Agencies." DHHS Publication no. (SMA) 07-4301. Rockville, MD: Substance Abuse & Mental Health Services Administration, Center for Mental Health Services, 2007.

Laschober, Mary A., Leslie Foster, Allison Barrett, and Jung Kim. "Case Studies Report: Best Practices for Enrolling Low-Income Beneficiaries into the Medicare Prescription Drug Benefit Program." Draft report submitted to the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. Washington, DC: Mathematica Policy Research, November 2007.

Lipson, Debra, Angela Merrill, Allison Barrett, and Noelle Denny-Brown. "Doors to Extra Help: Boosting Enrollment in the Medicare Part D Low-Income Subsidy." Washington, DC: AARP Public Policy Institute, September 2007.

Lipson, Debra, and Allison Barrett. "Long Term Care Reform in New York State: Issues and Priorities." Final report submitted to the AARP Public Policy Institute. Washington, DC: Mathematica Policy Research, September 2007.

Felt-Lisk, Suzanne, Allison Barrett, and Rebecca Nyman. "Toward Transparency: Public Reporting of Quality Information on Medicaid Health Plans." *Health Care Financing Review,* vol. 28, no. 3, spring 2007, pp. 5-16.

Verdier, James, Allison Barrett, and Sarah Davis. "Administration of Mental Health Services Under Medicaid." Presentation at the Substance Abuse & Mental Health Services Administration Joint National Conference on the Future of the Mental Health System, Washington, DC, May 31, 2007.

Barrett, Allison. "Characteristics of Food Stamp Households: Fiscal Year 2005." Final report submitted to the U.S. Department of Agriculture, Food and Nutrition Service. Washington, DC: Mathematica Policy Research, September 2006.

Barrett, Allison, and Daisy Ewell. "Technical Documentation for the Fiscal Year 2005 FSPQC Database and QC Minimodel." Report submitted to the U.S. Department of Agriculture, Food and Nutrition Service. Washington, DC: Mathematica Policy Research, September 2006.

Barrett, Allison, and Anni Poikolainen. "Food Stamp Participation Rates: 2004." Report submitted to the U.S. Department of Agriculture, Food and Nutrition Service. Washington, DC: Mathematica Policy Research, June 2006.

Czajka, John, Scott Cody, Sarah Avellar, Julie Sykes, and Allison Barrett. "Analysis of Long-Term Dynamics with the Survey of Program Dynamics." Washington, DC: Mathematica Policy Research, September 2004.

Information Technology

SAS, Stata, SPSS, Excel, Access, PowerPoint, Word

MATHEMATICA
Policy Research

Amy Wodarek O'Reilly
Senior Program Analyst

Education

2007	M.P.A, The Ohio State University
2004	B.A., Spanish, magna cum laude, St. Louis University
2004	B.A., History, magna cum laude, St. Louis University

Positions

2007 -	Mathematica Policy Research
2011 -	Senior Program Analyst
2007 - 2011	Program Analyst
2006 - 2007	Medicaid Health Systems Analyst, Ohio Health Plans, Columbus, OH
2004 - 2005	Inside Sales Representative, IC Flow Controls, Inc., Rossford, OH
2003 - 2004	Intern, Robert E. Faerber, Esq., Clayton, MO
1999 - 2004	Lead Supervisor, St. Louis Gateway Arch, St. Louis, MO

Experience

Mathematica

Senior Program Analyst, Research and Evaluation of the Money Follows the Person Demonstration Grants and Technical Support to Centers for Medicaid and State Operations (2011 -). Update the Centers for Medicare & Medicaid Services (CMS) conceptual data model by collecting additional business requirements for data and identifying the data relationships to program operations. Assess technical alternatives to collecting Medicaid and the Children's Health Insurance Program (CHIP) claims and encounter data to ensure that CMS has sufficient data to analyze program operations and investigate program integrity issues. Provide substantive support on Medicaid and CHIP data quality issues.

Senior Program Analyst, Performance Standards and Reporting for Supplemental Nutrition Assistance Program (SNAP) Modernization Initiatives (2008 -). Conduct research and stakeholder interviews to identify performance data and measures being used in SNAP modernization initiatives. Colead a group of 10 data collectors; convened team meetings; and provided guidance, oversight, and quality assurance. Lead development of data collection template preliminary analysis and interview protocols. Assisted in the development of the data collection plan from more than 300 telephone interviews and 10 site visits for information about SNAP performance measures used to assess modernization initiatives. This project for the U.S. Department of Agriculture, Food and Nutrition Service examines SNAP modernization activities and assesses the pros and cons of applying alternative performance measures and standards across states.

Program Analyst, Medicaid Statistical Information System (MSIS) (2011). Assisted with creating a new MSIS data dictionary by reviewing data element definitions and valid values, which reconciles the MSIS 2010 version with the proposed MSIS Plus files, and incorporated limited data requirements. The revised MSIS data dictionary will be used in a pilot project to assess the ability of state Medicaid programs to extract additional data needed to assess the enrollment and expenditures of the Medicaid and CHIP programs. This work supports CMS's Medicaid and CHIP Business Information Solutions Council information management strategy to develop an enterprise system to collect, store, and analyze Medicaid and CHIP program policies and administrative data.

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Program Analyst, Evaluation and Technical Assistance: Ticket to Work (TTW) Initiatives, Project Year 3 (2010 - 2011). Translated business requirements into the Medicaid and CHIP conceptual data model and identified data standards from other agencies such as the U.S. Department of Health and Human Services and the U.S. Census Bureau to guide the model development. Led the analysis of and authored report sections on current sources of and needs for data on services and expenditures, providers, and quality. Identified opportunities to reduce state reporting burden and duplicative data submissions. Analyzed provider claims submission and payer remittance procedures to state Medicaid agencies and clearinghouses when using Health Insurance Portability and Accountability Act forms, other electronic methods, and paper forms. This project involved designing an implementation strategy to improve the completeness, accuracy, timeliness, and processing of state Medicaid data, developing a Medicaid and CHIP conceptual data model, and documenting data and functional needs of all CMS staff using Medicaid data, including CMS, CHIP, and Survey & Certification, the Center for Innovation and Strategic Planning, and the Center for Program Integrity.

Program Analyst, Evaluation and Technical Assistance: Ticket to Work Initiatives, Project Year 2 (2009 - 2010). Conducted stakeholder interviews and detailed requirements analysis to identify business needs and requirements for a decision support system (DSS) for the CMS Disabled and Elderly Health Programs Group (DEHPG). Designed data collection profiles and templates. This project for CMS identified all administrative data sources DEHPG uses to manage large grant programs, Medicaid waiver programs, and state plan amendments; outlined an approach to increase analytic abilities; and developed system specifications for the development of a DSS, which would be comprised of an integrated database of Medicaid and Medicare claims data, as well as other sources, and business intelligence tools for reporting and analytics.

Lead Program Analyst and Project Manager, State Unemployment Insurance (UI) Independent Verification & Validation (IV&V) Reviews (2007 - 2010). Managed client relations, technical assistance, and training for state staff; led site visit reviews of state manuals; managed on-site data element validation; performed project management; and drafted interim and final reports. Under direct contracts with more than a dozen states, Mathematica conducted IV&V of state UI benefits and tax data systems. Mathematica assesses all state validation products against federal standards and issues certification once the assessment is complete.

Program Analyst, Evaluation and Technical Assistance: Ticket to Work Initiatives, Project Year 1 (2008 - 2009). Developed a comprehensive information management plan for the CMS DEHPG. Developed interview protocols, conducted site visit interviews, and summarized key findings and wrote recommendations for reports. This project for CMS identifies all administrative data sources DEHPG uses to manage large grant programs, Medicaid waiver programs, and state plan amendments; outlines an approach to increase analytic abilities; and develops system specifications to be used for the development of a DSS.

Program Analyst, Performance Reporting and Administrative Support for the Medicaid Grant Initiatives (2007 - 2009). Designed site visit protocols, prepared site visit briefings, conducted site visit interviews with state staff, prepared state profiles and cross-state summaries, developed the conference presentation, and wrote the site visit summary report. Mathematica, in collaboration with Ascellon Corporation, is assisting CMS DEHPG and the Office of Acquisition and Grants Management in managing several grant programs established through the New Freedom and TTW initiatives. The programs covered by this project include the Medicaid Infrastructure Grant, Real Choice Systems Change grants, and Direct Service Workers grants.

Program Analyst, Senior Community Service Employment Program (SCSEP) Software Technical Assistance and Data Collection and Reporting System (2007). Assisted in the implementation of the SCSEP data validation initiative including selecting data elements to validate, developing the process and procedures, writing the SCSEP data validation handbook, and testing the web-based data validation system. Mathematica assists the U.S. Department of Labor, Employment and Training Administration, Division of Adult Services (DAS) with the implementation of SCSEP program requirements. SCSEP Performance and Results QPR is a web-based data collection, reporting, and performance measurement system used by 74 SCSEP grantees and approximately 1,000 users to report participant information and performance results to DAS.

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Ohio Department of Job and Family Services

As **Medicaid Health Systems Analyst (2006 - 2007)** for Ohio Health Plans (the state Medicaid program), researched and prepared issues briefs on federal and state cost avoidance initiatives, as well as reimbursement methodologies and policies, for senior-level managers and the governor. Analyzed Medicaid's inpatient hospital reimbursement system by conducting statistical analysis, using cost-to-charge ratios and the health care inflationary index for the years 2001-2005. Researched emerging trends in Medicaid policy and summarized the key findings in a weekly newsletter for the Bureau of Health Plan Policy. Collected and verified hospitals' National Provider Identifiers to assist the state in transitioning to the new billing policies initiated under the Health Insurance Portability and Accountability Act. Drafted administrative rules for the state of Ohio and developed the pricing structure for new ICD-9 and Healthcare Common Procedure Coding System medical procedure codes. Served on of two Medicaid committees. Researched the methods other Medicaid programs and health care insurance companies used to ensure their beneficiaries received adequate care and reimbursement methodologies for adverse medical events. Researched CMS pay for performance initiatives and presented findings on how these initiatives might be transitioned into a new program for the Ohio Medicaid program.

IC Flow Controls, Inc.

As **Inside Sales Representative (2004 - 2005),** coordinated sales efforts between German, Mexican, and U.S. operations. Translated sales documents to and from Spanish to ensure successful completion of transactions. Processed sales and purchase orders and created promotional materials for clients. Managed company affairs as backup to the vice president of sales.

Robert E. Faerber, Esq.

As **Intern (2003 - 2004),** researched case information and managed client communications. Served as a liaison with the St. Louis County and City Courts. Assisted in administrative and operations tasks.

St. Louis Gateway Arch

As **Lead Supervisor (1999 - 2004)** for the Bi-State Development Agency, developed, advanced, and operated entertainment and transportation enterprises. Instrumental in planning, implementing, and evaluating multiple projects, including developing and directing the Gateway Arch call center and redesigning the employee performance evaluation system.

Papers and Publications

Borden, William S., Cheryl Camillo, Stephen Kuncaitis, Nathan Myers, Megan Reilly, Cara Weiss, and Amy Wodarek O'Reilly. "Revised Medicaid Statistical Information System: Data Dictionary." Washington, DC: Mathematica Policy Research, April 29, 2011.

Borden, William S., Cheryl A. Camillo, Matthew Potts, Megan Reilly, Cara Weiss, and Amy Wodarek O'Reilly. "Improving the Completeness, Accuracy, and Timeliness of Medicaid Data." Report submitted to Centers for Medicare & Medicaid Services Disabled and Elderly Health Programs Group. Princeton, NJ: Mathematica Policy Research, July 13, 2010.

Borden, William S., Cheryl A. Camillo, Megan C. Davis, Henry T. Ireys, Matthew Potts, Megan Reilly, Cara Weiss, and Amy Wodarek O'Reilly. "Medicaid Decision Support System User Requirements and Data Specifications." Report submitted to the Centers for Medicare & Medicaid Services, Disabled and Elderly Health Programs Group. Princeton, NJ: Mathematica Policy Research, January 22, 2010.

Borden, William S., Brandon N. Kyler, Gail Eulenstein, Amy Wodarek O'Reilly, and Michael M. Kerachsky. "Nebraska Workforce Development Final UI Benefits IV&V Report." Princeton, NJ: Mathematica Policy Research, July 28, 2009.

Borden, William S., Brandon Kyler, Amy Wodarek O'Reilly, Michael Kerachsky, and Gail Eulenstein. "Georgia Department of Labor Final UI Benefits and Tax IV&V Report." Princeton, NJ: Mathematica Policy Research, March 31, 2009.

Borden, William S., Brandon Kyler, Amy Wodarek O'Reilly, Michael Kerachsky, and Gail Eulenstein. "New York Department of Labor Final UI Benefits and Tax IV&V Report." Princeton, NJ: Mathematica Policy Research, March 31, 2009.

Borden, William S., Brandon N. Kyler, Michael M. Kerachsky, Gail Eulenstein, and Amy Wodarek O'Reilly. "District of Columbia Department of Employment Services Final UI Benefits and Tax IV&V Report." Princeton, NJ: Mathematica Policy Research, March 31, 2009.

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Ireys, Henry T., William Borden, and Amy Wodarek O'Reilly. "Building a Decision Support System for the Disabled and Elderly Health Programs Group: Phase 1, An Information Management Plan." Princeton, NJ: Mathematica Policy Research, February 19, 2009.

Borden, William S., Brandon Kyler, Amy Wodarek O'Reilly, and Michael Kerachsky. "Utah Department of Workforce Services Final UI Benefits and Tax Independent Verification and Validation Report." Princeton, NJ: Mathematica Policy Research, December 15, 2008.

Borden, William, Brandon Kyler, Kevin Conway, Amy Wodarek O'Reilly, and Michael Kerachsky. "Virginia Employment Commission Final UI Benefits and Tax IV&V Report." Princeton, NJ: Mathematica Policy Research, September 20, 2008.

Borden, William, and Amy Wodarek O'Reilly. "Ability of MIG Grantees to Report on Program Participation and Outcomes for People with Disabilities: Findings from Four State Site Visits." Princeton, NJ: Mathematica Policy Research, July 18, 2008.

Borden, William S., Brandon N. Kyler, Kevin J. Conway, Gail Eulenstein, Amy Wodarek O'Reilly, and Michael M. Kerachsky. "Tennessee Department of Labor and Workforce Development Final UI Benefits and Tax IV&V Report." Princeton, NJ: Mathematica Policy Research, March 31, 2008.

Borden, William S., Brandon N. Kyler, Kevin J. Conway, Gail Eulenstein, Amy Wodarek O'Reilly, and Michael M. Kerachsky. "Employment and Security Commission of North Carolina Final UI Benefits and Tax IV&V Report." Princeton, NJ: Mathematica Policy Research, March 21, 2008.

Borden, William, Kevin Conway, Terry Cram, Shelly Craig, Yingying Xu and Amy Wodarek O'Reilly. "SCSEP Data Validation Handbook." Princeton, NJ: Mathematica Policy Research, February 6, 2008.

Borden, William S., Grace F. Roemer, and Amy Wodarek O'Reilly. "MIG Performance and Outcome Data Quality Pilot: State Site Visit Protocol." Princeton, NJ: Mathematica Policy Research, January 24, 2008.

Borden, William S., Brandon N. Kyler, Kevin J. Conway, and Amy Wodarek O'Reilly. "Kansas Department of Labor UI Benefits Data Validation IV&V Certification: Final Report." Princeton, NJ: Mathematica Policy Research, January 18, 2008.

Borden, William S., Brandon N. Kyler, Kevin J. Conway, and Amy Wodarek O'Reilly. "Rhode Island Department of Labor and Training UI Data Validation IV&V Certification: Final Report." Princeton, NJ: Mathematica Policy Research, January 14, 2008.

Borden, William S., Kevin J. Conway, Theresa D. Cram, Shelly Craig, Amy Wodarek O'Reilly, and Yingying Xu. "SCSEP Data Validation Handbook for Program Year 2006." Princeton, NJ: Mathematica Policy Research, November 28, 2007.

Borden, William S., Brandon N. Kyler, Kevin J. Conway, and Amy Wodarek. "Texas Workforce Commission UI Benefits Data Validation IV&V Certification: Final Report." Princeton, NJ: Mathematica Policy Research, September 27, 2007.

Presentations

Borden, William S., and Amy Wodarek O'Reilly. "State Data Capacity to Report on MIG Progress." Presentation at the Medicaid Infrastructure Grant/Demonstration to Maintain Independence and Employment Summit: Melding Data and Policy. New Orleans, April 22, 2008.

Awards

2004	University Honors Program Graduate
2004	Phi Alpha Theta, National History Honors Society
2004	Sigma Delta Pi, National Spanish Honors Society
2000, 2004	Dean's List, St. Louis University
2000 - 2004	St. Louis University Dean's Scholarship
2000 - 2004	Missouri Higher Education Academic Scholarship

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Information Technology

Word, Excel, PowerPoint, Access, Visio, Outlook, SPSS, SAS

Languages

Fluent in Spanish

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MATHEMATICA
Policy Research

Thomas Bell

Principal Program Analyst

Education

1991	M.B.A., Wake Forest University
1981	B.S., Business Administration, University of Pittsburgh

Positions

2008 -	Mathematica Policy Research
1999 - 2008	Senior Programmer Analyst, Social & Scientific Systems, Inc., Silver Spring, MD
1991 - 1999	U.S. Census Bureau, Washington, DC
1995 - 1999	Supervisory Survey Statistician
1991 - 1995	Survey Statistician
1983 - 1989	Survey Statistician, U.S. Census Bureau, Washington, DC

Experience

Mathematica

Principal Program Analyst, Project Evaluation Activity in Support of Partnership for Patients (PfP) (2011 -). Provide feedback on design plan that will conduct impact analysis of the PfP initiative on health care outcomes and spending and audit the adverse inpatient events and readmission rates of participation hospitals. Provide guidance on data sources that can be used to conduct this analysis.

Principal Program Analyst, Development of Physician Quality and Resource Use Reports Using Medicare Fee-for-Service Beneficiary Data (2011 -). Review SAS program code that calculates Medicare quality measures. Review code to make sure it is consistent with specifications, is efficient and will optimize production resources, and follows standards and acceptable practices for eliminating errors. Provide feedback the programmer and specification writer and follow-up as needed.

Principal Program Analyst, Production and Implementation of Hospital Outcome/Efficiency Measures (2011 -). Serve as quality adviser to ensure that all measures are computed according to state quality plan review plan for this project for the Centers for Medicare & Medicaid Services (CMS). Provide feedback and suggestions on the design and implementation of the quality review plan.

