4.0 TAB 4: BIDDERS APPROACH TO MEETING DELIVERABLES.

We increase project efficiency and effectiveness and reduce risk with our proven methods of success starting with identifying the right local key personnel with highly relevant experience and required credentials who are immediately ready to begin operations.

The Iowa Medicaid Enterprise seeks a vendor to achieve important policy goals: improve quality, safety, and efficiency and reduce avoidable cost. We developed our solution to attain these goals with an effective, collocated team based on 30 years of experience, 90% staff retention rate; client satisfaction over 95%, and an average 12:1 ROI across similar programs.

4.1 GENERAL OBLIGATIONS (1.3.1.1)

We understand that it is critical to put together a team of expert professionals that not only understand the complexity of the work; they are local to the project, have relationships with providers, and are dedicated to the highly specialized population served. IME expects a contractor to deliver quality performance, exemplary and honest behavior and to sponsor trusting and professional relationships with everyone involved and related to the program. KEPRO has earned the respect and trust of our customers and stakeholders alike and guarantee to meet IME's expectations while also ensuring that our team can be trusted as subject matter experts in their related roles and are prepared and able to provide sound policy advice and solid support to the Agency.

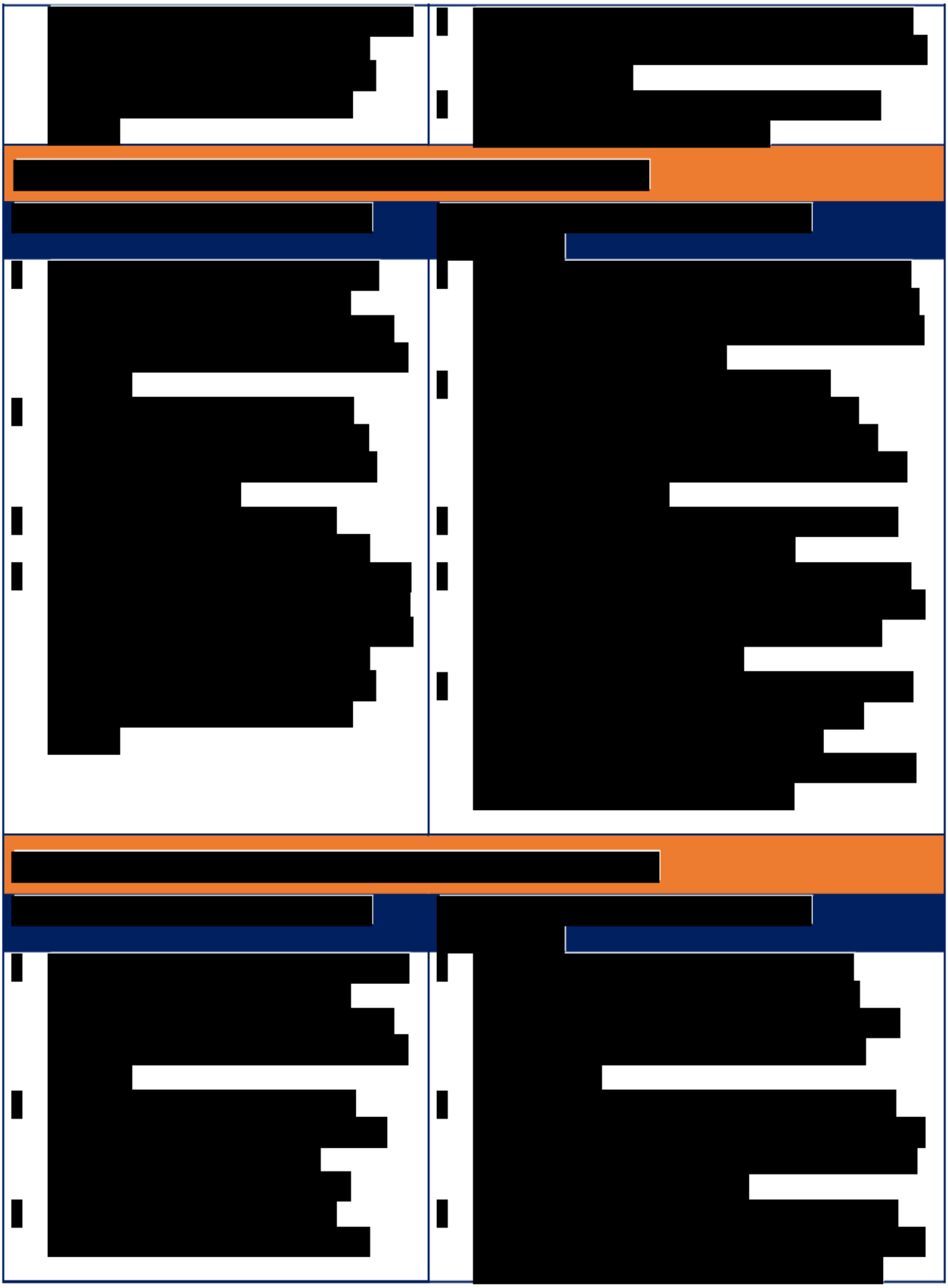
We introduce our named key personnel in the following section and understand that the Agency reserves the right to approve all identified positions.

4.1.1 STAFFING (A.)

1. *The Contractor shall designate individuals as "key personnel," subject to Agency continued approval. The Agency reserves the right to interview any and all candidates for named key positions prior to approving the personnel. Special requirements for key personnel are as follows:*

[redacted]

Table 4.1-1. Proposed Key Personnel



3.2.4.1.2 Proof of licensure for the following key staff:

- *Medicaid Medical Director (MMD) - MD or DO*

Proof of an active and clear license for Dr. Manning was found at:

[redacted]

[redacted]

Table 4.1-3. Proof of an active and clear license.

Key Personnel for PHI Special Projects

f. Key Project Personnel for Population Health Improvement Special Projects, as identified within Contract Section 1.3.1.5.

Table 4.1-4. Key Personnel for PHI Special Projects

[redacted]

2. *Named key personnel shall:*
   a. *Be committed to the project full time and co-located with Agency staff at the IME permanent facility in Des Moines, Iowa;*
   b. *Be onsite during normal Business Hours to respond to questions and concerns related to the Contract, except for routine absences or participation in required off-site meetings. Account Manager and Operations Manager positions*

are required to communicate absences with the Agency contract manager and provide suitable coverage during extended absences;

c. *Provide policy advice and support to the Agency and participate in meetings with the Agency as subject matter expert;*
d. *Prepare and present status updates periodically to the Agency and other stakeholders, as requested by the Agency;*
e. *Comply with all timelines in the Agency-approved implementation plan; and*
f. *Develop and maintain a plan for job rotation and knowledge transfer to ensure that all functions can be adequately performed during the absence of key personnel for vacation and other reasons. Any planned absences of key personnel shall be immediately communicated to the Agency. The Contractor shall ensure staff are trained and able to perform the functions of sensitive positions when the primary staff member is absent.*

[redacted]

3. *The Agency reserves the right of prior approval for any replacement of the key personnel:*
   a. *The Contractor must commit named key personnel to the project on or before the conclusion of the transition period of the Contract and for at least six months, and must not replace key personnel during this period except in cases of termination, death, or the key person's resignation.*
   b. *The Contractor shall provide the Agency with a minimum of 15 days' notice prior to any proposed transfer or replacement of named key personnel. At the time of providing notice, the Contractor shall also provide the Agency with the resumes and references of the proposed replacement of named key personnel;*
   c. *Replacement personnel must be in place performing their new functions before the departure of the personnel they are replacing;*
   d. *Replacement personnel shall have knowledge transfer, experience, and ability comparable to the person originally in the position; and*
   e. *The Agency may waive requirements (a) through (d) above upon presentation of good cause by the Contractor. In those instances when good cause is granted, the Contractor commits to replacing key personnel within thirty days (30) of the departure of a key person and to providing temporary personnel in the interim that are capable of maintaining operational performance at acceptable levels.*

[redacted]

Table 4.1-5: Standard Operating Procedures Ensure Compliance with ALL RFP Staffing Requirements

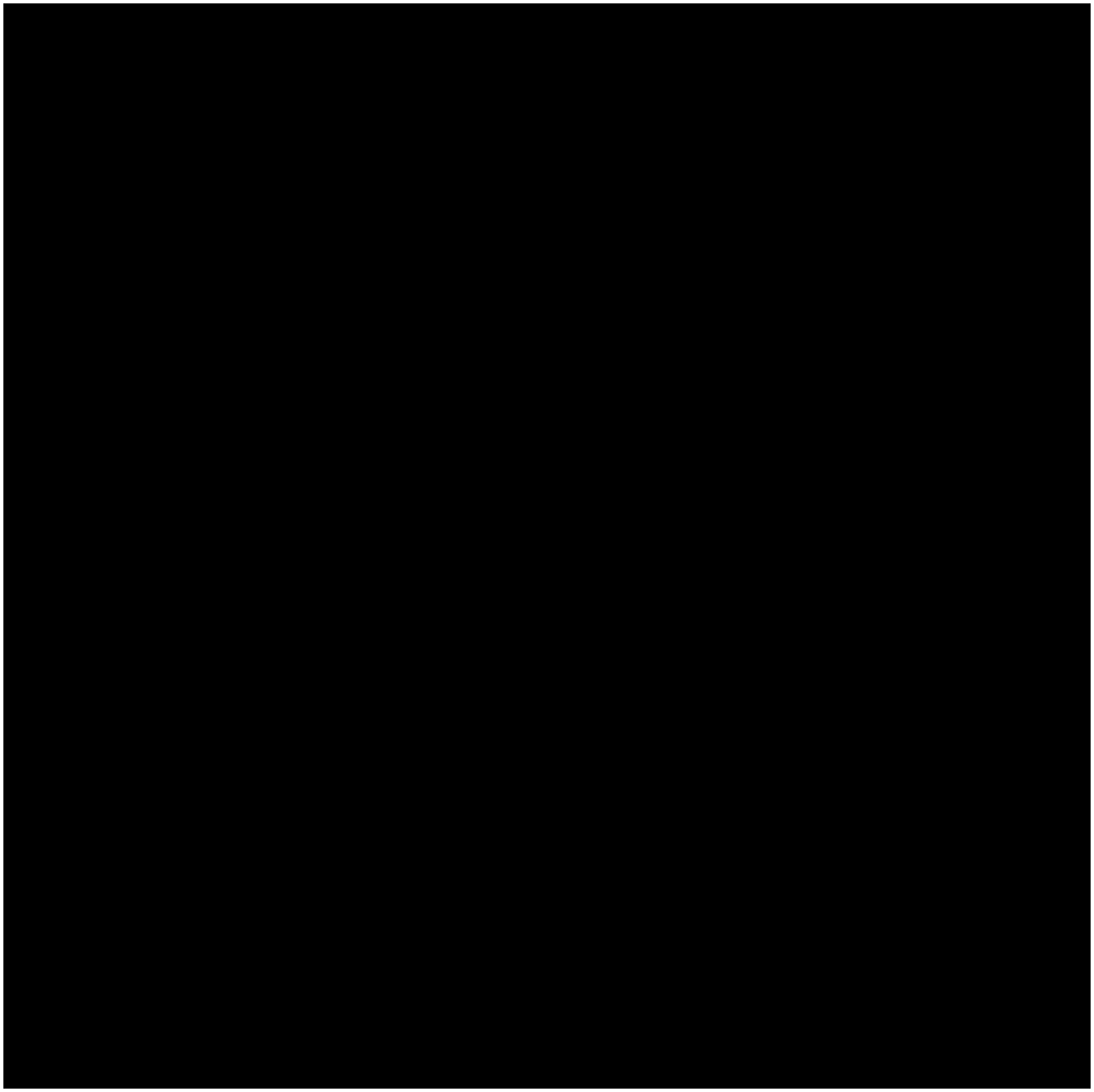


Table 4.1-6. Clearly Defined Succession Plan Ensures Operational Continuity

4. *The Contractor shall retain (on staff or in a consulting capacity) medical and social service professionals and other fields as deemed necessary by the Agency in order to perform Contractor duties identified within the Contract. Contractor staff and/or consultants shall be knowledgeable about the Iowa Medicaid Program's policies and procedures regarding coverage and limitations. These professionals shall provide consultation to the Agency in the following areas at a minimum:*
   a. Anesthesiology

b. *Audiology*
c. *Brain injury*
d. *Cardiovascular, vascular, and thoracic surgery*
e. *Child psychiatry*
f. *Chiropractic services*
g. *Dentistry*
h. *Developmental disability services (such as autism spectrum, cerebral palsy, intellectual disability, and similar conditions)*
i. *Disability services*
j. *Geriatrics*
k. *Family practice*
l. *Hematology*
m. *Medical supplies and equipment*
n. *Neurology*
o. *Obstetrics/gynecology*
p. *Occupational therapy*
q. *Oncology*
r. *Ophthalmology*
s. *Optical*
t. *Optometry*
u. *Organ transplant services*
v. *Orthodontics*
w. *Pathology*
x. *Pediatrics*
y. *Physical medicine*
z. *Plastic surgery*
aa. *Podiatry*
bb. *Psychiatry*
cc. *Psychology*
dd. *Radiology and nuclear medicine*
ee. *Rehabilitation (physical therapy, occupational therapy and speech therapy)*
ff. *Speech pathology*

[redacted]

[redacted]

Table 4.1-7. KEPRO Can Supplement our Iowa-Specific Specialist Pool to Meet Highly Specialized Needs as They Arise

[redacted]

5. *The Contractor shall ensure that all staff, whether they are employees, agents, subcontractors or anyone acting for or on behalf of Contractor, are properly licensed, certified or accredited as required under applicable State law and/or Iowa Administrative Code. Contractor shall establish standards, subject to Agency approval, for service providers who are not otherwise required to be licensed, certified or accredited under State law and/or Iowa Administrative Code.*

[redacted]

[redacted]

Table 4.1-8. Primary Source Verification, Re-credentialing Every 2 Years = Integrity

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

Recruiting Des Moines Based Professionals

6. *The Contractor shall primarily recruit Des Moines-based professionals and ensure that as many staff as possible directly associated with the provision of Contract services are collocated at the IME's permanent facility to ensure collaboration with Agency staff. See Special Contract Attachment 3.2.*

[redacted]

4.1.2 SYSTEM AND SOFTWARE REQUIREMENTS (B.)

1. *The Contractor shall utilize and maintain systems and software listed in Attachment 3.2, as necessary, to support all QIO functions.*

Confirmed. We will use and maintain the systems and software listed in Attachment 3.2 to support all QIO functions. Two exceptions to maintenance polices are MQUIDS and QPS. We understand that while both MQUIDS and QPS are hosted by the Agency, we will be responsible for updating and maintaining application source code.

Maintenance of Custom Applications:

Our Change Management (CM) process ensures that requested system changes are viable and will not adversely affect Iowa Medicaid operations. The process for defining, developing, and deploying requested system modifications follow industry-standard application development best practices. Proven quality processes for maintenance of proprietary software applications will provide the Agency with solid applications to support the delivery of quality care to the people of Iowa.

Our process begins with the identification of a need for a system modification. A ticket for that requested change is opened in a change tracking system, and a User Story that describes the requested change is created. A requested modification for Iowa Medicaid systems are presented to the Change Control Board (CCB) for consideration. CCB is charged with assessing requested changes to consider the

impact on the system functionality, usability, and output. The CCB is comprised of Directors of Business Analysis, Implementation Services, Development, and key operations Vice Presidents. Iowa QIO Program Managers and their designees will be integrated into CCB meetings and included in all discussions related to requested changes. Modifications approved by the CCB, are presented to our Application Services Steering Committee (ASSC) for approval and prioritization. Members of the ASSC are KEPRO's Chief Operating Officer (COO) who serves as the chair, the Vice President of Information Technology Services (ITS), Directors of Business Analysis and Software Quality Assurance, Implementation Services, Health Intelligence, and Application Services. Input to the Steering Committee includes the definition of the project, an estimated level of effort to complete the project, input from our Operations, and Agency Program Managers to define the urgency of the change. Using this input, the Committee decides on the required due date for the delivery of the change and organizes priorities to meet the due date as necessary.

Changes approved and scheduled by our Steering Committee are turned over the Business Analysis and Application development staff.

Table 4.1-9. Application Development Process

We incorporate a "Rollback" plan in the event an inadvertent problem is identified after the production deployment. This approach minimizes the impact of potential problems.

2. The Contractor shall provide sufficient staff to maintain and update code as necessary for current MQUIDS and QPS applications hosted by the Agency. The applications are deployed in a 3 tier configuration:

a. Client components are installed on the user system, along with the executable application and its associated libraries;

b. Application server components are hosted in Internet Information Services (IIS) running on Windows 2008 server and .NET Framework; and

c. SQL end database.

We are dedicating a staff of 4 subject matter experts to maintaining and updating MQUIDS and QPS applications. To support the maintenance of the Iowa MQUIDS and QPS applications, we will add a full-time programming resource who will be 100 percent dedicated to supporting the MQUIDS and QPS systems. In addition to this dedicated resource, we will involve an existing Business Analyst and Software Quality Assurance Analyst to provide staffing for requirements development and testing.

Our ITS Application Services group is comprised of 15 Software Engineers. Our Business Analysis (BA)/Software Quality Assurance (SQA) group is comprised of five Software Quality Assurance and three Business Analysts. We also employ two Database Analysts (DBAs). All staff have experience with the tools employed in the maintenance and support of the MQUIDS and QPS applications.

Our multi-tier internal systems are based on the same technology platform which includes Microsoft Visual Studio for the development of .NET Windows and APS.NET Web applications, Windows Server 2008 and IIS to support Web applications, the Microsoft .NET framework, and Microsoft SQL Server.

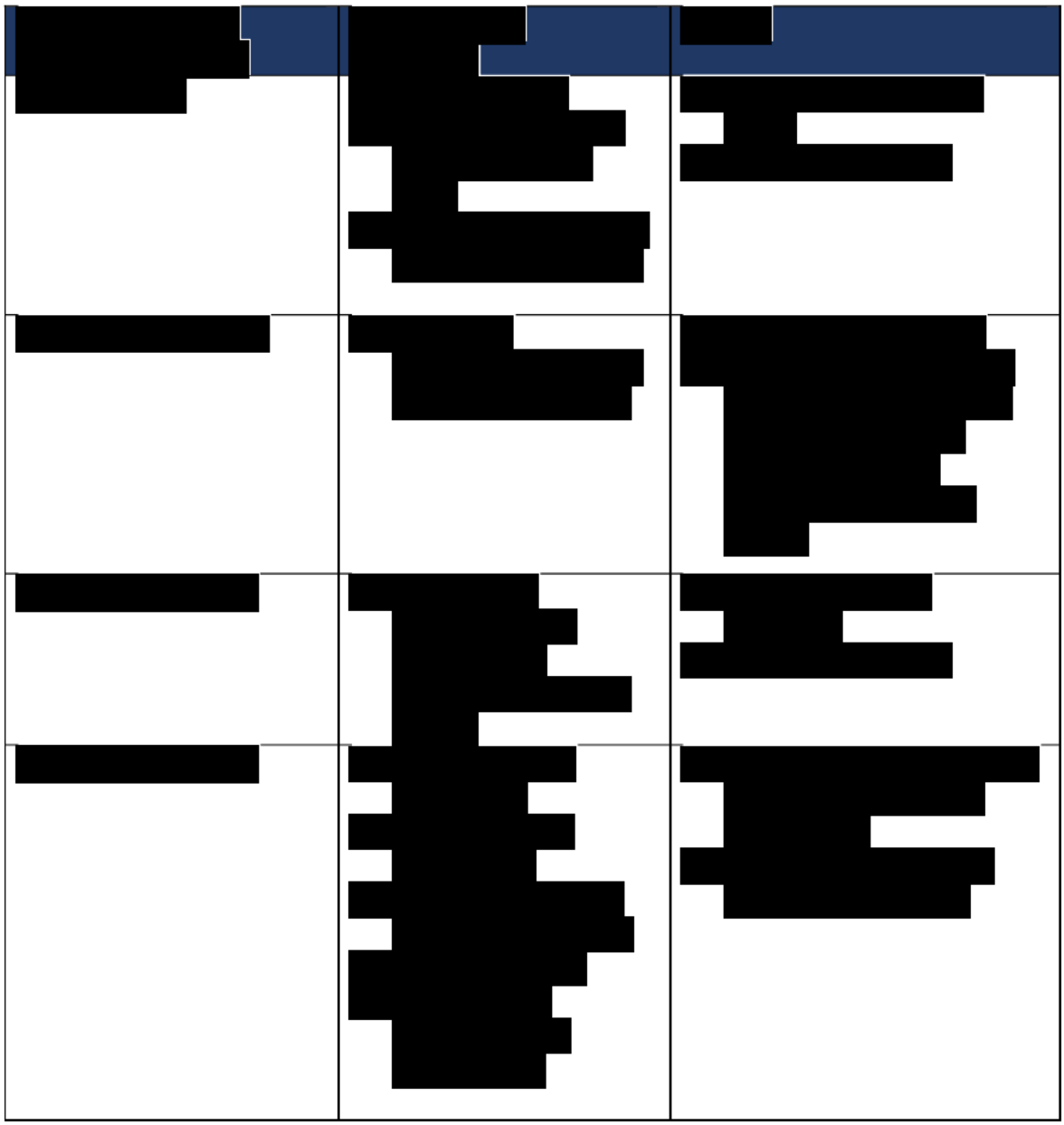
Based on our experience with system development and the architecture of these systems, we anticipate:

- A dedicated full-time Software Engineer will handle the maintenance of the existing MQUIDS and QPS applications. If requested changes warrant additional development time, we will leverage existing development staff.
- An existing Business Analyst will provide change analysis and requirements development.
- An existing Software Quality Assurance Analyst will provide testing services.
- Although Agency staff will maintain the application database, one of our Database Analysts will be available as needed to assist developers or the Agency in managing the database.

