Quality Improvement Organization Services for Iowa Medicaid

Technical Proposal

Public Copy - Electronic

Telligen

Submitted:
January 26, 2018

To:
Stephanie Clark
Hoover State Office Building, 1st Floor
1305 E Walnut Street
Des Moines, IA 50319-0114
Phone: (515) 256-4646
RFPMED-18-015@dhs.state.ia.us

1 TRANSMITTAL LETTER (RFP SECTION 3.2.1)

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(515)223-2900
(800)383-2856

1776 West Lakes Parkway
West Des Moines, Iowa 50266
telligen.com

January 26, 2018

Stephanie Clark
Hoover State Office Building, 1st Floor
1305 E Walnut Street
Des Moines, IA 50319-0114

Dear Ms. Clark:

The transmittal letter serves as a cover letter for the Technical Proposal. It must consist of an executive summary that briefly reviews the strengths of the bidder and key features of its proposed approach to meet the specifications of this RFP.

Iowa Medicaid is a significant and important part of the Iowa healthcare fabric, responsible for improving quality of care and lowering costs for 558,980 members – or nearly 25 percent of the state's total population. As such, it is imperative that the state's program continue to be successful and meet the healthcare needs of all Medicaid members. Telligen is a trusted partner that has performed Quality Improvement Organization (QIO) services for the state's Medicaid population, and we look forward to delivering high-quality, cost-saving support that will help the Iowa Medicaid Enterprise (IME) meet its future goals.

The introduction of Medicaid Modernization and the managed care organization (MCO) model in April 2016 resulted in 95 percent of Iowa's Medicaid population transitioning from FFS to one of the state's MCOs for services. This created a new set of challenges for IME – such as necessary coordination to support level of care (LOC) decisions, the need to respond to increasing volumes of provider inquiries, and MCO quality oversight. Telligen has worked – and continues to work – very closely with the Agency to address these challenges.

From our 39-year history with the Agency, and our interactions and efforts in our existing current work, we fully understand the factors critical to the success of this new QIO Services contract:

- Ensure we make responsive and quality person-centered decisions for all Medicaid members and providers in a cost-effective manner
- Demonstrate successful collaboration with the Agency and other co-located vendors to make sure that information exchange and processes related to MCO and FFS activities remain seamless and continue to meet member needs
- Apply ongoing professional medical expertise to review all clinical guidelines to determine if there are changes to treatment modalities for members, and if state policies should be adjusted to accommodate evolving standards of care
- Represent the state in appeals processes for waiver program participants

As shown in Figure 1, we offer several distinct strengths and features that will lead to the success of this new contract:

Figure 1. Telligen expertise. ***We have demonstrated our expertise and leadership throughout our current QIO Services contract***

Telligen Strengths and Added Value

[redacted]

Figure 2. *Telligen consistently looks for ways to innovate our processes to add value to the Agency.*

Testimonial

[redacted]

[redacted]

Key Features of our Proposed Approach

Here, we outline key components of our approach, as well as the value that the Agency will derive:

- [redacted]
- [redacted]
- [redacted]
- [redacted]

Telligen offers more than three decades of IME QIO experience and renewed commitment to the Agency's objectives. Our modernization capabilities, personnel, tools and processes will ensure the success of this program.We look forward to again partnering with you on the new QIO Services contract.

If you have any questions, please feel free to contact Peg Mason, Vice President, State Health Management at 515.223.2920 or pmason@telligen.com with any questions.

Sincerely,

Jeff Chungath

Chief Executive Officer

Testimonial

[redacted]

2 Proposal Table of Contents (RFP Section 3.2.2)

3 RFP Forms (RFP Section 3.2.3)

3.1 ATTACHMENT A: RELEASE OF INFORMATION

Telligen, Inc. hereby authorizes any person or entity, public or private, having any information concerning the bidder's background, including but not limited to its performance history regarding its prior rendering of services similar to those detailed in this RFP, to release such information to the Agency.

The bidder acknowledges that it may not agree with the information and opinions given by such person or entity in response to a reference request. The bidder acknowledges that the information and opinions given by such person or entity may hurt its chances to receive contract awards from the Agency or may otherwise hurt its reputation or operations. The bidder is willing to take that risk. The bidder agrees to release all persons, entities, the Agency, and the State of Iowa from any liability whatsoever that may be incurred in releasing this information or using this information.

Telligen, Inc.
Printed Name of Bidder Organization

Denise Sturm
Signature of Authorized Representative

1/23/2018
Date

Denise Sturm, CPA
Printed Name

3.2 ATTACHMENT B: PRIMARY BIDDER DETAIL & CERTIFICATION FORM

(Return this completed form behind Tab 3 of the Proposal. If a section does not apply, label it "not applicable".)