Principal Program Analyst, Commercial Health Insurance and Public Sector Health Coverage Technical Assistance (2011). Wrote SAS programs that computed the coverage rate for employer health insurance for selected services of interest to the client. These rates were calculated using the Medical Expenditure Panel Survey (MEPS) event files. These coverage rates will be used by the client during the design phase of health exchanges.

Principal Program Analyst, Commercial Health Insurance and Public Sector Health Coverage Technical Assistance (2011). Wrote SAS programs to identify the percentage of health care services covered by employer group insurance using MEPS. Designed plan to determine which services are covered, not covered, or covered and paid by insurer during the deductible period. Programmed tables from the April filings from the National Association of Insurance Commissioners on the market share of association health plans.

Principal Program Analyst, Planning for Alabama's Health Benefit Exchange (2011). Programmed micro-simulation models assessing the characteristics of persons that will purchase insurance through the Alabama health exchange under the Patient Protection and Affordable Care Act. Wrote SAS code to proportionally reweight the 2009 American Community Survey (ACS) data to represent 2010 population. Produced report tables using SAS and provided input for the report's method section.

Principal Program Analyst, Reducing Hospital Readmissions in New York State (2011). Programmed micro-simulation models of interventions to reduce hospital readmissions in New York State. Wrote SAS programs to identify 14-day and 30-day hospital readmissions and transfers using the New York hospital discharge database. Wrote SAS code to determine the probability of readmission occurring under each of the interventions and produce tables showing results.

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Principal Program Analyst, Minnesota's Health Reform Initiative: Provider Peer Grouping (2010 - 2011). Prepared plans for converting Minnesota All-Payer Database from Oracle database to SAS. Based on analysis plan, rearranged data from Oracle tables to SAS files so that SAS programs to compute the peer-grouping were efficient.

Principal Program Analyst, Analysis of Health Care Provider and Health Care Payer Costs and Cost Trends (2009 - 2011). Directed a staff of programmers on tasks to load, clean, and tabulate data from commercial health insurance carriers in Massachusetts. Prepared specification to match programmers' skill and experience with health insurance claims and enrollment data. Provided guidance for efficient SAS coding for large data sets. Scheduled tasks and monitored progress. Provided support to research team about data limitations and proper interpretation of results.

Principal Program Analyst, Study of Rhode Island's Uninsured (2009). Wrote SAS code to proportionately weight the MEPS Household Component to the projected 2010 Rhode Island population. Produced tables of the number and health care spending of uninsured in Rhode Island through 2010. In addition, prepared MEPS analysis files used to determine the direct and indirect costs of care for the uninsured.

Principal Program Analyst, Establishing Health Care Spending Projections and Certifying Actual Health Care Spending (2009). Prepared an analysis of improving the estimate of health spending among Minnesota residents. Options for improvement were provided and a recommendation was offered for each payer group in the current Minnesota health account.

Principal Program Analyst, Health Insurance Partnership (HIP) Board Studies (2008 - 2009). Programmed micro-simulation models assessing the impacts of HIP on small-group and individual coverage, cost, and financing. Produced simulations in SAS using data from the Washington State Population Survey, administrative data on public programs and insurance markets, and MEPS. Mathematica conducted two studies for the HIP Board. The first was a preliminary study of HIP as a single (and exclusive) market for small groups and individuals within HIP, with common health plan options and rating. The second was a final study, including various public insurance programs in HIP.

Principal Program Analyst, Health Insurance Exchange Study (2008). Used SAS code to reweight the initial data file using results from the 2007 Minnesota Health Assessment Survey. Prepared files for further simulations of take-up and offer. This project assesses the potential impacts of major health insurance reforms that might accompany the development of a statewide health insurance exchange to serve the individual and small group markets in Minnesota.

Social & Scientific Systems, Inc. (SSS)

As **Senior Programmer Analyst (1999 - 2008)** participated in the following projects:

Administration on Aging (AoA) Integrated Database System (2005 - 2008). Managed design and development of an integrated database system of health, social, and economic data of the elderly population for AoA, including defining system requirements and standards in collaboration with AoA staff. Directed staff that processed data from AoA and external sources including the State Programs Reports and National Ombudsman Reporting System data (AoA), Census 2000 and ACS public microdata (U.S. Census Bureau), MEPS (Agency for Healthcare Research and Quality [AHRQ]), and the National Health Interview Survey.

State Universal Health Care Initiatives (2004 - 2008). Developed SAS programs and analytic methods for micro-simulation modeling of program enrollment and cost, as subcontractor to Mathematica. Used extensive knowledge of content and limitations of public data sources including the Annual Social and Economic (ASEC) Supplement (formerly known as the Current Population Survey [CPS] March Supplement), MEPS Household Component, and the ACS Public Use Microdata Sample (PUMS). Built baseline level databases that simulated current condition of program enrollment and costs, including modeling state specific programs and eligibility rules.

State Health Expenditure Account for Maryland Residents (2000 - 2008). Directed the collection and appropriate use of data for annual report on total reimbursements for health care services for Maryland residents, under contract with the Maryland Health Care Commission. Included data from more than 30 sources to produce the total reimbursement estimates provided in the report. Sources included CMS, Maryland Department of Health and Mental Hygiene, Maryland Insurance Administration, CPS, MEPS Household Component data, and other state and federal government sources. Modeled private insurance expenditures by type of service using the MEPS Household Component data (supplemented with data from Area Resource File [ARF]) and the ASEC.

Agency for Healthcare Research and Quality Medical Expenditure Panel Survey (2000 - 2008). Worked with MEPS Insurance Component employer survey data, extracting and tabulating data for AHRQ to respond to data requests. Merged data from U.S. Census County Business Patterns, PUMS, and ARF to MEPS establishment-level data based on industry classification (Standard Industrial Classification and North American Industry Classification System) and geographic location.

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National Academies' Investigation of Social Security Administration (SSA) Representative Payee Program (2006 - 2007). Created analysis files (SAS) from large SSA enrollment databases and representative payee databases. Programmed sample selection methods for a survey of representative payees and beneficiary. This work was done on-site at SSA on the SSA mainframe.

Rush University Chicago Healthy Aging Project (CHAP) (2004 - 2007), Managed project to support obtaining, unduplicating, and validating name and address data of persons to be included in the updated frame for CHAP conducted by Rush University. Assisted in preparing CMS Data User Agreements to acquire Medicare claims and enrollment data for persons enrolled in CHAP. Analysis files were prepared from the CMS Medicare Claims file for use by Rush University staff.

Estimating Enrollment and Eligibility of Native Americans and Alaskan Natives in Centers for Medicare & Medicaid Services Programs (2003 - 2005). Provided programming support to estimate enrollment in each CMS program using enrollment file from CMS, states, and the Indian Health Services (IHS). The project compared enrollment estimates to eligibility estimates derived from CPS and other sources. CMS program enrollment data were obtained from the monthly extract of Medicare Enrollment Database and the Medicaid quarterly enrollment files. Beneficiary records were extracted using the CMS mainframe, and matching to IHS data files was performed locally at SSS.

Medicare Payment Advisory Commission (MedPAC) (1999 - 2005). Provided processing support for various analyses requested by MedPAC. Modeled payments to inpatient providers, modeled cost for rural hospitals, analyzed payment to end stage renal disease patients, validated diagnosis related groups, analyzed payments for the frail elderly, and characterized psychiatric facilities. Most of the processing was done using data provided by CMS on Medicare beneficiaries, claims, stays, and providers. The analyses were completed using SAS, SUDAAN, DFSORT, and COBOL on the National Institutes of Health IBM OS/390 (MVS) system and local desktop Windows environment.

Support for RAND Corporation (2000 - 2002). Created analysis files in support of project to analyze end-of-life patterns of care and spending practices for Medicare beneficiaries. Compiled files from seven years of Medicare Standard Analytic Files claims data and from Medicare Current Beneficiary Survey Access to Care and Cost and Use Files, including claims files.

National Institute on Alcohol Abuse and Alcoholism National Hospital Prevalence Study (2000 - 2002). Provided statistical programming support (SAS, SUDAAN, and MedStat Disease Staging Software) for evaluating population subgroups, investigating validity of measures, exploring the distribution of health conditions associated with alcohol abuse, determining prevalence of drug abuse, and examining various utilization questions related to alcohol. Maintained analytic data set from the Hospital Quality Initiative, including data collected on-site, medical and billing record data, and derived analysis data. Performed comparable analysis using National Longitudinal Alcohol Epidemiology Survey. Assigned and directed work of junior programmer and prepared budget reports for project manager.

U.S. Census Bureau

As **Supervisory Survey Statistician, Economic Planning and Coordinating Division Survey Processing and Products Branch (1995 - 1999),** oversaw annual Company Organization Survey (COS) that collects payroll and organization structure of businesses in the United States. Designed report forms and other mailing materials including the Office of Management and Budget Forms Clearance process. Improved data edits of COS with the increased use of administrative data. Directed and scheduled staff in the resolution of data edit referrals for COS. Oversaw compilation of the annual County Business Patterns (CBP) data product that provides data on employment and payroll data by industry and county. Improved the CBP process by streamlining processing, adding new products by ZIP code, and offering the data in new electronic formats.

As **Survey Statistician, Business Division, Cross Industries Branch (1991 - 1995),** served as the principal analyst for the design and development of the Business Census Automated Processing System, a client-server interactive application that supported all post-data collection activities of the 1992 Economic Censuses. Developed user interface guideline and standards, presented system requirements to senior staff, assisted with database design, wrote system specifications, tested initial system, trained staff, and provided maintenance.

As **Survey Statistician, Business Division, Cross Industries Branch (1983 - 1989),** designed data collection instruments, wrote procedures for data capture, developed techniques for data editing, managed processing flows, determined mailout selection criteria, and created and marketed publications.

Papers and Publications

Chollet, Deborah, Jeffrey Ballou, Allison Barrett, and Thomas Bell. "Study of Rhode Island's Uninsured: Current Costs and Future Opportunities: Final Report." Washington, DC: Mathematica Policy Research, March 11, 2010.

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Chollet, Deborah, Su Liu, Allison Barrett, Kate Stewart, and Thomas Bell. "Massachusetts Health Care Cost Trends Part III: Health Spending Trends for Privately Insured 2006-2008: Technical Report." Boston: Massachusetts Department of Health, Division of Health Care Finance and Policy, February 2010.

Chollet, Deborah, Jeffrey Ballou, Alison Wellington, Thomas Bell, Allison Barrett, Gregory Peterson, and Stephanie Peterson. "Analytic Support for Washington Citizens' Work Group on Health Care: Evaluation of Health Care Reform Proposals. Report to the Washington State Legislature." Washington, DC: Mathematica Policy Research, 2009.

Verdier, James, Margaret Colby, Debra Lipson, Samuel Simon, Christal Stone, Thomas Bell, Vivian Byrd, Mindy Lipson, and Victoria Pérez. "SoonerCare 1115 Waiver Evaluation." Final report submitted to the Oklahoma Health Care Authority. Washington, DC: Mathematica Policy Research, January 2009.

Information Technology

SAS (BASE, STAT, MACRO, ODS), SUDAAN, JPL, Excel

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MATHEMATICA
Policy Research

Grace Ferry
Research Analyst

Education

2009	M.P.H., Health Management and Policy, University of Michigan
2007	B.A., Religion, summa cum laude with honors curriculum, University of Georgia
2007	B.S., Psychology, summa cum laude with honors curriculum, University of Georgia

Positions

2009 -	Mathematica Policy Research
2007 - 2009	Project Manager/Research Assistant, University of Michigan, Ann Arbor, MI
2008	Program and Policy Analyst, Nemours Health and Prevention Services, Newark, DE
2005 - 2007	University of Georgia Center for Undergraduate Research, Athens, GA
2005 - 2007	Research Assistant
2005	Summer Research Fellow

Experience

Mathematica

Research Analyst, Commercial Health Insurance and Public Sector Health Coverage Technical Assistance (2011 -). Led protocol development for semi-structured interviews with insurance brokers and carriers about the impact of current regulations and market factors on the individual and small group market. Conducted interviews with respondents and wrote the report section focused on the qualitative data collection. This analysis will be used to help the Center for Consumer Information and Insurance Oversight develop the health insurance exchange regulations.

Research Analyst, Evaluation of the Children's Health Insurance Program Reauthorization Act of 2009 Quality Demonstration Grant Program (2010 -). Lead development of semi-structured interview protocols for the first round of site visits to 18 states. Wrote sections of the evaluation design report. Helped lead the development and completion of evaluation matrices to track design, measurement, and data collection issues for the distinct initiatives states are implementing under the demonstration. Coauthored the technical assistance plan and coordinated calls with grantees and their partner states to discuss evaluation design issues. This project evaluates a grant program funding 18 states to implement 47 initiatives to improve child health quality. Activities cover a range of areas including quality measurement, health information technology, and medical homes.

Task Leader, Synthesis Reports for Grants and Cooperative Agreements for Transforming Healthcare Quality Through Information Technology (THQIT)—National Research Council Domain 2 (2009 -). Coordinate semi-structured interviews with 17 THQIT grantees. Oversee subcontractor work, lead grantee interviews, and orchestrate the analysis. Conducted qualitative interviews with grant recipients selected as "success stories" and authored two case write-ups highlighting their health IT implementation. Led development of a survey to assess the experiences of planning grant recipients, wrote specifications for data analysis, and authored a memo synthesizing the survey results. Tested and helped refine an abstraction tool to support the project's literature review. Abstracted and helped analyze final reports and publications from grantees and wrote sections for two reports that resulted from the analysis. This synthesis project aims to further the state of knowledge regarding health IT planning and implementation by synthesizing the experiences and reported effects of THQIT grantees.

Research Analyst, Program Evaluation of the Eighth and Ninth Scope of Work Quality Improvement Organization (QIO) Program (2011). Coordinated site visit logistics and led interviews with QIO staff as well as providers at nursing homes, hospitals, and physician offices. Identified key themes from the interview data. This project aims to determine the impact of the QIO program on quality of care for Medicare beneficiaries.

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Research Analyst, Health Care Survey of the U.S. Department of Defense (DoD) Beneficiaries: Data Analysis and Presentation Support (2010 - 2011). Wrote specifications for data analysis and authored an issue brief on DoD beneficiaries' access to specialists. Conducted a literature review on provider acceptance of and beneficiary access to Medicare and Medicaid. This DoD-funded survey assesses beneficiaries' perception of care quality.

Research Analyst, Community Tracking Study (CTS) Round 7 Site Visits (2009 - 2011). Contributed to discussions on protocol development. Coordinated interviews with respondents from large health care organizations for five site visits. Completed semi-structured interviews, analyzed interview data, and contributed to site visit summaries and community reports. Conducted analysis of data from all sites visited to identify cross market themes and trends. CTS, conducted by the Center for Studying Health System Change, is a longitudinal study that tracks changes in the health care systems in 12 markets randomly selected as nationally representative.

Research Analyst, Evaluation of the Electronic Health Records (EHRs) Demonstration (2010). Coordinated site visit logistics and analyzed interviews with small physician practices in Pittsburg participating in the EHR demonstration. Wrote a section of the site visit report summarizing findings from Pittsburg. This project will evaluate the impact of a demonstration to encourage small- to medium-sized physician practices to adopt and better use EHRs to improve care quality.

Research Analyst and Project Manager, Identifying Mental Health Policy Issues in the Context of Health Care Reform, (2009 - 2010). Helped convene an expert panel meeting to discuss white papers on the implications of health insurance exchanges for individuals with mental illness, the impact of expanded health insurance coverage on individuals with mental illness, and the impact of health care reform on the mental health delivery system. Analyzed notes from the expert panel meeting and synthesized the findings in the white papers. Contributed to a policy memo based on this analysis.

University of Michigan

As **Project Manager/Research Assistant (2007 - 2009),** managed financial and logistical operations for the evaluation of a quality improvement intervention aimed at increasing appropriate utilization of services in rural Tanzanian health clinics. Conducted site visits to rural Tanzanian clinics to perform quality assurance checks of local data collection efforts, maintained the project database, and contributed to analysis. Collaborated in questionnaire and sample frame development for a survey to determine the health needs and preferences of Liberian citizens. Drafted grants for program evaluation.

Nemours Health and Prevention Services

As **Program and Policy Analyst (2008)** for Nemours Health and Prevention Services, a nonprofit aimed at preventing obesity and promoting emotional health in children, helped to quantify the social benefits gained through the organization's programs and policies. Reviewed and recommended new programs based on scientific evidence. Wrote program and policy briefs. Presented work to senior managers and external audiences.

University of Georgia Center for Undergraduate Research

As **Research Assistant (2005 - 2007)** for the Barriers to Medication Taking in Pediatric Transplant Patients project, conducted and helped analyze interviews to assess the social and emotional issues facing pediatric transplant patients. Findings from the interviews were used to create programming to improve the health and quality of life for transplant patients in Atlanta area hospitals. Assisted in the creation and testing of a parent-directed intervention that increases appropriate referrals for children with psychological concerns, such as depression and anxiety, for the Increasing Pediatric Referral Rates to Psychological Care project.

As **Summer Research Fellow (2005)** for A Family-Focused Emotion Communication Training Module project, created program materials, including handouts, for a course aimed at teaching caregivers to effectively communicate with maltreated children about emotional experiences. Assisted in developing a system to code parent-child interactions to evaluation the program.

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Papers and Publications

Anglin, Grace. "THQIT Planning Grantee Top-Line Survey Results." Memo submitted to the Agency for Healthcare Research and Quality. Washington, DC: Mathematica Policy Research, October 2011.

Anglin, Grace, and Sue Felt-Lisk. "THQIT Surveys: Results of Questions Asked in Two or More Surveys." Memo submitted to the Agency for Healthcare Research and Quality. Washington, DC: Mathematica Policy Research, October 2011.

Ireys, Henry, Anna Christensen, Leslie Foster, Kelly Devers, Lisa Simpson, Lauren Smith, Rachel Burton, Grace Anglin, Chris Trenholm, and Jenny Kenny. "Design Plan for the National Evaluation." Report submitted to the Agency for Healthcare Research and Quality. Washington, DC: Mathematica Policy Research, February 2011.

O'Malley, Ann, Grace Anglin, Amelia M. Bond, Peter J. Cunningham, Lucy Stark, and Tracy Yee. "Greenville & Spartanburg: Surging Hospital Employment of Physicians Poses Opportunities and Challenges." Issue brief. Washington DC: Center for Studying Health System Change, February 2011.

Felt-Lisk, Suzanne, Rachel Shapiro, Christopher Fleming, Brenda Natzke, Allison Barrett, and Grace Anglin. "Electronic Health Records Demonstration Evaluation: Implementation Report 2010. Final Report." Washington, DC: Mathematica Policy Research, January 20, 2011.

Anglin, Grace. "Referrals to Specialists. Survey of DoD Beneficiaries (HCSDB)." Issue brief submitted to the U.S. Department of Defense. Washington, DC: Mathematica Policy Research, December 2010.