To manage the application development workload and project time per task, our developer will work with our Business Analyst to understand requirements and estimate a Level of Effort (LOE) for each requested change. After approval by the Steering Committee, assigned tasks will be added to our Application Development plan to track priority and progress. Our Director of Application Services manages this process. Tasks will be worked in priority order based on priorities designated by the Agency and our internal Operations.

Since the systems supporting this contract are hosted and maintained by the Agency or other Agency contractors, we will work within the systems provided. Program information such as documents, reports, application data, and any other data or information related to the applications provided by the Agency will be stored solely on Agency-owned systems. Table 4.1-6 outlines our approach to maintain current program information.

Table 4.1-10. Using Proven, Best Practice, Increases our Success in Maintaining Current IME Program Information.



4.1.3 RECEIPT OF CHECKS (C.)

Receipt of Checks

1. *In the event that the Contractor receive checks or money orders related to the work that it performs, the Contractor shall deliver them to the Revenue Collections contractor's designated point of contact for daily deposits.*

Based on our experience with similar projects, we occasionally receive misdirected checks and money orders from a variety of sources. Although this rarely occurs, we will utilize the following protocol:

1. Check is received via mail. Customer Service Center Supervisor is notified immediately.
2. Supervisor logs check information and associated mailing information into KEPRO's tracking within (two) 2 hours.

3. Check is sent to the States designated Revenue Collections via certified, return receipt mail the same business day. All return receipts received are immediately scanned, and placed in the tracking system (linking it to the specific tracking number).
4. Supervisor alerts the collections supervisor via telephone of the incoming check and provides all associated tracking information. The call is documented in our tracking system, noting the date, time, tracking number and individuals name and title who received the alert.
5. Supervisor places a five (5) day follow-up flag in tracking system.
6. Supervisor receives automated follow-up prompt via email. Tracking system is accessed to ensure that the check receipt was received. When the corresponding receipt is received, the system tracking will be "closed". If no receipt was received, supervisor places follow-up call to the original representative notified to resolve the issue. Any further discover will be documented.
7. Every month, each unresolved issue will be reviewed by the Quality. Quarters audits will be conducted to ensure compliance and effectiveness of the established process and results will be documented in the monthly and quarterly reports to the State.

Our Project Director will work with IME leadership to further customize this process and align with all policies and procedures.

4.1.4 APPEALS AND HEARINGS (D.)

1. *The Contractor shall provide administrative assistance to the Agency in tracking and assigning all IME appeals related to the FFS population, as well as any appeals the IME may receive of MCO decisions, utilizing protocols and timeframes determined by the Agency.*

KEPRO has over a decade of experience in reviewing MCO denials and providing expert testimony for Medicare and Medicaid appeals. From this experience we have developed administrative procedures that enable our Staff to: (1) assign expert physicians to each appeal review request; (2) track and communicate all due dates of appeal review requests; (3) schedule expert physicians to testify at hearing; and (4) communicate all expert physician assignments and complete appeal reviews to our Client.

Requests for Medical Necessity Reviews (MNRs) are received from Agency staff via email to a virtual mailbox monitored by support staff then reviews the request and assigns the MNR to a specialty matched physician to complete the review, depending on case type (medical, behavioral, or dental, with additional sub-specialties on our panel). Support staff also ensure that the physician is aware of the appeal timeframe for completion of the MNR based on whether it is an emergency, expedited, or standard review, which are processed respectively in 1, 4, or 11 days. Once assigned, the physician reviews the case to determine whether services were medical necessary based on IME rules and applicable criteria. The physician uses a KEPRO developed standardized template to communicate the clinical and other considerations that factored into the findings of the MNR.

If we support the MCO's reconsideration denial, the case will proceed to fair hearing. On average, 84% of these cases proceed to fair hearing. The remaining 16% are accounted for as withdrawals, or services found medical necessary. Requests for a witness are handled similarly. Requests for witnesses are received in a virtual mailbox monitored by Admin staff. As with MNRs, the request is reviewed by Admin to determine what specialty matched physician is needed for the hearing. Whenever possible to assign the physician who wrote the MNR to the hearing. The date and time of the hearing, Administrative Law Judge, and Agency attorney assigned to the case are all communicated by Admin to the assigned physician. In preparation for the hearing, the physician reviews all relevant evidence including the MNR and any additional information that may have been received and reduces his or her clinical and other considerations into a standard hearing notes template. Our physicians may reach out to providers if warranted as part of the hearing prep process for a peer to peer discussion of the denied services, and KEPRO often conferences with Agency attorneys prior to hearing to ensure the attorney has a solid understanding of the clinical issues involved.

We support staff daily evaluate / triage incoming review requests based on varied timelines (expedited, accelerated, standard). Next, we assign appeals to physicians based on requested service, appeal timeline, physician specialty, physician availability, physician current workload (reviews, assigned hearings, meeting schedule). Daily, Weekly, and Monthly review of reports are instrumental in insuring deliverables are not missed & that reviews are assigned according to the direction of the Medical Director. The following reports are utilized:

- Daily Review Requests Received
- Daily Completed Reviews
- Daily Dental Evidence Received
- Daily Outstanding Review Report (3x)
- Daily MNR Tracking Report
- Daily MNR Decision Audit
- Daily Review Request – Necessary Null
- Daily Completed Reviews by Due Date
- Daily Dental Events
- Daily Start Date Audit
- Weekly Additional Information Requested Report
- Weekly Data Entry Audit
- Monthly Closed Dental Appeals

After the reviews have been completed and edited, the appeal coordinator enters data in the Agency tracking system. Data entered includes: diagnosis, determination, physician time to complete the review, issues with the appeal and if additional information has been requested or submitted. The data must be entered without error as it is used in various reports for internal use, as well as reports used by the client. Internal reports catch data entry errors. These daily reports are used by support staff to make corrections as necessary before the data is used by the client.

Completed reviews are submitted to the client in several different ways. One is via email. The subject lines must be entered exactly as requested by the client for their proxy mailbox rules (which KEPRO created for the Agency as an efficiency) to process correctly. Daily calendar maintenance for review

requests and scheduled hearings is also performed, which includes adding, deleting, and modifying 18 different calendars. The review and hearing appointments also serve as a portion of our business continuity plan.

Our support also includes merging daily dental evidence into a single pdf, and the inclusion of a label to clearly identify the enrollee. This evidence is added to the Agency tracking system and is used by an Agency unit to distribute the Notice of Hearing for the upcoming scheduled hearing. On average, we receive between 20-45 dental reviews per day. Each containing 1-8 pages of x-rays, study models and/or photos.

KEPRO performs daily review of requests for witnesses from an Agency unit. To assign a witness, it is necessary to evaluate the physician's availability, current workload, current assigned hearing docket, physician specialty, and meeting schedule.

Processing a witness request requires generating a work sheet in the Agency tracking system, entering the assigned witness in the Agency tracking system, merging the Notice of Hearing, work sheet and any other pertinent documents required for the scheduled hearing, as a single pdf. An appointment, containing the required hearing documents must be sent to the physician's calendar. The appointments serve as another portion of our business continuity plan.

Once hearing prep sheets are completed by the physicians and sent to Admin, it scans and adds the individual prep sheets to each enrollee's folder. These prep sheets are created and used by the physicians for upcoming or continued hearings. Ongoing communication with Agency managers and staff regarding appeal issues on the physician's behalf, including continuances/rescheduled hearings, withdrawals, and changes in attorney or physician schedules and assignments.

The process described above is the result of decades of experience with and refinement of appeals and fair hearings procedures. This experience and expertise will be brought to bear on Iowa's Administrative Law Judge Appeals.

Assigning Expert Physicians to Appeal Review Requests
All new physicians are required to submit their Curriculum Vitae (CV) and license for corporate credentialing (see section4.1.1 Staffing for details on our credentialing process). After being reviewed and accepted, the new physicians undergo standard orientation including any corporate courses and State required courses (such as PHI training). KEPRO's comprehensive training package includes training on proper use of the MNR template, Agency rules and applicable federal regulations, as well as the specifics of the scheduling process and use of calendars to ensure each physician is aware of assignments and hearing dates. Training is of course catered to physician specialty, though our medical physicians receive training on many different appeal types ranging from medications to home health care. The length of orientation varies physician to physician and accounts for factors such as full time and contract positions. Our

Medical Director is kept up to date on all new physician progress via internal meetings with KEPRO's corporate Clinical Research Specialist, who oversees all physician training.

After completion of the trainings that are necessary to ensure each physician understands applicable rules, criteria and process, medical necessity review training is undertaken with the Clinical Research Specialist and physicians are assigned de-identified cases, and supplied with applicable information and medical records. The physician is also provided a training MNR template which guides the review production process and ensures that the physician addresses each element in the appeal in the appropriate section in the template. Completed reviews are then graded and discussed with the reviewer to identify issues and improve the physician's work. This process is repeated as many times as is necessary until the reviewer is ready for live work. The decision to allow a reviewer to begin live work is a collaborative one, which involves discussion among the Medical Director, the Associate Medical Directors and the Clinical Research Specialist in charge of training. Hearings training consists of detailed hearing prep coaching, job shadowing/attending live hearings. Our physicians are first coached by colleagues on the standard hearing prep worksheet, and ensuring each reviewer understands what information the judge will expect to be presented to support a denial. Care is taken to ensure that sometimes voluminous medical records are organized in a way that key information can be accessed quickly. Once there is a comfort level with hearing prep based on a collaborative discussion like the one described above, new witnesses will attend hearings with a seasoned witness, and after a docket is complete a de-brief is held to discuss how the hearing went, why the witness offered the testimony they did and at what point during the hearing. Again, this process is repeated as many times as necessary to ensure the new witness is fully prepared for a live hearing.

Monitoring Quality and Consistency

To monitor the progress and consistency of all our physicians, we have an MNR Committee that meets quarterly. Each KEPRO physician is assigned five appeals randomly selected for review, and each KEPRO physician reviews the MNRs written by a colleague and grades it. Review types are selected by the denied services at issue in each appeal. For example, we want to ensure that for medical physicians we cover a broad range of service types including pharmacy, home health, and surgical. For behavioral reviewers, residential treatment cases tend to be more complex, so we ensure those are included in each quarterly review. For our dental and orthodontic physicians, we want a mix of dental and ortho cases.

Grading occurs via use of a KEPRO developed template that has been refined over years of experience with appeals. Examples of the questions physicians must answer as part of the grading process include:

- Is the clinical situation adequately and thoroughly described?
- Does the Reviewer Rationale construct a logical argument that included a literature search (if applicable)?
- Is the alternative plan of care (APOC) adequate and defended?
- Does the auditor agree with the final determination?
- Does the review provide sufficient information to go to hearing?

Questions are weighted for scoring to ensure the most important questions have a higher weight. Each physician then submits the completed scoring sheet to nurses for compilation. The review committee meeting is then held to discuss why each physician graded the MNR the way that they did, and a

collaborative discussion takes place about ways to improve future MNRs. Any physician receiving a score of less than 80% on a 100 scale meets individually with the medical director to discuss how to improve future MNRs.

We mirror this process for its hearing committee meetings, and cases are assigned to committee members along with transcripts of each hearing. Examples of some of the salient questions physicians must answer as part of their transcript review include:

- Did the witness understand the facts of the case?
- Did the witness present the case appropriately?
- Did the witness demonstrate reasonable knowledge of medical issues?
- Did the witness demonstrate knowledge of and apply the Agency Rules to the facts of this case?

Scoring and associated weights mirror the MNR committee process, and remedial action is taken on any case scored below 80%.

Scheduling Expert Physicians to Testify at Hearing

KEPRO's expert physicians may be requested to testify at a State Fair Hearing on their upholding of an MCO's denial. Much like the Review Request Management Application used for new appeal review requests, our Administrative Staff utilizes a custom-built Witness Request Application. Upon receiving a new witness request, hearing appointments are automatically generated. After attaching all hearing information, which includes the information packet containing relevant medical records, the MNR, and any additional information that that was submitted, the appointment is added instantaneously to the physician's hearing calendar. This ensures all hearings are staffed. The Administrative team maintains all hearing calendars and notifies all applicable parties if a hearing has been continued or withdrawn. Table 4.1-7 demonstrates our contributions to a more effective and efficient process.

Table 4.1-11. Demonstrates our effective and efficient process.

Communicating all Expert Physician Assignments and Delivering Completed Appeal Reviews

KEPRO's approach to communication includes delivering timely reports with relevant information, email and phone communication with applicable agency staff and in person meetings to discuss important trends or issues. KEPRO fully understands the importance of adhering to all due dates as we know that

Medicare and Medicaid appeals are driven by regulated timelines. We know that clear and accurate communication is crucial to any successful partnership. Therefore, we communicate daily, through generated reports, all physician assignments for appeal review requests and all expert witness assignments.

Additionally, KEPRO physicians may conduct peer to peer conversations with providers on an as needed basis. If from their review of relevant information and medical records it is determined that communication with a provider may be of benefit to clarify an issue in an appeal, outreach will be made to provider to have that conversation. Peer to peers can be conducted as part of the MNR production process, or part of hearing prep, and potentially both. KEPRO physicians also understand that ensuring the Agency attorney assigned to the case is well-versed in the clinical issues at play is crucial to a good hearing result, so pre-hearing conferences are conducted to parse through the issues in each appeal. This ensures that the Agency attorney's strategy is clear to the physician, and that the Agency attorney has a good understanding of the clinical aspects of the appeal.

Our Administrative Staff sends an email notification and submits the complete appeal review within the timelines required in the RFP. In upholding these timelines, we not only fulfill our contractual obligation, but a timely independent appeal review of MCO denials ensures that enrollees receive a timely decision on their appeal as required by law. In some instances, KEPRO completes review requests the same day they are made when needed, thus we stand ready to meet Iowa's time frame requirements for hearings.

2. The Contractor shall submit a report of all IME appeal hearings to the Agency on a quarterly basis. This includes but is not limited to:
   a. Status;
   b. Disposition of case;
   c. Analysis of appeal trends and recommendations for policy changes identified from appeals; and
   d. Breakout analysis of appeal hearings for Level of Care and needs based assessment determinations and PAs, with fiscal year-to-date totals, analysis of trends, and recommendations for improvements (including internal quality improvements).

KEPRO Analytical Staff works to provide detailed and customized quarterly reports on hearing outcomes and scheduled hearing trends of KEPRO witnesses. These reports detail the status of each scheduled hearing and provide a count and percentage of how many hearings occurred, did not occur, were withdrawn or continued. These reports are part of a reporting package that is delivered to the Agency's Chief Medical Officer and Associate Medical Director in advance of a monthly meeting where verbal discussion with KEPRO executive staff centers around the appeal trends represented in the reports along with potential recommendations for rule or policy changes.

A recent example of KEPRO's partnership with and support of the Agency regarding policy was its detailed research and reporting on Hepatitis C drugs. KEPRO's clinical team made recommendations and provided information that informed Agency policy regarding which drugs were covered under which clinical circumstances. KEPRO's clinical team also highlights trends seen as part of our role as an independent medical reviewer. In one of the monthly meetings with Agency clinical leadership KEPRO's Medical Director highlighted a trend with one of the Agency MCOs where home health clinical staff were not performing on site assessments prior to reducing hours. The Agency could act to address this deficiency before it became a larger issue, and to ensure the best possible care for its members.

Lessons Learned

We conduct an annual review of all reports that are delivered to State Agency personnel. It is exceedingly important to us that the reports we deliver are beneficial and meets the needs of our Client. We communicate with all Agency Unit Managers and assess the usefulness of the reports/data being delivered. Based on the feedback we receive, it may be appropriate to retire, modify, or create new reports. This annual review includes all reports associated with medical necessity reviews and hearings.

KEPRO also conducts a survey each year which asks each Agency attorney who works in conjunction with KEPRO witnesses in appeal hearings to rate each physician on their performance. This survey consists of 10 questions where KEPRO physicians are rated.

Attorneys rate KEPRO witnesses on a five (5) point scale, and the 2017 survey reflects that KEPRO's lowest scored witness based on individual weighted averages was 3.64, and only one other reviewer scored less than 4. Many witnesses scored a perfect 5 on many individual questions. If the survey reflects performance deficiencies for any given question or an overall unsatisfactory score, KEPRO's medical director follows up individually with the physician to discuss the scores, and training or other corrective action is taken as necessary. Please see the chart below for our impressive results across all reviewers for each question.

4.1.5 QUALITY IMPROVEMENT AND MCO QUALITY OVERSIGHT (E)

The IME expects its vendor to be an expert in quality improvement – internally and externally across delivery systems and providers. This expertise means the organization can "walk the walk" with an authenticity that is essential to efficient operations and credibility with stakeholders.
We focus on beneficial outcomes that our clients value – improvements in medical necessity of care and settings, independence for individuals, and delivery system performance.

QUALITY & COMPLIANCE OVERVIEW

Our corporate quality and compliance departments assist our local teams by integrating our corporate framework with local requirements. Our Quality Improvement Director is responsible to administer URAC accreditation and coordinate quality improvement activities across contracts for reporting to executive management. Administered by our corporate Compliance Manager, our compliance program includes ongoing efforts to monitor, assess, audit, and evaluate compliance with KEPRO's policies and procedures (P&P), state and federal regulations, and contract requirements. The Compliance Manager conducts ongoing audits to ensure that the organization applies all compliance policies and procedures consistently throughout the organization. We assess the following items during the audit process:

- P&Ps adhere to federal and state laws and employees receive annual compliance training
- Employees follow the KEPRO Code of Conduct and established policies in support of that code
- Employees sign Conflict of Interest Disclosure Statements hire and at changes in status
- Employees sign Confidentiality Agreements upon hire and addendums as modifications are made to the Confidentiality Policies
- Completion of background checks and other credentialing requirements specific to individual contracts.

We integrate our corporate framework with contract-specific requirements during the transition period for a seamless approach to managing quality at the local level. The local team reports quality management results to our corporate departments, and we share these results across the organization

to promote recognition and adoption of best practices. Our framework has a process that we use to embed proven and approved quality practices into local operations for the six primary activity areas in the SOW (1.3.1.1-1.3.1.6) as shown in Table 4.1-12:

1) Specify contract goals and requirements as defined by the client.
2) Document the Operations Plan to encompass requirements and deliverables.
3) Ensure quality review of processes and deliverables, including client approval.
4) Evaluate results compared to standards, benchmarks, and evidence.
5) Decide on improvement strategies and develop action plans.
6) Re-measure, evaluate results, and update Operations Plan.

Table 4.1-12. KEPRO Quality Management Framework.

Our proven approach to managing quality at local and national levels focuses on the goals and requirements of our clients to align tasks and deliverables and exceed expectations.

Monitoring Quality and Accuracy of Work

Successful contract performance requires efficient, effective methods of receiving inputs, adding value and innovation, and producing quality outputs that meet or exceed our customer's expectations.

As a leader among QIOs, we were the first QIO in the nation to receive CMS funding for a formal quality program (then Deming-based), and the first to receive ISO registration. Our experience includes leading quality initiatives, including the CMS National Medicaid Protocol Contract, in which we established quality protocols for external quality review of Medicaid managed care at the national level. Given our

role in quality management and improvement for Medicaid, Medicaid, and Department of Defense health systems, many QIOs adopted KEPRO quality policies and procedures.

As the description of our quality framework indicates, our business philosophy is rooted in continuous quality improvement principles – ongoing improvement that is consistently planned, measured, and evaluated. This philosophy both requires and ensures that we:

- Comply with all federal and state legal and statutory requirements
- Perform all contract activities in a professional and ethical manner
- Provide products and services characterized by the utmost integrity and reliability.

Our QI program includes both quality assurance activities (oversight and monitoring of provider credentialing and adherence to all contract-specific QI agreements) and interventions based in Continuous Quality Improvement (CQI) principles to achieve improved quality of care for beneficiaries.

4.2.1.1 MONITORING CONTRACT PERFORMANCE- *WE MEASURE EVERYTHING WE DO!!*

Our local and national quality teams monitor data on key processes and outcomes to assess overall contract performance as well as staff performance. Throughout the contract, we adjust our metrics when services, procedures, or structures undergo critical changes. The frequency of measurement is determined by:

- The need to establish new baseline data
- The stage of the process/activity
- Contract or regulatory requirements
- The frequency, volume, or risk of the process/activity.

When data reflects variation in performance, we bring it to the Quality Assurance Committee. The Committee determines if we need to initiate an intensive assessment or if we need to commission a quality improvement team to identify the root cause of the variation and develop action plans.

4.2.1.2 MEETING DELIVERABLES

During transition, we develop a Schedule of Deliverables and major contract activities. The contract Program Director has the ultimate responsibility for the completion of all deliverables and major SOW activities. Various team members contribute to the preparation, monitoring, and completion of deliverable requirements depending on their area of expertise. We review, edit, and perform a quality check. The quality check consists of the following:

- Compliance – Does the deliverable follow the approved format?
- Completeness – Are all required elements addressed?
- Accuracy – Is the presented information accurate?

We also develop a Corporate Compliance Internal Audit Plan to monitor performance indicators and deliverables for all operations and contracts. This approach ensures that all federal, state, and

commercial contracts perform to internal and external customer expectations. Meeting our contract obligations is paramount to the success of our organization. The operational key indicators assess individual contract performance as part of our Operations plan. For each contract, we identify Critical Success Factors (CSFs). CSFs are significant events that are critical to our successful operation of the contract, objectively evaluate customer satisfaction, and are reported to the Board of Directors.