Primary Contact Information (individual who can address issues re: this Bid Proposal)	
Name:	Peg Mason
Address:	1776 West Lakes Parkway, West Des Moines, IA 50266
Tel:	515.223.2930
Fax:	515.222.2407
E-mail:	pmason@telligen.com

Primary Bidder Detail	
Business Legal Name ("Bidder"):	Telligen, Inc.
"Doing Business As" names, assumed names, or other operating names:	Telligen
Parent Corporation Name and Address of Headquarters, if any:	N/A
Form of Business Entity (i.e., corp., partnership, LLC, etc.):	100% Employee Stock Ownership Plan (ESOP) S Corporation
State of Incorporation/organization:	Iowa
Primary Address:	1776 West Lakes Parkway, West Des Moines, IA 50266
Tel:	515.223.2900
Local Address (if any):	1776 West Lakes Parkway, West Des Moines, IA 50266
Addresses of Major Offices and other facilities that may contribute to performance under this RFP/Contract:	100 Army Post Road Des Moines, IA 50315
Number of Employees:	743
Number of Years in Business:	46 years
Primary Focus of Business:	Population health management
Federal Tax ID:	[redacted]
DUNS #:	087131785
Bidder's Accounting Firm:	Stout, Causey & Horning P.A.
If Bidder is currently registered to do business in Iowa, provide the Date of Registration:	12/13/2013 as Telligen 05/19/1971 as Iowa Foundation for Medical Care (IFMC)
Do you plan on using subcontractors if awarded this Contract? {If "YES," submit a Subcontractor Disclosure Form for each proposed subcontractor.}	No

Request for Confidential Treatment (See Section 3.1)		
Location in Bid (Tab/Page)	**Statutory Basis for Confidentiality**	**Description/Explanation**
Tab 1/pages 2-9	Section 22.7(6)	Telligen proprietary information
Tab 3/page 14	Section 22.7(6)	Telligen proprietary information
Tab 4/pages 21-34	Section 22.7(6)	Telligen proprietary information
Tab 4/pages 38-44	Section 22.7(6)	Telligen proprietary information
Tab 4/page 57	Section 22.7(6)	Telligen proprietary information
Tab 4/pages 65-85	Section 22.7(6)	Telligen proprietary information
Tab 4/pages 95-97	Section 22.7(6)	Telligen proprietary information
Tab 4/page 122	Section 22.7(6)	Telligen proprietary information
Tab 4/page 123	Section 22.7(6)	Telligen proprietary information
Tab 4/page 139	Section 22.7(6)	Telligen proprietary information
Tab 4/page 147	Section 22.7(6)	Telligen proprietary information
Tab 4/pages 167-172	Section 22.7(6)	Telligen proprietary information
Tab 4/page 181	Section 22.7(6)	Telligen proprietary information
Tab 5/pages 186-200	Section 22.7(6)	Telligen proprietary information
Tab 5/pages 201-234	Section 22.7(6)	Telligen proprietary information

Exceptions to RFP/Contract Language (See Section 3.1)			
RFP Section and Page	**Language to Which Bidder Takes Exception**	**Explanation and Proposed Replacement Language:**	**Cost Savings to the Agency if the Proposed Replacement Language is Accepted**

PRIMARY BIDDER CERTIFICATIONS

1. BID PROPOSAL CERTIFICATIONS. By signing below, Bidder certifies that:

1.1 Bidder specifically stipulates that the Bid Proposal is predicated upon the acceptance of all terms and conditions stated in the RFP and the Sample Contract without change except as otherwise expressly stated in the Primary Bidder Detail & Certification Form. Objections or responses shall not materially alter the RFP. All changes to proposed contract language, including deletions, additions, and substitutions of language, must be addressed in the Bid Proposal. The bidder accepts and shall comply with all Contract Terms and Conditions contained in the Sample Contract without change except as set forth in the Contract;

1.2 Bidder has reviewed the Additional Certifications, which are incorporated herein by reference, and by signing below represents that Bidder agrees to be bound by the obligations included therein;

1.3 Bidder has received any amendments to this RFP issued by the Agency;

1.4 No cost or pricing information has been included in the Bidder's Technical Proposal; and,

1.5 The person signing this Bid Proposal certifies that he/she is the person in the Bidder's organization responsible for, or authorized to make decisions regarding the prices quoted and, Bidder guarantees the availability of the services offered and that all Bid Proposal terms, including price, will remain firm until a contract has been executed for the services contemplated by this RFP or one year from the issuance of this RFP, whichever is earlier.

2. SERVICE AND REGISTRATION CERTIFICATIONS. By signing below, Bidder certifies that:

2.1 Bidder certifies that the Bidder organization has sufficient personnel resources available to provide all services proposed by the Bid Proposal, and such resources will be available on the date the RFP states services are to begin. Bidder guarantees personnel proposed to provide services will be the personnel providing the services unless prior approval is received from the Agency to substitute staff;

2.2 Bidder certifies that if the Bidder is awarded the contract and plans to use subcontractors at any point to perform any obligations under the contract, the Bidder will (1) notify the Agency in writing prior to use of the subcontractor, and (2) apply all restrictions, obligations, and responsibilities of the resulting contract between the Agency and contractor to the subcontractors through a subcontract. The contractor will remain responsible for all Deliverables provided under this contract;

2.3 Bidder either is currently registered to do business in Iowa or agrees to register if Bidder is awarded a Contract pursuant to this RFP; and,

2.4 Bidder certifies it is either a) registered or will become registered with the Iowa Department of Revenue to collect and remit Iowa sales and use taxes as required by Iowa Code chapter 423; or b) not a "retailer" of a "retailer maintaining a place of business in this state" as those terms are defined in Iowa Code subsections 423.1(42) & (43). The Bidder also acknowledges that the Agency may declare the bid void if the above certification is false. Bidders may register with the Department of Revenue online at: http://www.state.ia.us/tax/business/business.html.