Felland, Laurie, Grace Anglin, Amelia M. Bond, Gary Claxton, Ann S. O'Malley, and Caroleen W. Quach. "Northern New Jersey Health Care Market Reflects Urban-Suburban Contrasts." Issue brief. Washington, DC: Center for Studying Health System Change, December 2010.

Au, Melanie, Suzanne Felt-Lisk, Grace Anglin, and Andrew Clarkwest. "Using Health IT: Eight Quality Improvement Stories." AHRQ Publication no. 10-0102. Rockville, MD: Agency for Healthcare Research and Quality, September 2010.

Christianson, Jon, Grace Anglin, Amelia Bond, Peter Cunningham, Gretchen Kishbauch, and Hoangmai H. Pham. "Detroit: Motor City to Medical Mecca?" Issue brief. Washington, DC: National Institute for Health Care Reform, August 2010.

Au, Melanie, and Grace Anglin. "Literature Review Summary for Planning Grantees." Report submitted to the Agency for Healthcare Research and Quality. Washington, DC: Mathematica Policy Research, February 2010.

Jones, J.B., Virginia Lerch, Andrew Clarkwest, Grace Anglin, and Sue Felt-Lisk. "Literature Review Summary for Implementation Grantees." Report submitted to the Agency for Healthcare Research and Quality. Washington, DC: Mathematica Policy Research, February 2010.

Kruk, Margaret E., Lynn P. Freedman, Grace A. Anglin, and Ronald J. Waldman. "Rebuilding Health Systems to Improve Health and Promote Statebuilding in Post-conflict Countries: A Theoretical Framework and Research Agenda." *Social Science and Medicine,* vol. 70, no. 1, 2009, pp. 89-97.

Redmond, Pat, Judith Feinson, and Grace A. Anglin. "New Expert Recommendations for Prevention and Treatment of Childhood Obesity in Primary Care." Policy paper no. 2. Newark, DE: Nemours Health and Prevention Services, 2008.

Simons, Laura E., Grace A. Anglin, Barry L. Warshaw, William T. Mahle, Robert N. Vincent, and Ronald L. Blount. "Understanding the Pathway Between the Transplant Experience and Health-Related Quality of Life Outcomes in Adolescents." *Pediatric Transplantation,* vol. 12, no. 2, 2008, pp. 187-193.

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Continuing Professional Development

2009 Certificate in Global Health, University of Michigan

Honors

Phi Beta Kappa

Phi Kappa Phi

2007 University of Georgia First Honor Graduate

2006 Courts Scholar

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MATHEMATICA
Policy Research

Marsha Gold
Senior Fellow

Education

1979	Sc.D., Health Services/Evaluation Research, Harvard School of Public Health
1976	M.P.H., Health Planning and Administration, School of Public Health, University of California, Berkeley
1971	M.C.P., Urban Studies and Planning, Massachusetts Institute of Technology
1969	B.S., with distinction, Child Development and Family Relations, Cornell University

Positions

1992 -	Mathematica Policy Research
1987 - 1991	Director, Research and Analysis, Group Health Association of America, Inc., Washington, DC
1986 - 1987	Assistant Professor, Department of Health Policy and Administration, University of North Carolina at Chapel Hill, NC
1981 - 1986	Director, Policy Analysis and Program Evaluation, Maryland Department of Health and Mental Hygiene, Baltimore, MD
1979 - 1981	Economist, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, Washington, DC
1978 - 1979	National Center for Health Services Research Doctoral Dissertation Fellow, Harvard School of Public Health, Cambridge, MA
1976 - 1979	Senior Analyst, Analysis, Management and Planning, Inc., Cambridge, MA
1976 - 1977	Research Assistant, Center for Analysis of Health Practices, Harvard University, Cambridge, MA
1972 - 1975	Senior Analyst, Abt Associates, Inc., Cambridge, MA
1971 - 1972	Administrative Assistant/Systems Analyst, Boston City Hospital Outpatient Department Reorganization Project, Boston, MA

Adjunct Academic Positions

1989 - 2005	Associate, Department of Health Policy and Administration, The Johns Hopkins School of Hygiene and Public Health
1991	Adjunct Associate Professor (summer faculty), George Washington University
1987 - 1988	Adjunct Assistant Professor, University of North Carolina at Chapel Hill
1981 - 1986	Lecturer, Department of Health Policy and Administration, The Johns Hopkins School of Hygiene and Public Health
1981 - 1986	Adjunct Instructor, Georgetown University, Department of Community Medicine

Experience

Mathematica

Coinvestigator, Evaluation of the Robert Wood Johnson Foundation Health Policy Center at the University of New Mexico (RWJF HPC) (2011 -). Contribute to this formative assessment of RWJF HPC and its associated support for doctoral training in the social sciences with an emphasis on expanding Hispanic and Native American leadership in health policy and research. Funded by the human capital team of RWJF.

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Project Director, Support to the Medicare and Children's Health Insurance Program Payment and Access Commission (MACPAC) (2010 -). Lead this rapid turnaround project to support MACPAC in its initial year of operation. Provided senior input on issues associated with managed care in these programs, and helped developed a general framework for use in monitoring access to care. Participated in drafting materials for mandated reports to Congress and oversaw work to convene an expert panel, conduct a literature review, and analyze relevant data to support its efforts.

Coprincipal Investigator, Global Assessment of the Value of Health Information Technology for Economic and Clinical Health (HITECH) Act and of the Office of the National Coordinator for Health Information Technology Programs (2010 -). Oversee analysis of how HITECH programs relate to one another and can be strengthened to promote HITECH"s broader goals. The project includes development of an interdependency model and ongoing capture and analysis of program data, documents, and analyses being generated by related evaluations. This is a five-year project to conduct a high-level assessment of this important national initiative.

Senior Adviser (2008 -), Project Director (2007 - 2008), Evaluation of the Business Case for Quality: Phase II (2007 -). Direct and provide guidance to this multiyear evaluation for the Center for Health Care Strategies, Inc. (CHCS). The project rigorously assesses quality outcomes and leadership on the overall evaluation and includes coordination with the financial outcomes being assessed by the University of North Carolina.

Project Director, Monitoring Medicare Advantage (MA) and Prescription Drug Plans (2004 -). Direct this long-standing collaboration with the Henry J. Kaiser Family Foundation to monitor the MA program, including at various points in time, data development for the Kaiser Health Plan Tracker, monthly monitoring, and issue brief development. The project was expanded to include the monitoring of Medicare prescription drug plans starting in 2006.

Coprincipal Investigator, Establishing Federal Resources to Support the Patient Centered Medical Home (PCMH) (2009 - 2011). Served as core team member on this project to help the Agency for Healthcare Research and Quality (AHRQ) develop an effective communications infrastructure and strategic leadership to reinforce and support emerging efforts around PCMH. Lead task involving environmental scan and stakeholder interviews to provide feedback to the agency on priorities for future work.

Project Director, Evaluation of the National Quality Forum (NQF) Consensus Development Process (CDP) (2010). Led this rapid response project to evaluate how to improve the timeliness, quality, and effectiveness of CDP. Directed the task involving interviews with all stakeholders and oversaw work on the technical process and how it compares with others.

Project Director, Assessing Cross-Cutting Issues in the Robert Wood Johnson Foundation State Focused Coverage Initiatives to Enhance Effectiveness (2009). Directed rapid turn-around project providing strategic consultation to RWJF"s coverage team to conduct a cross-cutting analysis of RWJF"s major state-based coverage programs with the goal of identifying existing linkages and ways of enhancing synergy across programs and between state and national efforts. The project involved document review and interviews with program directors and outside organizations as well as close collaboration with RWJF and program staff.

Senior Adviser, Analysis of the Medicare Advantage Marketplace (2008 - 2009). Advised project team on work for the Assistant Secretary for Planning and Evaluation (ASPE) related to constructing databases and analyses relevant to MA trends and issues. Worked to link beneficiary and plan level data to study enrollment/disenrollment patterns and reviewed literature on pay for performance and other work.

Project Director, Understanding the Structure of Medicare Advantage Plan Benefits and Revealed Beneficiary Preferences (2008 - 2009). Developed issue briefs and reports on characteristics of MA plan premiums and benefits in 2008-2009 and policy implications for issues related to standardization, discrimination, and other issues. The project analyzed the Centers for Medicare & Medicaid Services (CMS) administrative data from Medicare Options Compare and other sources, for AARP"s public policy institute.

Project Director, Evaluation of the American Workers Initiative (2007 - 2009). Directed this formative evaluation of the Rockefeller Foundation's national initiative to enhance the economic security of American workers including short-term income security, retirement security, and health security. The evaluation involved tracking and logic model development, interviews and document review, interim feedback, and assistance with strategic development, including convening and moderating an expert panel. The project paid particular attention to how private products can be used to further public policy goals related to economic security.

Project Director (2005 - 2007), Senior Adviser (2007 - 2009), Evaluation of a Learning Collaborative's Process and Effectiveness to Reduce Health Disparities Among Minority Populations (2005 - 2009). Directed and provided advice for this two-phased evaluation funded by AHRQ of a joint AHRQ/RWJF national health plan learning collaborative intended to reduce racial and ethnic disparities in health care. The evaluation involved document review, interviews, and network analysis to assess communication patterns and other factors that may influence the success of the collaborative, which brings together major health plans and numerous support organizations.

Project Director, Looking at Medicare Advantage: What Has Happened? What Will Happen in the Future? (2007 - 2008). Directed this project to provide timely, policy-relevant analysis for the U.S. Department of Health and Human Services (DHHS), ASPE. The project included descriptive analysis of plan participation, enrollment, benefits/premiums, and quality indicators, using publicly available 2006-2008 MA data and conduct of discussions with a diverse set of national and local firms involved in MA.

Project Director and Principal Investigator, Incorporating Disparities into State Strategies to Monitor and Improve Health Status (2006 - 2008). Directed this project to identify state capacity to monitor the 10 leading health indicators in Healthy People 2010 at the state, substate, and subgroup level; and used case studies to identify the organization, political, and other forces that promote or impede state efforts to use such data to achieve these goals. RWJF sponsored this project through AcademyHealth's Health Care Financing and Organization Project.

Project Director, Evaluation of the Effectiveness of the Agency for Healthcare Research and Quality Grant-Supported Research on Health Care Costs, Productivity, and Market Forces (2006 - 2008). Directed this project to describe the extent, nature and effectiveness of AHRQ's grants-supported research in this area. The project included document review, analysis of administrative and interview data, literature review and framework development, grantee survey, and case study development to describe and provide formative feedback and insight to the agency and others.

Project Director, Assessment of Current Technical Assistance Infrastructure in Relation to the Evolving Regional Quality Strategy of the Quality/Equality Team (2007). Directed this rapid turnaround and intense three-month project that assisted RWJF staff in developing the infrastructure to support this major new project. The work included document review and interviews spanning 19 identified national programs and other organizational grantees to prepare a cross-cutting report as well as individual program summaries.

Senior Adviser, Impact of the Nation's New Medicaid Documentation Requirements in California (2006 - 2007). Assisted the California Endowment in evaluating the impact of these requirements under subcontract to Health Policy Associates. Moderated an advisory panel meeting with national and California stakeholders and commented on evaluation plans and analysis.

Project Director, Study of Federal Spending on Diabetes (2006 - 2007). Directed this fast-paced and broad project to identify the respective role and spending by each federal department on activities that have a bearing on the incidence and progression of diabetes and its complications nationwide. Phase I involved logic model development, cost studies, and budget analysis to develop findings, conclusions, and recommendations for strengthening the federal role. Phase II involved efforts to disseminate findings and encourage their application. The project was sponsored by the National Changing Diabetes Program of Novo Nordisk.

Project Director, Medicare Advantage Benefits and Premiums and Special Needs Plans (SNP) (2006 - 2007). Directed this project for the AARP Public Policy Institute to develop an issue brief analyzing how details of MA benefits and premiums are changing for different types of contracts in 2006 as a result of the introduction of regional offerings and the new Medicare prescription drug program. The brief included analysis of administrative data and a comparison of general MA and SNP benefits and premiums.

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Project Director, Expansion of Consumer Assessment of Health Plans Surveys (CAHPS) Project to Assess Gaps and Long Term Measure Gaps for the Hospital Quality Alliance (HQA) (2006). Evaluated the current state of hospital performance measurement to identify gaps in measures and future priorities to meet the needs of consumers and other stakeholders. The project briefed senior leadership of the HQA, analyzed and consulted with stakeholders, and produced a white paper.

Senior Adviser (2006), Project Director (2005 - 2006), Evaluation of the Medicaid Value Program (MVP): Health Supports for Consumers with Chronic Conditions (2005 - 2006). Directed and served as senior adviser to this project for CHCS to evaluate MVP, which is funded by Kaiser-Permanente"s community benefits program. The project involved work with CHCS and grantees to specify logic models, performance measures, and reporting templates; review reports; and conduct grantee interviews.

Project Director, Analysis of Characteristics of Medicare Advantage Plan Participation (2005 - 2006). Directed this project to provide timely, policy-relevant analysis for the DHHS, ASPE. The project involved a descriptive analysis of publicly available MA data in 2005-2006 and discussions with a diverse set of national and local firms involved in MA.

Project Director, Evaluation of the Agency for Healthcare Research and Quality Partnerships for Quality Program (2005 - 2006). Directed this evaluation of the success and lessons from this early AHRQ program to move research on effective care into practice by forging partnerships with organizations that are in a good position to reach those involved in the delivery of care. The evaluation involved document review and interviews.

Project Director, Assessing Ways to Strengthen the Role of Consumer Groups Within the National Quality Forum (2005 - 2006). Oversaw this RWJF-funded project to examine the ways in which consumers are engaged in NQF, the barriers to engagement, and the strategies RWJF"s quality team might use ensure an appropriate consumer role. The assessment involved document review and interviews.

Project Director, Setting Future Directions: Evaluating Efforts by the Consumer Assessment of Health Plans Surveys and Survey User Networks Projects to Measure and Report on Health Care Quality (2004 - 2006). Directed this project on CAHPS to lead a strategic planning process to help AHRQ and the CAHPS team assess current performance, identify future priorities, and determine appropriate public-private sector roles in meeting these priorities and an appropriate infrastructure to accomplish this. The evaluation included a Delphi Process to assist in priority setting.

Project Director, Evaluation of the National Health Care Purchasing Institute (2002 - 2006). Directed this project that synthesized the history of the program prior to its termination and the lessons to be drawn. This project also included a general analysis of the technical assistance needs of public and private purchasers and their ability to support these efforts and a review of Leapfrog"s efforts to engage purchasers in quality improvement.

Project Director, Medicare Payment Advisory Commission (MedPAC) Task Order Contract to Complete Small Defined Projects on Topics Relating to Medicare, 2000-2002 and 2002-2004 (2000 - 2006). Served as project director for this master contract.

Senior Adviser, 2005 Medicare Advantage Benefits and Premiums (2004 - 2005). Advised staff on this project to analyze trends in MA benefits and premiums in 2005, including trends and variation by plan type.

Project Director, Analysis of Dissemination and Impact of the Integrated Delivery System Research Director (2003 - 2005). Directed this project for AHRQ to provide feedback on issues relevant to the design of program renewal. The analysis included AHRQ interviews, document review, and site visits.

Senior Adviser (2004 - 2005), Principal Investigator (2002 - 2003), Design and Implementation of a Targeted Beneficiary Survey on Access to Physician Services Among Medicare Beneficiaries (2002 - 2005). Conducted a targeted beneficiary survey for Medicare. Provided analytic direction to this study for CMS that surveyed Medicare beneficiaries in the traditional program in selected markets to identify whether there was evidence that physician access was eroding in response to reductions in Medicare physician fees.

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Project Director, Further Evaluation of the Medicaid Managed Care Program of the Center for Health Care Strategies, Inc. (2002 - 2005). Directed this multidimensional evaluation for RWJF to provide systematic feedback on accomplishments to support decisions on program renewal. The evaluation involved surveys of key audiences (state agencies, health plans, consumer groups) among other analyses.

Project Director and Principal Investigator, Evaluation of the Development Process of the National Healthcare Quality Report and the Analysis of the National Healthcare Quality Report Product and National Healthcare Disparities Report Product (2003 - 2004). Evaluated the development and dissemination process for the National Healthcare Quality Report and National Healthcare Disparities Report. Oversaw provision of formative feedback to AHRQ on the development of the National Healthcare Quality Report.

Project Director, Evaluation of California Health Care Foundation's Program for Elders in Managed Care (PEMC) (2002 - 2004). Directed this evaluation of PEMC's efforts to develop and evaluate innovative models of integrated care for Medicare managed care enrollees who are sick and infirm. The evaluation involved synthesizing documents and conducting telephone interviews to guide analysis.

Project Director, Assessing Physician Access in Medi-Cal and Healthy Families (2001 - 2004). Directed this two-part project to develop a conceptual framework identifying barriers to access and the tools available to remedy them; and survey plan and plan sponsors participating in Medi-Cal and Healthy Families about their experience with physician participation, including access to specialists.

Project Director, Monitoring of Medicare+Choice (M+C): Effects on the Insurance Decision Process of Medicare Beneficiaries (1999 - 2004). Directed this major study for RWJF to provide timely and credible information on how beneficiaries were responding to the early implementation of M+C. The study involved national and community-based components with surveys, site visits, administrative data analysis, and an active, multifaceted dissemination strategy. Included a two-year follow-on through 2004.

Project Director, Analysis of Trends in Medicare Managed Care Plan Benefits and Premiums (1998 - 2004). Directed this four-phased project to assess trends in benefits and premiums from 1997 to 2004 and to convene researchers involved in examining M+C to share insights and perspectives.

Project Director, Variation in Medicare Supplemental Markets: Views from the Field (2003). Directed this study involving case studies to multiple markets to learn about the way supplemental markets are structured and the implications of market diversity for Medicare reform.

Project Director, Trends in Coverage Offered Active Workers in Group Plans (2002). Wrote a paper synthesizing existing national studies on employment-based health benefit trends to support MedPAC in preparing its June 2002 report to Congress, modernizing the Medicare benefit package.

Project Director, Analysis of Medicare+Choice Participation Trends (2001 - 2002). Directed this study for the Henry J. Kaiser Family Foundation to analyze various aspects of M+C participation nationally and in California using quantitative and qualitative techniques.

Project Director, Survey of Medicaid Managed Care/State Children's Health Insurance Program (SCHIP) Plans (2000 - 2002). Directed this study of Medicaid and SCHIP contracting health plans for the Henry J. Kaiser Family Foundation to assess its continued participation, provider networks, and quality programs.