Examples of CSFs are:

- Measurable outcomes relevant to IME's goals.
- On-time deliverables.
- Prevention of Corrective Action Plans.
- Positive results of Customer Satisfaction Surveys.

Our internal audit plan validates contract performance in meeting CSFs and provides trending information that we use to identify opportunities for improvement in all operations. We perform monthly internal audits of our operations, and share the results of these audits with IME. We examine reviews and case records for quality of documentation, timeliness, citation of diagnosis, evidence of appropriate criteria usage, and compliance with workflow.

We assess both first-level clinical reviewer and second-level specialty reviewers for accuracy, timeliness, and reliability monthly to ensure we continually provide valid decisions on time. Monitoring falls into two categories, cases audits (Did the reviewer make the right decision in this case?) and inter-rater reliability (Will all reviewers make similar decisions given similar situations?).

We audit clinical reviewer performance against industry standards. Our rigorous audit process provides timely feedback to reviews to identify training and intervention needs; it provides detailed information for the design of review training and systems; and it assures our clients that the results we deliver are valid and reliable – sound, evidence-based, clinical decisions. Table 4.1-13 lists the individual elements we examine as part of this process.

Table 4.1-13. Elements Evaluated during Audit Process

Using a comprehensive audit process ensures delivery of valid results

If a reviewer falls below the 90% accuracy rate, we immediately initiate a performance improvement plan. Managers provide immediate feedback through case-specific monitoring results to staff, and provide additional feedback on an ongoing basis.

Managers will use data reports and audit results to make sure their assigned staff are meeting established standards. Supervisors will provide coaching and training to help improve individual performance. Developmental goals also may be initiated to plan for improvement. KEPRO asserts that such systematic feedback provides objective information about staff progress.

Inter-Rater Reliability. Inter-rater reliability (IRR) assessment is used to measure adherence of the staff, physicians and nurses, in applying utilization management guidelines and standards which include maintaining consistency in application of Medicaid policy, navigating accurately in the systems, and applying sound clinical knowledge.

Reviewers complete a set of tests, or gold standard, cases monthly to assess reliability and dependability of decisions and knowledge of the review process. A "gold standard" case is defined as a case with clinical information meeting only one InterQual subset, State Medicaid rule, or proprietary clinical criteria. These test cases measure the reviewer's proficiency of the approval process; application of criteria, and application of workflows - especially referrals.

Since all reviewers receive the same sample cases, we can analyze the agreement between reviewers (inter-rater reliability). Test cases will be given to all reviewers at the completion of initial training. Subsequently, gold standard cases are assigned to assess reliability on an ongoing basis.

Our Health Intelligence team selects a random sample from cases completed the prior month, stratified by each level of reviewer. The sample includes all staff members who completed reviews. We expect the inter-rater agreement to be 90 percent over a three-month period.

Perform Continuous Workflow Analysis

Our 6-point model relies on continuous analysis of workflow. This analysis is the responsibility of the local project team, who are most familiar with contract requirements and deliverables. The Project Director is responsible to coordinate this activity, with members of the management team responsible for the work under their direction. We will compile the results of our analysis, and include descriptions of our corrective actions. We will develop the format for this electronic submission for advance approval by the Agency, and report to IME on a quarterly basis.

4.2.1.2.1 Provide Agency with Description of Changes in Advance

We submit the initial documentation of workflow, tools, and materials to the Agency for advance review and approval during the transition process. Once the project achieves operational status, we submit changes to the approved approach at least 30 days in advance for IME review and approval. The Project Director will be responsible for submission of these materials to the IME contract monitor, and serve as the point of contact for comments and suggestions from IME staff as applicable.

In addition, when the changes will affect the provider community, we will offer training/technical assistance to providers on the upcoming changes at least 30 days in advance.

4.2.1.3 BENEFITS OF PROACTIVE QI

Workload and scheduling for Medicaid quality improvement programs can be unpredictable and vary significantly from month to month. The effects of regulatory changes at the federal and state level, introduction of updated technologies and methods, and seasonal fluctuations all can inflate workload and create backlogs and delays. The benefit of continuous improvement is that it creates efficiency in the process to accommodate variation without affecting deliverables.

Our review contract in Florida is an excellent example of this benefit, and illustrates our expertise in behavioral health and assistance to states to meet federal requirements. The federal mandate for turnaround of confirmatory evaluations is 7 days. Our initial turnaround for this contract averaged between 4 and 5 days – and through application of continuous improvement principles, we reduced the average turnaround to 2 days. A regulatory change in Florida resulted in a short-term increase of over 200% in the volume of review. Because of our efficient operations, we absorbed this increase and maintain a turnaround of 4.5 days – still more than 2 days below federal requirements.

4.2.1.4 MCO QUALITY OVERSIGHT

2. *MCO Quality Oversight. In accordance with CMS Special Terms and Conditions for Iowa's 1915(b) Waiver, the Contractor shall:*
   a. *LTSS Care Plan Review. Duties include but are not limited to:*
      i. *Review a representative sample of LTSS plans of care that includes a reduction, suspension, or termination in services for the first year.*
      ii. *Receive a monthly service plan reduction report from each of the MCOs documenting any reductions they have made in the past month;*
      iii. *Request additional information from a representative sample of these service plan reductions;*

iv. Review the information provided for these service plan reductions to see if the rationale for reduction provided by the MCOs is consistent with the MCOs documentation and permissible under federal and State laws as well as the terms of the contract; and
v. Report findings to the Agency on a monthly basis.

4.2.1.4.1 LTSS Care Plan Review

Iowa's managed care program, including Long-term Services and Supports (LTSS), is a delivery system innovation recently implemented. IME and CMS both have an interest to make sure that LTSS members receive high quality care, retain functional capacity, and have choices in their services and settings. Members may receive LTSS care at home, in a community setting such as an assisted living facility, or in a long-term care facility. Although many plans have experience delivering LTSS services in other states, Iowa providers and members will be new to managed long-term care. Additionally, managed care structures can inadvertently incentivize reductions or limits in access to needed services. For these reasons, quality oversight of managed care implementation is an important safeguard, especially in the first year.

KEPRO has over a decade of experience with reviewing services and supports delivered in community and long-term care settings, combined with our experience with PASRR evaluations for individuals seeking long-term care placement who have serious mental illness (SMI) and/or intellectual or developmental disabilities (IDD). Completing over 37,000 face-to-face evaluations/assessments and care plans during 2016 alone, we have the corporate expertise to implement an efficient and accurate MCO oversight system that exceeds IME's and CMS' expectations.

4.2.1.5 MCO QUALITY OVERSIGHT: LTSS CARE PLAN REVIEW

The review process for the first year will encompass care plans that were modified to include fewer services or a shorter duration of services; where services stopped for a period; or where the MCO stopped services permanently.

In preparation for implementing this review function, we will work with MCOs as directed by IME to ensure our readiness to provide accurate and informed oversight of selected LTSS care plans. Our preparations will include:

- **Orientation.** We will request each MCO to provide an orientation of their assessment and care planning process. This orientation will include a review of their instruments, guidelines, and care plan format. We will also request that we meet with MCO Case Managers for them to provide background regarding their approach to care planning for LTSS members.
- **Self-direction.** We understand from the UnitedHealthcare LTSS Guide that self-direction is available to members. This benefit has the potential to influence care plans as well as introducing unique features to individual plans. We will request an overview and orientation to self-direction options and processes from each MCO as there may be significant differences between these options.
- **MCO Report.** To support appropriate sampling, the report must have specific features. We will provide our preferred format (Microsoft Excel) and content to the MCOs, once IME approves. This information will help MCOs provide the information we need to select samples without having to request additional information:

- MCO Identifier
- Member Unique Identifier (e.g., Medicaid Number if unique or proprietary number)
- Member Social Security Number
- Member Name and Birthdate
- Last Assessment Date
- Next Assessment Date
    - Setting Indicator (Home, Community/AL, and Residential Facility
- Reason for Reporting Indicator
    - Reduction of Service, Suspension, and Termination
- Service Changes – Multiple lines detailing the services reduced, suspended, or terminated

- **Submission Process.** This process includes the timeframe for securely submitting the MCO sample report. Every MCO that includes an LTSS population will have to submit on the same timeline, and we will coordinate to ensure that MCOs have adequate time for preparation. We understand that IME will procure new MCOs to support the program since AmeriHealth Caritas withdrew. Our approach for these new MCOs may have to be different than for UnitedHealthcare, for example. A benefit of our approach is our flexibility to develop tailored solutions to each state's unique circumstances. We will be available to provide technical assistance and training to new MCOs to help ensure their readiness to participate in this process. We will also adjust the review process and recommendations for interventions to reflect the fact that another MCO may have been responsible for the assessment and care plan. This approach helps ensure that we are equitable in our review and that each MCO has the information and support it needs to deliver high quality LTSS care to each beneficiary.
- **MCO check list**. We will develop a check list for MCOs to provide information that is complete, clear, and ready to use.
- **Transition Call Center Support**. We will provide special Call Center training to support the call center during the transition period including providing responses to MCO information submission and related questions.

STAFFING

Differences in care plans based on setting (home, community facility, or institution) can be significant. Providing appropriate review of LTSS care plans may involve more than one type of professional reviewer depending on the type and setting of services. For this reason, our proposed staff includes licensed Registered Nurses, Licensed Clinical Social Workers, and physicians.

The primary reviewer will be a RN, licensed in Iowa, with a background in geriatric care and LTSS settings. The RN Reviewer will refer questions to a Licensed Clinical Social Worker (LCSW) for issues concerning self-direction, community-based services, and concerns with social services. If a Reviewer disagrees with the medical basis of the diagnosis and/or assessment, we will refer the case to a physician reviewer for clarification.

Statistical and Data Support

Our local review team has the support of our corporate Health Intelligence team including experts in design and sampling. This group assists in making recommendations on sample size and process. For example, in this proposal we suggest stratifying the sample by MCO and setting. The sample size may need statistical adjustment for the sample to be equitably representative of the two initial MCOs, since most of the former AmeriHealth Caritas members are enrolled in UnitedHealthcare. The Health Intelligence Group will select a supplemental sample to replace cases if we cannot conduct review of all the original selection.

APPROACH TO LTSS CARE PLAN REVIEW

Table 4.1-14 provides an overview of our proposed 10-step approach to care plan review (RFP Section 1.3.1.1. E2. a. i). We will discuss this process with IME, and adjust as needed after final approval. Once approved, we will distribute to the MCOs and discuss with each of these organizations prior to implementation. We will also meet with LTSS community stakeholders, such as AARP, to brief them on the process and outcomes subject to IME approval.

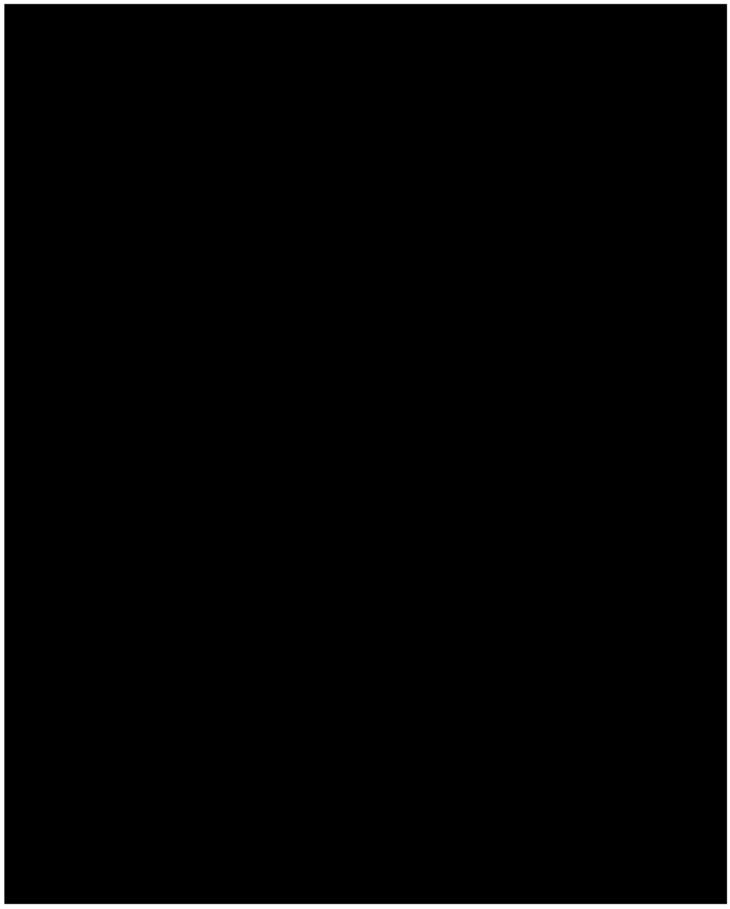


Table 4.1-14. Overview of Care Plan Review Process

1) **Check in and Add Report Data**. Our Administrative Assistant will check in the report for the MCO, and upload it to the Sampling Database. Note: We will maintain a longitudinal database of records received, and flag those selected for review for tracking and reporting and Having established the format and process for monthly reporting, we will issue a reminder request for the report to the MCOs. The report will be due by the 15th of the following month. MCOs will send this report to the Quality Director co-located with our QIO team in Iowa. (RFP Section 1.3.1.1.E.2.a.ii)

2) **Stratify Members.** The HI Analyst will stratify the combined data set by MCO and setting of care.

a. **Select Sample of LTSS Members**. The Analyst will select a representative sample for each MCO and members in each setting. We recommend a sample with a 95%

Our expertise in LTSS care planning will provide accurate and timely data IME can use to make informed decisions about MCO performance.

confidence level and 5% sample error at the MCO level with a 90% confidence level and 10% sample error at the setting level. Now, we estimate that we will select up to 125 members per setting depending on the size of the sample population. This approach

b. generates a sample with a high degree of generalization to both the MCO and setting, considering the level of effort for the review and administrative burden for the MCOs.

3) Request Materials for selected Members. We will request assessment results and care plans for each beneficiary in the sample. Our data request will also include the written rationale for the change in service, as well as any re-assessment the MCO conducted to support the changes.

Our transition approach is an important benefit in this area, since MCOs will have the information in advance that describes the information we will request, including format and timeframes. (RFP Section 1.3.1.1.E.2.a.iii)

4) Initial Review of Materials. Once we receive the materials, we will conduct an administrative review to ensure we have all the information we need to conduct the complete review.

1) If information is missing, our Administrative Assistant will contact the MCO and request the specific materials we need.

2) We will suspend the review in anticipation of receiving this information. After 10 business days we will issue a second request. After an additional five business days, we will document missing information as a deficiency.

5) Document findings and rationale. The RN Reviewer will examine the materials to determine if they document an acceptable rationale for the change in services. The Reviewer will use the assessment as the documented source of service needs, and examine any supplementary assessments or other information that reflects the functional status and service needs of the beneficiary. (RFP Section 1.3.1.1.E.2.a.i and 1.3.1.1.E.2.a.iv).

Materials we will request and use include:

- Care Plan, or Individual Service Plan (depending on MCO nomenclature).
- Most recent assessment.
- PASRR Level I and Level II (if relevant) results.
- Documented rationale for change in service levels, such as medical review results, direction from the beneficiary.

6) Contact Plans for additional materials as needed. If Reviewers cannot complete the evaluation with the information the MCO submits, they will contact the MCO and request additional information. This effort is particularly important given that MCOs may file self-direction documentation differently than assessment and care plan information. Case Managers for beneficiaries in home and community settings may also maintain supplemental information that documents the rationale for service levels.

8) Coordinate reviewer findings. The Reviewers may also consult with other licensed professionals, LCSWs and physician specialists. In our decade of experience with these services,

the diversity of care offered in different settings requires different sets of clinical capabilities for a complete and accurate evaluation. Our process is designed to make sure that each beneficiary care plan reviews are made by experienced reviewers for optimal review outcomes. When multiple reviewers examine the care plan and substantiating documentation, the RN Reviewer will consolidate and reconcile the findings for a coherent and unified review.

9) **Complete review and update system.** On completion of the review process, the RN Reviewer will update system documentation with the results of review. We will code these results for each changed service and provide summary reports to IME as well as trend results by MCO and setting:

   a. **A – Agree.** This finding indicates that the Reviewer(s) concur with the MCO decision.

   b. **U – Agree with changes.** This finding indicates that the original services are unnecessary.

   c. **P – Partial Agreement.** This finding reflects that we may agree with only part of the MCO decision. We will include specific documentation to show our agreement with the services reduced/suspended/terminated.

   d. **N – No Agreement.** We will document this finding when we do not concur with any of the changes made by the MCO.

   The distinction between a review outcome of "A" and "U" is important. If services were not necessary, there is an opportunity to improve care planning, eliminate wasteful services and avoidable review activities. This approach adds value to the system by making it more accurate and making resources available to other beneficiaries who need them.

10) **Report finding to IME.** After the process, we will include the findings in a monthly report to IME. This report will be specific to MCOs, and within the MCO universe, to reviews by setting of care. We will summarize the review results, and provide a narrative interpretation of the findings, with recommendations to improve care planning. (RFP Section 1.3.1.1.2.a.v)

Note: If we determine that beneficiary health and or safety is at risk we will immediately notify IME and appropriate agencies such as Adult Protective Services.

CARE PLAN REVIEW DETAIL

By definition, the care plans we will review reflect negative changes in service levels. Our objective is to determine if these changes are accurate and necessary, based on the assessment and supporting documentation.

The benefit of our multi-disciplinary review teams is that they can evaluate all beneficiary factors as they relate to appropriate care planning. For example, our LCSWs are qualified to assess if the Specialized Services required to address documented mental health needs (as reflected in a PASRR Level II evaluation) are met by the care plan. Because managed LTSS is new to Iowa, during the first year we will go beyond the basic RFP requirements to assess the suitability of the care plan overall – not just the changes. This approach will enable us to provide feedback to MCO Case Managers they can use to make care plans more specific.

When reviewers examine the MCO materials, they will ask the following questions:

1) Was the original assessment complete?
2) How did the beneficiary/caregiver/family participate?
3) Did the assessment include documentation of beneficiary choice?
4) What changes in status, utilization, or health occurred to justify a change in service?
5) How did the MCO decide it was appropriate to reduce/suspend/terminate services?
6) Who made the decision to change the care plan?
7) Did the beneficiary/caregiver/family participate in and agree with the change?
8) How will the change affect beneficiary goals, and how does the documentation support the continued achievement of these goals with changes in services?

Assessment Model. Since the beneficiary's assessment and goals drives the care plan, we expect to see changes in beneficiary factors underlying the change in service levels and/or types. Our review will document the process that the MCO used to make their determinations to ensure our decisions are accurate, thorough, and person-centered. Please see section 4.0, *Quality Oversight Operations* for specific details concerning our LTSS plan.

4.2.1.5.1 MCO Interdisciplinary Team Ride Alongs

b. MCO Interdisciplinary Team (IDT) Ride Alongs. This scope of work will cease on June 30, 2020. To ensure that MCO IDTs follow a person-centered process, are individualized to address Member-specific needs, and result in person-centered service plans based on historical information and future desires and outcomes. Contractor duties include but are not limited to:

i. Randomly select 5 IDT meetings from each MCO to participate in each month;
ii. Observe the service planning process during the IDT meetings;
iii. Record observations on Agency-approved forms; and
iv. Report findings to the Agency on a monthly basis.

The methodology of accompanied assessment and care planning is a proven practice for training and evaluation of staff members. We use this process to train our field-based staff who conduct assessments, develop care plans, and complete PASRR Level II face-to-face evaluations. We propose that the same staff members who conduct the MCO Quality Review also conduct the MCO IDT Ride Alongs. Integrating this function with our review of care plans allows us to evaluate the MCO process of service planning in the context of how the IDT eventually determines whether to reduce, suspend, or terminate care plans.

MCO QUALITY OVERSIGHT: IDT RIDE-ALONGS

We will continue this scope of work task until 2020, when all of IME's selected MCOs have participated in the process, and their IDT process and outcomes satisfy the Agency. Since oversight of HCBS and other LTSS-related activities remains a part of the scope of work, we will retain the capacity to provide technical assistance and training to the MCOs and IDTs throughout the life of the contract. IME can rely on us to support its person-centered vision with expertise and direct experience with the MCOs.

It is important to successful implementation that the MCOs and their IDTs are ready to participate in this function with our observer. Since ride-along reviews involve face-to-face meetings with beneficiaries, caregivers, and family members, teams must be comfortable with our staff members, and collaborate in

the process of observation and reporting as partners with us. This approach puts the beneficiary at the center of the care planning process to improve care through impartial review.

Our preparations will include the following:

- **Orientation.** We will cover the process of ride-along observation when we meet with the MCOs to discuss our review of care plans. Orientation will include reporting on scheduled IDT meetings, and the process of notification from us on meetings we select for participation, forms, logistics, and rescheduling in the event of a cancellation.
- **Documentation.** We will document, track, and report on cancellations and rescheduling to identify any pattern of change that may reflect an attempt to avoid an observation for any specific scheduled meeting.

- **Reporting.** We will request a monthly report of scheduled IDT visits in advance by the 20th of the preceding month, in electronic format. Contents of this report include:

• MCO Name/Identifier	• Location of Meeting
• Beneficiary Name/Identifier	• IDT Attendee Names
• Date and Time of Meeting	• IDT Point of Contact Telephone and Email address
	• Expected Attendees (if known) and relationship t beneficiary

- **Expected Process for Ride-Alongs.**
  - Attendees
  - Time and location of meeting prior to the visit
  - Observation process, form, and report

Approach to IDT Ride-Alongs **Error! Reference source not found.** we provide an overview of the workflow for the 11 steps in our proposed ride-along process.