3. EXECUTION.

By signing below, I certify that I have the authority to bind the Bidder to the specific terms, conditions and technical specifications required in the Agency's Request for Proposals (RFP) and offered in the Bidder's Proposal. I understand that by submitting this Bid Proposal, the Bidder agrees to provide services described herein which meet or exceed the specifications of the Agency's RFP unless noted in the Bid Proposal and at the prices quoted by the Bidder. The Bidder has not participated, and will not participate, in any action contrary to the anti-competitive obligations outlined in the Additional Certifications. I certify that the contents of the Bid Proposal are true and accurate and that the Bidder has not made any knowingly false statements in the Bid Proposal.

Signature:	Denise Sturm
Printed Name/Title:	Denise Sturm, CPA Vice President, Finance and Administration and CFO
Date:	January 23, 2018

3.3 ATTACHMENT C: SUBCONTRACTOR DISCLOSURE FORM

Not applicable – Telligen has the capabilities to perform the statement of work without subcontractors.

3.4 ATTACHMENT E: CERTIFICATION AND DISCLOSURE REGARDING LOBBYING

(Return this executed form behind Tab 3 of the Bid Proposal.)

Instructions:

Title 45 of the Code of Federal Regulations, Part 93 requires the bidder to include a certification form, and a disclosure form, if required, as part of the bidder's proposal. Award of the federally funded contract from this RFP is a Covered Federal action.

1) The bidder shall file with the Agency this certification form, as set forth in Appendix A of 45 CFR Part 93, certifying the bidder, including any subcontractor(s) at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) have not made, and will not make, any payment prohibited under 45 CFR § 93.100.

2) The bidder shall file with the Agency a disclosure form, set forth in Appendix B of 45 CFR Part 93, in the event the bidder or subcontractor(s) at any tier (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) has made or has agreed to make any payment using non-appropriated funds, including profits from any covered Federal action, which would be prohibited under 45 CFR § 93.100 if paid for with appropriated funds. All disclosure forms shall be forwarded from tier to tier until received by the bidder and shall be treated as a material representation of fact upon which all receiving tiers shall rely.

Certification for Contracts, Grants, Loans, and Cooperative Agreements

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, ''Disclosure Form to Report Lobbying,'' in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file

Statement for Loan Guarantees and Loan Insurance

The undersigned states, to the best of his or her knowledge and belief, that:

If any funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this commitment providing for the United States to insure or guarantee a loan, the undersigned shall complete and submit Standard Form-LLL, ''Disclosure Form to Report Lobbying,'' in accordance with its instructions.

Submission of this statement is a pre-requisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required statement shall be subject to a civil penalty of not less than $10,000 for each such failure.

I certify that the contents of this certification are true and accurate and that the bidder has not made any knowingly false statements in the Bid Proposal. I am checking the appropriate box below regarding disclosures required in Title 45 of the Code of Federal Regulations, Part 93.

X The bidder is NOT including a disclosure form as referenced in this form's instructions because the bidder is NOT required by law to do so.

☐ The bidder IS filing a disclosure form with the Agency as referenced in this form's instructions because the bidder IS required by law to do so. If the bidder is filing a disclosure form, place the form immediately behind this Attachment E in the Proposal.

Signature:	Denise Sturm
Printed Name/Title:	Denise Sturm, CPA Vice President, Finance and Administration and CFO
Date:	January 23, 2018

4 Approach to Meeting Deliverables (RFP Section 3.2.4)

4.1 General Obligations (RFP 1.3.1.1)

4.1.1 Staffing

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:

4.1.1.1 Key Personnel

Telligen offers a talented and qualified leadership team with experience and familiarity with Agency operations. As the incumbent contractor, we bring continuity in the key personnel. They have valuable Medicaid medical services and HCBS experience that meets or exceeds all Agency requirements.

Key Personnel	Meets/Exceeds RFP Qualifications	Distinct, Relevant Qualifications
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

Key Personnel	Meets/Exceeds RFP Qualifications	Distinct, Relevant Qualifications
[redacted]	[redacted]	[redacted]

Table 1. Key Personnel

a. Account Manager. Responsible for the overall service delivery of the team, complying with contractual requirements and meeting the Agency's expectations. The Account Manager shall be responsible for Contract compliance and general project oversight. The Account Manager must adopt an exemplary behavior; also he or she must collaborate, and cultivate and promote the spirit of trust and professionalism with the Agency, other IME Units, and stakeholders. The Account Manager shall represent the Contractor and be the primary liaison with the Agency. Minimum qualifications include:
i. Three years of experience in account management or major supervisory role for government or in the private sector as a healthcare payer or provider.
ii. Bachelor's Degree or at least 4 years relevant experience to the position.
iii. Previous management experience with Medicaid, specifically Medicaid managed care, LTSS, medical services, behavioral health, utilization management, coding and billing, and knowledge of HIPAA rules and requirements, is desired.

[redacted] e has a proven record of collaborating with customers, providers, and internal and external stakeholders to meet the demands of a dynamic managed care marketplace. He is also adept at transforming processes to align with value-based payer arrangements and population health initiatives by using technology, improvement tools, performance metrics and project management.