Project Director, Expert Panels for the Medicare Payment Advisory Commission (2000 - 2002). Convened and led expert panels on withdrawals from the M+C program on the viability of Medical Savings Accounts in Medicare, and on evolving trends in medical practice and their implications for the Medicare benefit package.

Project Director, A Short-Term Assessment of the Medicaid Managed Care Program of the Center for Health Care Strategies, Inc. (2000 - 2001). Directed this study for RWJF to develop five case studies and an overall analysis of major activities and recommendations for the future.

Senior Adviser, Strategies for Providing Financing for Pharmaceuticals, Implications for Medicare (1999 - 2000). Advised on this study examining techniques used by private and public purchasers to manage drug costs and their implications for cost management of a Medicare drug benefit.

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Project Director, Review of Health Plans' Selection and Payment of Health Care Providers (1998 - 2000). Directed this study for MedPAC to use surveys and other tools to learn how health maintenance organizations (HMOs) and the entities with whom they contract form provider networks, the characteristics of these networks, and how they are paid.

Project Director, Low-Income Populations and Managed Care: Follow-Up Study of Effects on Access, the Safety Net, and Public Policy (1997 - 2000). Directed this study for the Henry J. Kaiser Family Foundation and the Commonwealth Fund of state efforts to restructure their health care systems for Medicaid and uninsured populations.

Principal Investigator, Study of Medicare Managed Care in Four Leading and Unique Markets (1996 - 1999). Collaborated on the design of this study, funded by the Henry J. Kaiser Family Foundation, to understand the dynamics of Medicare managed care in a market context through comparison of four markets: Los Angeles; New York; Portland, Oregon; and Tampa, Florida. Led case studies in two markets and participated in cross-cutting analysis.

Project Director, Research Symposium and Analysis of Measuring Access to Care Through Population-Based Surveys in a Managed Care Environment (1997 - 1998). Directed this project to consider the implications of the changing market for measuring access to health care. Developed framework paper to guide project, convened symposium, and prepared synopsis and dissemination activities.

Senior Adviser and Task Leader, Phase III Evaluation of the Information for State Health Policy Project (1997 - 1998). Advised on this project for RWJF, to prepare materials that disseminate key findings from the evaluation and Phase II work to states and direct the update of the evaluation through the end of the program.

Task Leader, Study of Medicare Managed Care and Delivery Systems for Chronically Ill Elderly Beneficiaries (1996 - 1998). Oversaw a collaborative effort to develop a conceptual framework paper to promote broad-based discussion of issues; helped guide the study for DHHS, ASPE.

Project Director and Principal Investigator, Study of Evolving Health Care Markets (1994 - 1998). Directed this project to help the Physician Payment Review Commission (PPRC)/MedPAC understand the dynamics of evolving health care markets. The study arranged and moderated expert panels on topics important to an understanding of lessons for Medicare and arranged and led site visits during which PPRC staff could discuss dynamics with market leaders and stakeholders.

Project Director, Description of the Changing U.S. Health Care System (1997). Directed and carried out this rapid-turnaround project for the President"s Advisory Commission on Consumer Protection and Quality in the Health Care Industry to prepare an evidence-based synthesis of recent changes in the health care system and their implications for consumers. Report provided the basis for Chapter II of the Commission"s final report.

Project Director, Assessment of the Adequacy of Information on the Changing Health Care System (1996 - 1997). Directed this project, funded by DHHS, to identify and synthesize prior and existing efforts to define and address information gaps associated with the evolving health care industry, key groups and activities under way, and implications for DHHS and others.

Adviser, Center for Analysis of Health Systems Change (1995 - 1997). Provided consultation and technical advice on this "community snapshots" project for 1995 and on the design of the broader, long-term monitoring project for which the center was established (by RWJF). Collaborated on special studies, including a study of the movement to nationwide managed care firms and of trends in Medicaid managed care plans.

Project Director and Principal Investigator, Study of Low-Income Populations and Managed Care (1994 - 1997). Directed this study for the Henry J. Kaiser Family Foundation and the Commonwealth Fund, involving case studies of seven states currently restructuring their health care systems for the Medicaid and uninsured populations, with emphasis on implementation and access to health services.

Project Director and Principal Investigator, Telephone Survey of Medicare Managed Care Enrollees and Disenrollees (1995 - 1996). Directed this study for the PPRC to design, field, and analyze the survey. Identified important content areas.

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Project Director and Principal Investigator, Study of Arrangements Between Managed Care and Physicians (1993 - 1996). Directed Mathematica subcontract on a collaborative effort with the Medical College of Virginia for PPRC to learn what arrangements network-based managed care plans make with physicians. Developed a background paper synthesizing existing research, convened an expert panel, conducted a telephone survey of 108 managed care plans of diverse types to identify practices and emerging trends, and made follow-up site visits to a subsample.

Project Director and Principal Investigator, Evaluation of the Robert Wood Johnson Foundation Information for State Health Policy Program (1992 - 1996). Directed an evaluation for RWJF to determine whether its program to enhance health policy information at the state level improved the quality of data and their application for health policymaking; to identify factors contributing to success, including the effectiveness of the interagency process established by the program; and to undertake related research on the basis of a survey of all 50 states.

Principal Investigator, Health Maintenance Organization Primary Care Practitioner Staffing Patterns (1993 - 1995). Provided technical guidance and oversight for this project for DHHS, Health Resources and Services Administration. Made site visits to more than 20 group/staff, network/Independent Practitioner Association, and heavily Medicaid-dependent HMOs in 10 markets. Topics addressed included primary care staffing and delivery patterns, recruitment effort and success, role of graduate medical education, data, and special issues of the disadvantaged.

Project Director and Principal Investigator, Evaluation of the Medicaid Managed Care Quality Assurance Program Demonstration (1993 - 1995). Directed this evaluation for the Henry J. Kaiser Family Foundation of a joint Henry J. Kaiser Family Foundation/Health Care Financing Administration (HCFA) demonstration of the feasibility and effects of a quality assurance reform initiative for Medicaid managed care programs.

Project Director, Study of the Effects of the Growth of Managed Care and Competitive Health Systems on Academic Medical Centers and Graduate Medical Education (1994). Directed this project to develop and integrate information and analysis of changes in financing and payments to academic medical centers shifting to increasingly competitive systems. The study involved a literature review and case studies of three markets.

Project Director and Principal Investigator, Development of a Medicaid Access Survey (1992 - 1994). Directed Mathematica's subcontract on a collaborative effort with the Georgetown University Center for Health Policy Studies to develop and pilot test an approach to, and instrument for, a national Medicaid Access Survey for PPRC that generated state-based estimates on a timely basis.

Project Director, Cost-Containment Measures for Physician and Other Services (1992 - 1994). Oversaw Mathematica's assistance to HCFA to review the literature and conduct an all-state Medicaid mail survey on the use and effects of Medicaid use management techniques.

Principal Investigator, Design of the All Payer System in Minnesota (1993). Directed the technical work on this contract with Minnesota to recommend a design for the regulated all payer option in Minnesota's health reform legislation, along with analysis of implementation issues and the interface with integrated service networks. The study involved close collaboration with the Minnesota Health Care Commission and Department of Health.

Project Director, Review and Analysis of Past Health Care Cost-Containment Efforts and Impacts on Cost, Quality, and Access to Health Care (1993). Directed this project to prepare background papers and convene high-level policy meetings for U.S. Public Health Service (PHS), HCFA staff. The project examined and synthesized existing research and convened experts on selected previous efforts in health care cost containment to identify their effect on cost quality and access and the lessons for health reform. The review included the Economic Stabilization Program, Carter era proposals, and Voluntary Effort Medicare payment policy, as well as state all payer rate setting. The project briefed senior administration health policy staff.

Project Director, Analysis of Small Group Health Insurance Reform (1992 - 1993). Directed Mathematica's collaborative effort with the Library of Congress Congressional Research Service to develop and execute a strategy for modeling the impact on firms of small-group market-reform proposals to modify underwriting and rating practices.

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Project Director, Technical Support to the Health Insurance Association of America (1992 - 1993). Coordinated Mathematica's technical support to the Health Insurance Association of America to analyze the use of the Current Population Survey, National Medical Expenditure Survey, and other national databases for identifying the characteristics of the uninsured and assessing the likely effects of policy options.

Group Health Association of America, Inc. (GHAA)

As **Director, Research and Analysis (1987 - 1991),** developed databases and performed analyses of the characteristics of and trends and performances in the HMO industry; performed policy analyses of technical issues of concern to the industry; and conducted, promoted, and presented research on the industry and its environment. Developed the *HMO Industry Profile* series and other reports that have become widely recognized; helped GHAA build a solid reputation as a credible source of analysis and research on the HMO industry.

Research Oversight and Direction. Directed a professional department with six staff members who designed, developed, and managed the technical content of all company research publications, including the *HMO Industry Profile* series (an annual three-volume, in-depth report), the *Research Briefs* series, the annual *HMO Market Position Report*, *Sourcebook on HMO Utilization Data*, and the *Patterns of HMO Enrollment*, as well as periodic special reports. Supervised GHAA's Annual HMO Industry Survey and Utilization Data Supplement, the Year End Member Survey, and other periodic surveys. Conducted press briefings and presentations of analytic results to a wide variety of audiences. Served as project officer on the development of *Consumer Satisfaction Survey and User's Manual*. Also served as principal contact with the Association for Health Services Research on external research and policy analyses involving HMOs, including oversight of GHAA's survey endorsement policy.

Policy Analysis and Support. Staffed a variety of analytic activities relevant to policy issues confronting the HMO industry. Served as lead staff member on Medicaid policy issues (including staffing Medicaid Subcommittee and acting as the representative on Medicaid-related panels). Chaired Technical Panel on Medicare Capitation Rating Reform and participated in HCFA expert panels on Medicare research, demonstration, and policy issues. Contributed to analysis of policy issues associated with the Federal Employee Health Benefits Program, restrictions on physician incentives in HMOs, the HMO experience of the Canadian health system as it affects health policy reform, the private insurance market, and other topics. Served on various advisory and technical panels for HCFA and others, and conducted briefings and presentations for policymakers, industry, the press, and others.

Department of Health Policy and Administration, University of North Carolina

As **Assistant Professor (1986 - 1987),** taught graduate students and undergraduates, counseled students, and conducted independent research. Held a concurrent appointment in the Center for Health Services Research. Served as principal adviser on five master's degree candidates' papers and on one doctorate dissertation committee.

Maryland Department of Health and Mental Hygiene

As **Director, Policy Analysis and Program Evaluation (1981 - 1986),** managed an office in the Office of the Secretary that provided department-wide technical support for the full range of health, mental health, and human service programs. Established this office as the first director. Analyzed and designed major legislative and policy initiatives, directed high-priority analytic projects, chaired intra- and extra-departmental committees and task forces, provided testimony before state legislative committees, and analyzed a range of medical care issues. Oversaw the policy analysis offices in each Assistant Secretariat. Was lead staffer for the department's analysis of private insurance issues, state employee health insurance, and new initiatives. Served as liaison with the Health Services Cost Review Commission (the state hospital rate-setting agency) and analyzed proposals for Medicaid reform, maternal and child health program restructuring, and other program initiatives. Testified before the Maryland General Assembly and briefed the governor and executive and legislative committees.

Reorganized Maryland Center for Health Statistics to emphasize analyses of health status and statistical support for policy. Developed the *Health Maryland* series. Added the division of Medical Practice Patterns Analysis to perform research and disseminate findings on variations in medical practices.

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U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation

As **Economist (1979 - 1981),** provided policy analysis and economic research on physician reimbursement, hospital outpatient services, and access to medical care. Analyses focused on potential legislative, regulatory, administrative, and budgetary actions. Served as ASPE's representative on DHHS health data advisory committee; as a member of several HCFA, PHS, and Office of the Secretary grant panels and contract proposal review panels; and as project officer on a $1.6 million evaluation of the Brooklyn Jewish Hospital demonstration. Conducted independent research on the demand for hospital outpatient services and access to care. Served as coordinator of cross-cutting issues involved in developing a procompetitive strategy. Conducted analyses of selection and trends within the Federal Employee Health Benefits program.

Harvard School of Public Health

As **National Center for Health Services Research (NCHSR) Doctoral Dissertation Fellow (1978 -1979),** conducted doctorate dissertation research, funded under an NCHSR grant, on "Hospital-Based Primary Care Costs: Relative Intensity of Care for Defined Episodes." Analyzed data from the Kaiser Permanente Health Care program through collaborative research with the Health Services Research Center, Kaiser Foundation Hospitals, Portland, Oregon.

Analysis, Management and Planning, Inc.

As **Senior Analyst (1976 - 1979)** at this small health services research and consulting firm, participated in the Analysis of the Conformance of 25 State C/N Programs with Minimum Federal Requirements (project director) and Transformation of Technical Materials for Health Planning Agencies (deputy project director).

Center for the Analysis of Health Practices, Harvard University

As **Research Assistant (1976 - 1977),** was a member of a project team on a Social Security Administration study of third-party reimbursement on physician behavior. Designed an organizational analysis of Blue Shield and commercial insurance organizations to examine how policies that affect physician behavior are established.

Abt Associates

As **Senior Analyst (1972 - 1975),** directed and conducted research for and provided consultation to federal and private clients. Performed market development and proposal management and writing. Projects included directing work on determining needs for ambulatory care services and serving as task manager for work on ambulatory reporting and information systems, technical assistance to community health centers, and hospital productivity.

Boston City Hospital Outpatient Department Reorganization Project

As **Administrative Assistant/Systems Analyst (1971 - 1972),** developed a reporting management and billing system for the Family Health Center.

Selected Courses Taught

1996 - 1998	Contemporary Issues of Managed Care, Washington Center, The Johns Hopkins University
1991	Alternative Delivery Systems, George Washington University
1987	Health Planning and Evaluation, University of North Carolina
1986 - 1987	Health Administration and Planning, University of North Carolina
1983	Primary Care, Co-taught at The Johns Hopkins School of Public Health
1983	Guest Lecturer at The Johns Hopkins School of Public Health, Harvard University Medical School, University of Maryland School of Nursing, Towson State University, American University, Medical College of Virginia, Northwestern University, University of Chicago, University of Michigan, the University of Pittsburgh's School of Public Health, and George

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Papers and Publications

Books

Bindman, Andrew B., and Marsha Gold (eds.). *Measuring Access to Care Through Population-Based Surveys in a Managed Care Environment*. Supplement to *Health Services Research,* vol. 33, no. 3, part II, 1998.

Gold, Marsha (ed.). *Contemporary Managed Care: Readings in Structure, Operations and Public Policy*. Chicago: Health Administration Press, 1998.

Journal Articles

Gold, Marsha. "Pathways to the Use of Health Services Research in Policy." *Health Services Research,* vol. 44, no. 4, pp. 1111-1136,. August 2009.

Esposito, Dominick, Erin Fries Taylor, and Marsha Gold. "Using Qualitative and Quantitative Methods to Evaluate Small-Scale Disease Management Pilot Programs." *Population Health Management,* vol. 12, no. 1, February 2009, pp. 9-20.

Gold, Marsha. "Medicare's Private Plans: A Report Card on Medicare Advantage." *Health Affairs* Web Exclusive, November 24, 2008.

Gold, Marsha, Allison Hedley Dodd, and Melissa Neuman. "Availability of Data to Measure Disparities in Leading Health Indicators at the State and Local Levels." *Journal of Public Health Management and Practice,* supplement, November 2008, pp. S38-S44.

Gold, Marsha, Patrick Dorien, and Erin Fries Taylor. "Understanding a Collaborative Effort to Reduce Racial and Ethnic Disparities in Health Care: Contributions from Social Network Analysis." *Social Science and Medicine,* vol. 67, no. 6, September 2008.

Gold, Marsha. "Medicare Advantage in 2006-2007: What Congress Intended." *Health Affairs,* vol. 26, no. 4, May 2007, pp. w445-w455.

Gold, Marsha, and Erin Fries Taylor. "Moving Research into Practice: Lessons from the U.S. Agency for Healthcare Research and Quality's IDSRN Program." *Implementation Science,* vol. 2, no. 9, March 2007.

Gold, Marsha, Justin White, and Erin Fries Taylor. "The Medicaid Managed Care Program." In *The Robert Wood Johnson Foundation Anthology: To Improve Health and Health Care,* vol. 9, edited by S.L. Isaacs and J.R. Knickman. San Francisco: Jossey-Bass, 2006.

Gold, Marsha. "Perspective: Commercial Health Insurance: Smart or Simply Lucky." *Health Affairs,* vol. 25, no. 6, November/December 2006, pp. 1490-1494.

Gold, Marsha, Sylvia Kuo, and Erin Fries Taylor. "Translating Research to Action: Improving Physician Access in Public Insurance." *Journal of Ambulatory Care Management,* vol. 29, no. 1, March 2006, pp. 36-50.

Gold, Marsha, Tara Krissik, and Jessica Mittler. "Collaborative Quality Improvement in Medicaid Managed Care: Experience of the Best Clinical and Administrative Practices Initiative." *Joint Commission on Quality and Safety,* vol. 32, no. 2, February 2006, pp. 81-91.

Gold, Marsha. "Private Plans in Medicare: Another Look." *Health Affairs,* vol. 24, no. 5, September-October 2005, pp. 1302-1310.

Mittler, Jessica, and Marsha Gold. "Physician Participation in Medicaid Managed Care: The California Experience." *Managed Care Quarterly,* vol. 13, no. 2, spring 2005, pp. 1-11.

Gold, Marsha, Timothy Lake, William E. Black, and Mark Smith. "Challenges in Improving Care for High Risk Seniors in Medicare." *Health Affairs* Web Exclusive, April 26, 2005.

Gold, Marsha, Lori Achman, and Randall Brown. "The Salience of Choice for Medicare Beneficiaries." *Managed Care Quarterly,* vol. 11, no. 1, winter 2003, pp. 24-33.

Felt-Lisk, Suzanne, and Marsha Gold. "Do Quality Improvement Strategies for Medicaid Enrollees Differ in Medicaid Dominant Versus Commercial Managed Care Organizations?" *American Journal of Managed Care,* vol. 9, no. 12, December 2003, pp. 806-816.

Draper, Debra, and Marsha Gold. "Provider Risk-Sharing in Plans Participating in Medicaid Managed Care." *Health Affairs,* vol. 22, no. 3, May/June 2003, pp. 159-167.

Gold, Marsha. "Can Managed Care and Competition Control Medicare Costs?" *Health Affairs* Web Exclusive, vol. 2, W3, April 2003, pp. 176-188.

Gold, Marsha, Jessica Mittler, Debra Draper, and David Rousseau. "Participation of Plans and Providers in Medicaid and SCHIP Managed Care." *Health Affairs,* vol. 22, no. 1, January/February 2003, pp. 230-240.