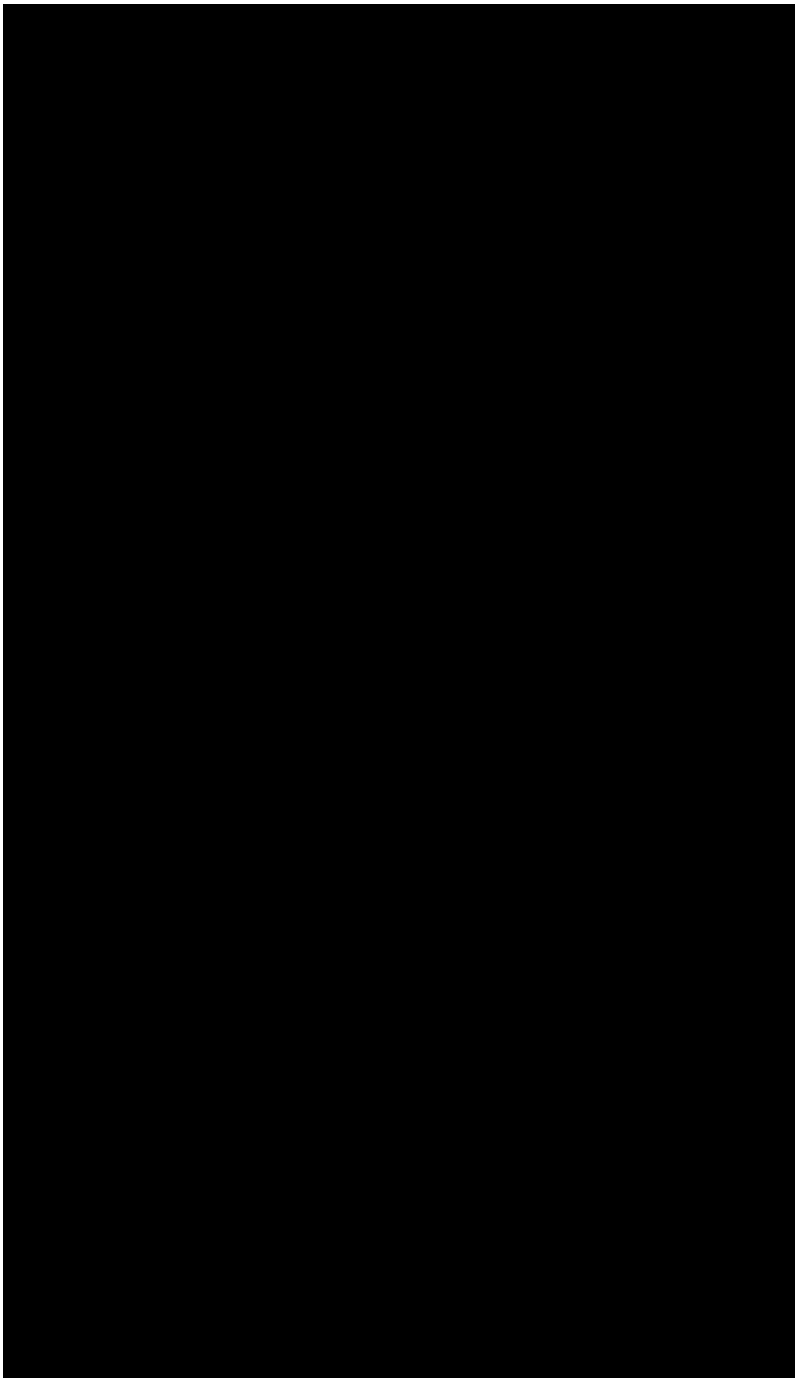


Figure 4.1-1. IDT Ride-Along Process.

We customize this process to provide tailored and actionable findings.

1) Request Report. We begin this monthly process with a reminder to the MCOs to submit the electronic schedule for IDT visits to the Quality Coordinator.

2) Upload Results. Once it is received, the Administrative Assistant will check it in and upload it to our sampling database. Note: We will maintain a longitudinal data set of these records for tracking and reporting.

3) Select Random Sample. The HI Analyst will stratify the records by MCO and select a random sample of five (5) visits per MCO. (RFP Section 1.3.1.1.E.2.b.i)

4) Notify IME & MCOs. The Quality Director will notify the MCOs and IME, and request the assessments for the beneficiaries in the sample. If the MCO does not reply, we will issue another request after five business days. If we do not have the assessment within one business day of the visit, we will note that in the observation.

5) Assign Observer. The Quality Coordinator will review the assessment and assign an appropriate observer. The Observer will review the assessment in more depth to become familiar with the beneficiary's care plan needs and to make accurate and informed observations.

6) Schedule Meeting. The assigned Observer will notify the IDT Point of Contact and make arrangements for meeting logistics, such as where and when to meet, and other information about the beneficiary and the team.

7) Reschedule. If the meeting is cancelled, we will work with the IDT Point of Contact to reschedule it. We will also

document the cancellation reason and monitor cancellations for patterns and trends.

8) **Observe IDT meeting.** The staff member will observe the IDT meeting and complete the observation worksheet. (RFP Section 1.2.1.E.2.b.ii).
9) **Conduct debriefing with IDT.** After the meeting, the observer will conduct a debriefing with the IDT team and include team comments in the observation. The purpose of this activity is to gain insight into the approach the IDT used to interact with the beneficiary and to provide a more informed observation report.
10) **Complete documentation.** The staff member will complete the observation record and enter it into the system. The Clinical Manager will review the observation prior to reporting and validate that it is complete.
11) **Prepare and submit report.** We will report results to IME monthly (RFP Section 1.2.1.E.2.b.iv).

RIDE-ALONG PROCESS DETAIL

CMS document requirement for a person-centered planning process are specified in 42 CFR 441.301(c)(1) i-ix. These requirements form the basis of our observation.

Patient and family engaged care planning is an important development in delivering care. In its January 31, 2017 Discussion Paper, the National Academy of Medicine reported a link between patient-centered processes and better outcomes.[1] These outcomes include adherence to care plans and improved self-management of chronic illnesses, such as heart disease.

Staff members will not participate in the discussion or offer comments or suggestions during the meeting. If there is evidence of a risk to beneficiary health and/or safety, Observers will immediately notify the Project Director, who will contact IME and other agencies as appropriate. If there is a concern, the staff member will also discuss it with the IDT and coordinate responses with IDT members. In the rare event that it is the IDT that represents a risk, the staff member will notify the Project Director, who will contact IME for guidance. The staff member will remain onsite until the risk is resolved. This approach is a basic safeguard all our field-based staff members employ, since we have experienced concerns with home-based beneficiaries that required immediate action.

Observers will look for the following characteristics in IDT engagement with beneficiaries, caregivers, and families:

1) Demonstrates beneficiaries chose individuals to be present for the meeting, including having input into the members of the IDT.
2) Shows evidence of the beneficiaries having the support they need to understand and direct the process of service planning. This support includes information beneficiaries need to make service and service provider choices.
3) Ride alongs are timely and convenient to beneficiaries and other attendees.

[1] Available: https://nam.edu/wp-content/uploads/2017/01/Harnessing-Evidence-and-Experience-to-Change-Culture-A-Guiding-Framework-for-Patient-and-Family-Engaged-Care.pdf. Accessed: December 8, 2017.

4) Reflects cultural considerations, including making the process accessible to individuals with limited English proficiency and/or individuals with disabilities. Cultural considerations also include gender, location types and other preferences.
5) The IDT can resolve process or team conflicts or disagreements, and guidelines are in place to prevent conflict of interest for all planning participants. This requirement will include the KEPRO Observer.
6) The IDT offers facts and figures to beneficiaries to make informed choices.
7) The process includes discussing how beneficiaries can request changes and/or updates to the plan as needed.
8) The discussion covers alternative home and community-based settings, and documents that beneficiaries had the opportunity to discuss and consider these alternatives. For beneficiaries who reside in facilities, the Observer will look for discussion of opportunities and processes for beneficiaries to leave the institutional setting and receive services in home or community settings.

The Observation Form will include these eight items, with a Yes/No indicator for staff members to document their observations. Using these categorical responses enables us to report on the results of ride-alongs and to compare results between MCOs and IDTs.

In addition, the form will include a section for staff members to include narrative comments on the interactions. We will share this information with the IDT members if IME approves, for their discussion and use in improving patient and family-engaged care planning.

IMPROVING SERVICES FOR BENEFICIARIES: EXAMPLE OF OBSERVATION OUTCOMES

In a project for TennCare, we acted as observers and provided secondary care planning services for individuals transitioning to a statewide waiver. We found many opportunities to improve services:

- **Management of meal delivery.** One vendor left meals on the back porch, which was inaccessible to the beneficiary. We found four days' worth of deliveries. Our RN worked with the vendor to refund the cost of the wasted meals, deliver services to the front door, and validate delivery with its workers and the beneficiary.
- **Need for respite.** We visited a beneficiary and found an exhausted and stressed caregiver who was unable to help the beneficiary move out of the bed. The beneficiary had been bed-ridden for several days without bathing because the personal assistant no longer worked for the vendor. Our RN contacted the Agency, located a facility for short-term respite care, and arranged for transportation for the beneficiary and a new personal assistant. The RN followed up with the beneficiary after discharge from the respite facility to validate that new services were in place.

In all our projects, our staff members exemplify the principles of person-centered planning and service delivery. Our experience managing LTSS in a variety of states and programs provides us with the real-world expertise to add value to the IDTs and help improve person-centered planning for Iowa beneficiaries.

HOW WE ACHIEVE YOUR GOALS FOR QUALITY IMPROVEMENT

We use the following six-step process to achieve high quality levels:

1. Establish Essential Metrics for Performance.

During transition, we establish the project metrics we will use to monitor performance based on RFP and contract requirements. While every contract is different, common metrics typically include:

- **Soundness of Determinations.** The reliability and validity of medical review and other audit/evaluation activities indicates how accurate these determinations are for stakeholders.
- **Average Turnaround Times.** Turnaround is the amount of time between initiation of a task and its completion, including notification to eligible entities. Reducing turnaround, delivers utilization review results to providers faster, reduces wait times for beneficiaries to have access to services and improves access to medically necessary care.
- **Timeliness Rate.** This metric measures the overall ability of operations to meet required turnaround times.
- **Call Center Statistics.** Call Centers provide information, resolve problems, and are the intake function for many review and other requests. Our Call Centers are the front line of exceptional customer service for stakeholders. Call Center statistics include:
    - Average Speed to Answer (ASA)
    - Average Wait Time (AWT)
    - Abandoned Call Rate (ACR)

2. Report Results.

Weekly, monthly, and quarterly reports identify the level of performance on the essential contract metrics. We submit report formats and content plans to the Agency during transition, and validate the accuracy and completeness of reports during transition. Once approved, the reports provide the data we use to identify opportunities to improve baseline performance. We also evaluate the effectiveness of the reporting mechanisms using the characteristics described in Table 4.1-15. Reports are an example of proactive quality improvement – increasing automation and clarity makes it easier to evaluate performance against internal and external benchmarks. By including comparative rates, such as benchmarking data and/or historical comparisons, our ability to use the information to measure, manage, and improve performance is significantly improved.

Table 4.1-15. Optimal Report Features.

Useful reports make proactive quality improvement possible with accessible, clear, and actionable data.

[redacted]	[redacted]	[redacted]

3. Assess Performance.

Evaluating performance for the reporting interval requires knowledge and imagination – knowledge of requirements and capabilities, and imagination to identify better ways to perform. Our local service teams solicit feedback from stakeholders, and compare results with other programs using external benchmarks to assess the performance level for potential improvements. We conduct this proactive activity even when the service levels meet contract standards as part of our continuous process improvement program.

Ideas to improve performance come from several sources, as we describe in

Table 4.1-16. A significant benefit of our local service center model, is our ability to collaborate with providers, beneficiaries, and other stakeholders to make productive changes that increase efficiency and reduce administrative burden.

Table 4.1-16. Sources of Quality Improvement.

Opportunities for quality improvement come from our adoption of national standards and close collaboration with internal and external stakeholders.

[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

4. Decide on Improvement Targets.

It is important to note that the ability to identify the right activities or processes to improve is critical to effective contract management. Not every change is an improvement, and knowing when to change and what to change helps prevent wasteful activities that do not offer meaningful or sustainable benefits.

We base our efforts on the goals of our contracts – efficiency, economy, and quality of care to improve access, reduce provider administrative burden, and deliver better performance? We achieve these goals by asking three questions foundational to quality improvement as shown in Figure 4.1-10. ***This model is a best practice developed for the Institute for Healthcare Improvement (IHI) and is in use in hospitals, other healthcare providers, and QIOs across the country.***

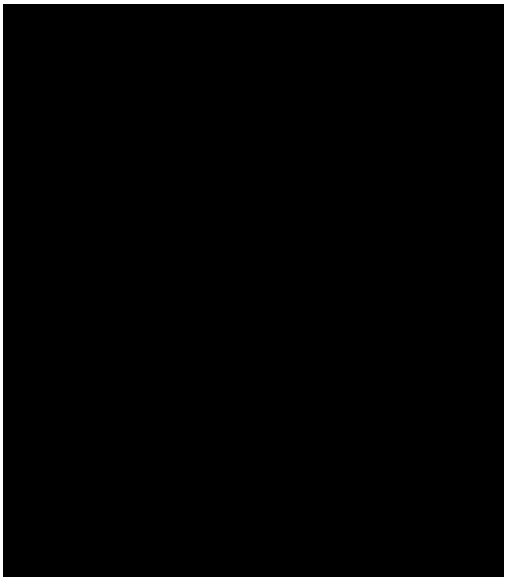


Figure 4.1-2. Quality Improvement Process

Asking the right questions leads to quality improvement initiatives based on adding value to contract outcomes.

1) **What are we trying to accomplish?** Whether our aim is to reduce turnaround time ((to increase access), or reduce administrative burden (to decrease costs) defining the aim is essential to framing clear goals for improvement.
2) **How will we know a change is an improvement?** This question speaks to defining appropriate metrics – measures that enable us to interpret the results of change. For example, if our aim is to reduce turnaround time, our measure is the average number of days between start and completion of an activity.
3) **What changes can we make that result in improvement?** Answering this question requires in-depth operational knowledge – the kind of knowledge earned through our 30 years of experience with healthcare system policy and management. For example, if our aim is to reduce the administrative burden of utilization review on providers, we must understand how to make it easier and more efficient for providers to comply:

- User-friendly forms and clear directions for requesting prior authorization.
- Automated processes, with drop-down boxes and data validation to prevent errors and assure requests are complete.
- Call Center, Review, and Help Desk staff trained as a team to provide support and technical assistance to providers to resolve issues on the first call.

Develop Action Plans and Strategies.

Our local teams have the support and assistance of our national quality experts and collaborate with clients, providers, and beneficiaries to create realistic action plans for improvement. These action plans include three primary strategies:

1) **Workflow Analysis and Engineering.** Examining the process of conducting tasks can reveal opportunities to add steps to improve specificity or remove steps to improve efficiency.
2) **Documentation Redesign**. Improving directions to make them clearer and easier to follow can improve accuracy and eliminate rework.
3) **Re-training.** Reducing variation is an important method to improve quality and efficiency, and retraining on original and/or new workflow procedures ensures adherence to improved practice.

Once the team determines the most effective strategies for improvement, they implement the changes. As we work through these processes, our clients are partners at each step. We ensure that clients

receive reports and analyses, participate in analysis and evaluation of improvement opportunities, and approve changes to workflow, tools, and materials in advance.

Re-measure, Evaluate Results, and Update Operations Plan.

Using the same metrics that identified the opportunity for improvement, we re-measure after implementing selected changes. We evaluate the results and determine if the changes were responsible for the level and scope of improvement intended. If the change were not responsible for the improvements, we conduct one or more additional iterations of steps 4 and 5 before we re-measure and evaluate the results again.

If the results indicate we achieved the improvement we intended, we update the materials and the Operations Plan to reflect the new approach. At this point, we may also conduct additional training and testing to ensure adoption of the change and to promote continuous improvements in customer care efficiency and value.

4.1.6 PERFORMANCE REPORTING AND CORRECTIVE ACTIONS (F)

F. Performance Reporting and Corrective Actions

iled and thorough, and summarized in Section 4.3.

Table 4.1-17. Performance Standard and Operational Approach to Achieving Compliance

Our track record of 99% program compliance demonstrates our ability to meet Contract Standards

[redacted]

Analyst completes the updates.

7

Figure 4.1-3. Overview of Report Validation.

Our formal process ensures accurate and complete reports for every deliverable.

COMPLIANCE 360

[redacted]

[redacted]

[redacted]

Table 4.1-18. Corrective Action Plans (CAPs)

[redacted]

4.1.7 REQUESTS FOR INFORMATION (1.3.1.1.G.)

G. Requests for Information

1. The Contractor shall respond to Agency requests for information and other requests for assistance within the timeframe that the Agency specifies. The Contractor shall provide information in response to:

a. Freedom of Information Act (FOIA) requests;
b. Requests for Information (RFIs) from Iowa Legislators;
c. Open Records Act requests, as required in Iowa Code Chapter 22; and
d. Miscellaneous requests.

We agree to all RFP requirements regarding Agency requests for information. Should we receive requests of any kind, from anyone other than the Agency, our first step will be to consult with the designated IME representative. Together, we will review the request to determine if it is:

1. Complete and addresses each of the FIOA requirements
2. Clear and reasonable (able to meet the required timeframe)
3. Exempt from public records laws
4. Complex enough to engage our attorney, or the Agency's council to provide support for reviewing and responding to these requests
5. Large enough to warrant additional staff to fulfill in a timely fashion.

All requests will adhere to our internal tracking process, providing a detailed record of every request. Once per week our compliance officer will review requests and tracking for compliance and overall quality assurance.

Requests for departmental information that is furnished to the general public through normal operations will not be treated as a FOIA request. This includes information readily available in printed materials (e.g. reports) produced for public information and disclosure. In addition, departmental guidelines, manuals and forms, adopted or used in the discharge of its functions should also be made available without a FOIA request.

2. The Contractor shall comply with information protocols and response timeframes determined by the Agency.

Confirmed. Company protocols and practices are documented in our policies and procedures. As a general matter, the response times related to each of the requests varies depending on the size and scope but we endeavor to comply with all request within any statutory time periods but not to exceed 20 calendar days. To reduce the risk of non-compliance or late responses, we have established a rigorous set of internal controls.

4.1.8 CENTRALIZED EMAIL MAILBOXES AND TOLL-FREE TELEPHONE LINES

H. Centralized Email Mailboxes and Toll-free Telephone Lines.

1. The Contractor shall manage assigned Agency centralized email mailboxes and toll-free telephone lines for communication with Members, authorized representatives, providers, and facilities necessary to support QIO functions.

We will manage assigned centralized email mailboxes and toll-free telephone lines for communication from our Iowa-based Customer Service Center. Our experience administrating other contracts ensures we understand the complexities associated with such contracts, and the needs of providers and enrollees in the State of Iowa to have uninterrupted access to our staff and services. Our commitment to

providing exceptional customer service has led to an overall 95 percent customer satisfaction rating, year over year.

Communication Systems Automate Monitoring

The Customer Service Manager will monitor incoming volumes to ensure that we have an adequate number of staff available to accommodate callers. We use a state-of-the-art telephone system with the latest in technology features to support the tasks described in this RFP. Our comprehensive Customer Service Center will support phone, fax and email requests. We will establish a unique, direct toll-free line with an integrated voice response (IVR) system to accept requests made by phone. A link will be available for members to send requests via email.

Our automated system provides full voice functionality with a comprehensive set of features that will provide menu-driven, efficient automated workflow processes. The system allows us to record all calls for quality monitoring purposes. IME can access the lines to monitor calls whenever desired. We will also be able to provide IME with online, read-only access to all computer files and databases used to support quality assurance program activities.

We have telecommunications capacity to handle the anticipated volume of calls and faxes. Further, capacity is flexible, so we can expand or reduce as needed. Emails will be handled by the same staff fielding calls.

Staffed Monday through Friday, from 8 a.m. to 5 p.m. EST, our Customer Service Center will field inquiries. Messaging systems will be in place after hours or on dictated and state holidays.

Customer Service Center Performance Measurement

Our Enterprise Management Information System is an integral part of the telephone system that is the backbone of the Customer Service Center. This system provides both real-time and traditional reporting to aid in the administration of an efficient and effective processing center. This management extends to both incoming and outbound calls. We have built-in call tracking and reporting capabilities including an electronic record that will document a synopsis of all calls. This management tool will also allow us to provide a complete record of provider, enrollee and others' communication to the call line.

Standard reporting includes system service levels over shift periods, e.g., percent of calls answered of calls offered, average speed of answer, length of calls in queue, average holding time by agent/group, agents required, queue/split comparisons; delay spectrum that reports abandoned and delayed calls hourly and over shift periods; trunk/trunk group as percentages busy, and information on trunk components such as idle and connect. We will report the number of callers encountering busy signals, those callers who hang up while on hold, and the number of calls transferred another staff member.

We will monitor and report on the peak time(s) for incoming calls by hour and day, as well as the number and length of calls that remain in the queue during these times. Real time access to this data enables us to track on a daily or even hourly basis, the abandonment rate, wait times, service levels, type of call, etc.