Throughout his career, he has managed a variety of accounts and teams with accountability for care management, HCBS, UM, risk management, including managed care payment arrangements, provider relationships and overall medical management. [redacted] has a strong understanding of the long-term care population and the opportunities that exist to improve enrollment eligibility processes for both members and providers. He has a record of successfully overseeing application of HIPAA rules and requirements.

[redacted]

b. Transition Manager. Responsible for facilitating all planning and operational readiness activities necessary to ensure a successful transition. This position will no longer be required once the Contractor has successfully transitioned to operations. The Transition Manager may also serve as the Account or Operations Manager. Minimum qualifications include:
i. Three years of experience in account management or major supervisory role for government or in the private sector as a healthcare payer or provider.
ii. Bachelor's Degree or equivalent relevant experience to the position.

[redacted]

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c. Medical and LTSS Operations Manager. Responsible for day to day project management and supervision. Minimum qualifications include:
i. Four years of experience managing a major component of a healthcare operation in an environment similar in scope and volume to the Iowa Medicaid Program. The experience shall include LTSS, utilization management, behavioral health, Medicaid managed care, and quality management.
ii. Bachelor's Degree or equivalent relevant experience to the position.

[redacted]

LTSS/HCBS Experience
✓ [redacted]
[redacted]
[redacted]
[redacted]
[redacted]
[redacted]
[redacted]
[redacted]

LTSS/HCBS: [redacted]

Utilization management: As [redacted] monitors trends and cost-saving measures to ensure Medicaid members receive the appropriate services based on medical necessity. [redacted] experience includes extensive collaboration with Agency personnel, Provider Cost Audit Unit and HCBS providers regarding the HCBS Supplemental Schedule D-4.

Behavioral Health: With a background in targeted case management, [redacted] has extensive experience with the Medicaid members in need of behavioral health services including in-patient and out-patient psychiatric services as well as waiver and state plan habilitation services. In her current role as the [redacted] This included developing a new form that

was uploaded to the Agency website for easy access and completion by hospital personnel. [redacted]

Medicaid managed care: With the implementation of managed care, [redacted].

Quality Management: [redacted].

[redacted]

d. HCBS Quality Oversight Operations Manager. Responsible for day to day project management and supervision. Minimum qualifications include:
i. Four years of experience managing a major component of a healthcare operation in an environment similar in scope and volume to the Iowa Medicaid Program. The experience shall include HCBS quality control and outcomes, federal requirements for HCBS waiver programs, and provider relations.
ii. Bachelor's Degree or equivalent relevant experience to the position.

[redacted].

HCBS Quality Control and Outcomes: To address quality control and outcomes, [redacted]

Federal Requirements for HCBS Waiver Programs: [redacted]

- [redacted]
- [redacted]
- [redacted]
- [redacted]

Provider Relations – As an [redacted] worked closely with providers to develop an educational relationship to support quality service provision. As part of her efforts with the state's transition planning, she has participated in onsite meetings to assist non-residential providers with settings evaluations. She is a ready resource for Iowa providers, helping them navigate the Medicaid HCBS process.

e. Medicaid Medical Director (MMD). Responsible for ensuring medical oversight of QIO professional staff, overall leadership related to all medical facets that may affect the Medicaid Program, and helping the Iowa Medicaid program deliver value-driven, high-quality, cost-effective health care in an efficient manner. The MMD shall participate in the Medicaid Medical Directors Learning Network (MMDLN), the IME quality committee, the Pharmacy and Therapeutics (P&T) and Drug Utilization Review (DUR) committees, and other State and national committees as requested by the Agency, chair the Clinical Advisory Committees, and provide input in the review of Medicaid policies and procedures. The Medical Director plays an important role in continuous quality improvement and the implementation of policy for an efficient Medicaid Program. The MMD shall collaborate with the Medicaid Director, MCO chief medical officers, and policy staff to ensure clinical policies and procedures are implemented consistently throughout the entire delivery system. Minimum qualifications include:

i. Four years of experience as a managing physician in a managed care environment as either an MD or DO.

Rounding out our team of key personnel is the [redacted].

[redacted]

- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]

[redacted] reputation in the Iowa healthcare industry has allowed Telligen to build strong relationships with key healthcare groups, such as the Iowa Healthcare Collaborative, University of Iowa Health

System, Accountable Care Organizations, Iowa Department of Public Health, Iowa Health Care Association and other stakeholders.

His long-standing position as a leader in Iowa's healthcare environment has also helped us forge strong relationships with providers. Because of [redacted] experience in the field, he understands provider concerns and promotes the use of evidence-based medicine to improve care for Medicaid members. [redacted] is a well-respected representative of and advocate for Iowa's Medicaid program.

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

Key Project Personnel for Population Health Improvement Special Projects

Key Personnel	Distinct, Relevant Qualifications
[redacted] Health Home Coordinator	✓ [redacted] [redacted])
[redacted] HIT Coordinator	✓ [redacted] [redacted]
[redacted] HIT Advisor	✓ [redacted] [redacted]
Vacant EHR Pre-payment Auditor	✓ [redacted]

Table 2. Special Projects Key Personnel

[redacted], Health Home Coordinator

We propose [redacted] as the Health Home Coordinator. She is a recognized and certified project management professional with proven success in project management, data analysis, system analysis, application development and production support.