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Gold, Marsha, Jessica Mittler, Anna Aizer, Barbara Lyons, and Cathy Schoen. "Health Insurance Expansion through States in a Pluralistic System." *Journal of Health Politics, Policy and Law,* vol. 26, no. 3, June 2001, pp. 581-616.

Gold, Marsha. "Medicare from the Beneficiaries" Eyes." *Harvard Health Policy Review,* vol. 2, no. 1, spring 2001, pp. 25-32.

Gold, Marsha, Robert Hurley, and Timothy Lake. "Provider Organizations at Risk: A Profile of Major Risk Bearing Intermediaries, 1999." *Health Affairs,* vol. 20, no. 2, March/April 2001.

Gold, Marsha, and Jessica Mittler. "Medicaid"s Complex Goals: Challenges for Managed Care and Behavioral Health." *Health Care Financing Review,* vol. 22, no. 2, winter 2000, pp. 85-101.

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Gold, Marsha. "ISO Quick Fix, Free Lunch and Share of Pie." *Journal of Health Politics, Policy and Law,* vol. 24, no. 5 (special issue, "The Managed Care Backlash"), 1999, pp. 973-982.

Gold, Marsha. "The Changing U.S. Health Care System: Challenges for Responsible Public Policy." *Milbank Quarterly,* vol. 77, no. 1, 1999, pp. 3-37.

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Gold, Marsha, and Judith Wooldridge. "Surveying Consumer Satisfaction to Assess Managed Care Quality." *Health Care Financing Review,* vol. 16, no. 4, summer 1995.

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Professional Activities

1998 - Editorial Board, *Health Affairs*

1997 - Editorial Board, *Health Services Research*

1994 -	Reviewer, Selected reports for the Institute of Medicine, Congressional Budget Office, Office of Technology Assessment, Public Health Service, Medicare Payment Advisory Commission and others
2008 - 2010	Nominating Committee, Academy Health
2003 - 2006	Advisory Board, Health Group, Brookdale Institute for Public Policy, Jerusalem, Israel
1996 - 2005	Faculty, User Liaison Program, Alpha Center/Agency for Health Care Policy and Research
2002 - 2003	Committee to Draft Guidelines on Ethics in Health Services Research, AcademyHealth
2000 - 2003	Board Member, AcademyHealth (formerly the Academy of Health Services Research and Health Policy)
1999 - 2003	AHSR/HAP Editorial Board, Chairperson
1999 - 2001	Working Group on Medicare, The Century Fund
1999 - 2000	AHSR Board Member (individual)
1999 - 2000	Faculty, Foundation for American Communications (education for journalists)
1993 - 1997	Robert Wood Johnson Foundation, National Advisory Committee for the Scholars in the Health Policy Research Program (original panel)

Professional Memberships

2009 -	Elected Member, National Association for Social Insurance	
2000 -	AcademyHealth	
	2008 -2010	Nominating Committee
	2002 - 2003	Ethical Guidelines in Health Services Committee
	2000 - 2003	Board Member
	2000 - 2003	Membership Committee
	Various years	Planning Committee
1973 - 2008	American Public Health Association	
	1990 - 1992	Action Board
	1988 - 89, 91-92	Governing Council
	1979 - 1990	Medical Care Section Program Committee Chairman, 1986; Associate Chairman, 1990
	1981 - 1983	Medical Care Section Nominating Committee
	Medical Care Section Long Range Planning Committee	
	1977 - 1979	Medical Care Section Social Policy Committee
1983 - 2000	Association for Health Services Research	
	1999 - 2000	Board Member
	1998 - 2000	Program Committee
1982 - 1985	Maryland Public Health Association	
1973 - 1980	Massachusetts Public Health Association	

Selected Expert and Review Panel Memberships

2003 -	Reviewer, Selected Proposals submitted to AcademyHealth for the Robert Wood Johnson Foundation's Health Care Financing and Organization (HCFO) program.

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1994 -	Agency for Health Care Policy and Research (AHCPR) Expert Panel, Developing a Research Agenda to Study Evolving Markets Advisory Panel, AHCPR/AAHP Conference on Managed Care Research Expert Panel, Design of a National Poll on Consumer Information Needs Grant Panel, Special Solicitation on Studies of Evolving Markets
1988 -	Centers for Medicare & Medicaid Services (CMS) (various technical panels for the Office of Research and Demonstrations) Demonstration Review Panel, ESRD Managed Care Demonstration Expert Panel, Monitoring Managed Care Access Study Grant Review Panel, Health Reform Financing Proposals Conference on the Health Risk Pool Initiative Expert Panel, Design of Second Generation S/HMOs Expert Panel, CMS"s HMO Research Strategy Expert Panel, Geographic Adjustments to the AAPCC Expert Panel, Bundling Hospital and Post-Acute Services Grant Review Panel, Access Research Proposals Grant Review Panel, Competition/Managed Care Demonstrations
2006 - 2010	Expert Panel, Evaluation of Florida"s Medicaid Health Reform
2002 - 2003	Expert Panel, Medicare FFS Consumer Assessment of Health Plans Survey
2001 - 2003	Expert Panel, A Study of Florida"s Provider-Sponsored Networks in Medicaid Managed Care
1997 - 2000	Technical Advisory Group, Picker Institute Project on Effective Practices in Managed Care
1997 - 2000	Advisory Panel, Brandeis University, Study of Behavioral Health Care Outside Managed Care
1997 - 2000	New York Academy of Medicine, Advisory Group, HMO Community Benefit Project
1997 - 2000	City University of New York, Advisory Panel, Project to Develop a Framework for Evaluating Managed Care Workers Compensation Project
1997 - 2000	University of Pennsylvania, Advisory Panel, Project for Meeting around Issues of Medically Underserved Areas and Managed Care Access
1995	National Institute for Drug Abuse, Contract Review Panel

Manuscript Reviewer

American Journal of Managed Care
American Journal of Public Health
Health Affairs
Health Care Financing Review
Health Services Research
Inquiry
Journal of the American Medical Association
Journal of Health Politics, Policy, and Law
Journal of Policy Analysis and Management
Medical Care
Milbank Quarterly
New England Journal of Medicine
Public Health Reports
Social Science and Medicine

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MATHEMATICA
Policy Research

Nathan E. Myers
Program Analyst

Education

2008	M.P.P., Social Policy, School of Public Policy, University of Maryland
2003	M.S., Education, Graduate School of Education, University of Pennsylvania
1999	B.A., English Literature, Swarthmore College

Positions

2010 -	Mathematica Policy Research
2008 - 2010	MDRC, New York, NY
2010	Research Associate
2008 - 2010	Research Analyst
2006 - 2008	Research Assistant, University of Maryland, School of Public Policy, College Park, MD
2007	Intern Analyst, U.S. Government Accountability Office, Washington, DC
2006 - 2007	Policy Research Fellow, National Human Services Assembly, Washington, DC
2004 - 2006	English Teacher, Montgomery County Public Schools, Rockville, MD
2003 - 2004	Reading Teacher, The SEED Public Charter School, Washington, DC
2000 - 2002	English Teacher, School District of Haverford Township, Havertown, PA

Experience

Mathematica

Program Analyst, Research and Evaluation of the 2011 Money Follows the Person Demonstration Grants and Technical Support (2011 -). Refine conceptual data model depicting data requirements of the Centers for Medicare & Medicaid Services (CMS) for Medicaid and the Children's Health Insurance Program (CHIP). Integrate and document feedback from CMS client and conduct additional research to define and clarify data model's entities and attributes. Analyze current Medicaid data and metadata and assist with developing repository for systematically classifying data quality issues. This work advances CMS's Medicaid and CHIP Business Information Solutions Council's efforts to create an enterprise system for collecting, storing, and analyzing Medicaid and CHIP program policies and administrative data.

Program Analyst, Senior Community Service Employment Program (SCSEP) Software Technical Assistance and Data Collection and Reporting System (2011 -). Conducted independent verification and validation of the SCSEP web-based case management and reporting system. Participated in regression and system testing. Developed test cases and analyzed test results.

Program Analyst, Center of Excellence in Research on Disability Services, Care Coordination and Integration (2010 - 2011). Collaborated with Mathematica research staff to develop a data infrastructure supporting comparative effectiveness research on different services, supports, and models of coordinated care for persons with disabilities. Assisted with import of record layouts and data dictionaries into a metadata repository for existing data sources to be used by the project, such as the Area Resource File. Assisted with drafting and refining technical specifications for Medicare and Medicaid enrollee data included within data infrastructure.

Program Analyst, Medicaid Statistical Information System (MSIS) (2011). Assisted with developing new MSIS data dictionary (for eligibility, claims, provider, and payment data) for CMS. Identified content for new data dictionary sections by reconciling extant MSIS 2010 and MSIS Plus files with new data requirements. Added and revised definitions, valid values, relevant error conditions, and file layouts to incorporate new data elements and resolve inconsistencies. CMS will pilot the refined MSIS data dictionary with Medicaid and CHIP state officials in order to assess the feasibility of extracting new data for tracking program enrollment and expenditures.

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Program Analyst, Business Process Review of Puerto Rico's Labor Exchange System (2010). Assisted with review of business rule applications within Puerto Rico Labor Exchange data. Drafted memorandum for clients outlining options for analyzing program participation and performance by using Labor Exchange Data Reporting and Validation System software.

MDRC

As **Research Analyst (2008 - 2010)** and **Research Associate (2010),** collected and analyzed data for the U.S. Department of Education (ED) evaluation of the Content Literacy Continuum (CLC), a literacy-across-the-curriculum high school reform model. Drafted CLC research protocols and analysis plans; analyzed student-level and school-level data; and evaluated schools' baseline characteristics, implementation fidelity, and student outcomes. Managed site relations and data collection for nine districts and 33 schools participating in the CLC evaluation. Collaborated on research design for ED's evaluation of response to intervention (RtI) elementary reading programs. Drafted materials for technical experts comparing research design options. Developed and piloted site visit protocols for RtI evaluation's implementation research phase.

University of Maryland, School of Public Policy

As **Research Assistant (2006 - 2008),** designed and implemented an ongoing evaluation of the Hillman Entrepreneurs Program, a transfer partnership between Prince George's Community College and University of Maryland. Developed methodology and performance measures, created survey instruments, managed data collection, and briefed Hillman Advisory Board throughout the evaluation process. Analyzed Hillman program's budget and fiscal performance, recruitment, retention and transfer outcomes, student academic performance, and community impact. Produced first comprehensive annual report. Conducted time-sensitive policy analysis examining likely demographic and economic impacts of proposed rent control policy in Montgomery County, Maryland. Communicated findings to Office of the County Executive.

U.S. Government Accountability Office

As **Intern Analyst (2007),** conducted data collection and collaborated on data analysis for performance audit of states' Title I school improvement funding under the No Child Left Behind (NCLB) Act of 2001. Researched statutory language, regulations, and guidance issued by ED regarding Title I school improvement funding and related provisions of NCLB. Facilitated site visit interviews with officials in state and local education agencies. Summarized and analyzed interviews and presented key findings from interviews to performance audit team.

National Human Services Assembly

As **Policy Research Fellow (2006 - 2007),** collaborated on survey design and implementation, interviews, and data analysis for evaluation of Annie E. Casey Foundation's Family Strengthening Policy Center. Summarized federal education and human services budget activity and legislation for Assembly's membership.

Montgomery County Public Schools

As **English Teacher (2004 - 2006),** designed, implemented, and assessed writing and reading instruction for high school students. Instructed multiple sections of Advanced Placement (AP) English Language and Composition, chaired AP Language and Composition team, and realigned AP curricula for revised 2007 exam. Chaired English Department's 11th-grade team and facilitated faculty collaboration.

The SEED Public Charter School

As **Reading Teacher (2003 - 2004),** designed, implemented, and assessed reading instruction for urban middle school students. Provided clinical instruction and assessment for students with reading and writing difficulties. Coordinated and evaluated SAT-9 and PSAT test preparation enrichment classes. Chaired academic faculty's eighth-grade team and facilitated reviews of student progress.

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School District of Haverford Township

As **English Teacher (2000 - 2002),** designed, implemented, and assessed writing and reading instruction for high school students. Refined school's English curriculum and aligned objectives with Pennsylvania standards. Revised summer reading curriculum for thematic continuity with English courses.

Papers and Publications

Borden, William S., Cheryl Camillo, Stephen Kuncaitis, Nathan Myers, Megan Reilly, Cara Weiss, and Amy Wodarek O'Reilly. "Revised Medicaid Statistical Information System: Data Dictionary." Washington, DC: Mathematica Policy Research, April 29, 2011.

Government Accountability Office. "Education Actions Could Improve the Targeting of School Improvement Funds to Schools Most in Need of Assistance." Washington, DC: U.S. Government Accountability Office, February 2008.

Awards

Phi Beta Kappa

Information Technology

SAS, Stata, SPSS, Word, Excel, Visio, PowerPoint

Resumes of Market Decisions Research Staff

Curtis A. Mildner

Education

MBA	University of Virginia	Business Administration	1982
B.S.	Rutgers University	Environmental Science and Biology	1975

Employment

Market Decisions, LLC	President, Senior Consultant	1999 -present
Central Maine Power Company	Vice President Marketing & Sales	1994-1998
Hussey Seating Company	Vice President Marketing	1987-1994
Dinsmore Communications	General Manager	1983-1987
Lehn & Fink (Now Reckitt Benkiser)	Marketing Manager	1982-1983

Experience

Mr. Mildner serves as President and Senior Consultant at Market Decisions, providing overall company leadership as well as managing research and leading analysis and reporting for specific projects.

His previous research experience includes new product research at a consumer products company, marketing research at a business to business manufacturing company and public opinion polling, advertising testing and tracking and new product testing at an energy company, Central Maine Power.

Mr. Mildner brings a unique combination of experience conducting research as part of the marketing and communications process and acting on research as a line manager. He has used research to execute successful product launches, organizational development and reengineering, communications programs and branding challenges. He brings a practical perspective to Market Decisions' research to make it more meaningful and useful for clients.

Mr. Mildner personally moderates focus groups for many clients and leads all qualitative research. He was trained in focus group facilitation at the RIVA Institute of Bethesda MD, and is an active member of the Qualitative Research Consultants Association (QRCA).

Professional Affiliations

Qualitative Research Consultants Association (QRCA)
American Association Public Opinion Research (AAPOR)
New England Chapter of American Association Public Opinion Research (NEAPPOR)
Market Research Association (MRA)

Brian Robertson

Education

Ph.D.	University of Utah	Anthropology	1999
B.S.	University of Utah	Anthropology	1991

Employment

University of New England	Associate Research Professor	2010-
Market Decisions, LLC	Research Director	2000-present
Valley Research, Inc.	VP, Director of Research	1995-1999
University of Utah Survey Research Center Survey	Analyst, Project Manager	1986-1996

Health Care Research and Evaluation Experience

Dr. Robertson has 25 years of health care research and evaluation experience. Dr. Robertson was recently appointed as an Associate Research Professor in the School of Graduate Studies at the University of New England.

Experience

Dr. Robertson has over 25 years of research experience, with hands on experience managing survey research centers, designing surveys, conducting statistical analyses and reporting the results. Dr. Robertson was employed at the University of Utah Survey Research Center for ten years, initially as a research analyst then as a project manager and finally as acting manager. His private research experience includes five years as Vice President and Director of Research at Utah's largest research company, Valley Research. Dr. Robertson has helped design and manage over 200 studies during the past five years, including large-scale mail and telephone surveys. Dr. Robertson has experience in a full range of marketing and public policy research areas. His areas of expertise include overall research design, survey design, sampling methodology, survey project management, statistical analysis of data, preparation of reports based on collected data, and development of policy goals and objectives.

Dr. Robertson has a Ph.D. in Anthropology and a Bachelor of Science from the University of Utah. He is a member of the Market Research Association, and the American Association for Public Opinion Research (AAPOR). He is a former president of the New England Chapter of the American Association for Public Opinion Research.

Computer Skills

Analytical Software: SPSS, SAS, SUDAAN
Expertise in CATI/CAPI programming: Ci3/WinCATI and CASES.
Sampling Software: GENESYS Sampling Systems Sample Generation Software

Professional Affiliations

AAPOR (American Association for Public Opinion Research)

NEAAPOR (New England Chapter, American Association for Public Opinion Research)
MRA (Market Research Association)

Jason K. Maurice

Education

Ph.D.	Brandeis University	Social/Developmental Psychology	2004
M.A.	Brandeis University	Social Psychology	1998
B.A.	University of Southern Maine	Psychology	1995

Employment

Market Decisions, LLC	Research Associate	2005-present
George Washington University	Adjunct Instructor	2002-2005
Brandeis University	Research Consultant	2004
Brandeis University	Teaching Fellow	1997-2003
Heller School for Social Policy	Research Associate	1997-2001
University of Southern Maine	Research Assistant	1995-1996

Health Care Research and Evaluation Experience

Dr. Maurice has 15 years of health care research and evaluation experience.

Experience

Dr. Maurice serves as a Research Associate for Market Decisions. His primary responsibilities include project management, survey and research design, advanced statistical analysis, preparation and writing of reports for healthcare and public policy research projects, SPSS and SUDAAN programming, data editing and coding.

Dr. Maurice has 15 years of experience in survey research regarding health and public policy related issues. He has been involved in several projects examining tobacco, drug, and alcohol use, as well as projects examining physical activity and nutrition.

Prior to joining Market Decisions, he served as Research Consultant for the Social Perceptions Lab at Brandeis University, as Research Associate at the Heller School for Social Welfare at Brandeis University and as Research Assistant at the University of Southern Maine. Dr. Maurice also has extensive teaching experience, teaching research methods for health professionals at George Washington University, research methods, statistics, introductory psychology, and social psychology at Brandeis University.

Computer Skills

Statistical: SPSS, SAS, SUDAAN
Programming: WinCATI, Ci3,
Other: Ci3, MS Word, Excel, and PowerPoint

Professional Affiliations

AAPOR (American Association for Public Opinion Research)
NEAAPOR (New England Chapter, American Association for Public Opinion Research)

Patrick A. Madden

Education

MBA	University of Southern Maine	Business Administration	2003
B.S.	University of Southern Maine	Business Administration	2001

Employment

Market Decisions, LLC	Research Analyst	2003-present
Center for Business & Economic Research	Research Assistant	2000-2003

Health Care Research and Evaluation Experience

Patrick Madden has 10 years of health care research and evaluation experience.

Experience

Patrick Madden has been a Research Analyst at Market Decisions since 2003. As such, he manages survey research projects and conducts ad hoc analysis related to healthcare and public-policy related research. Mr. Madden develops survey instruments and sampling methodology, and is responsible for development and administration of internet surveys. He also has expertise in CATI programming, GIS development, and Visual Basic programming. He often performs data analysis and prepares written reports.