Quality Monitoring

Customer Service Representatives (CSRs) are monitored for call quality. Supervisors listen to at least one call per week per representative to look for accuracy, opportunities for improvement, consistency, help with goal setting and progress tracking, and to expedite learning and growth. The same is done for email communication. They then meet with the CSRs to provide feedback and plan for ongoing training and improvement. This leads to higher quality service, and higher customer satisfaction.

Education and Training

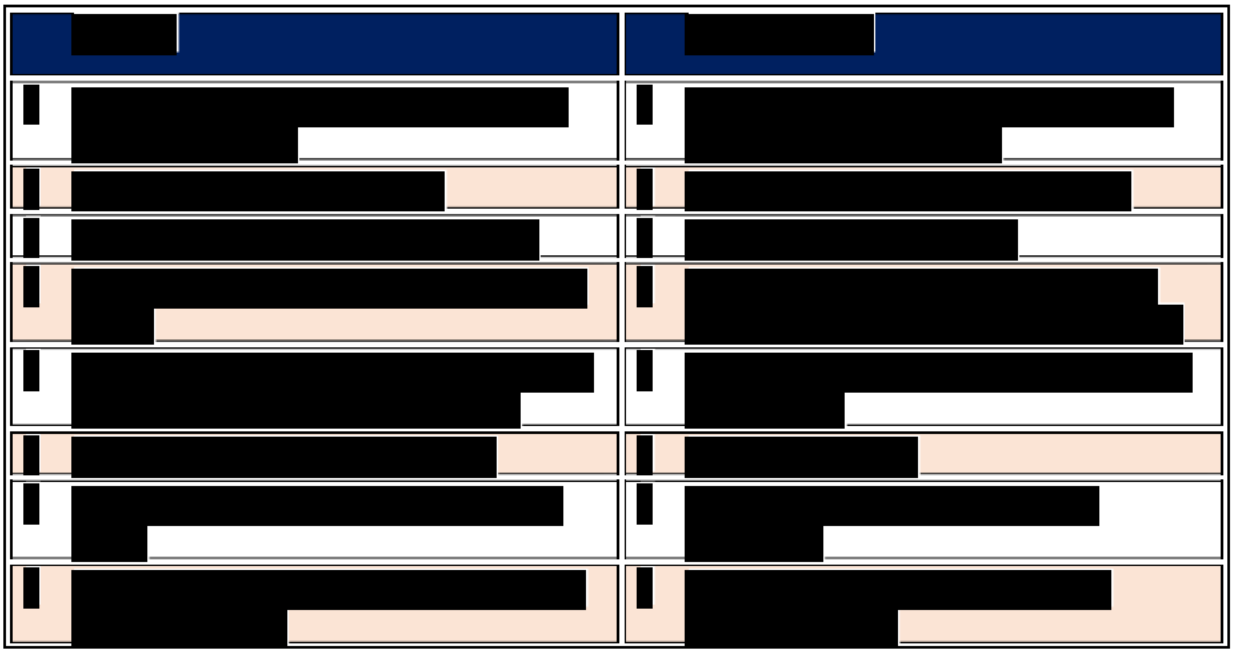
CSRs receive two weeks of thorough training before taking live calls. Training is completed online and in a classroom setting, and includes mock calls, how to handle sensitive calls, and system and software training. Additionally, CSRs are trained on unique aspects of the customers they will serve. The CSRs serving IME will be trained on the specific aspects of your program.

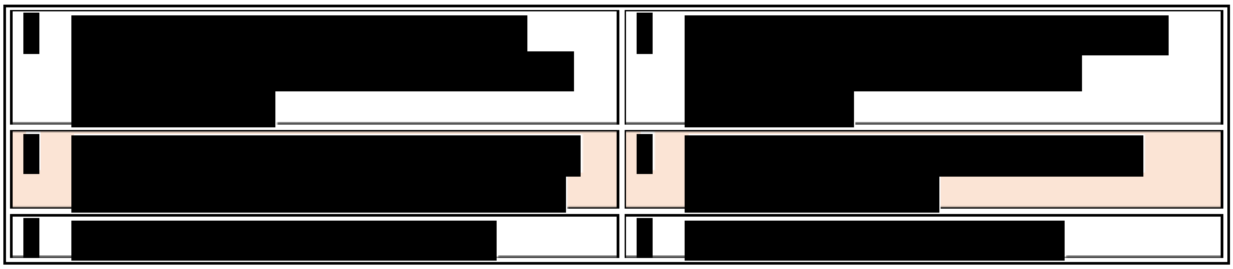
Supervisors sit with new CSRs for initial calls to ease the transition from training to independent CSRs. They provide coaching and feedback, and are available to answer questions or escalated calls. We ensure they have the skills and tools necessary to do the job well prior to putting them in the queue.

Performance Measurement

The system will have a digital voice recorder, and a logging and monitoring system (logging – capturing events on every port, every call; monitoring – observation for quality and productivity evaluations using pooled channels.). The system is scalable allowing for the expansion of seats/consoles, system components and system recording channels. 4.1-Table 12 offers the various features that will be available.

Table 4.1-19. Customer Service Center Management System Features and Benefits





We will provide sufficient staff, facilities, and technology such that 95 percent of all calls received in the processing center are answered. The total number of busy signals and abandoned calls measured against the total calls attempted shall not exceed five percent on an average daily basis.

- We will answer calls within three rings or 30 seconds. Our automated voice response system affords the caller with an option to speak directly with an operator.
- Our queue wait time will not be longer than three minutes for 95 percent of incoming calls.
- We will call customers back within one business day of receipt 100 percent of the time for all calls except those requests that require further investigation.

Customer Satisfaction

In support of our customer satisfaction goals, we issue a satisfaction survey twice a year to measure satisfaction with our customer service and service quality. We distribute two types of surveys:

- Lower level management (contract officers)
  - Focuses on the details of the services/product at the operations level
  - Incorporate all product/service lines, new contract implementation, and Web site accessibility ratings.
- Higher level (bureau chiefs)
  - Solicit feedback from those in higher level positions who can make a difference with the legislation, propose new contracts/RFPs, policy changes, etc.

The higher-level survey is meant to gain a greater understanding of what our customer's value and what drives their purchasing behavior. This survey provides us a precise view of our customers' opinions, issues, and what they want from us so to continue contracting with KEPRO. These responses will help drive/define/support our organizational goals/direction.

Operational leaders will identify opportunities for improving customer satisfaction and our future overall measurement rates. We develop an action plan for each key issue identified through our analysis of survey responses. Actions will address the underlying issues identified, and will be designed to achieve substantial improvements.

We will be able to produce real-time management and historical reporting capabilities to monitor our performance. The basic system includes a voice messaging solution and contact center solution with group calling capabilities. The call center will integrate with the data network. We will be able to provide IME the combination of real time service monitoring and resource management, allowing a supervisor to balance and manage their resources (e.g., staffing levels against traffic, levels of incoming calls) and thus improve customer service.

Email Response

When fielding email communications, our CSRs are trained to personalize every interaction. We call this human service, and it leads to more effective communication, quicker resolution, and higher satisfaction rates. Each interaction is an opportunity for us to improve. By tracking feedback, both positive and negative, supervisors have real scenarios for training. Realizing that email can be a challenging communication channel, CSRs are also trained on writing style. Voice, tone, structure, flow, and personalization are part of our customer service training curriculum. Our email communications are simple and straightforward, so customers need little, if any, clarification. Detailed information and forms are provided via active links.

Common communications and confirmations are automated so that CSRs can focus on those customers needing specialized attention. CSRs will provide a response, or an action plan noting specific timing, so the need for follow-up is less likely. Typically, email inquiries are resolved within five business days and require fewer than three exchanges.

4.1.9 BRANDING (I.)

I. Branding

1. The Contractor shall not reference the Contractor's corporate name in any Deliverables associated with this Contract and shall not mark Deliverables as confidential or proprietary.

We understand the importance of branding and document control, knowing that failures in the process may have significant negative consequences on quality, costs and customer satisfaction. A cornerstone of our quality management system (QMS) is stringent control of all documents. Document control is an essential preventive measure ensuring that only approved, current documentation and branding is used throughout the company. As your contractor, no document will be labeled with our company name or stamped as “proprietary and confidential”.

4.2 TRANSITION

We reduce risk and increase project effectiveness with a comprehensive work plan developed and executed using proven processes on similar transformation projects.

The Iowa Department of Human Services needs a qualified QIO contractor with experience developing and executing detailed work plans using established processes and templates for meetings, testing, deployment, and operational readiness. We have a proven track records of successful implementations and long-term relationships with their clients and partners. Key to earning and maintaining these relationships is the successful implementation of the project – on-time, on-budget, and accountability to DHS for results.

We understand Iowa's requirement for a QIO program that aligns with the six CMS Quality Strategy goals. This project requires an astute understanding of the Iowa's Medicaid business and the ability to research, recommend and implement best practices in all areas. Our comprehensive work plans drive operational readiness and provide transparency of our intent to fully comply with deliverables and performance measures. Skilled management and quality assurance staff will monitor system queues and allocate additional resources, as necessary to prevent missing performance measures/deliverables.

Compliance 360 (C360°) is our comprehensive compliance monitoring/reporting system that helps to ensure we are compliant with all contract, URAC, and other regulatory requirements. We upload contract, vendor, and employee data into C360° to provide an instant "state of compliance" for the entire organization. Through a series of highly configurable security levels and reporting dashboards, users can drill down to the contract level to monitor the status of deliverables and other critical contract components. With the addition of C360° to our IT infrastructure, we are extremely proactive in attaining the highest levels of service to our customers. Not only does C360° track compliance, policies, and other contract data, it gives us the additional benefits of working in tandem with our analytics processes/systems to identify trends and quality improvement opportunities.

4.2.1 PLANNING A (1.3.1.2)

Transition

A. Planning. The Contractor shall develop, maintain, and comply at all times with the following, subject to Agency approval:

1. Project work plans. Work plans include:

a. A transition plan detailing Contractor's strategy to implement the staff, systems, applications, software, and services contemplated by this Contract;

A draft Transition Plan is included in Section 4.2.1.1 of this proposal.

b. An operations plan detailing the daily performance of all required activities by the Contractor, including required coordination and safeguards;

A draft Operations Plan is included in Section 4.2.1.2 of this proposal.

c. A communications plan specifying expectations for all parties involved. This plan shall be developed in consultation with the Agency;
d. A quality assurance plan detailing requirements and timeframes for monitoring the quality and accuracy, as well as continuous workflow analysis, of the Contractor's QIO and MCO oversight functions.
e. A reporting plan detailing requirements for submitting reports to the Agency. This plan shall be developed in consultation with the Agency. Reporting plan requirements include but are not limited to:
i. Use of standard naming conventions;
ii. Templates for standardized reports that may be necessary to implement the project. The Contractor shall revise report content as needed and upon Agency request;
iii. Use of the Agency-designated SharePoint site to upload reports, with links sent to relevant Agency staff via email;
iv. Detail of whom the reports should be delivered to for review and approval, as necessary;
v. Any posting requirements for external stakeholders;
vi. Frequency and due dates for reports;
vii. An Agency report monitoring tool similar to the sample in Attachment 3.3; and
viii. A monthly performance reporting tool similar to the sample in Attachment 3.4.
f. A training plan detailing, at minimum:
i. Training of Contractor staff in all systems, applications, and software that they will use.
ii. Training of Contractor staff on privacy and security policies and procedures to include but not limited to:
a) Orienting new employees on privacy and security policies and procedures;
b) Conducting periodic review sessions on privacy and security policies and procedures; and
c) Developing lists of personnel to be contacted in the event of a potential or suspected security breach;
iii. Training of Contractor staff in operational procedures required to perform the Contractor's functions under the Contract.
iv. Continuous standard operating procedures training process for Contractor staff. At minimum, the Contractor shall train staff when:
a) New staff or replacement staff are hired;
b) New policies or procedures are implemented; and
c) Changes are made to any existing policies or procedures prior to the change's implementation if possible, and if not, concurrent with the change's implementation.
v. Training of Agency employees and other Agency contractors, as requested. Such training shall be at no additional cost to the Agency.

Each plan shall generally adhere to the approximate timing and requirements set forth in Section 1.3.1.3, to include, at minimum:

a. Definition of each project activity;
b. Sequence of activities;
c. Identification of who is responsible for each project activity;
d. Defined deliverables and outcomes;
e. Timeframe in which each activity will be completed;
f. A plan update schedule, which shall include updates no less frequently than quarterly; and
g. Identification of Agency responsibilities and expectations.

Project work plans are the cornerstone to a successful transition, implementation, maintenance and compliance to the contract. The Transition Plan and Operations Plan we will provide within 15 calendar days of the Contract Execution Date will incorporate the Agency's comments and related modifications made during the first two weeks of the project. The final Quality Assurance and Training Plans will be submitted to the Agency after contract award. The Communications and Reporting plans will be developed in consultation with the Agency.

Our process for planning follows a three-step approach: Develop, maintain and comply. We develop the plans, maintain them with routine/ongoing updates and then monitor compliance through them.

Ultimately, all plans are designed to minimize disruption to the Agency, members and associated providers as implementation takes place.

4.2.1.1 PLAN DEVELOPMENT

KEPRO utilizes a standardized template to begin plan development. Seasoned transition and implementation staff begin by evaluating the Agency's expectations, work flows, existing standard operating procedures and any new developments. Based on KEPRO's understanding of the work as well as over-arching knowledge of Medicaid business, staff outline the logical steps necessary to reach the project objectives. We identify and assign the resources necessary for each task as well as timeframes, start and end dates. Plans are parsed into reasonable sections of work (by program, for example with an Implementation Plan) and then the sections are combined into a master plan. Key Milestones are identified and the integrated master plan is further adjusted.

The plans are submitted to the Agency within identified timelines. We will schedule contract kick-off meetings with the Agency to receive necessary information and coordination for the Communications and Reporting plans.

For Agency-required updates, we recommend the Agency provide written feedback by section so that no requirements are missed or misunderstood. We will request clarification on any items/issues identified, as necessary.

4.2.1.2 PLAN MAINTENANCE

Plans are strictly monitored to assure timelines are maintained and on-track. All necessary changes to the plan must be reported to the assigned Transition/Project Director who will maintain the plans. KEPRO proposes revisions undergo version control by date <IA> <Plan Name> <YYYYMMDD>. During transition, the Transition/Project Director will verify Agency approval of changes for applicable plan(s) and will maintain a record of modifications with each plan. The modification record shall include: IMS #, date of modification, summary of modification, author and approver. Plans will be stored and disseminated to applicable parties electronically unless otherwise requested by the Agency.

4.2.1.3 PLAN COMPLIANCE

We shall comply with all Agency-approved project plans always. As plans will have been developed with ultimate "compliance" in mind, it is imperative that controls be put into place to proactively identify all risks before they become a problem. The Transition/Project Director will monitor individual task, milestone compliance throughout the implementation/transition and will report any risks to the applicable responsible party/parties. Risks would include: Perceived inability to comply with the timeline or task, the possibility for missed milestones, deliverables or performance measures. We blend program management control and project management phases to oversee compliance of approved plans.

We are dedicated to developing, maintaining and complying with program plans and operations that meet the Agency's needs. We have a thorough understanding of the Medicaid business, extensive experience with implementations and a strong desire and expectation to meet all deliverables, performance measures throughout the duration of the contract.

Plan compliance is monitored through project monitoring and control. From beginning to end, we will check whether the project is going as planned and whether there are deviations from the plan. KEPRO will:

- Actively act to control the project by making sure necessary steps, control points and actions are taken by responsible persons;
- Measure performance to determine if the project is going well;
- Determine variances and whether they warrant change;
- Influence factors that could potentially cause change, such as receiving specific expectations from the Agency;
- Request changes, as necessary, and receive Agency approval;
- Perform integrated change control by considering the overall impact a change may have on the total project.

Standard Operating Procedures (SOPs)

2. Standard operating procedures (SOPs).
a. SOPs shall be maintained in the Agency-prescribed format using standard naming conventions in the documentation.
b. SOPs shall document the processes and procedures used by the Contractor in the performance of its obligations under this Contract, including but not limited to:
i. Notification and issue escalation procedures and timelines; and
ii. Policy manuals required.
c. SOPs shall be updated with any changes to the methods and procedures used by the Contractor in the performance of its duties under this Contract. The Contractor shall document all changes within 30 calendar days of the change, subject to Agency approval.
d. The Contractor shall use version control to identify the most current documentation and any previous versions, including their effective dates.
e. The Contractor shall provide all documentation in electronic form and store all documentation within the Agency-designated repository.
f. Collaborate with other IME Units to incorporate information relevant to provider operations on all levels.
g. Develop and distribute informational letters, emails, and Agency website postings for HCBS providers that provide a brief description of changes, as appropriate.
h. SOPs shall be reviewed with the Agency no less than semi-annually.

Standard Operating Procedures (SOP) are essential to staff training and performance measurement, addressing new policies/procedures, and successful daily operations. They help all applicable parties understand the workflow, thus improving compliance all-around. KEPRO has reviewed the Agency's available SOPs and understands the requirement to submit SOPs for Agency approval within 25 business days after the execution of the contract. We will receive final approval no later than 10 days after initial submission and will document all SOP changes within 30 calendar days of the change.

We agree to all SOP requirements (2a. through h.) and will dutifully and willfully comply with all expectations. We will prepare and submit SOPs within timelines. Upon Agency approval and implementation, program managers will routinely monitor/review SOPs and will consider staff, provider and Agency input for when an update should be considered. Those performing the work oftentimes have valuable input and can make recommendation for efficiencies. SOPs will be in prescribed formats and will be stored with the Agency repository. When necessary, SOP change notifications will be prepared so they can be disseminated to all stakeholders and/or posted on applicable websites.

3. The Contractor shall collaborate with the Agency and other IME Units to maintain and update provider manuals as necessary.

During routine correspondence, contract management meetings or simply upon request, the need for updated provider manuals may become apparent. Provider manuals serve as the source for policies and procedures, and direct providers on requirements for providing, managing and documenting services.

We will maintain and update the manuals upon the Agency's request. We propose a standardized request form, on which changes to the manuals can be documented, tracked and approved. We will coordinate any necessary meetings during which Agency staff can brainstorm, trouble-shoot and determine a clear path for the provider manual's content. We will offer subject matter experts, as necessary, to participate in policy revisions. The SME will make suggestions based on best practice and knowledge of the Iowa Medicaid programs. We will document the Agency's final decisions and will update the applicable policies. Upon Agency approval, we will prepare correspondence as well as the updated/revised policy manuals and submit for Agency approval. We will disseminate program changes to applicable stakeholders, as necessary. All program manuals will be maintained in the Agency-designated repository.

3.2.4.1.1 Draft project work plans detailing all activities and timelines, to include:

- *Transition Plan*
- *Operations Plan*

4.2.1.4 TRANSITION PLAN

Purpose

The purpose of the Transition Plan is to design the tasks and activities that need to take place to efficiently and smoothly transition DHS work from another contractor to KEPRO. The Transition Plan addresses the general requirements, emphasizes the importance of collaboration and cooperation and identifies the activities necessary for our Operations Team to successfully begin implementations for Iowa Department of Human Services. We present this plan as an outline of tasks, timelines and responsible parties necessary to minimize systemic disruption and to start operations by July 2, 2018

Transition Strategy

Our transition strategy begins with evaluating the current business rules, information and data, applications, landscape, political environment and infrastructure in Iowa DHS. Upon that evaluation, we identify and acknowledge issues/risks and identify key personnel integral to a successful transition. Our Transition Team will devise necessary categories, tasks and sub-tasks and will submit the final Transition Plan within 15 business days upon contract execution. We will make any required updates, per Agency feedback and will receive final Agency approval within 10 business days of the first submission.

We anticipate the need for consultation and collaboration with the Agency and the outgoing contractor(s). First, this will allow us to solidify and clarify any Agency expectations. Secondly, it will facilitate relationship-building necessary for successful implementation of the programs.

Schedule

Iowa DHS has provided a preliminary schedule of events to occur during transition. These events have been incorporated into the Transition Plan so that KEPRO and all others can remain on task, minimize business disruption and follow a logical sequence of events. See Transition Plan for schedule details and milestones.

Detailed Activities and Timelines

We have provided a DRAFT Transition Plan with this proposal.

Organization

We have provided Organizational Charts for both the Implementation and Operations phases of the contract.

Staffi

We are committed to onboarding qualified named key personnel before the end of the transition period; we will not replace key personnel for at least six months (except in the event of termination, death or resignation). We will request Agency approval, and make any necessary accommodations for Agency inquiries/interview, as requested pertaining to key personnel. Our Operations Team will supply sufficient staff/resources to provide all services herein, and staff will be available to begin by July 2, 2018. Throughout the duration of the contract management will designate back-up personnel, job rotation plans and cross-training for tasks and to reduce/eliminate any down-time in the event of planned or unplanned staff absences. Open positions will be posted when they come about, and our Human Resources department will recruit focusing on Des Moines-based professionals.