[redacted]

[redacted], HIT Coordinator

[redacted]

[redacted]

- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]

In [redacted] work with the state's Regional Extension Center, she engaged clinics and hospitals to encourage their participation in the program, and with the Iowa Department of Public Health and the Iowa Health Information Network to promote the use and development of health information technology and interoperability.

[redacted]

[redacted] has in-depth knowledge of using HITECH funding opportunities, the national interoperability roadmap, and the transition to the Quality Payment Program, which includes payment and delivery system reform and infrastructure needed to support the move to value over volume. [redacted]

- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]

[redacted], HIT Advisor

[redacted] will serve as the HIT Advisor. [redacted] has several years of experience working in various healthcare management roles. As part of her leadership positions, she was a project manager that supported the roll out and activation of an EHR system for six critical access hospitals and their clinics. She was the primary lead and support of the EHR incentive and Quality Payment Programs for the hospitals and providers. She has had a significant amount of experience with two well-recognized electronic health record applications which included system functionality, end user training, data sharing, and integration.

As part of [redacted] management and system support roles she:

- Collaborated with a variety of stakeholders, such as population health resources, EHR vendors, end users, IT, leadership, providers, the Iowa Department of Public Health and hospital quality assurance staff
- Stayed abreast of regulation changes in relation to the EHR incentive and Quality Payment programs by attending CMS webinars, subscribing to multiple list services, research and outreach. Communicated updates through a variety of venues to various stakeholders to ensure changes were understood and implemented if necessary. This included creating and maintaining training materials for end users of the electronic health record
- Provided online and in-person support for electronic health record end-users specific to meaningful use system requirements and workflows
- Created and maintained project plans in relation to the electronic health record readiness and implementation
- Analyzed and monitored provider and hospital meaningful use reports to ensure goals were being met. Conducted weekly meetings with key resources to discuss progress for each objective and measure as well as updates to the program
- Completed eligible provider and hospital attestations for the facilities, including running meaningful use and clinical quality measure reports as well as requested and gathered supporting documentation from needed sources
- Regularly conducted system testing for upgrades and application fixes, identifying issues and monitoring system performance

This previous work experience directly translates to the HIT Advisor role. [redacted]:

- [redacted]
- [redacted]
- [redacted]

[redacted]

EHR Pre-payment Auditors

We are in the process of recruiting two EHR pre-payment auditors. We will have the EHR pre-payment auditors in place by the start of new contract operations (July 1, 2018). In addition to recruiting new talent, we also work diligently to transition incumbent staff to glean subject matter expertise and ensure continuity of project deliverables, since this work is currently performed by another contractor.

Two of our current staff performed this role previously and will be available to support the new EHR pre-payment auditors.

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.

Our experienced key personnel will continue to be co-located with the Agency at the IME facility and committed full time to the scope of work outlined in the contract. Our key personnel will make sure they are covered during planned and unexpected absences. [redacted] will keep the Agency informed of their absence, including identifying who will provide coverage any time they will be out for extended periods. They will also inform the Agency of any planned absence of key personnel. We will provide cross-training to ensure personnel are equipped to provide coverage for key positions. Our experienced key personnel and subject matter experts will continue to support the Agency by

providing recommendations related to our scope of work. We will continue to participate in internal and external stakeholder meetings to provide periodic updates as requested by the Agency.

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.

We understand and respect that the Agency has the right to approve replacements for key personnel. As the incumbent, we have personnel in place for all key positions. In the event we need to replace key personnel during the contract period, we will provide the Agency written notification at least 15 days before the proposed transition date. We will provide the Agency resumes and references for proposed new key personnel. We will make all efforts to ensure we equip new personnel with the knowledge to perform all functions related to our scope of work prior to the departure of key personnel. In the event we are unable to hire key personnel prior to the departure of current staff, we will identify interim coverage to ensure we complete operational tasks as specified in the contract.

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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

Telligen has arrangements with medical and service professionals in each of the specialties listed. [redacted]. We will recruit additional professionals as necessary to address any policy coverage or limitations under consideration.

5. The Contractor shall also provide the following non-managerial positions:
a. Claims and coding staff qualified to provide technical assistance and support to the Agency, providers, and MCOs;
b. Quality assurance/quality control staff with experience developing, executing and reporting formal quality assurance plans.

Our QIO Services staff includes [redacted] who can provide technical assistance and support to the Agency, providers and MCOs.

[redacted] are experienced at developing and monitoring formal quality assurance plans. They will work with Agency staff to ensure we include the appropriate metrics and monitor them on an ongoing basis.

6. 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.

As a URAC-accredited organization, Telligen will ensure all staff and consultants are properly licensed, certified, or accredited, as required under applicable state law and/or Iowa Administrative Code. We also conduct regular background checks to verify all licensures and certifications.

7. 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.

As the incumbent contractor, Telligen is committed to recruiting Des Moines-based professionals. As an Iowa-based company, we are well positioned to understand the Iowa labor market.

We have experienced the benefits of being co-located at the IME facility. Co-location enables a deeper relationship with our customer and a faster response time to inquiries and customer needs. Our personnel have benefited from the colocation through involvement in special projects, access to Agency staff when needed, and the ability to directly work with other IME units. It is our goal to maintain the established working environment within IME for these reasons.