Mr. Madden has also worked as a Research Assistant at the Center for Business and Economic Research, at the University of Southern Maine between 2000 and 2003. At the Center, he managed a variety of program evaluation studies, conducted advanced statistical programming and analysis, and prepared extensive reporting on research results and evaluative findings.

Mr. Madden has Bachelor of Science degree in Business Administration and a Masters Degree in Business Administration from the University of Southern Maine. Mr. Madden is a Phi Kappa Phi Honor Society member, a Beta Gamma Sigma Honor Society member and a cum laude graduate of The University of Southern Maine

Computer Skills

Statistical: SPSS, SAS, SUDAAN
Programming: WinCATI, Ci3, ArcView GIS, Visual Basic, SQL, ColdFusion, JavaScript
Database: Access, SQL Server
Other: MS Office

Professional Affiliations

AAPOR (American Association for Public Opinion Research)
NEAAPOR (New England Chapter, American Association for Public Opinion Research)

Brian Brinegar

Education

B.A	C.S.U. Fullerton	American History	1996
A.A.	Pasadena City College	Communications	1994

Employment

Market Decisions, LLC	Field Services Manager	2004-present
ZAM'Z LLC	Partner	2001-2003
Breaktime LLC	Manager	1999-2001
PhoneWare LLC	Regional Manager	1997-1999
Jones Clinic	Private Teacher	1996-1997

Experience

Mr. Brinegar serves as Field Services Manager for Market Decisions and is responsible for the daily management of the telephone research room. He is also responsible for the interviewing, hiring and training of the field services staff. He assists in survey pre-testing and CATI programming of new projects. Mr. Brinegar also oversees the quality control and monitoring of data collection as well as performing data verifications and refusal conversions.

Mr. Brinegar has many years of experience training interviewers to conduct telephone research regarding a wide variety of topics. His training methods utilize traditional classroom methods and personal one-on-one attention. Every interviewer is trained to use the Ci3 CATI program and receives a question by question introduction to each new project that they will be working on. Having started at Market Decisions as a telephone research interviewer, he is aware of the common questions and difficulties a new interviewer may have. Mr. Brinegar uses "mock" interviews to simulate these scenarios and uses live monitoring of calls to ensure high quality interviewing takes place.

Prior to joining Market Decisions, Mr. Brinegar owned a small business in California, was a Regional Sales Manager for the telecommunications company PhoneWare, and taught privately at the Jones Clinic.

Computer Skills

WinCATI, Ci3, MS Word, Excel

Jennifer L. MacBride

Education

B.A.	University of Maine - Orono	Sociology	1999

Employment

Market Decisions, LLC	Project Manager	2004-present
	Research Assistant	2001-2004
Jimmy V's	Customer Relations	1999-2001

Experience

Ms MacBride is a Project Manager at Market Decisions. She is a 1999 Magna Cum Laude graduate of the University of Maine at Orono, with a Bachelor of Arts in Sociology.

Ms MacBride is responsible for coordinating and managing research projects at Market Decisions, more specifically for focus groups and qualitative projects. Ms MacBride works closely with clients in terms of research needs and has overseen and been directly involved with more than 100 research projects since she has been employed at Market Decisions. Ms MacBride is also a trained focus group moderator specializing in younger age groups. In addition, she performs a wide variety of research responsibilities including report writing, preparation of charts and graphs, programming CATI surveys, analytical programming, cleaning and coding data, and specialized interviewing.

Ms MacBride's academic achievements and awards include: Member of Phi Beta Kappa National Honor Society, Recipient of the Dean's Award for Research and Creative Achievement, University of Maine Dean's List '95-'99, Member of Golden Key National Honor Society, Member of Phi Kappa Phi National Honor Society, Member of Alpha Kappa Delta National Honor Society

Computer Skills

SPSS, WinCATI, Ci3, MS Word, Excel

Professional Affiliations

AAPOR (American Association for Public Opinion Research)
NEAAPOR (New England Chapter, American Association for Public Opinion Research)
MRA (Market Research Association)
QRCA (Qualitative Research Consultants Association)

Mercer Consulting Resumes

SHEREE SWANSON, ASA, MAAA

CURRENT RESPONSIBILITIES

Sheree currently serves public entity clients in Mercer's Government Human Consulting practice, as well as employer clients in Mercer's Health & Benefits practice. She is involved in several projects related to health care reform including providing assistance to Arizona with their health insurance exchange planning, examining the feasibility of a California Basic Health Program, and participating in Mercer's bid desk review of MA and PD reviews for CMS' Office of the Actuary. She is also currently working with a large commercial retail client in the private sector to use their health plan data to compare average risk scores among plans using Verisk's DxCG software.

EXPERIENCE

In addition to her current health care consulting experience, Sheree spent four years working exclusively with a large aerospace company as their lead actuarial consultant. She continues to assist the aerospace company and the Washington State Health Care Authority with their ongoing joint initiatives to influence health care reform locally in Washington state (e.g., individual provider level reporting, hospital payment reform, and medical home models to serve patients needing chronic care.) Before joining Mercer in 1998, Sheree was a principal with an international accounting firm, consulting for 18 years with government clients, health plans/providers, and other employers, and in that role worked closed with John Bertko, now with CCIIO, on health care reform projects including risk adjustment.

Risk adjustment-related experience:

- Annual risk adjustment analysis to adjust premium payments to health plans participating in the Washington Health Care Authority's PEBB program for state employees (1998-2000, 2005-2008)
- Annual risk assessment analysis to set normalized premium contributions for large aerospace company (2003-2005); analysis of ETGs (episode treatment groups) for same employer to compare provider efficiency within largest health plan
- Analysis of health plan experience for large retail company using DxCG Rx and full encounter models to compare cost efficiency of company's plan offerings
- Worked with State of Montana to interpret and use risk assessment results in experience reporting (2005-2008)
- Provided peer review on State of Oregon's risk adjustment analysis implemented for their Medicaid and Oregon Health Plan prioritized health program

EDUCATION AND TRAINING

- Bachelor's in applied mathematics, University of California, Berkeley

AFFILIATIONS/ DESIGNATIONS

- Associate of the Society of Actuaries and Member of the American Academy of Actuaries
- Risk Adjustment Topic Team lead on International Association of Actuaries Health Section (IAAHS) (2007- present)
- Former participant on several American Academy of Actuaries and Society of Actuaries committees related to federal and state health care reform and postretirement health care benefits
- Washington State licensed life and disability insurance broker

Sudha Shenoy, CERA, FSA, MAAA

(Atlanta)

CURRENT RESPONSIBILITIES

Sudha Shenoy is a consultant in the Atlanta office of Mercer Government Human Services Consulting .

EXPERIENCE

Sudha has extensive experience working in areas including Medicare & Medicaid, new product development, provider reimbursement & risk management. She has worked for over 15 years as a heath actuary in Connecticut at Anthem BCBS and at Aetna.

Before joining Mercer last year, she was working for health plans in various capacities.

Highlights of her projects include:

Pricing & rate filing for Medicare Advantage, Medicare Part D & Medicare Supplement products

Responsibility for Medicaid line of business including the underlying capitation risk model

Cross functional team lead on due diligence and mergers and acquisition opportunities

Product development, provider reimbursement & pricing for commercial health products

Participated in American Academy of Actuaries workgroups responding to the MLR regulation, preventive services and Exchange related provisions of the ACA

Experience in Exchange modeling, actuarial analysis including risk adjustment implementation for other state health Exchanges including the District of Columbia , Nebraska and Maryland.

EDUCATION

- Bachelor degree in Science & Bachelor's degree in Education, University of Mysore, India.
- Master's degree in Urban & Policy Sciences, State University of New York, Stony Brook, NY

AFFILIATIONS/ DESIGNATIONS

- Chartered Enterprise Risk Analyst
- Fellow of the Society of Actuaries
- Member, American Academy of Actuaries

Alexander "Sander" Domaszewicz

Sander is a Principal and Senior Consultant housed in the Mercer Health & Benefits Services (Mercer) Newport Beach, California office. He is Mercer's National Practice Leader for Consumerism and leads Engagement efforts for the Total Health Management group, specializing in emerging benefits and ways to encourage groups to become involved and informed around health care cost and quality. Areas of focus include health care strategy, consumer directed health care, health management, health and benefits decision support tools, web health resources, HR portals and online benefits.

Sander's prior experience includes project management in the Health & Group Benefits Delivery Services group at a large multi-national consulting firm for flexible benefits administration outsourcing. In this capacity he addressed outsourcing issues, systems integration, design, and testing as well as database administration and training relating to flexible benefits. Prior to benefits outsourcing project management, Sander managed a hearing health care facility in Southern California, giving him exposure to issues from the provider perspective.

Sander is a frequent presenter at health care and benefits-related events and has published articles in Benefits Quarterly, Employee Benefit News, HR Magazine, Workforce and HR Executive. His consulting assignments include work with many large and small public and private organizations in both the benefits and product development areas.

Sander holds a Bachelor of Science degree in Mechanical Engineering from San Diego State University, a Masters degree in Business Administration from the University of Phoenix and a certificate in Human Resources Management from Cornell.

WENDY S. WOSKE, RN, MHA

PROFESSIONAL EXPERIENCE

MERCER HEALTH & BENEFITS Phoenix, AZ

Senior Consultant

- *Health Care Reform*: Assisting Arizona in Exchange Implementation efforts, including gap analysis to address requirements necessary to define qualified health plans and quality framework under which the Exchange may operate, provided Mercer's actuarial team clinical insight and high level analysis on Connecticut's state mandated coverage regulations and the potential impact on the Essential Health Benefit package.
- *External Quality Review*: Contract lead in the State of Delaware evaluating compliance with Balanced Budget Act requirements for quality, access and timeliness of Medicaid managed care service delivery, providing technical assistance to health plans on performance measure (PM) development and performance improvement projects PIPs), performing validation of PMs and PIPs.
- *Cost Containment Efforts*: Development and maintenance of clinical efficiency analyses to quantify inefficient care delivery in areas such as low acuity non-emergent Emergency Department utilization, Potentially Preventable Admissions, Ambulatory Care Sensitive conditions high cost radiology and durable medical equipment.
- *Vendor Procurements*: Assisted the State of Arizona Department of Health Services in the evaluation of RFP responses for the Children's Rehabilitative Services program and drafted RFP requirements for the implementation of electronic medical records and associated information technology/security standards for the Arizona Department of Corrections to support procurement of a comprehensive health services vendor.
- *Performance Measurement*: Developed performance indicator dashboards and technical specifications for the State of Delaware's Managed Medicaid program including CHIP and LTC program components; assisted the Commonwealth of Pennsylvania in the development of the Behavioral Health programs online dashboard including data layout and underlying data logic
- *Long Term Care*: Assisted the State of Connecticut in review of administrative operations of their home and community based waiver programs, performed stakeholder facilitation and the development of Connecticut's right-sizing strategies for HCBS; assisting the State of Delaware in the implementation of their managed long term care program and leading efforts to assess readiness of the managed care programs.

EDUCATION

1986 – 1990 **MOUNT HOLYOKE COLLEGE – B.A., International Relations** South Hadley, MA

1994 – 1997 **COUNTY COLLEGE OF MORRIS – A.D Applied Science, Nursing** Randolph, NJ

2001 – 2007 **SETON HAL UNIVERSITY – Masters, Health Care Administration** East Orange, NJ

CERTIFICATION

RN Licensure, without restriction AZ and NJ

Advanced and Pediatric Advanced Cardiac Life Support

Kurt Giesa, FSA, MAAA

PROFESSIONAL EXPERIENCE

1990 - present **Oliver Wyman Actuarial Consulting, Inc**. Milwaukee, WI
Director

Kurt Giesa is a Director in the Milwaukee, Wisconsin office of Oliver Wyman Actuarial Consulting, Inc. where he has spent over 20 years of his career working with health insurers, regulators, and providers.

His work with health insurers includes the design of group health and HMO rating techniques, rating specialized coverages, provider contracting, Medicare Advantage and Medicaid risk contracting, product design, regulatory filing, and mergers and acquisitions.

His work with health care providers includes assistance in contracting with payers, the design of capitation and risk-sharing mechanisms, the development of fee schedules, HMO creation, and the development of business strategies to anticipate and respond to the changing health care environment.

His work with state regulatory agencies includes the review of health insurance rate filings, providing expert testimony at rate hearing, market analysis, and the development of regulation, specifically health insurance rate regulation.

EXPERIENCE

Analysis of the impact of health insurance reform on premiums for a large, national association of health plans.

Analysis of the impact of health insurance reform in Massachusetts on the individual market.

Rehabilitation of a troubled health insurer.

Review of a carrier's compliance with certain undertakings required by a regulator as part of a merger.

Development of a specialty benefits product strategy for a large, national carrier including pricing and product design.

EDUCATION

University of Wisconsin - Madison, M.B.A, Actuarial Science

University of Washington, Bachelor of Arts, mathematics, and English, cum laude

DESIGNATIONS

Fellow of the Society of Actuaries (1993)

American Academy of Actuaries (1991)

PUBLICATIONS

"Impact of the Patient Protection and Affordable Care Act on Costs in the Individual and Small-Employer Health Insurance Markets." This paper described the impact of the Senate Finance Committee's health reform bill.

Karen Bender, FCA, ASA, MAAA

PROFESSIONAL EXPERIENCE

1995 - present **Oliver Wyman Actuarial Consulting, Inc.** **Milwaukee, WI**
Principal

Karen Bender is a Principal in the Milwaukee, WI office of Oliver Wyman Actuarial Consulting, Inc. She specializes in health care and supports the actuarial needs of the risk assuming entities in the insurance and managed care industry. This includes providing services to insurance and managed care companies, governmental entities as well as providers on traditional actuarial matters, underwriting issues, provider contracting, and reimbursement arrangements, capitation development, data requirements and reporting, product design and implementation, operational issues, as well as determining the impact of proposed and/or passed legislation..

Karen has provided actuarial consulting services for over 35 years and has been with Oliver Wyman since 1995. Karen's experience includes pricing of products for the individual, small group and large group markets, as well as the pricing or drug, vision, dental and specialty HMO products. She has developed underwriting manuals as well as policy forms; designed reporting and experience systems; forecasting models and pricing models for the entire spectrum of health care benefits.

Recognized as an expert in health care reform and has conducted and/or participated in modeling of many proposed reforms at both the state and national levels.

Participated in many briefings of U.S. Congressional aides on topics pertaining to proposed reforms.

Testified before U.S. Senate HELP committee regarding small employer health insurance issues in 2009.

Active on many American Academy of Actuaries (AAA) committees and is the official spokesperson for the AAA on health issues and was the author of the letter to HHS pertaining to interim final regulations for federal benefits effective in 2010; member of the AAA group providing input to both NAIC and HHS on minimum loss ratios (MLR); member of AAA group providing input on proposed Exchange rules.

Member of the AAA Health Practice Council

EXPERIENCE

Assisted several states with implementation of effective rate review programs.

Currently assisting several states plan and implement state-based Exchanges

Analysis of proposed mandated benefits for several states.

Modeling of various reforms, including current federal reforms for many entities

including states, associations and health care plans.
.Considered an expert in the small group and individual medical markets and is the current chairperson of the AAA Individual and Small Employer Task Force which is charged with analyzing issues that impact these markets, including health care reforms.
Reviews rate filings for comprehensive medical insurance several states including Vermont
Supporting clients in developing alternative provider reimbursement methodologies
Actuarial reviews for commercial blocks of business including development of base rates, pricing factors and underwriting strategies.
Has provided expert witness testimony at both state and federal levels.

EDUCATION

University of Wisconsin - Stevens Point, BS, Mathematics and Economics, Highest Honors

DESIGNATIONS

Fellow of the Conference of Consulting Actuaries (2000)
Associate in the Society of Actuaries (1992)
American Academy of Actuaries (1984)
Qualified Health Actuary (1982)

PUBLICATIONS

Karen has authored and co-authored several papers.
She is frequently in demand to speak at professional meetings.

Tammy Tomczyk, FSA, MAAA

PROFESSIONAL EXPERIENCE

2000 - present **Oliver Wyman Actuarial Consulting, Inc**. **Milwaukee, WI**
Principal

· Tammy Tomczyk is a Principal in the Milwaukee, WI office of Oliver Wyman Actuarial Consulting, Inc. Tammy has over 19 years of experience and provides consulting services to insurers, providers and regulators on health insurance pricing, reserving, financial reporting, provider contracting, trend, and underwriting issues.
· In addition to having experience pricing both traditional and managed care products, Tammy has also priced dental, vision, Medicare supplement, limited benefit, critical illness and prescription drug programs.
· Tammy has applied her programming experience to create pricing models that her clients use in developing quotes for new and existing groups. Tammy is heavily involved in healthcare reform. In addition to assisting states improve their rate review processes and in the development of state based exchanges, Tammy is assisting her commercial clients as they prepare for the changes that reforms will bring.
· Tammy is a Fellow of the Society of Actuaries and a member of the American Academy of Actuaries.

EXPERIENCE

· Assisted several states with the implementation of effective rate review programs.
· Currently assisting states plan and implement state based Exchanges
· Tammy is considered an expert in the small group market and has prepared small group certifications in over 30 states.
· Responsible for the creation and maintenance of the Practice's medical rating software used nationwide to price traditional and managed care products, as well as the development of various quoting and merit rated underwriting models.
· Actuarial pricing reviews for commercial group blocks of business including the development of base rates, risk adjustment factors, and target loss ratios.
· Performed comprehensive reviews of new business and renewal underwriting strategies.
· Pricing, preparation, certification and audit of Medicare Advantage Part C and Part D Bids.
· Review of regulatory health filings for several state departments of insurance.
· Expert witness, Virginia Bureau of Insurance Credit Insurance Hearing, June 2009.
· Expert witness, Maryland Insurance Administration Effective Rate Review Hearing, June 2011.
· Member, American Academy of Actuaries Healthcare Reform Premium Review, Health Care Reform Benefits, and Insurance Exchanges workgroups

EDUCATION

· University of Wisconsin – Whitewater, B.B.A., Finance and Mathematics, cum laude

DESIGNATIONS

· Fellow of the Society of Actuaries (2004)
· Member American Academy of Actuaries (2001)
· Fellow of the Life Office Management Association (1995)
· Associate of the Health Insurance Association of America (1993)

PUBLICATIONS

· Tammy has authored several study manuals and other materials used by students preparing for the Society of Actuaries exams.

Beth Fritchen, FSA, MAAA

PROFESSIONAL EXPERIENCE

1989 - present **Oliver Wyman Actuarial Consulting, Inc**. Milwaukee, WI
Principal

· Beth Fritchen is a Principal in the Milwaukee, WI office of Oliver Wyman Actuarial Consulting, Inc. She has been with Oliver Wyman for over 20 years. Her primary responsibilities are in the area of health insurance consulting. In particular, she provides consulting services to state regulatory agencies, health insurance companies, and health care providers.