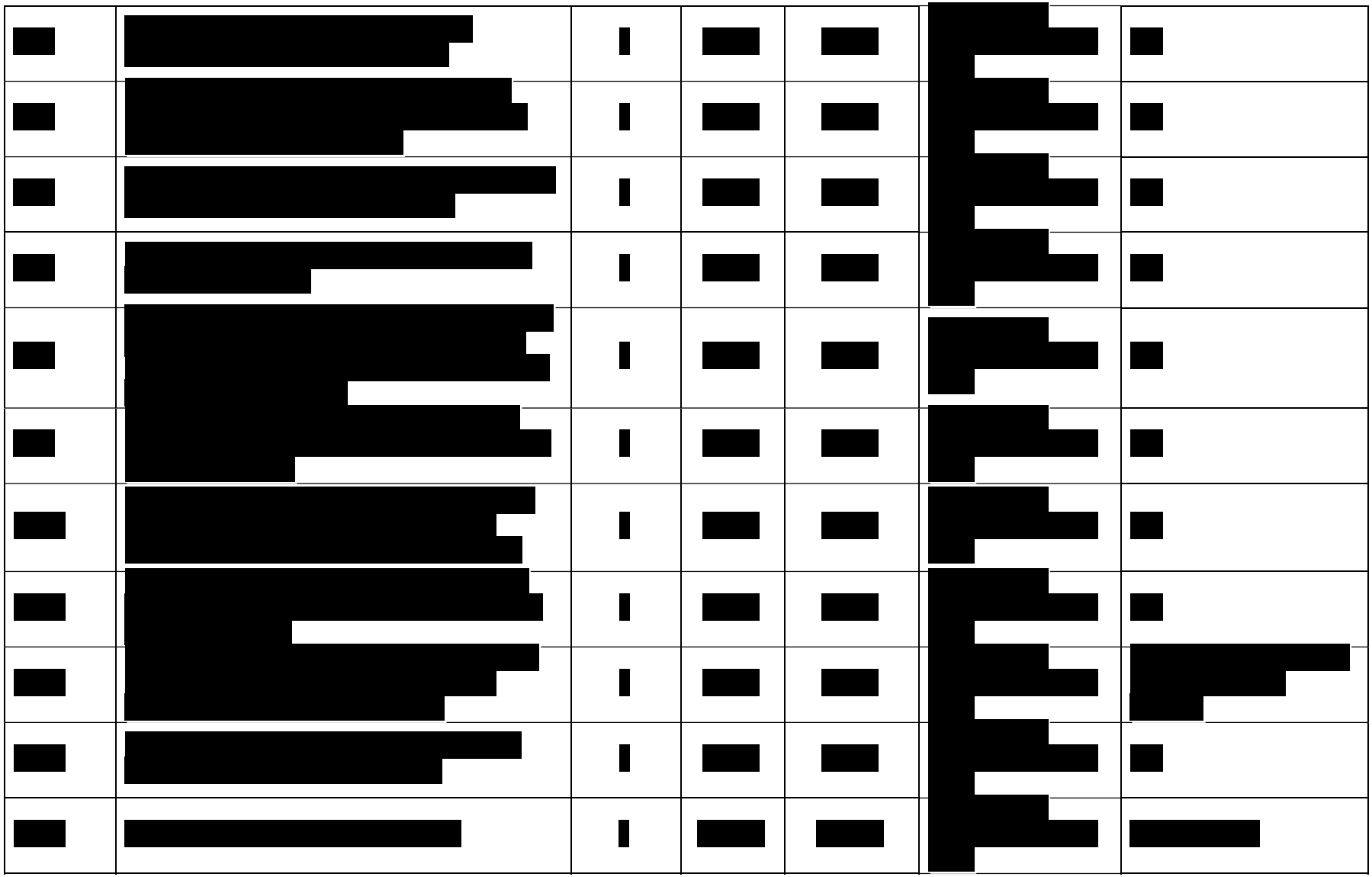
Coordination

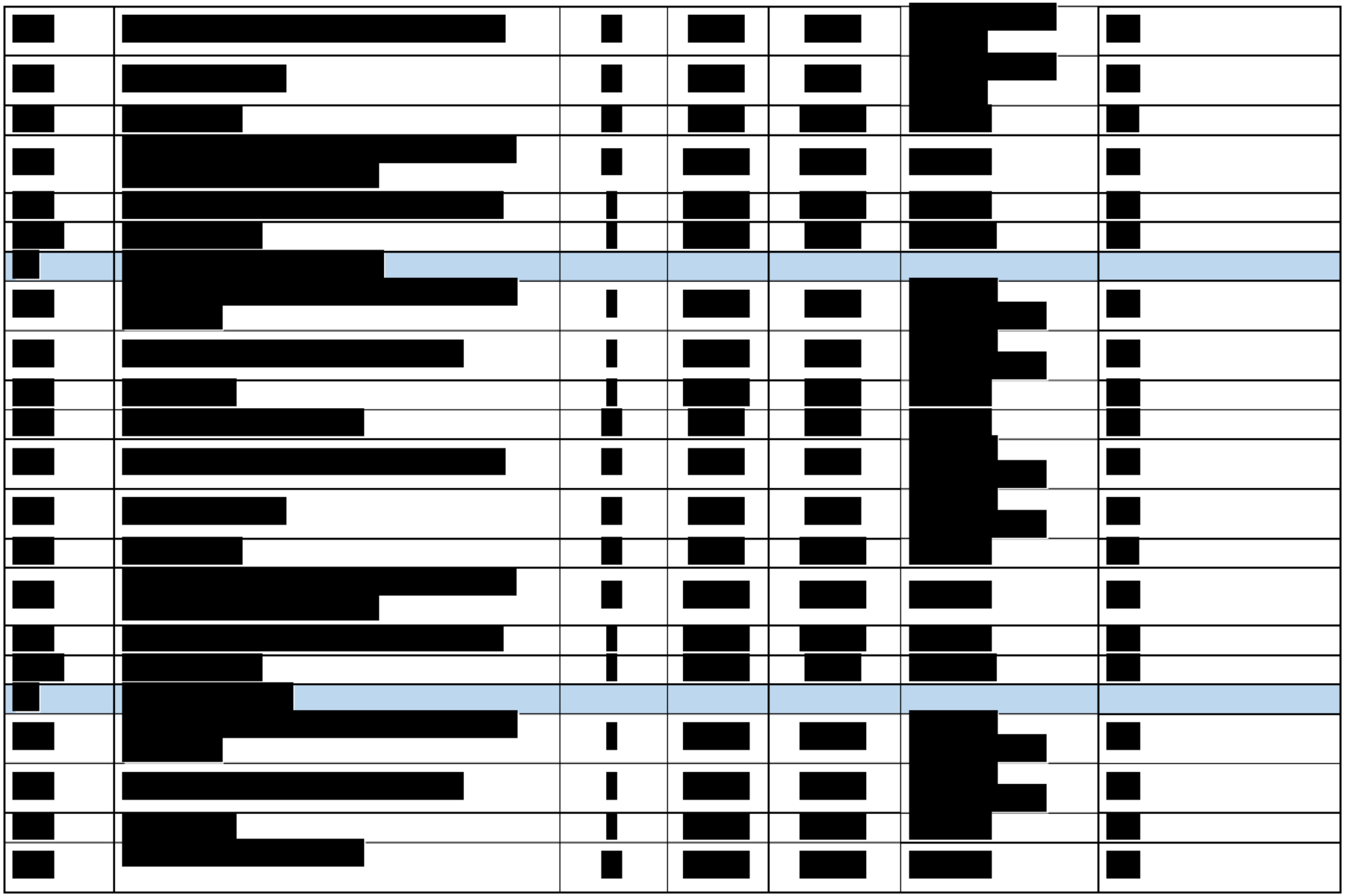
Coordination will be essential during both the transition and operation phases of the contract. We value collaboration and will schedule and arrange for a sequence of contract management meetings (driven by management level and/or program) during which the Agency and KEPRO can discuss program issues/concerns, determine plans of action to remedy concerns, devise communication plans for specific issues/tasks and discuss KEPRO's performance as the QIO. We will then coordinate with specific internal or external persons necessary to carry out any tasks identified.

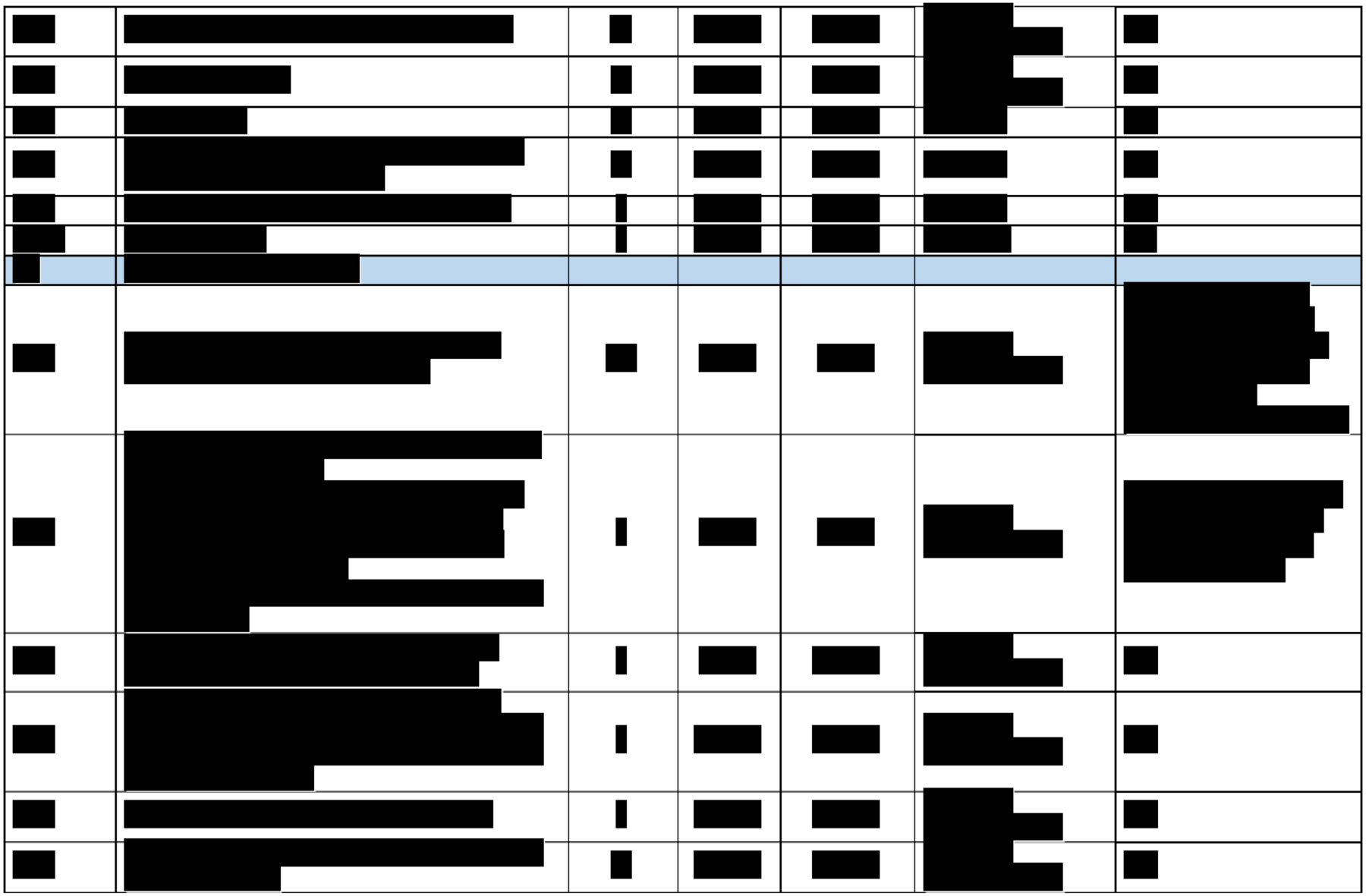
Safeguards

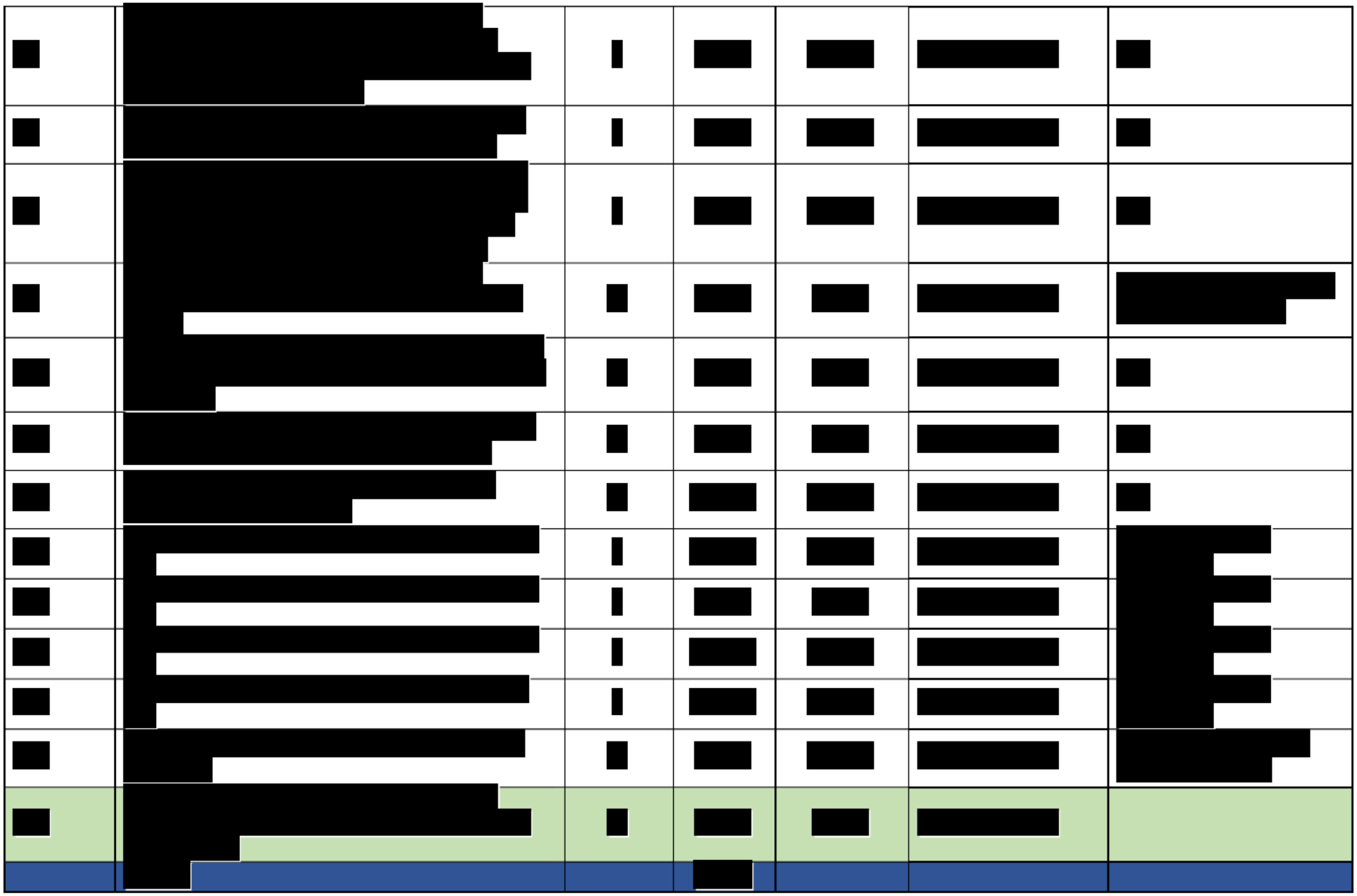
We will implement a robust array of safeguards in all phases of transition and operations. Each transaction activity is thoughtfully planned and given a target completion date upon which to evaluate performance, timelines and compliance. Our Transition Team begins with planning activities (development of and submission of named plans), identifying contingency resources, and development of a specific risk mitigation plan and processes. We will verify all deliverables and determine the roles and responsibilities necessary to meet those deliverables. We will enlist a Director of Quality to oversee the quality management plan and all related functions and activities.

Compliance 360's comprehensive compliance monitoring and reporting capabilities provide the ultimate safeguard at all levels of contract compliance. The system tracks a multitude of data including, but not limited to: Contract uploads, vendor and employee data, contract compliance, policies and procedures. Combined with our IT infrastructure, Data Analytics, Reporting Team, Human Resources and Operations Team, we will be extremely proactive in attaining the highest levels of service during both transitions and operations phases of the contract.









4.2.1.5 Operations Plan (Draft)

4.2.1.5.1 Draft Operations Plan

Purpose

We present a draft Operations Plan to provide the Agency and IME with a clear picture of tasks and responsibilities in line with the goals and objectives set forth in the contract. The plan is developed for the implementation of strategies, to meet established policy and procedural guidelines and to comply with deliverables and performance measures. The draft Operations Plan will be presented to the Agency for approval within 15 days of contract execution. Our Transition Team will work with the Agency and make any necessary and timely updates to the plan, per the Agency's request. We will gain final approval within 10 business days after the first submission.

Operations Approach

We strive to create the highest level of efficiency possible within the organization. Because of these efficiencies, we can minimize unnecessary or duplicative tasks. We enlist an active operations management approach that includes analyzing the company's internal processes, determining where changes need to be made, implementing those changes, and evaluating the effectiveness of the changes. When an organization's operations are properly managed, the department can function smoothly and efficiently; failure to properly manage operations can result in system failure.

Key to managing operations is an effective Quality Assurance and Improvement Plan. KEPRO follows a data-driven continuous quality improvement approach to operations.

- **Plan** - Standards, goals, structures and processes are established in the Operations Plan;
- **Do** - Staff are trained and implement systems, tasks, ensuring coordination and compliance;
- **Study** - Quality assurance data is collected and analyzed to evaluate operational performance;
- **Act** - Results of the QA data is analyzed, recommendations for feedback, interventions, training etc. are considered.

Schedule

The attached draft Operations Plan outlines tasks to be performed during the first year of implementation. The final Operations Plan will be submitted to DHS within 15 business days upon contract execution. We will make any required updates, per Agency feedback and will receive final Agency approval within 10 business days of the first submission.

The Operations Plan will be updated no less frequently than quarterly; therefore, we propose the plan updates be submitted to the Agency by: October 1, 2018, January 1, 2019, April 1, 2019 during the first contract year and subsequently each quarter throughout the duration of the contract.

Detailed Activities and Timelines

KEPRO has provided a draft Operations Plan with this proposal.

Organization

KEPRO has provided Organizational Charts for both the Implementation and Operations phases of the contract.

Staffing

Throughout the duration of the contract our management team will designate back-up personnel, job rotation plans and cross-training for tasks and to reduce/eliminate any down-time in the event of planned or unplanned staff absences. Open positions will be posted when they come about, and our Human Resources department will recruit focusing on Des Moines-based professionals.

Coordination

We will assign key transition and operational staff who are ultimately responsible for and capable of managing the project. We will also facilitate coordination by:

- Developing a clear division of responsibilities/tasks internally and externally;
- Finalizing work plans that are logically structured, clear, specify milestones, deliverables and performance measures and which incorporate time frames to meet the Agency's expectations;
- Evaluating for and furnishing staff and resources necessary to successfully implement the project;
- Devising a communications plan that incorporates collaboration and synergy (networking);
- Identifying internal and external collaborators who are required and adequate to support each stage of the project;
- Incorporating work methods to consider differing perspectives and contributions;
- Establishing communication channels necessary for proper coordination of the project;
- Identifying potential obstacles/risks for the project.

Safeguards

As with the Transition Plan safeguards, we will implement the same/similar components, concepts, systems and teams to ensure the Operations Plan is fully developed, incorporates all required tasks, deliverables, outlines performance measures and meets the needs and expectations as outlined in the contract. The draft Operations Plan included with this proposal will be the foundation for a final Operations Plan, which will be submitted within 15 business of contract execution.