4.1.2 System and Software Requirements

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

Telligen has remained a dedicated partner in developing, using and maintaining Agency systems for the past 12 years for numerous IME programs. In 2004, Telligen observed a need for a system to support data entry and retrieval application for documenting review data and outcomes related to LOC reviews for waivers and facilities. We used our IT capabilities to create the system now known as Medicaid Quality Utilization Information Data System (MQUIDS) that bring efficiency to the QIO services work. Managers will use MQUIDS for LOC reporting. We also subsequently developed the QPS in 2013 for use in the HCBS programs to provide a workflow tool for Telligen and the Agency to document and manage the HCBS activities, tracking timeliness and steps in the process including obtaining appropriate Agency approvals directly into QPS as well as ensuring compliance with CMS and state rules.

Better Solutions for IME

Telligen provides:

- ✓ The greatest knowledge of IME systems
- ✓ Lowest risk for maintenance yielding highest reward
- ✓ Innovative solutions for the future modernized Medicaid system

Over time, these systems have become instrumental in support of the QIO services and HCBS programs and we have collaborated with the Division of Data Management (DDM) to continue to enhance the systems. The Agency has benefited from continued enhancements to the MQUIDS and QPS systems for more efficient workflow, storage of medical information to support decisions, and for reporting of information from the various programs. Since Telligen developed these two systems and has maintained them since inception, our institutional knowledge of these systems is unmatched, and our experience working with the Division of Data Management (DDM) to enhance the MQUIDS and QPS provides the Agency with an unsurpassed level of confidence in our ability to use and maintain all systems and software listed in Attachment 3.2 of the RFP.

Our unique MQUIDS and QPS development experience will provide the Agency with the development and maintenance of code that provides the best system performance for end users and enables us to respond quickly for requested system changes. Our experience and collaboration with DDM has allowed over 100 system changes in the past six months for MQUIDS and QPS, at no cost to the Agency. Success stories such as these will remain our priority in helping the Agency leverage modernized systems to meet and exceed its future goals.

We use the Agency's systems and software daily, often serving as experts within specific systems and trouble-shooting when the need arises. The table below provides a description of who, how and why our staff will use each of the systems specified in the RFP.

Agency Systems & Software	Currently Used and Maintained by Telligen QIO Staff at IME
Adobe Acrobat	Project assistants (PA) and review assistants (RA) will use Adobe Acrobat to create and manage documents for reporting.
Appeals Information System (AIS)	PAs, RAs, review coordinators (RC) and managers will use AIS to obtain appeal documentation, research appeals in process, and obtain hearing results.
Cisco CallRex	PAs and RAs will use CISCO CallRex to manage and answer incoming calls. Managers will use CISCO Call Rex to run reports for call statistics.
Cisco VPN	Telligen field RCs will use the Cisco VPN to connect to the DHS network when conducting member and provider reviews from a remote site.
Code IT	RCs will use Code IT to complete claims reviews.
First Data Bank (FDB) (previously known as MEDISPAN)	PAs, RAs and RCs will use FDB for pharmacy claims pricing and Prior Authorization reviews.
Google Mail	All Telligen staff assigned to this contract will use the Agency email system to communicate with Agency personnel and other vendors.
Go-To-Meeting	Telligen staff will use Go-To-Meeting to conduct provider training webinars.
Iowa Health Information Network (IHIN)	PAs and RAs will use IHIN to obtain clinical data from providers to complete Prior Authorization reviews.
Iowa Medicaid Portal Access (IMPA)	HCBS specialists will use IMPA, an Agency system for securely uploading documents, to research incident reports, assist providers using system. PAs and RAs will access and download documentation uploaded from providers. RCs will obtain documentation from providers and MCOs to complete LOC reviews. Program managers will use for the EHR program to obtain documents from providers. We will continue to provide technical assistance to other IME vendors on the use of IMPA.
Individualized Services Information System (ISIS)	HCBS specialists will use ISIS for MFP, IPES, IDT, and provider information to complete reviews and communicate with case workers. PAs, RAs, RCs and managers use ISIS to manage LOC milestones, research review workflow, confirm MCO/FFS eligibility status, and obtain services rendered information.
Microsoft Office 2010 (Access, Excel, PowerPoint, Project, Publisher, SharePoint, Visio, Word)	All Telligen staff will use the Agency-approved Microsoft Office 2010 office suite software loaded to the Agency issued computers to perform the functions of this QIO contract.
Microsoft Windows 7 Enterprise Operating System	All Telligen staff will use the Agency approved Microsoft Windows 7 Enterprise Operating System software loaded to the state-issued computers to support Microsoft operating solutions and perform the functions of this QIO contract.
Medicaid Management Information System (MMIS)	PAs, RAs and RCs will use MMIS to check MCO/FFS eligibility, procedures, claims history, PA history, TPL status; provider enrollment, and enter PA review results.
Medicaid Quality Utilization Information Data System (MQUIDS)	PAs, RAs and RCs will use MQUIDS, a data entry and retrieval application for documenting review data and outcomes related to LOC reviews for waivers and facilities. Managers will use MQUIDS for LOC reporting.