· Beth has provided actuarial consulting services for over 22 years. Her present responsibilities include product development for managed care and traditional plans, trend analysis, review of filings for state insurance departments, fee schedule analysis, financial management and forecasting, compliance, underwriting issues, provider capitation development, mental health pricing, Medicare capitation development, Medicaid capitation development, reserve analysis, and legislative analysis. She has performed forecasting and financial valuations for start-up organizations, as well as for potential mergers and acquisitions.

· Beth has participated in many rate hearings over her career with Oliver Wyman. She is recognized as an expert in the individual health insurance market, as well as in the Medicare supplement insurance market.

EXPERIENCE

· Developing Medicaid capitation rates for managed health care plans.

· Financial reporting and forecasting for health insurance plans.

· Pricing of individual and group health insurance rates. This includes manual rates for the small group business as well as experience rating large group business.

· Quantifying the financial impact of legislative proposals for health plans as well as consumers.

· Trend analysis for small group, individual and other medical products.

· Pricing, preparation, certification and audit of Medicare Advantage Part C and Part D Bids.

· Review regulatory rate filings for several insurance departments and attorney general offices.

· Expert witness for Maine Attorney General since 2006 for individual medical rate hearings.

· Expert witness for the Vermont Department of Banking, Insurance, Securities and HealthCare, AARP/UHC Medicare supplement hearing since 2003

EDUCATION

· University of Wisconsin - Madison, B.S., Mathematics with an emphasis in Actuarial Science

DESIGNATIONS

· Fellow of the Society of Actuaries (2002)

· American Academy of Actuaries (1995)

PUBLICATIONS

· "Government-Sponsored Health Insurance Purchasing Arrangements: Do They Reduce Costs or Expand Coverage for Individuals and Small Employers."
· "Impact of Association Health Plan Legislation on Premium and Coverage for Small Employers."
· "Impact of Prior Approval Requirements for Rate Changes of Small Employers Group and Individual Health Policies."
· The semi-annual Oliver Wyman Trend Survey.

Erica Garfin, M.A.
102 North Street
Montpelier, VT 05602
802-229-4481(voice) 802-229-6937 (fax)
egarfin@comcast.net

Consultant in health and social services planning with 25 years of experience in planning, public policy, government relations, advocacy, non-profit administration, and organizational development. Skilled in research, design, and implementation of planning processes and program development. Areas of expertise include:

- Planning, development, and evaluation of services and programs in health and social services.
- Development of methodology and facilitation of strategic planning processes.
- Focus groups and qualitative research.
- Needs assessment.
- Working with groups with diverse viewpoints to set goals, identify priorities, and reach decisions.
- Creating processes for consumer involvement in planning.
- Project coordination and management.
- Meeting facilitation.
- Clear writing for lay persons, including "easy-to-read" publications.
- Organizational planning.

PROFESSIONAL EXPERIENCE

Independent Consultant to State Government and Non-Profit Organizations 1996-present
Please see my Client and Project List for a detailed list of consulting clients and projects.

- American Hospital Association
- Behavioral Health Network of Vermont
- Department of Vermont Health Access (DVHA)
- Green Mountain United Way/Central Vermont Coalition for Health
- Rutland Regional Board for Family Services/Rutland Area Prevention Coalition
- Students FIRST of Chittenden County
- Vermont Association of Court Diversion Programs
- Vermont Cancer Survivor Network
- Vermont Center for Crime Victim Services
- Vermont Children's Forum
- Vermont Commission on Women
- Vermont Department of Banking, Insurance, Securities and Health Care Administration
- Vermont Department of Disabilities, Aging and Independent Living
- Vermont Department of Health
- Vermont HIV/AIDS Care Consortium

- Vermont Information Technology Leaders, Inc.
- Vermont People with AIDS Coalition
- Vermont Program for Quality in Health Care
- Vermont Supreme Court / Chief Justice Paul Reiber
- Waterbury Senior Center

Sun Yat-Sen University, Guangzhou, China 2006
Guest lecturer for Masters and undergraduate students in the Social Work Department.

Bi-State Primary Care Association, Montpelier, VT 2000 – 2002
Women's Health Coordinator
Coordinator of Women's Health Vermont, a diverse, statewide coalition of providers, consumers, and advocates working to increase access and reduce health disparities for underserved women in Vermont. Responsible for all aspects of project, including recruitment, member relations, planning, research, staffing work groups, and meeting facilitation. Prior to moving into this position, served briefly as Community Development Coordinator, focusing on establishing federally qualified health centers in Vermont.

Vermont AIDS Council, Montpelier, VT 1990-1995
Executive Director
Director of non-profit, statewide coalition of community-based AIDS service organizations. Performed systems planning and public policy advocacy with state agencies and other organizations. Lobbied in Vermont legislature. Performed administrative, grant writing, fiscal, fundraising, and board relations functions. Administered grant programs that funded AIDS service organizations, including overseeing creation of quality improvement program. Provided technical assistance to member organizations. Created media presence about AIDS in Vermont.

Vermont Center for Independent Living, Montpelier, VT 1984-1990
Director, Information and Referral Program
Administered telephone-based program that provided intake counseling, assessment, information and referral, and technical assistance on disability-related issues. Hired, supervised, and evaluated staff. Wrote grant proposals, documented activities for major federal grants. Designed and implemented staff training program. Participated in systems planning and advocacy.

Johnson State College, Johnson, VT 1983-1987
Advisor
Advised independent studies and internships on health-related subjects for students in the External Degree Program.

Community College of Vermont, Barre, VT 1983-1984
Instructor
Taught Concepts of Health, an introductory health survey course.

EDUCATION

Sarah Lawrence College 1982
M.A., Health Advocacy

Clinical training in helping patients to negotiate health care systems, both in (as patient representative) and out of institutions, with emphasis on patients' rights.

University of California, Berkeley 1972
B.A., South and Southeast Asian Language and Literature

PROFESSIONAL DEVELOPMENT

Working in the Groan Zone: Tools for Facilitating Difficult Meetings – Woodbury College

Planning and Running Effective Meetings – TAP-VT

Advanced Low Literacy Communication Skills Training for Health Professionals --University of New England, Maine AHEC Health Literacy Center

PROFESSIONAL AFFILIATIONS AND AWARDS

Vermont Program for Quality in Health Care, Board of Directors; Chair 2005-08 2003-2008

Recipient of Vermont Dept. of Health/Dept. of Education AIDS Service and Education Award 1993

Vermont HIV/AIDS Care Consortium, Steering Committee 1992-1995

AIDS Professional Training Group, Steering Committee 1990-1995

Vermont Consumers' Campaign for Health, Board of Directors 1989-1996

Vermont Ethics Network, Steering Committee 1989-1990

COMMUNITY INVOLVEMENT AND PUBLIC SERVICE

Central Vermont Adult Basic Education. Volunteer teacher. 2010-

Vermont Human Rights Commission. Gubernatorial appointment. Chair 1999-2005. 1997-2005

Vermont Public Radio, Community Advisory Board 1996-1999

Vermont Health Policy Council. Gubernatorial appointment. Chair, Long Term Care Committee 1988-1991

Volunteer and board member for grassroots community-based organizations. Activities included crisis intervention, support, counseling, advocacy, and referrals. Performed grant writing, fundraising, and public relations functions:

- Vermont Refugee Assistance 1986-1989
- Sexual Assault Crisis Team of Washington County 1984-1987
- Chelsea Area Help for Battered Women 1983-1984

P e t e r K r i f f

Producer, Director, Project Manager

vtsilcpeter@gmail.com - 802.233.4908 - PO Box 56, Winooski, VT 05404

[Experience **]**

2010 - Present Executive Director, VT Statewide Independent Living Council (SILC), Vermont

2001- Present Owner, Creative Director for PDI Creative Communications. Burlington, VT

1999 - 2001 VP Marketing, GUI Designer for IGS Software, Burlington, VT.

1995 - 1999 Owner, Operator of PK Design. Winooski, VT.

1992 - 1995 Art Director, Associate Creative Director for Kelliher, Samets, Volk. Burlinton, VT.

1990 - 1992 Art Director, Project Manager for Sandage Advertising. Burlington, VT.

1987 - 1990 Associate Publisher, Project Manager for Creating Excellence Magazine. Winooski, VT.

1986 - 1987 Marketing Manager for Universal Lighting. Washington, DC.

1980 - 1986 Freelance Jazz Musician, East Coast, United States.

[Skill Sets **]**
Integrated Marketing Communications
23+ years experience producing effective and targeted communications in every media. Includes direction of staff,
subcontractors and co-marketing businesses for national and regional projects. Projects from media campaigns to health
program communications to corporate identity and brand management. Media deliverables include print ads, brochures,
booklets, magazines, websites, radio, TV, web applications and public relations.

Technical Communications and Application Development
Strategic Planning, Partnership Facilitation, Co-marketing Development
Health-related Communications

[Education **]**
1980 BS Psychology, with honors. Brown University.
1981 Elected to Sigma Psi, a scientific honors society.

Ralph J. Montefusco
172 Woodbury Road
Burlington, Vermont 05408
802-862-4085 (home)
802-598-5613 (mobile)
Rmontefu@Sover.net

EMPLOYMENT:

Montefusco Consulting
Burlington, VT
January 1, 2011 – Present
Sole proprietor / Consultant
Government Relations, Lobbying, Visibility, Advocacy, Outreach, Mobilizing

State of Vermont, Department of Labor
Montpelier, VT
September 19, 2011 – October 31, 2011 **(Temporary Position)**
UC Customer Service Representative (CSR)
General Job Description: *"Specialized work for the Department of Labor involving the interviewing of claimants by telephone for unemployment benefits. Duties involve conducting initial and subsequent assessment of individual needs, and persuading claimants to accept referrals to Career Resource Centers for reemployment services. Duties will include investigation and resolution of eligibility issues. Work is performed under the supervision of an administrative supervisor."*

Communications Workers of America (CWA)
Endicott, NY and Washington, DC
February 3, 2003 – November 12, 2010
Organizer, responsible for Alliance@IBM / CWA Local 1701 chapters across the country, communicating with members and supporters and coordinating legislative/political activities. Also supported other CWA efforts and campaigns such as Stop-the-Sale and served as the CWA's New England Legislative/Political coordinator.

IBM Corporation
Essex Junction, Vermont
March 4, 1985 – January 24, 2003
Customer Interface for quality issues, specializing in Asia Pacific companies.

EDUCATION:

Associate of Applied Science in Chemical Technology,
Community College of Rhode Island.

Also completed a total of 106 other college credits at Rhode Island College plus Calculus I&II at UVM.

Obtained National Career Readiness Certificate# TTB388VRHTXS, issued August 29, 2011, Silver level (Platinum on two sections, Silver on the third).

BOARDS and COMMISSIONS:

South Hero Planning Commission member, April, 1993-June, 1999. Chair from June 1995-June 1997. (Obtained party status and represented the South Hero Planning Commission in the VELCO power line hearings before the Vermont Public Service Board.)

Vermont Sierra Club Executive Committee member, March, 1997-January, 2000. Delegate to the national Sierra Club Council of Club Leaders (2000).

Appointed by Governor Howard Dean to the Vermont Citizens Advisory Committee on Lake Champlain's Future (CAC). Served from April 1997-March 2005. (The CAC received EPA New England's Environmental Merit Award in April, 2000.)

Appointed by Governor Howard Dean to the District #4 Environmental Commission (alternate member). Served from May 10, 2000 - March 25, 2003.

Burlington Planning Commission member April, 2005 through June, 2010.

Vice-President, Champlain Valley Labor Council, AFL-CIO 2002-2006.

VT AFL-CIO E-board member (District VP), 2001-2005. Elected Member-at-Large October 2007.

Board member, VT Toxics Action Center 2004-2007.

Board member, VT Chapter of the Alliance for Retired Americans 2005-2007.

Chair, VT MS Society Government Relations Committee, 2008-present.

POLITICAL ACTIVITIES:

Vermont Sierra Club Political Committee Chair, 1999-2001.

South Hero Town Democratic Committee Chair, 1991-1995.
(Committee member through December, 1999)
Grand Isle County Democratic Committee Chair, 1993-1995.
(Committee member through December, 1999)
Vermont Democratic State Committeeman for Grand Isle County, 1991-1997.

Colchester Town and Chittenden County Democratic Committees member, December, 1999 – January, 2003.

Notary Public August, 1996 – February, 2011. (Voter Registration)

Burlington Democratic Committee member, Chittenden County Democratic Committee member since March, 2004.

Patricia Brooks

7906 Flower Ave, Suite 6, Takoma Park, MD 20912 · (202) 351-1757 · patricia@matchmapmedia.com

WORK EXPERIENCE

MatchMap Media
Sept. 2010-current

Principal

- Conduct media outreach for public relations firms and in-house communications groups; moderate press events, placing op-eds, write press releases, and pitch media stories
- Clients include ActionAid USA, RenewComm, Turner Strategies, Dupont Circle Communications, David Gardiner & Associates, TigerComm, Massey Media, Potomac Conservancy and Rainforest Action Network

Kelley Campaigns/RenewComm, College Park, MD

Media Relations Director, Senior Media Relations Specialist
Feb. 2007- Sept. 2010

- Served as top media relations staff member for small public relations firm; overseeing and guiding all press outreach, provided strategic counsel to clients and internal staff on proposals and plans, and maintained media lists and relationships with reporters
- Wrote and edited press releases, messaging documents, op-eds, talking points
- Pitched reporters on story ideas that would further the goals of my clients; placing national and local print, broadcast and online news features
- Coordinated social media efforts using Twitter and Facebook and conducted blog outreach
- Hosted press conference calls and planned media events, working with vendors to set up events and prepare clients for media interviews through a training process
- Balanced eight to ten clients at once, all of them with tight budgets and deadlines. Clients included Rocky Mountain Institute, Rockefeller Family Fund, Ceres, 1Sky, 350.org, Clean Air, Cool Planet, and Abengoa Solar.

94.7 The Arrow/94.7 The Globe/94.7 Fresh-FM, Washington DC

Part-Time Street Team Promoter
Oct. 2005-Dec. 2009

- Staffed events interacting with listeners and general public to increase station visibility
- Set-up and dismantled equipment and materials at on-site events
- Promoted "Enter to Win" contests and other station giveaways

Hill & Knowlton, Washington, DC

Account Executive
Aug. 2006-Feb. 2007

- Assisted in client services and administrative duties on several accounts
- Created and maintained press lists for press pitching various efforts
- Acted as team-member and worked with others to come up with strategies for clients

Center for a New American Dream, Takoma Park, MD

Communications Fellow
July 2005-July 2006

- Wrote press releases and newsletter articles for environmental non-profit
- Coordinated major media campaign, Simplify the Holidays, reaching coverage in over 200 papers; circulation for media hits of 30,000,000
- Implemented promotions plan for national online contest, increasing activist base

National Public Radio, Washington, DC

Media Relations Intern
Jan. 2005-May 2005

- Publicized *American Stage Series*, receiving more press than any other cultural piece
- Served as NPR communications crisis plan team member, developing strategy in the event of injury to a field reporter following September 11, and took notes on discussions with public relations consultants
- Created messaging for launch of the program *This I Believe*

EDUCATION
Ashland University, Ashland, OH

Bachelor of Arts in Speech Communication and Electronic Media Productions

Peter Bregman

Creative Tactician/Copywriter

Simple. Strategic. Smart.

(914) 391-8110
pdbregman@aol.com
www.pdbregman.com

About Peter Bregman and his view on ads and advertising:

Peter Bregman is one of the most insightful and respected individuals in advertising today and remains on the cutting edge of messaging in the digital age. For the last 30 years he's worked at some of the most famous ad agencies in the world and as a result has experience and familiarity in over 100 industries from financial services to academic marketing to healthcare to packaged goods to B2B to technology to basic retail.

Management-wise, he's led creative teams around the globe and mentored even more (he's taught advertising principles for 5 years at the School of Visual Arts in NYC). He knows all aspects of printing, electromagnetic and digital media as well as photography, video and their pre- and post-production processes. Moreover, he understands estimates and how to make sure costs keep from getting out of hand.

Want awards? He's won scores of awards for his work and his creative style is best described as strategic, witty and smart.

But here's his basic view on the craft. You see, ads don't have to be overly complicated or elaborate or complex to work. Just simple, strategic and smart. (An approach 99.9999901% of today's ad folks seem to have forgotten.) So he prefers smart headlines with simple visuals, strategically considered and placed, to get your point across. (And he thinks you will, too.) Peter feels there's enough complication out there already. In short, smart, simple and strategic stands out.
Speaking of strategic, Peter will often take advantage of the „environment" where the ad will be placed in consideration while coming up with an ad concept. This approach which he calls „contextual" advertising is TOTALLY unique and perhaps one of the most powerful tools a company can have today in today's ridiculously cluttered (and expanding) media landscape.

When it comes to getting noticed in the media morass out there his view is this: "You don't need a bigger hammer. You need a sharper nail." In short, bigger isn't better. *Smarter* is better.

Recent Career History:
Copywriter @ Large (2005 –) **DDB New York** (2003 – 2005) **Group Creative Director**
Lowe Worldwide (1993 – 2003) **Group Creative Director**

Previous Agency Experience
Wells Rich Greene, NY (1990 – 1993) **Lowe & Partners, NY** (1988 – 1990) **JanklowBender, NY** (1987 – 1988) **Scali McCabe Sloves, NY** (1985 – 1987) **Doyle Dane Bernbach, NY** (1978 – 1985)

Areas of Experience:
Academic: Boston University School of Management

Automotive: GMC Trucks, Mercedes Benz, Saab, Subaru & Volkswagen

Beverages: Baileys Irish Cream, Heineken Beer, Malibu Rum, Stroh□s Beer & Tea Forte

Consumer Goods: Braun, Nikon, Polaroid & Sharp

Fashion: Candies Shoes, Gates Gloves, Nutmeg Sportswear & Wigwam Socks

Financial Services: Chase Bank, Citibank Visa, Fidelity Investments, Fine Art Capital, First Responders Financial, The NYSE, Radianz Financial Network & Prudential Insurance

Food: Bama Jams & Perdue Chicken

Pharma/Healthcare: Bristol-Myers Squibb (HBV and HIV), Endo Pharmaceuticals (Menstrual Migraine & PHN), Galderma (Dermatology), Merck (Arthritis Pain, Asthma and Cholesterol), Novartis (Cardiovascular, Eczema & Oncology), Pfizer (Epilepsy), Sanofi-Pasteur (The Flu Vaccine), Schering Plough (Allergy) & Wyeth (GERD)

Packaged Goods: Brawny Paper Towels, J&J Kids Soaps, Nabisco, Quilted Northern Bathroom Tissue & Robitussin

Retail: American Airlines, Continental Airlines, Denny□s, ExxonMobil & Hertz

Recruitment Fidelity Investments (Albuquerque, NM and Cincinnati, OH service centers)

Technology: 3Com, IBM, Sun Microsystems, GTE & Verizon

Awards: 16 Andy Awards, 18 Art Directors Club Awards, 9 Communication Arts Awards, 21 Clio Awards, 2 Effie Awards, 24 One Show Pencils plus 27 miscellaneous awards
Education: University of Virginia (Art History & Chemistry)

Other: Avid motorcyclist, photographer and cultural observer.