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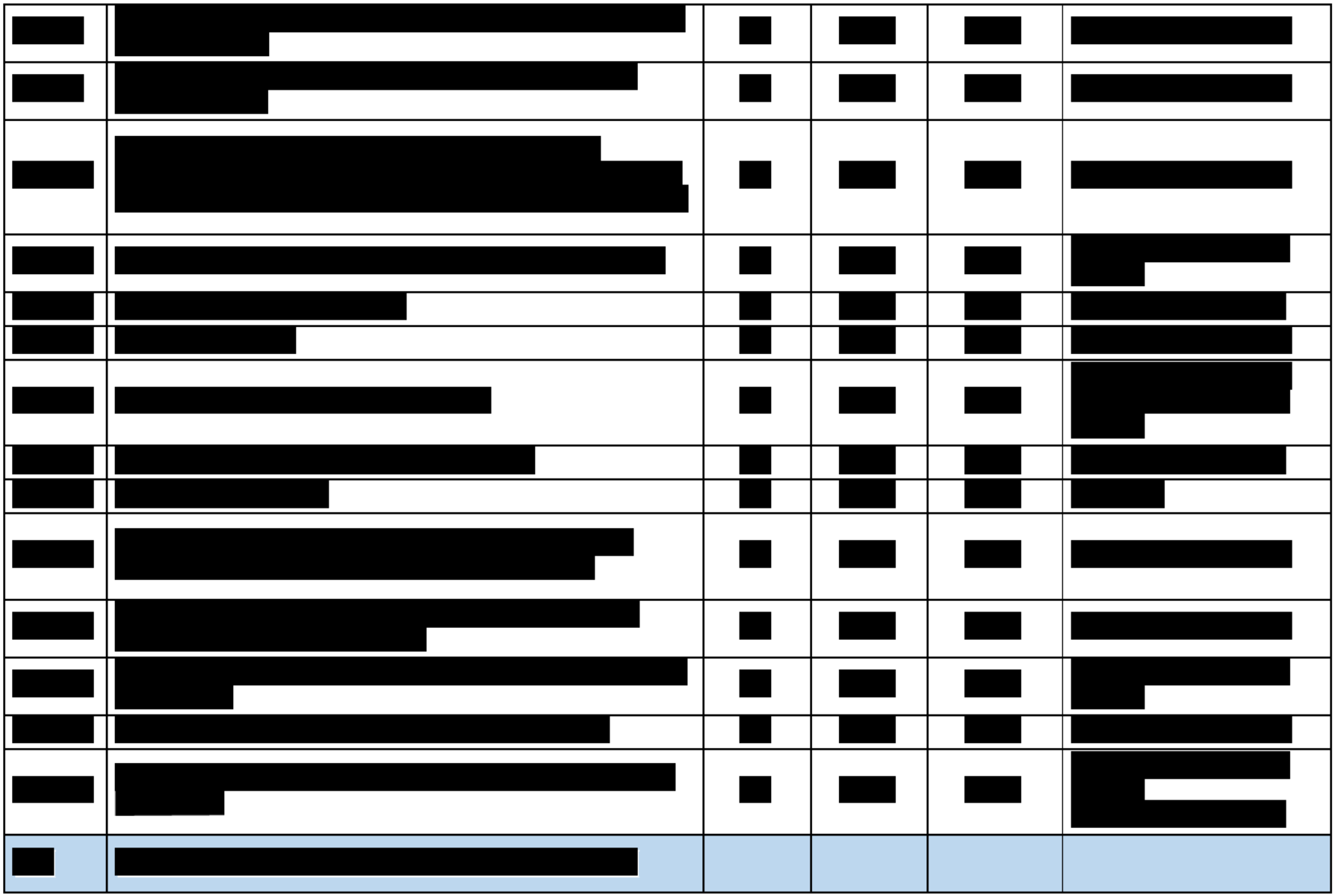

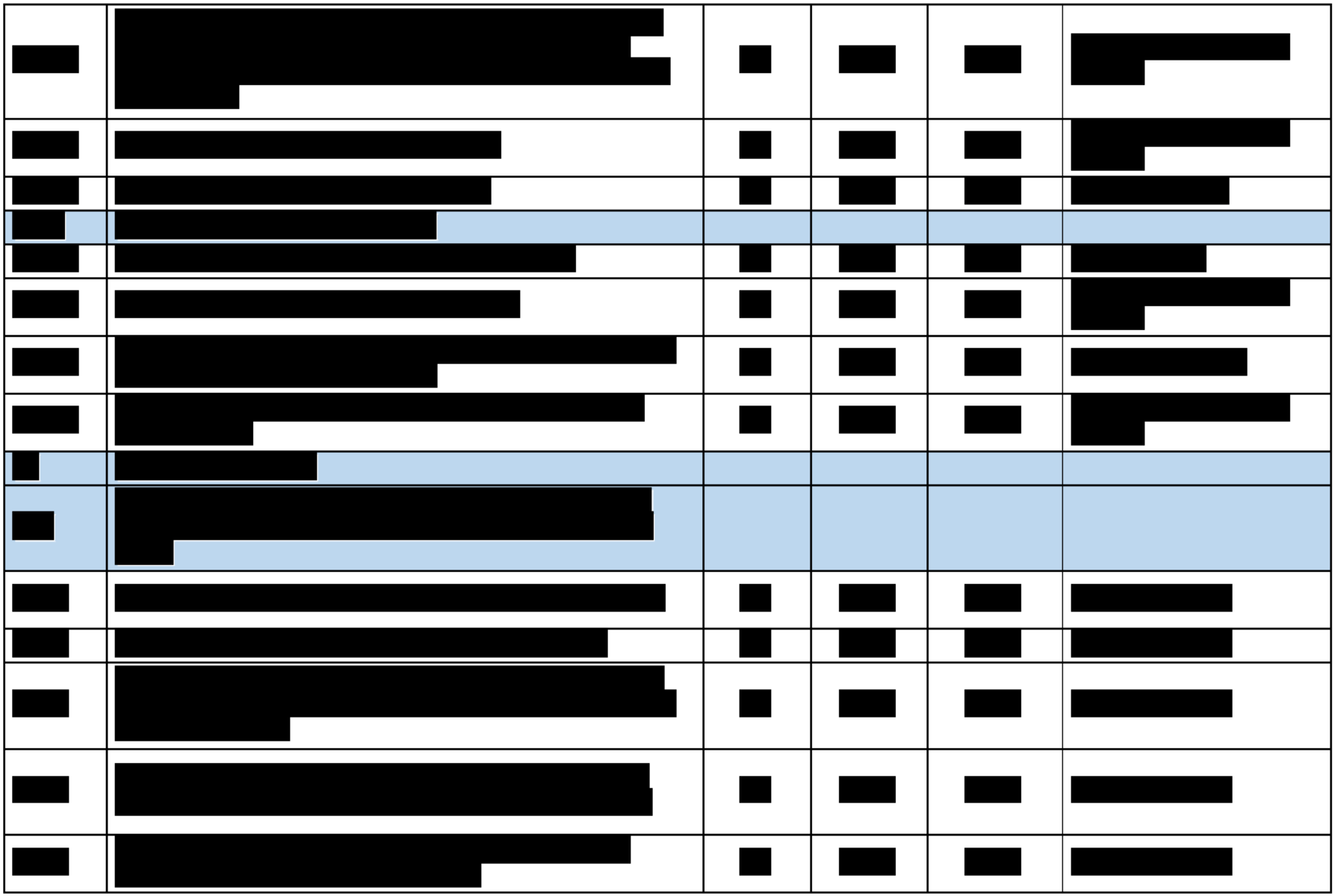

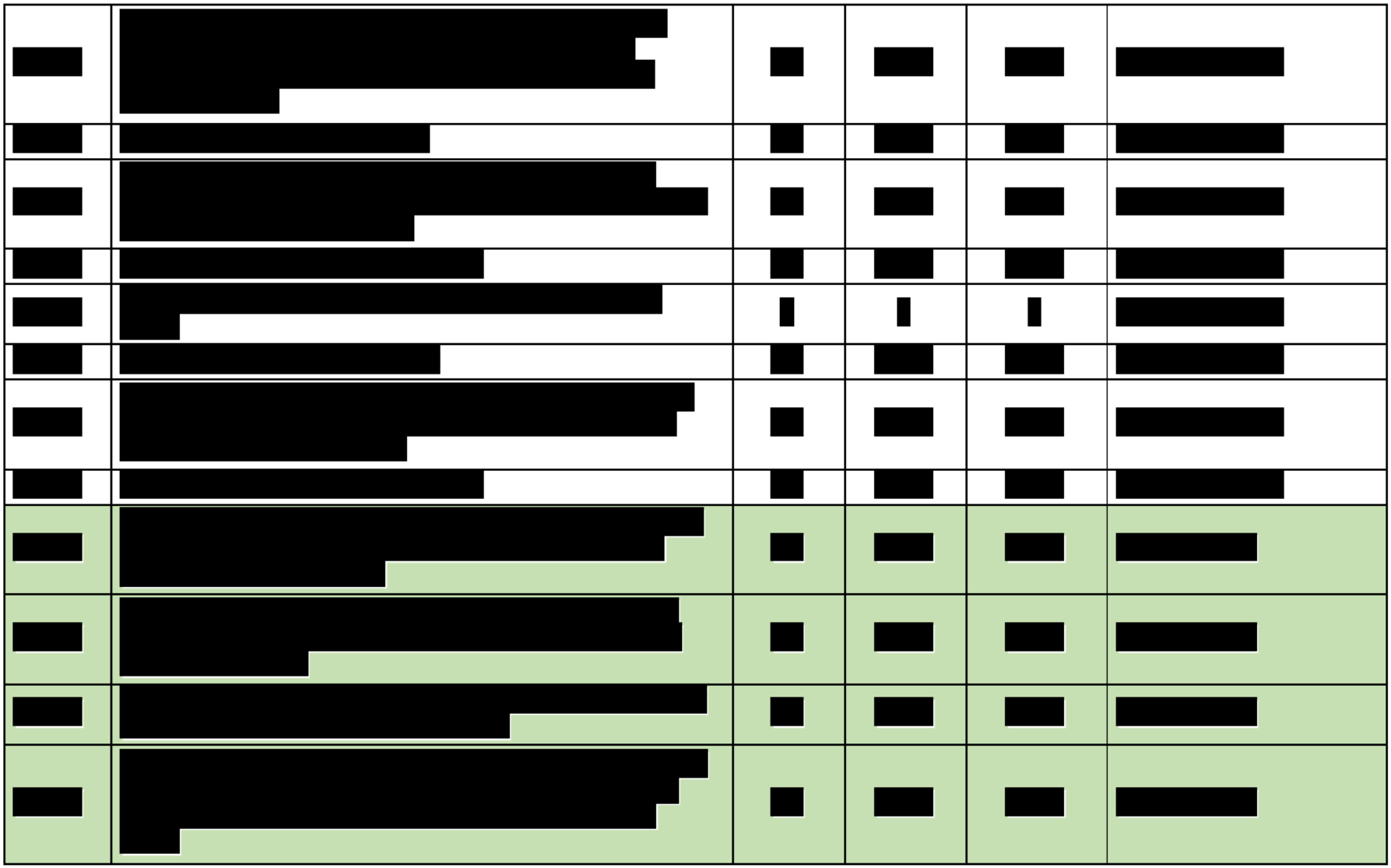

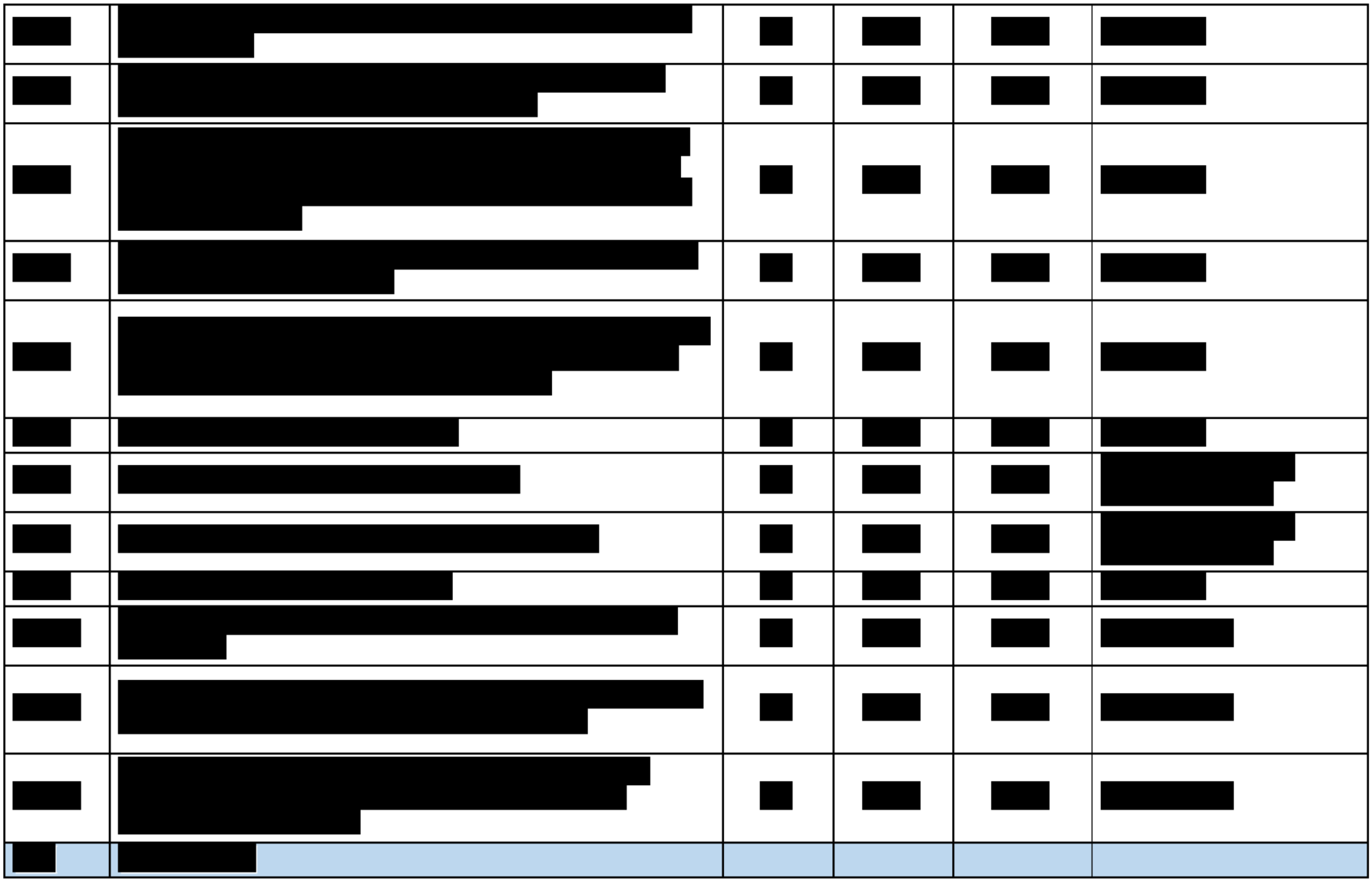

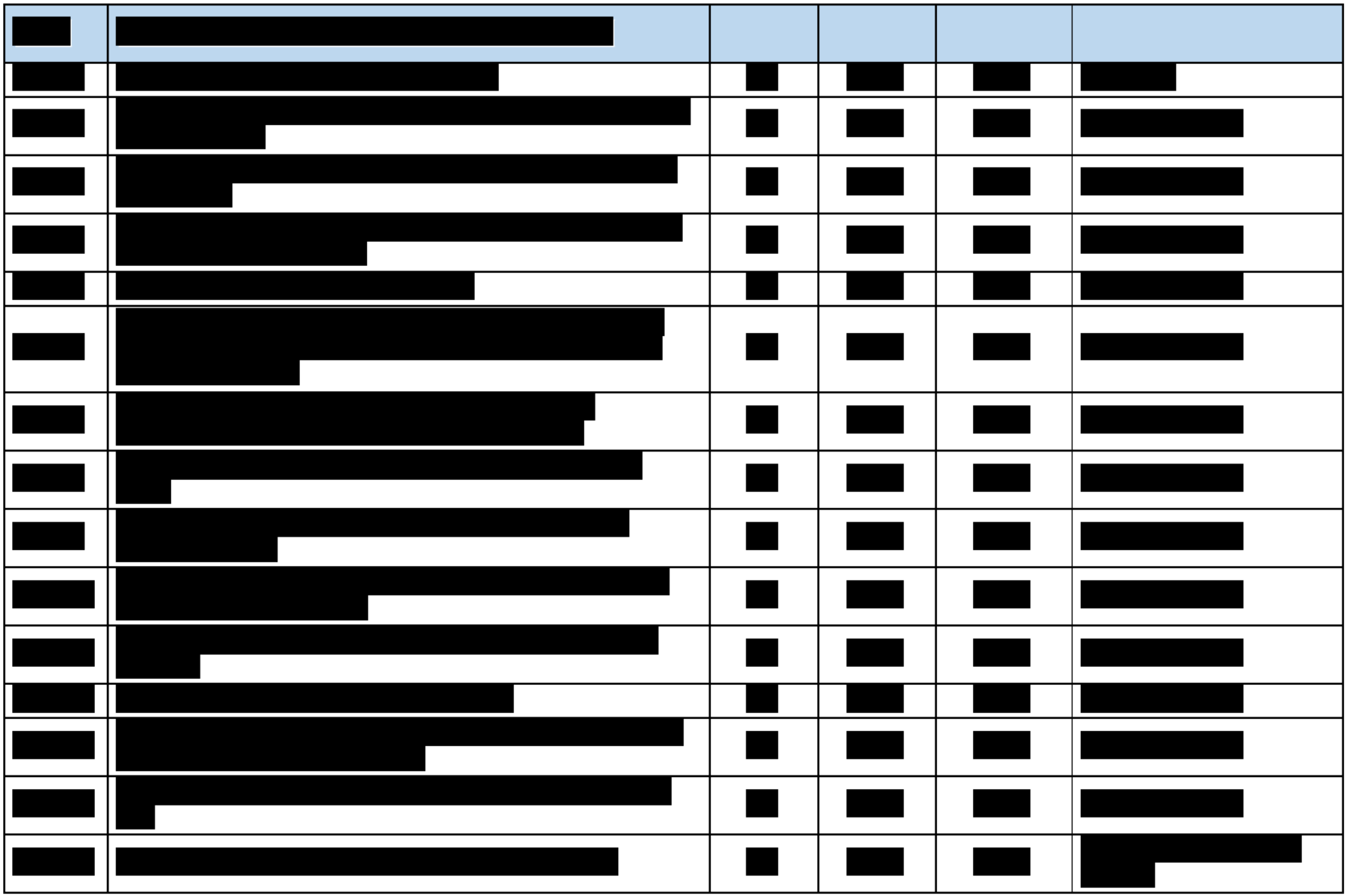

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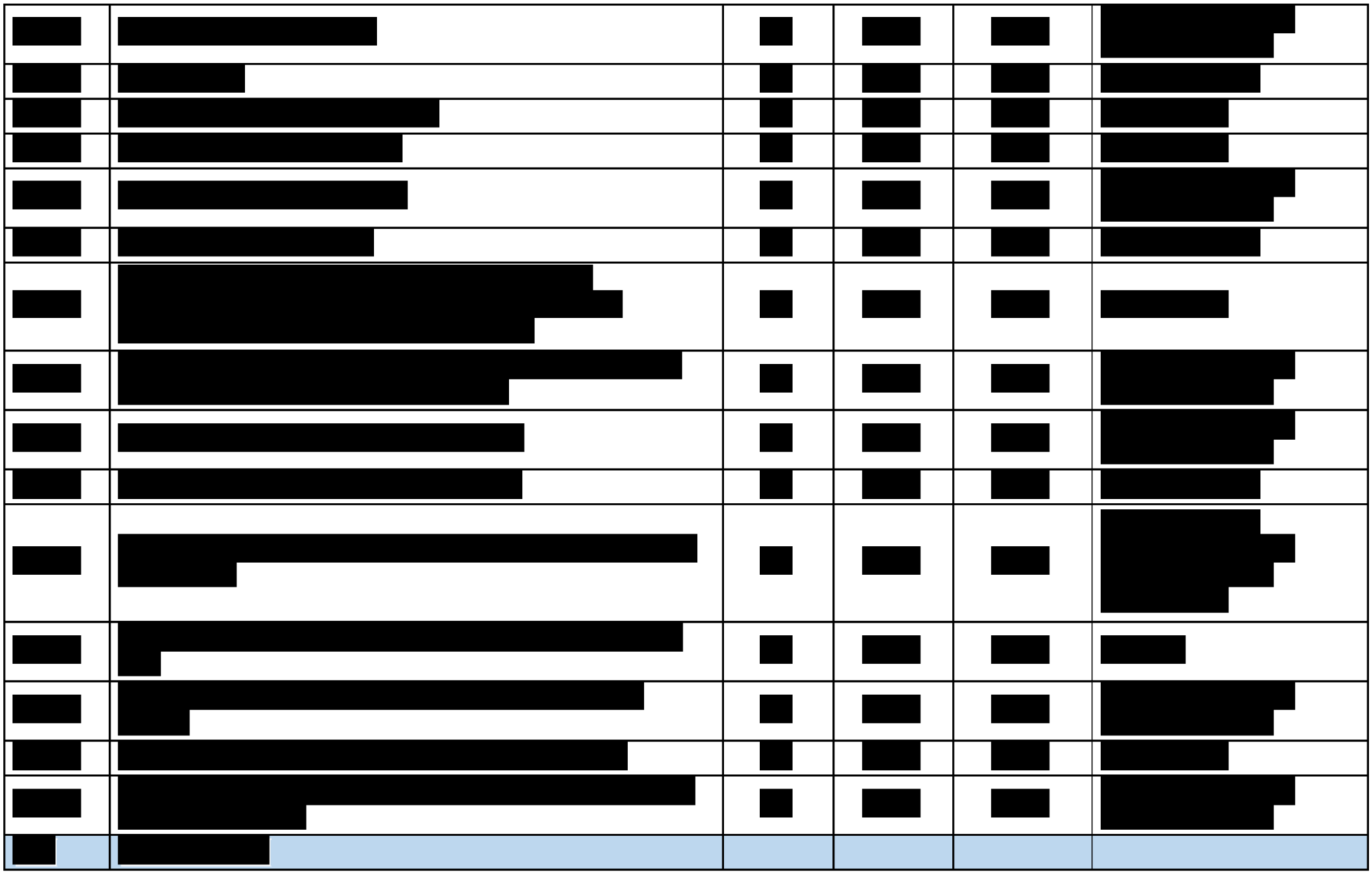