Agency Systems & Software	Currently Used and Maintained by Telligen QIO Staff at IME
OnBase Unity Client	All Telligen staff will use OnBase, a workflow and document management system that houses all documentation received at IME for document retrieval, review entry, logging and reporting.
QualAssure Performance System (QPS)	HCBS specialists, Pas and RAs will use QPS to document and manage data related to provider reviews. Program managers will conduct reporting to support Agency personnel and the HCBS program.
RightFax Utility Software	PAs, RAs and RCs will use RightFax to fax and store documentation from OnBase.
Roxio CD/DVD Creator Basic	PAs and RAs will use Roxio CD/DVD Creator Basic to provide reports for Agency program managers to support reporting during state budget process or other report requests from Agency program managers.
Worker Information System Exchange (WISE)	HCBS slot manager, Pas and RAs will use the WISE database to enter slot status and releases. The program manager will use WISE for reporting on the number of slots filled, released and member information. HCBS specialists will use WISE for technical assistance, completing reviews, viewing letters from providers for certification and focused review timeliness.
WinZip	All Telligen staff will use WinZip as needed to send, receive, or compress encrypted files.

Table 3. Current IME Systems Usage by Telligen QIO Staff

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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.

Telligen's Information Management Division is based in West Des Moines, Iowa, and includes over 250 technical professionals featuring developers, project managers, statisticians, data analysts, and healthcare IT thought leaders. We have been developing innovative technology solutions for state, federal and commercial programs for over 40 years. Our focus is building solutions that meet the unique needs of our clients. This focus is supported through our development and maintenance of systems, business intelligence solutions, data management solutions, and integrating systems as indicated in Figure 3.

Experience & Commitment Matters

- ✓ Over 12 years managing MQUIDS code & three years managing QPS code
- ✓ Ongoing partnership and collaboration with DDM and Agency program managers
- ✓ Onsite technical lead backed by local corporate IT staff

Figure 3. Telligen Information Management. ***Telligen IM provides broad support***

[redacted]

[redacted].

While the Agency will have the support of all our technology experts at Telligen's corporate office in West Des Moines, [redacted].

[redacted]. He has more than 15 years of experience in various software development roles, including development, project management, data analysis, and quality assurance. He has worked professionally with MS Visual Studio, .NET, Java, Javascript and numerous web technologies connected to databases MS SQL Server, Oracle, Teradata, DB2, MySQL, Postgres, Mongo, and ElasticSearch and helped build out infrastructure for in-house datacenters to Amazon Web Services.

[redacted] experience allows him to best support the three-tier structure of MQUIDS and QPS. These applications follow a client-server structure, with a thick client executable running on users' computers talking to a middle tier running on Microsoft IIS (Internet Information Services). The middle tier retrieves and stores data to a Microsoft SQL Server database, as we display in Figure 4.

[redacted]

Figure 4. MQUIDS/QPS Three-Tier Configuration. ***Applications follow a client-server structure***

[redacted]. There is a continuous process of managing the product backlog to identify the highest priority changes that need to be made. He collaborates with the QIO Services leadership team to set the priority and release schedules. Once the timeline and scope are determined, he will develop code updates and deploy them to the test environment. He will complete quality assurance and user acceptance testing in partnership with the QIO Services team to verify that new code enhancements are ready to be deployed to production.

We use a standard process for deployments to ensure alignment across the three-tier configuration. A successful deployment requires these four steps:

1. Request review and approval from Program Management
2. Coordinate with DDM Database Administrator
3. Coordinate with IIS Admin through [redacted] request through the IIS Admin Help Desk. This triggers the Development Team at the Hoover Building location to schedule the deployment changes in the application server

4. [redacted] will coordinate the needed changes with the Desktop Support team to update the end user desk top with the changes in MQUIDS or QPS

Once he has completed the deployment on production, the QIO Services team verifies that release, and considers that product release complete. This coordinated effort provides greater visibility for Agency and DDM staff.

Over the last six months, we have been able to regularly deploy a new release about every six weeks. In this time, Telligen has made over 100 enhancements to these two systems, at no additional cost to the Agency. Telligen does not submit ongoing contract change requests; we believe in doing the right thing that is best for our partner and the Medicaid members of our home state.

Technical leadership for the QIO Services team will also include [redacted] to provide strategic direction for the MQUIDS and QPS products. This IT leadership team will ensure product enhancements are in line with overall program and Agency direction, and that we follow development best practices to ensure we make high quality, efficient IT solutions available to our users. In addition, our IT leadership team can bring additional resources to support the Agency as the business needs require.

QPS and MQUIDS provide maximum flexibility for rapid deployment of changes to address new program requirements or priorities. **Since we developed the applications, we have the flexibility and processes in place to quickly respond to the Agency's changing needs and priorities.** Our dedicated team members work effectively with the DDM team today, and we can easily bring in additional local technical experts for both short and long-term projects.

3. The Contractor shall maintain all current program information within the Agency's computer network.

Maintaining integrity of program data is critical. We will continue to follow best practices to maintain all current program information within the Agency's computer network to ensure the integrity of the data housed in the Agency's data systems. Additionally, if at some point in the future the Agency decides to adopt a different hosting strategy, Telligen's technical capabilities support various hosting options to ensure all IT solutions align with the new strategy.

Preparing for the Future - Technology Matters

As the Agency continues to evaluate a move toward incremental Medicaid modernization, modularity, and component-based solutions, we are prepared to support the Agency in achieving these goals by including MQUIDS and QPS as part of the modernization effort.

