Attachment I
Client History Form
Actuarial Services
710-25-001

Attachment I

Actuarial Services

Instructions: This form is intended to help the State gain a more complete understanding of each Respondent's experience. This form **must** be completed completely and accurately.

The State reserves the right to verify the accuracy of these answers by contacting any of the listed clients, and all applicable clients **must** be listed. Omission of a client will constitute a failure to complete this form.

For purposes of this form, the "client" is not an individual but the entity which held the contract. By way of explanation, in the Contract resulting from this RFP, Arkansas DHS will be the client. For each listed client, Respondents may (but are not required) provide the contact information for a person at the client entity who is knowledgeable of the named project. If the State contacts clients listed on this form, the State reserves the right to contact the listed individual or another person at the listed client.

The boxes below each prompt will expand if necessary. The form **must** be signed (please see the final page) by the same signatory who signed the Response Signature Page.

1. Please list at least three (3) state clients where your proposed key consulting and actuarial personnel served as the actuary of record in commercial and Medicaid Managed Care rate setting to achieve ten (10) years professional experience.

   Experience must include, at minimum, managed care environments for behavioral health and developmental disability services, plus services for one or more of the following populations: foster care, juvenile justice, or special needs. For each client, please specify the organization/agency/division, not just the state or political subdivision. Please briefly describe the scope of the contract, population, and duration of services. If there are no contracts which meet this definition, please state "none."

2. Provide a list state clients where your organization gained professional experience with at least three (3) of the following state Medicaid Programs: each of the below.
   a. The 1915(b) waiver cost requirements, including implementation of directed payments;
   b. The 1915(c)waiver cost neutrality requirements;
   c. The 1115(a) waiver budget neutrality requirements;
   d. Rate development; and
   e. Supporting a public entity through policy and finance review and recommendations.

For each client, please specify the organization/agency/division, not just the state. Please briefly describe the scope of the contract including the associated Medicaid Program(s), and duration of services. If there are no contracts which meet this definition, please state “none.”

By signature below, vendor certifies and agrees that omission of any of the above: a negative contract action, statewide contract termination, or a civil regulatory enforcement action will constitute a failure to complete this form. The State reserves the right to verify the accuracy of these answers by contacting any of the listed parties. DHS, at its sole discretion, reserves the right to review the disclosed information and may be used to determine whether the Contractor is “responsible.”

Authorized Signature: _____ **Title:** _____

Printed/Typed Name: _____ **Date:** _____