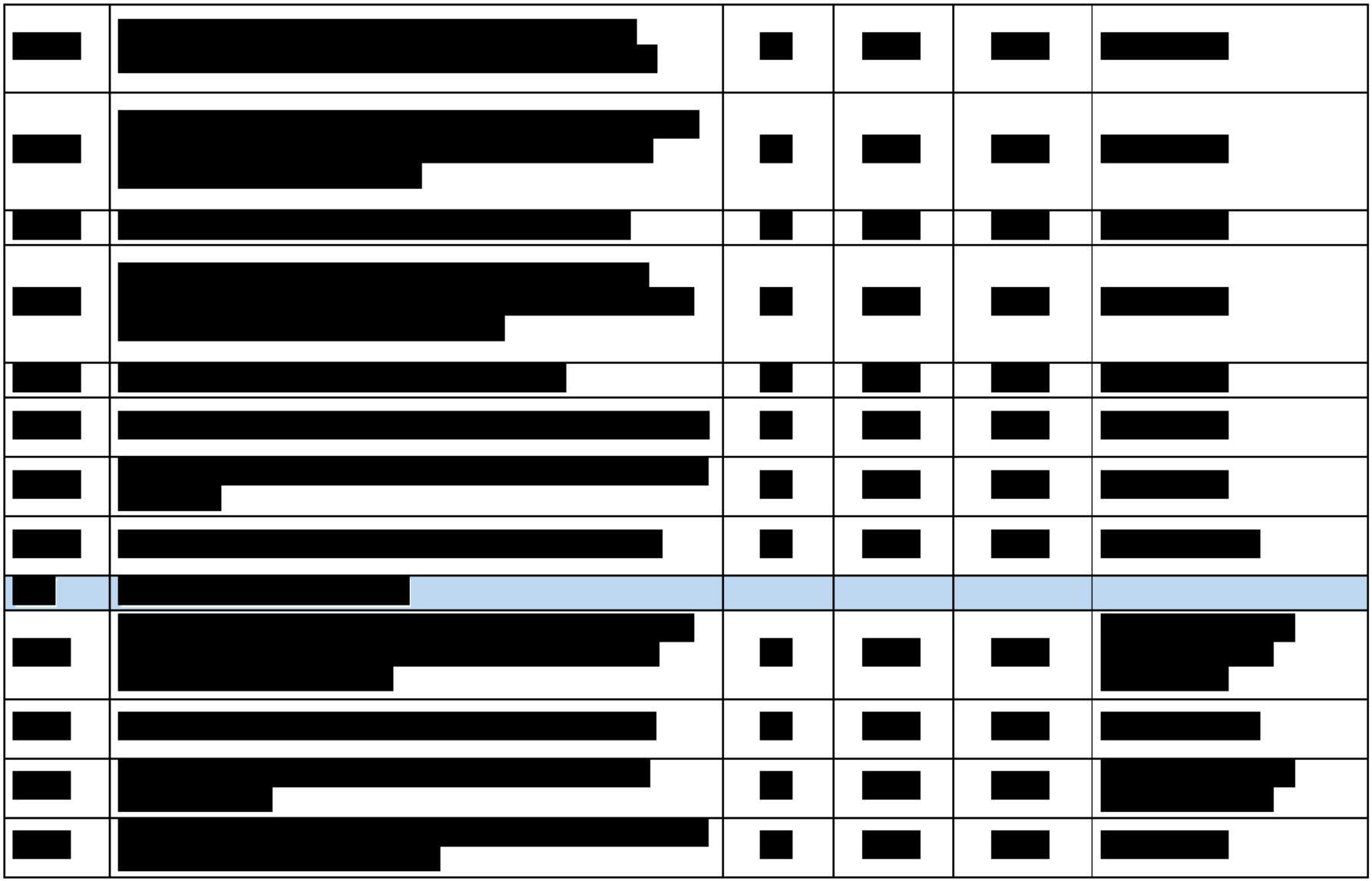

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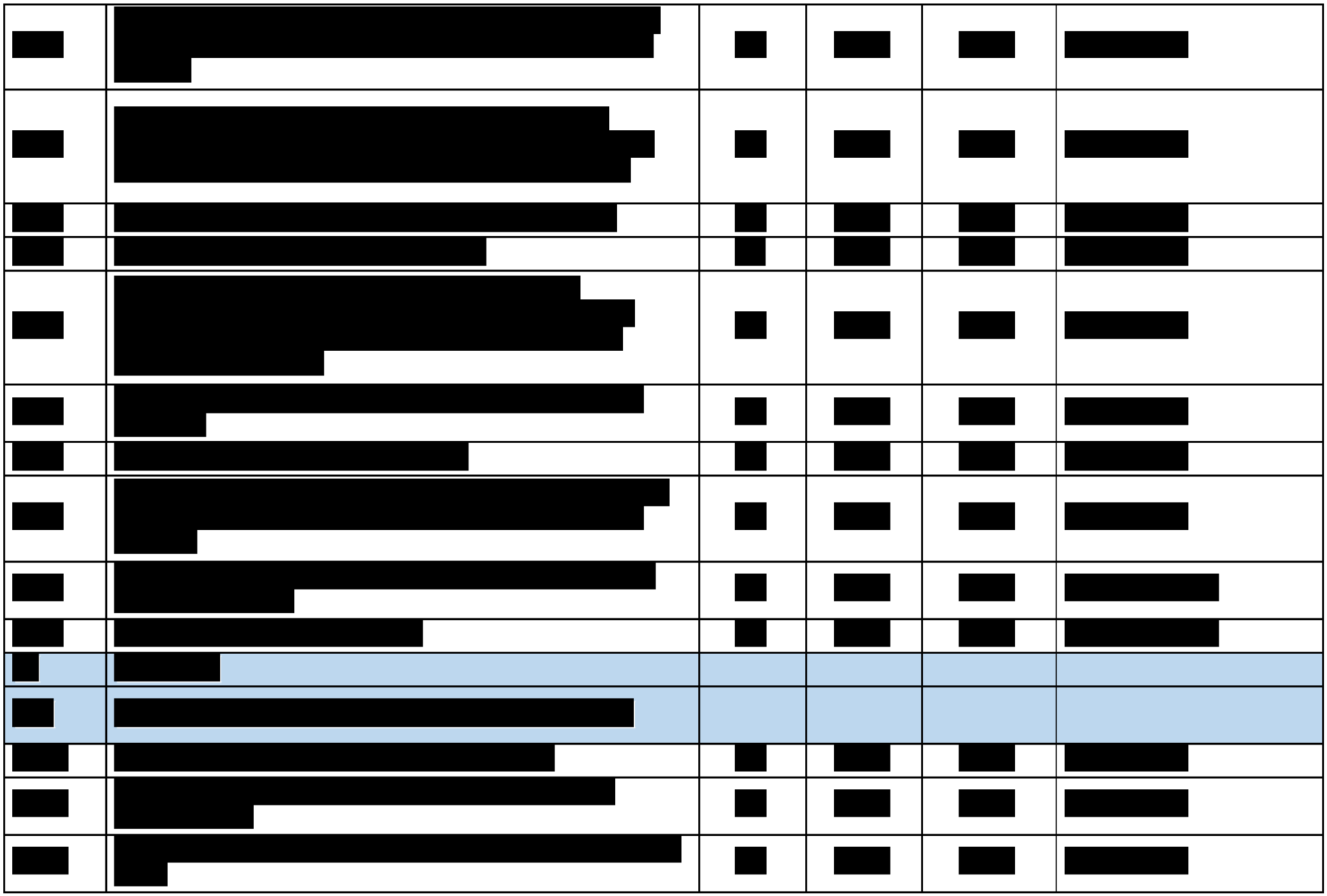

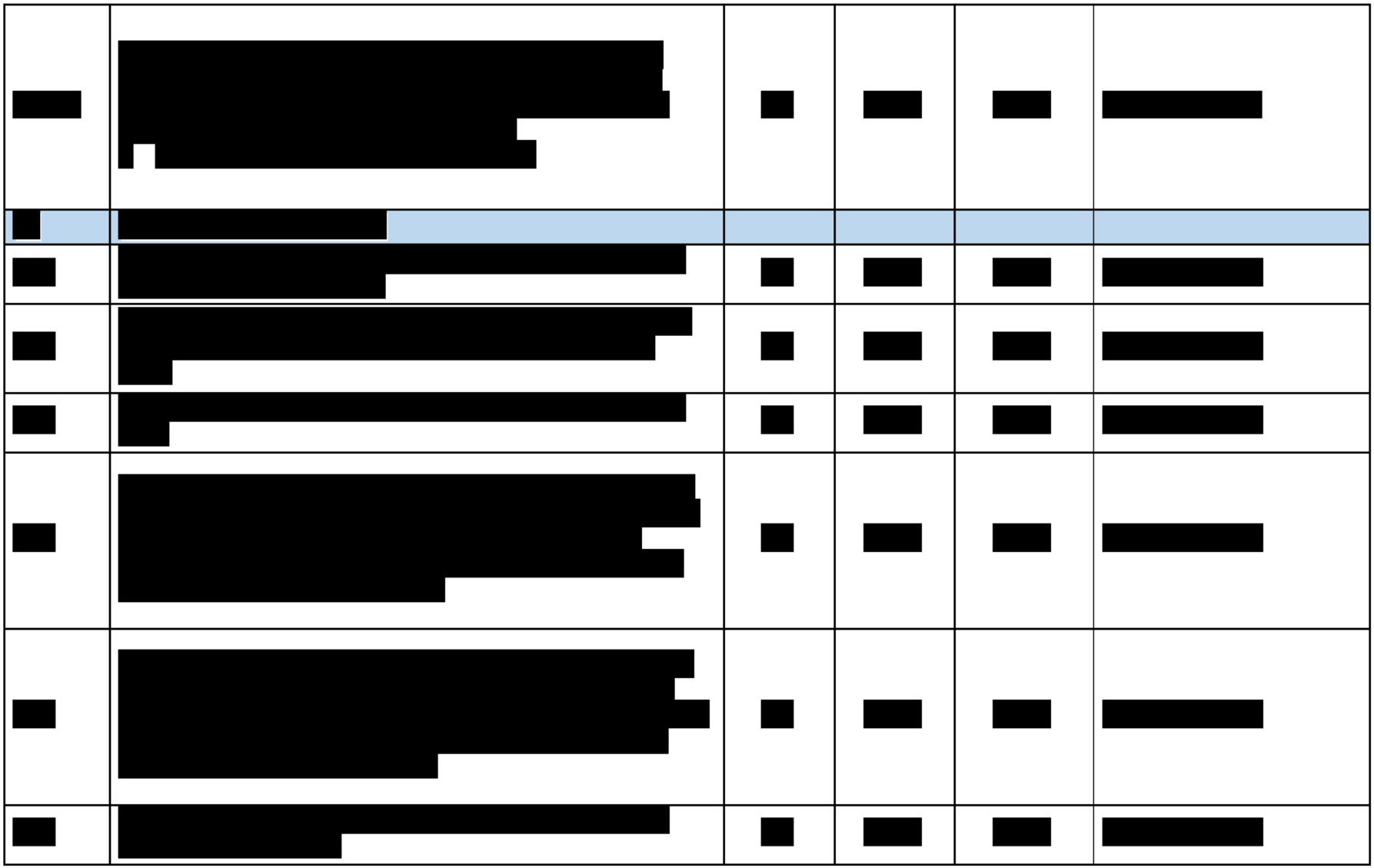

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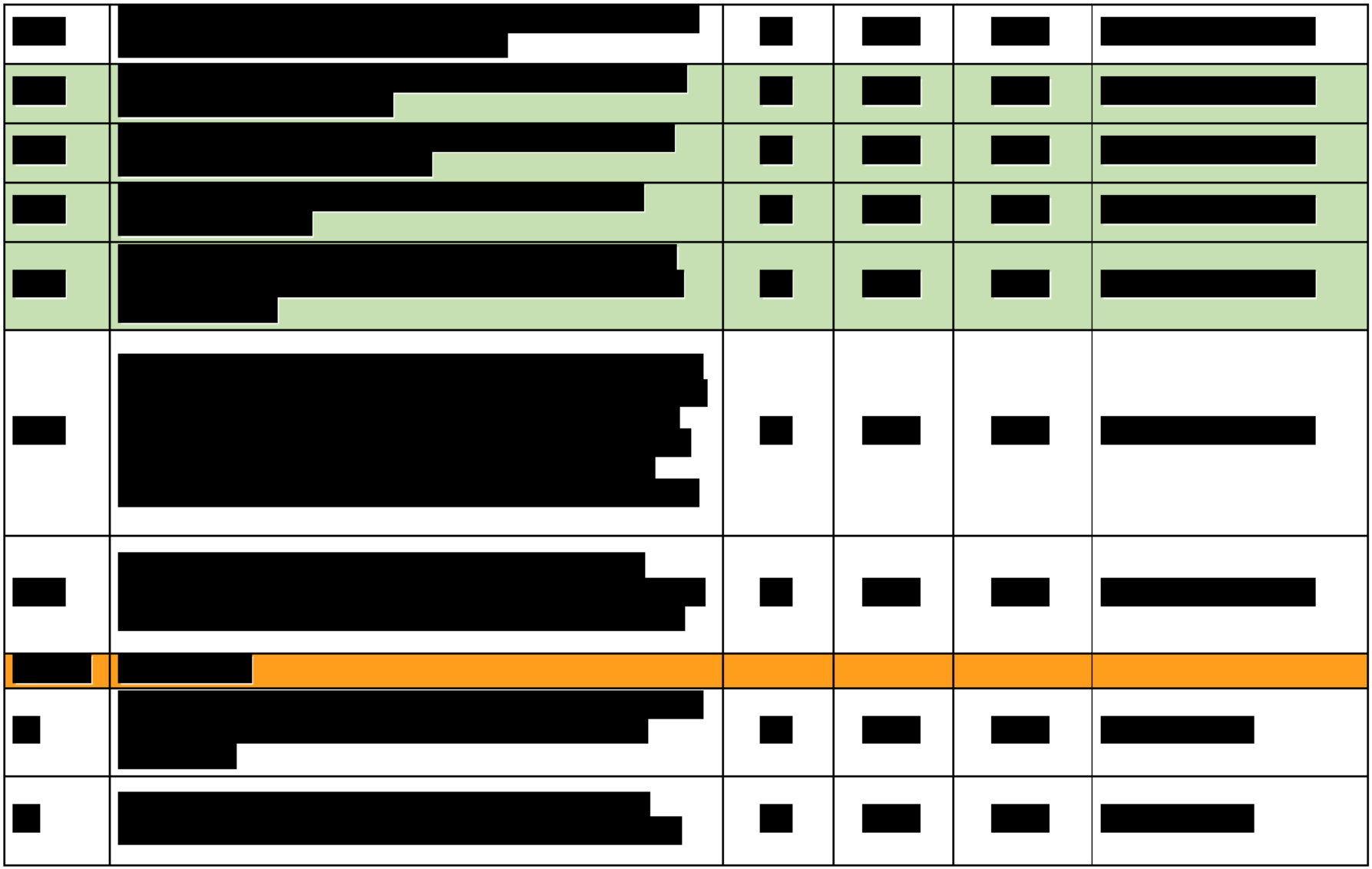

4.2.2 Operational Readiness (B.)

B. Operational Readiness

1. The Contractor shall prepare for the onset of operations in the existing Agency environment. This includes but is not limited to the following:

a. Review the turnover plan from the current contractor;
b. Utilize the Agency's comprehensive operational readiness checklist of its start-up activities;
c. Ensure that all checklist activities have been satisfactorily completed and signed-off by the Agency;
d. Develop and implement a corrective action plan for all outstanding activities for review and approval by the Agency;
e. Conduct training for its staff;
f. Gather and document all Agency technical and operational requirements pertaining to work performed under this Contract;
g. Produce and update all operations documentation and obtain Agency approval of each iteration;
h. Establish Agency-approved interfaces, as necessary; and
i. Obtain written approval from the Agency to start operations.

Operational Readiness Assessment (ORA) Planning and Review of Turnover Plan (B1a-d). We selected an elite group of professionals to staff the Operational Readiness team. This team prepares for and conducts internal pre-operational readiness checklist and then supports the accomplishment of the Operational Readiness Checklist for the Agency. The initial task accomplished by this team is to generate the Operational Readiness Plan, which will be based on the Agency's comprehensive Operational Readiness Checklist. The Operational Readiness Plan establishes the focus, structure, direction, critical success factors, individual assessment checklists, team composition, and milestones for the Operational Readiness Checklist.

Table 4.2-20. Operational Readiness Plan Composition

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Once the Transition and Operational plans are finalized, coordinated, reviewed, and approved by the Agency, the OR team completes the designated activities. This includes preparing for and conducting the Agency's comprehensive Operational Readiness Checklist. Every finding is evaluated, assigned to the

proper manager to implement a correction, and tracked to closure. Then the results of the Operational Readiness Checklist are prepared for and submitted to the Agency for approval, – confirming all findings from the checklist have been accounted for and/or corrected and that every checklist item is ready to go live. A final report is published. If any findings are noted throughout, we will develop and implement a Corrective Action Plan and the checklist/assessment is repeated until no findings occur (i.e., KEPRO is ready to go live July 2, 2018).

KEPRO will receive the outgoing contractor's turnover plan, and will conduct an initial analysis to verify our transitions and operations plans align with the transfer of work from the prior contractor to KEPRO. We will seek clarification from the Agency and/or the outgoing contractor so that all systems, processes and functions are accounted for. It will be imperative to conduct job shadowing and practice sessions of the work so that staff are fully prepared to implement the work. We recommend staff have access to the Agency's systems' training sites so proper, realistic training can occur.

Staff Training, Evaluation and Retraining (B1e). At the start of any contract, training is essential to orient employees to the scope of work. We will develop and submit a comprehensive Training Plan and submit to the Agency for approval within 20 business days after execution of the contract. The Training Plan will consist of both corporate and local training objectives and courses will include all required compliance, department-specific and other regulatory training, privacy and security policies and procedures, internal and external policies and procedures, inter-rater reliability, as applicable, and customer service.

Corporate human resources professionals' deliver employee orientation training. We will gather and analyze all job-specific training materials associated with Agency systems and processes and will identify any gaps as well as a schedule for all staff training. Local management staff will deliver department and task-specific training based on the Agency's available training materials as well as the approved Standard Operating Procedures.

KEPRO recognizes that successful contract performance requires efficient, effective methods of receiving inputs, adding value and innovation, and producing quality outputs that meet or exceed our customer's expectations. In order to maximize satisfaction with our services, we analyze all stakeholder feedback to identify opportunities for improvement. Key process indicators and minimum thresholds are established for all activities and areas of staff performance. Results obtained from stakeholder feedback are analyzed along with desktop auditing data to evaluate the effectiveness of our processes and performance of staff. The four primary avenues of identifying potential quality issues include:

- Performance indicators are significantly outside of control limits;
- Customer complaints from the Agency, related offices, contractors, members, or other stakeholders;
- Poor member survey results;
- Negative internal or external audit results.

Any areas that fall below minimum thresholds are flagged as opportunities for improvement and corrective actions are implemented. Corrective actions are designed to address individual training needs and also systemic issues in which process changes and/or additional full staff training are required. Training and corrective actions provide interventions to address gaps between objectives and performance. Components of our effective corrective action performance improvement plans include:

- Retraining of staff;
- Revision of review manuals, processes, procedures or training curriculum;
- Increased frequency of performance monitoring and evaluation;

- Issuance of internal Review Bulletins to clarify a specific review issue or procedure;
- Use of Continuous Improvement (CI) tools and techniques to uncover root causes and correct problems; and
- Systematic feedback to provide objective information about progress.

The system is transparent across the organization to ensure knowledge of, and readiness to, manage performance at all levels. In addition, information is shared on an ongoing basis with our Training Department. Curriculum developers work with the management team to identify areas to develop further training modules and/or modify current training modules to clarify particular points in a process.

We track each identified issue and monitor it to resolution. Issues tracking includes root cause analysis; documentation of corrective action); establishing corrective schedules and progress toward resolution; and auditing and documentation to ensure corrective actions demonstrate long-term improvement.

Agency Technical and Operational Requirements and Interfaces (B1f-h). KEPRO has already begun reviewing and incorporating the Agency's current operating procedures into the Operations Plan. Upon contract award, we will initiate a contract kickoff meeting which will begin our exhaustive requirements gathering and information seeking efforts. During the kickoff meeting, there should be sufficient time to discuss the project background, parameters, timeframes data needs/requirements and reports. Staff introductions will be necessary so we can identify the Agency's essential decision-makers. We will begin building relationships with Agency staff so we can establish connections between our department-level managers and their Agency counter-parts.

We will immediately commence gathering the Agency's prescribed templates, forms, formats and preferences so that all Standard Operating Procedures can be updated and submitted to the Agency within 25 business days after contract execution. All procedures will be reviewed, updated, evaluated for consistency and efficiencies and finalized prior to submission. All operational functions will be verified as documented; analysis will be conducted to identify gaps in documentation of procedures so new requirements can be produced.

KEPRO will evaluate available interfaces and determine gaps so that new interfaces can be established, as necessary. KEPRO will seek the agency's guidance and ultimate approval prior to designing and implementing any new interfaces.

Agency Approval (B1i). KEPRO understands and appreciates the value in the Agency having ultimate approval and authority over all procedures and functions performed under this contract. Therefore, it will be imperative to establish per department, function or rule who, at the Agency, can approve which contract operations. KEPRO will maintain chain of approval requirements and will obtain written authorization from the Agency to begin operations.

2. *The Contractor shall work proactively with the Agency and the outgoing contractor to take over the management of any work that remains open when the outgoing contract ends on June 30, 2018, such as Utilization Management activities identified in Contract Section 1.3.1.3 and HCBS Reviews identified in Contract Section 1.3.1.4.*

We will receive a routine queue of outstanding utilization management work (and all other operational functions) from the outgoing contractor and/or the Agency. We will receive a list/schedule of completed HCBS reviews and a schedule of upcoming reviews. We will maintain a list of these activities and will elect the appropriate management staff to oversee the transition of the work. Management staff will be responsible to designate responsible persons for each portion of the operational function, once the contract is operational July 2, 2018. Ongoing, we will work with the outgoing contractor to collect information and provide status updates to the Agency.

As incumbent staff are informed their company no longer has the business, it is often the case that the contractor experiences a substantial increase in employee resignations. We understand this, and will work diligently with the outgoing contractor to maintain status reports of transitioning work. Once operational, we will triage any outstanding queues of work and prioritize those most at risk of being delivered out of timeline. We will work to maintain the integrity of the Iowa programs and facilitate a smooth transition with as little disruption as possible by continually evaluating current against the expected status. If necessary, we will identify resources necessary to retroactively complete the work left incomplete.