Kimberley O'Connell

[Art Director, Designer]

Kimberley has considerable background with various forms of print design, including advertising, collateral and direct mail, logos and corporate ID systems, and websites. With over seven years as a professional designer, she has worked on a variety of campaigns, including brand makeovers for The Essex Resort & Spa, Green Works - Vermont Nursery & Landscape Association, Burlington International Waterfront Festival, and the "U Matter" Teen Suicide Prevention Campaign for Center for Health & Learning.

She has also worked extensively on implementing stunning advertising campaigns and environmentalgraphics for clients such as groSolar, USA Risk, the State of Vermont, Center for Health & Learning, and the Essex Resort & Spa.

Kim is particularly adept with and fond of logo creation, and holds a Communications Design degree from Syracuse University.

When she is not working at her computer, you will most likely find her summiting mountains on her mountain bike or skis, gardening, or at the pottery studio.

Toni Drowne

[Web Designer, New Media Director]

Toni's experience working on public health, environmental and marketing-driven Web sites gives her endless experience to drive the interface design, conception and usability of many Web sites. Before working at PDI, Toni was responsible for designing applications and Web sites for a diverse set of clients including: Harvard University, the State of Texas, The U.S. Environmental Protection Agency, The University of North Carolina, the town of Lexington, Massachusetts, the Jim Casey Youth Opportunities Initiative, and the International Methane to Markets Partnership. Toni has also developed award-winning sites for the Trammell Crow Company, the U.S. Department of Labor and the Centers for Disease Control. Adding to this diverse design set, Toni has provided training and workshops on such topics as Adobe Dreamweaver, Web Application Design and Section 508 responsibilities to her peers. She subscribes to the theory that everything should be pulled together seamlessly in the web site design - the information, the technology and the graphical elements

Law Office of Caroline S. Earle, PLC

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Caroline S. Earle is an experienced trial lawyer concentrating in general civil and employment law litigation. Her 17 year career has bridged both the public and private practice sectors in Vermont, making her uniquely poised to handle diverse litigation. Ms. Earle holds degrees from McGill University (B.A., First Class Honors) and Indiana University School of Law (J.D., Cum Laude). In the private sector, she held Associate and Shareholder positions with Wilson & White, P.C. where she litigated employment law, personal injury, tort, and contract matters. She also served Of Counsel with Legus & Bisson, PLLC focusing largely on insurance defense. In the public realm, Ms. Earle served as Chief of the Civil Litigation Division of the Vermont Attorney General's Office, where she led a team of 14 attorneys and paralegals. As Chief, Ms. Earle litigated employment law, tort defense, wrongful death, contract, and constitutional claims. Most recently, Ms. Earle served as Commissioner of the Department of Human Resources, where she was responsible for administering the State of Vermont's largest workforce. This role included evaluating and pursuing human resources policies and initiatives, reviewing employment related legal and administrative strategy and decisions, selecting and administering the State of Vermont's health care benefits, and administering four collective bargaining agreements that governed the terms and conditions of employment for over 7,000 state employees.

Ms. Earle has assisted a variety of organizations in the following roles:

- Treasurer, Washington County Bar Association
- President, Washington County Bar Association
- Board Member, Central Vermont Adult Basic Education
- Member, Board of Bar Examiners
- Ex Officio Member, Governor's Workforce Equity and Diversity Counsel
- Ex Officio Member, State of Vermont Employee's Association Retirement Board
- Ex Officio Member, Governor's Health Care Cabinet
- Various Board Positions, Vermont Bar Association
- Mentor, Everybody Wins!

Ms. Earle concentrates her practice in civil litigation, tort defense, insurance defense, and all aspect of employment law and human resources practice. She welcomes your consultations, business, and referrals.

Robert B. Murray

Professional Contact Information:
President, Global Health Payment,
1723 West Joppa Road
Towson, Maryland 21204
Tel: 443-909-9191 Fax: 410-358-6217
Email: RMurray@GlobalHealthPayment.com

Personal Contact Information:
LLC RMurray16@Comcast.net

Profile

• Economist with expertise in the development and operation of provider payment systems, health care financing, public policy development, and health care administration and management;

• 18 years of experience as Administrator of the nation's only All-Payer Hospital Rate Setting agency, overseeing the financing of an industry in excess of $13 billion of annual hospital revenue and an administrative budget of $100 million per year. Maryland's All-Payer Hospital Payment System is the most enduring and successful cost containment system in the United States over the past 34 years;

• Extensive experience in designing and implementing provider payment systems and quality improvement initiatives, provider payment negotiation, public policy development, data collection and analysis, governmental relations, and the development of state and federal legislation;

• Particular policy interest in the area of health care payment system reform and delivery system integration to promote the goals of cost containment, efficient resource allocation, improved access to care, equity and fairness in payment, accountability and financial stability;

• Primary research and project work focusing on the development and implementation of: pay-for-performance quality improvement initiatives; bundled inpatient and outpatient payment systems; and hospital and physician gain-sharing arrangements;

• Experience and expertise in analyzing and assessing payment and contractual arrangements between hospitals and payers as part of the Commission's legal authority to approve experimental case-rates for cardiac, orthopedic, obstetric and solid organ and bone-marrow transplants.

• Consulting experience with governments, including health and finance ministries, in the areas of health policy development and provider payment systems.

Professional Experience

1994-2011 Maryland Health Services Cost Review Commission ("HSCRC") – Baltimore, Maryland
Executive Director: Longest serving Chief Administrator of the HSCRC, an independent state agency reporting directly to the Governor of Maryland. Appointed by Governor William Donald Schaefer in 1994 and served under four different administrations.
The HSCRC regulates the payment levels of all 46 acute care general hospitals, 3 chronic care hospitals and 2 private psychiatric facilities, an industry of over $13 billion in annual gross revenues. Since 1976, Maryland has experienced the lowest rate of growth of hospital costs of any state in the U.S. The system finances over $1 billion of hospital uncompensated care annually, prohibits so-called "cost-shifting" by hospitals, maintains unparalleled financial stability and is now leading the nation in the implementation of broad-based quality (pay-for-performance) initiatives. It is estimated that the hospital rate setting system has saved the State in excess of $45 billion in averted hospital costs over past 33 years. Maryland continues to be the only state to maintain and operate a waiver from federal Medicare/Medicaid reimbursement methods and has fulfilled its role as a "demonstration" state for many federal policy initiatives.

As Executive Director of the HSCRC, I reported to a board of seven volunteer Commissioners appointed by the Governor. I was responsible for overseeing the administration and operation of the agency and its $100 million annual operating budget and directing the activities of a staff of 30, including economists, accountants, statisticians, computer specialists and legal personal in the development of Commission methodologies and policy.
In addition to my normal operational and managerial responsibilities, I testified regularly before the Maryland General Assembly and in contested HSCRC rate cases and Certificate of Need cases.
Maryland is now demonstrating its role as a leader in the nation in payment system and delivery system reform.

Other Responsibilities and Achievements

Payment System Development & Implementation:

- Methodology development and negotiation of enforceable Global Hospital Budget arrangements, establishing a cap on all inpatient and outpatient revenues (100% fixed cost system) for 10 sole-community hospitals in the State covering approximately $1.3 billion of hospital revenue (2010). Cost savings from this effort are estimated to be in excess of $300 million per year.

- Methodology development and negotiation of the nation's first broad-based episode of care payment structure covering both admissions and readmissions for 27 hospitals and covering approximately $7.2 billion of inpatient revenues (2011). Cost savings from this effort are estimated to be in excess of $500 million per year.

- Implementation, review, and approval of numerous experimental, global and bundled hospital and hospital/physician payment structures or "case rates" for transplant, cardiac, orthopedic and other services (1994-present).

- Development and implementation of the nation's first severity-adjusted Diagnostic-Related Groups ("DRG") payment system for all-payer inpatient hospital reimbursement with mechanisms to protect against case-mix coding creep (2005).

- Development and implementation of Maryland's bundled outpatient "Charge per Visit" payment system, a highly bundled method of reimbursing ambulatory hospital services (ambulatory surgery, emergency room, clinic, and referred ancillary) utilizing Enhanced Ambulatory Patient Groups (EAPGs 2010).

Quality of Care (Pay-for-Performance) Initiatives:

- Development and implementation of Maryland's Value Based Purchasing initiative – applying approximately $12 million of payment incentives to hospitals to promote the use of evidence-based processes of care in the areas of Pneumonia, Acute Myocardial Infarction, Heart Failure, and Surgical Infection Prevention (2008).

- Development and implementation of Maryland's Hospital Acquired Condition initiative applying $70 million in payment incentives to hospitals based on their relative performance across 49 categories of hospital acquired complications. In the second year of the initiative, the State witnessed an approximate 12% drop in the frequency of hospital acquired complications (after adjusting for difference in patient mix from year to year). This improvement means that hospitals responded to the Commission's system of quality incentive system and removed approximately $62.5 million of cost associated with preventable complications. Complications that are included in the HSCRC initiative collectively cost public and private insurers in the state $521.3 million in FY2010.

• Development of a ranking and reporting system comparing hospitals on their relative performance of risk adjusted readmission rates for a subset of "Potentially Preventable Readmissions" (PPRs) (2011).

• Spearheaded a surveillance initiative using publicly available HSCRC data, to identify and investigate potential areas of inappropriate use of Percutaneous Coronary Interventions ("PCI" or "Stents"). Worked with a team of clinicians and statisticians to develop an algorithm to identify cases with a high probability of inappropriate use by physician and hospital in the state. These results were used as the basis for an on-going investigation by Maryland's Department of Health and Mental Hygiene.

Operational and Policy Achievements

• Led negotiation efforts with hospitals and insurers in the State to determine the annual inflation update to HSCRC-approved hospital rates. Organized industry-workgroups and attempted to gain consensus. Prepared the HSCRC staff's annual recommendation on payment updates to the Commission and successfully negotiated the lowest payment updates in Commission history in 2010 and 2011.

• Negotiated the closure of five acute care hospitals and lead operational and rate setting efforts to facilitate these reductions in excess hospital capacity (1996-2004).

• Spear-headed improvements in the rate setting system's accounting, data reporting and compliance system and the current development of the State's All-Payer data set for all health care providers (1995-2011).

• Led an effort to provide up-front seed financing for the development of the State's Patient Safety Center (2006) and Regional Health Information Organization (2008).

• Developed and successfully negotiated the implementation of a State-wide pooling mechanism for the equitable financing of over $1 billion of hospital uncompensated care (2009), and the implementation of an innovative mechanism to facilitate the State's expansion of Medicaid eligibility (2008-2011).

• Member of the Governor's Health Care Reform Coordinating Council overseeing the implementation of planned insurance expansion activities, including the implementation of the State's Insurance Exchange (2010-2011).

• Initiation of a project to identify and rank hospitals and hospital/physician payments on the basis of risk-adjusted and "quality-adjusted" cost metrics to be used as the basis for potential benefit design policy applications (tiered-networks and reference pricing).

2003-2011 Maryland Health Insurance Plan (MHIP) – Baltimore, Maryland
Board Member: MHIP is the State of Maryland's High Risk Insurance Pool. The Plan was established by the Maryland General Assembly to provide premium subsidies to make health insurance coverage more affordable for the State's medically uninsurable population. Responsible for operational and policy decisions related to benefit design, marketing, premium strategies, and other oversight in the administration of this $250 million health plan.
Other Professional Experience:
1993-94 Health Services Cost Review Commission – Baltimore, Maryland, **Deputy Director**
1989-93 BTT Consulting Services, Baltimore, Maryland
Sole Proprietor of an independent consultant to the health care industry
1986-89 Ernst and Young/Amherst Associates - San Francisco, California & Baltimore, Maryland
Associate, Senior Associate and Manager in the finance consulting division.

Education

STANFORD UNIVERSITY
B.A. Economics, 1979 M.A. Economics, (The Food Research Institute). 1979 Emphasis in Development Economics and Commodity Futures Markets.
STANFORD BUSINESS SCHOOL
Masters of Business Administration. 1984

Membership in Professional Societies

International Health Economic Association (2005-present);
Academy Health, Washington D.C (2004-present).
Health Financial Management Association (2002-2005);

Consultancy and Short-term Assignments

2011 Short Term Consultant to The World Bank – Hyderabad, India
Provided consulting assistance to the World Bank and India's Government Sponsored Health Insurance Schemes regarding institutional and infrastructure development to support the development of a case-based payment system for all inpatient care.
2009 Short Term Consultant to The World Bank – Sao Paulo, Brazil
Presented at the 2009 Seminar for Improvements in Information Systems and Governance of Sao Paulo's Public Hospital system. Provided consulting assistance to the World Bank and Secretariat of Health for Sao Paulo on implementation of a prospective payment system based on Diagnostic Related Groups.
2005-2007 Short Term Consultant to the World Bank - Moscow, Russian Federation
Organized and presented a series of workshops sponsored by the World Bank, on hospital data collection, payment design, and related policy issues to representatives of the Ministry of Health, the Russian Academy of Sciences, and Regional Health Authorities. Building on these presentations and the resulting discussions, I authored a comprehensive Operational Manual and Case Study detailing the key policy, design, and operational characteristics required for the implementation of a hospital rate (tariff) setting system for the Russian Federation. The Manual and Case Study were translated into Russian and is now being used as a resource guide in current health reform deliberations in the country.
2006-2007 Consultant to the Agência Nacional de Saúde Suplementar (ANS) – Rio de Janeiro, Brazil
Presented an overview of the Maryland Hospital Rate Setting System at the First International Health Care Conference sponsored by the ANS (national supplementary insurance agency) of the Brazilian government in November 2006. Conducted a full day work-shop on health payment and policy issues for agency directors and staff of the ANS. Currently organizing a series of workshops and presentations for ANS personnel focusing on the developmental, operational, and administrative aspects of a comprehensive hospital payment system.

Recent Research Activities and Publications

"The Case for All-Payer Rate Setting" Point-Counterpoint Series, *Journal of Health Policy, Politics and Law*, scheduled for January-February 2012 Publication
"Hospital Performance and Health Quality Improvements in Sao Paulo (Brazil) and Maryland (USA)" A Medici and R Murray, *En Breve* April 2010, World Bank Publications, www.worldbank.org/enbreve
"Maryland's Approach in Enhancing Effectiveness and Efficiency in Healthcare Delivery: Comment on Achieving Cost Control, Care Coordination, and Quality Improvement through Incremental Payment System Reform," *Journal of Ambulatory Care Management,* R Murray, Winter 2009, Vol. 33, No. 1, pp 61-68.
"Setting Hospital Rates to Control Costs And Boost Quality: The Maryland Experience," R Murray, *Health Affairs*, September/October 2009; 28(5): 1395-1405.
"Bundled Payment for Hospital Ambulatory Care Services: A DRG-Analog for Outpatient Surgery Reimbursement." *Journal of Ambulatory Care Management,* JG Atkinson and R Murray. Fall 2007
"Using Severity-Adjusted DRGs for Payment: The Experience in Maryland." *Western Health Economics Association Conference,* P Redmon and R Murray, Summer 2007

Presentations (Selected)

November 2011 "Results Based Financing in the Context of Comprehensive Payment Design" Presentation for the International Work Group on Results Based Financing (RBI) for low-income countries sponsored by The World Bank and The Department of International Financing and Development (DIFD), London, U.K.
June 2011 "The Value of Rational Pricing of Hospital Services" Presentation for the Commission on High Performance Health Systems, The Commonwealth Foundation, Boston, Mass.
October 2010 "Bending the Hospital Cost Curve in Maryland" George Washington University, Health Policy Forum presentation for federal health care agency staff and Congressional staffers, Washington D.C.
November 2009 "All-Payer Hospital Payment in Maryland and the use of Diagnostic Related Groups (DRG)" Seminar on Information Systems and Performance Assessment of Public Hospitals: The Case of Sao Paulo. Department of Health of the State of Sao Paulo and the World Bank.
July 2007 "All-Payer Pay for Performance Systems for Improving Hospital Quality of Care," International Health Economics Association Conference, Copenhagen, Denmark.
July 2007 "Development of a DRG-based Hospital Payment System: Data Collection, Medical Coding, DRG-weight Development, Grouper Selection, and other Operational Considerations." International Health Economics Association, Half-day Pre-Conference Session, Lund, Sweden.
November 2006 "Application of All-Payer Hospital Rate Setting to Countries with Social Health Insurance Systems," Agência Nacional de Saúde Suplementar (Agency for National Supplemental Insurance Regulation - ANS) First International Health Care Conference. Rio de Janeiro, Brazil. October 2006 "Setting Incentives in Health Care: The Role of Provider Payment"; Served as Chair of a panel discussion for the World Bank Annual Human Development Conference Session, Washington D.C.
July 2006 "Overview of the Maryland All-Payer Hospital Payment System," European Economic Association Conference, Budapest, Hungary.
January 2006 "Application of All-Payer Hospital Rate Setting to Countries with Social Health Insurance Systems," Presentation before representatives from the Ministry of Health, Armed Forces Health System, Finance Ministry, and Israeli Sickness Funds, sponsored by the Myers-JDC-Brookdale Institute, Jerusalem, Israel.
September 2003 "Application of All-Payer Hospital Rate Setting to the Russian Federation." Presentations sponsored by the World Bank for Representatives of the Russian Ministry of Health, Academy of Sciences and Regional Health Authorities. Moscow, Russia.
August 1999 "Overview of the Maryland All-Payer Hospital Rate System: Operations and Policy Lessons," Presentation for the Taiwanese Provincial Government and Ministry of Health, Taipei, Taiwan.

Additional Information

Language Skills: Conversant in Spanish and German, limited conversational ability in Russian.
Named as one of the top 30 most influential citizens in the State, by *Baltimore Magazine*, January 2011;
Studied music and language at Stanford University in Vienna, Austria, in 1977-78;
Classical and Jazz pianist, performing chamber music and solo jazz concerts;
Member of the Baltimore Symphony Chorus 1990-1993;
Freelance travel writer and photographer. *New York Times* and other publications.