MQUIDS and QPS are applications that meet the current needs of the QIO Services scope of work. As we look out over the next several years, there is an opportunity for the Agency to take advantage of technology improvements, as well as the modernization that occurs across the Agency.

The Agency has already begun migrating some services to the cloud. As the strategy for cloud-based modular solutions expands, MQUIDS and QPS could be included in that migration. Leveraging the management of data in the cloud, as well as ensuring full integration of these applications with other

cloud-based applications, will be vital to the continued maintenance and future enhancement of the QIO Services program.

Telligen is the right partner to collaborate with the Agency and determine the next generation of QIO Services software. There are a variety of approaches the Agency could take, and collaboration between Telligen and Agency IT leaders will lead to a smooth evolution in alignment with IT initiatives across the Agency.

We recommend as a part of the contract implementation, we set up a strategy session with all stakeholders to discuss future software needs. Understanding the Agency's vision and long-range plan will help ensure that the software can be effectively maintained and supported in alignment with IT solutions across the Agency.

One option for the future is to incorporate QPS and MQUIDS functionality into Telligen's Commercial Off-The Shelf (COTS) product called Qualitrac™.

Qualitrac is an integrated suite of products and features that support Agency personnel, providers, members, and Telligen operations staff. [redacted]:

Figure 5. QualiTrac components. ***QualiTrac provides an integrated platform or stand-alone modules, depending on customer needs***

[redacted] Table 4 highlights a sample of Qualitrac's features and the benefits each feature provides to Agency personnel, providers, or users.

Qualitrac Features	Benefits to the Agency
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

Qualitrac Features	Benefits to the Agency
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

Table 4. Qualitrac Features and Benefits

Access to Data for Agency Personnel

[redacted]

Figure 6. Program Summary Dashboard. ***Provides an up-to-date snapshot of activity***

We mention Qualitrac here for Agency awareness as a consideration for the future of the QIO Services program. There are many approaches to the future state, including maintaining the status quo. Reaching consensus about the strategy is the most relevant point. As technology changes, and as the Agency modernizes its MMIS environment, it will be beneficial to continually evaluate and innovate to advance the program for members and providers. We look forward to helping the Agency achieve those advancements.

4.1.3 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.

Daily, we will deliver any checks or money orders we receive related to our work to the Revenue Collections contractor's designated point of contact.

4.1.4 Appeals and Hearings

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.

We understand tracking and assigning appeals is an integral step in the appeal process that supports timely responses, efficient management and reporting of data. Our appeals database meets the Agency's operational requirements for tracking and assigning appeals related to the FFS population as well as Medicaid members enrolled in managed care and has served as the appeals data repository for more than 12 years.

State Fair Hearings

- ✓ Telligen has more than three decades of experience providing testimony at State Fair Hearings
- ✓ Our recommendations have resulted in changes to state systems
- ✓ Appeal workgroup discussions resulted in revisions to Iowa Administrative Code

Our recommendations have had lasting impacts on IME policy and administration. Our suggestions have resulted in changes in ISIS for the FFS population to include an appeal workflow and the development of a workgroup to review and update current Iowa Administrative Code (IAC) language related to Brain Injury diagnoses. This workgroup allowed our clinical staff to align policies related to identifying appropriate Brain Injury diagnoses with that of the Agency, resulting in a decrease in the number of Brain Injury Waiver appeal requests.

We have built a collaborative relationship with the Iowa Department of Inspections and Appeals (DIA) to gain a comprehensive understanding of the appeal process. In Iowa, the Appeals Information System (AIS) managed by DIA generates all appeals. AIS is the document repository where all information related to appeals is stored for review by Agency staff, Administrative Law Judges (ALJ) and DIA personnel.

Our medical and professional staff, including internal and external consultants, promptly and effectively manage this process and will continue to support the Agency in responding to appeals using Agency defined timeframes and protocols. We currently possess, and will maintain, a specialized appeals unit responsible for representing the Agency in State Fair Hearings. Our support staff will continuously monitor the IME appeals mailbox for new appeals. When we receive appeal information, we will review the information in AIS to determine which department is responsible for representing the Agency in the Appeal. We assign all appeals outside our scope of work to the appropriate unit. We will communicate appeal information, including hearing date and supporting documentation, to the appropriate IME unit and Agency personnel responsible for the program. We will track the appeal information for both the FFS and MCO populations in our appeals database within one business day, including:

- Appeal type
- Status
- Outcome

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

Appeal activity reports provide policy makers with a snapshot of client satisfaction and the effectiveness of review decisions. This information allows the Agency to see if our staff are following Agency recommendations and the Iowa Administrative Code while keeping with current medical standards of care. Telligen professionals will maintain a comprehensive reporting system for all types of IME appeals. We will expand on our current reporting process by developing a comprehensive report detailing appeal information, including the status and disposition of each case as well as appeal trends, and submit the report to the Agency on a quarterly and annual basis. Our updated report will also include recommendations for policy changes identified by our review team. Our current appeals database has the capability to distinguish between appeal types which will allow for a breakout analysis of appeal hearings for LOC, NBA determinations and PAs. We can quickly and easily modify our appeals database to capture additional reporting parameters if needed, along with real-time reporting capabilities. Please refer to the sample Appeals reports in Figure 8. The reports allow the Agency to hover over the results for a summary (shown below) and to click for details about the data.

Figure 7. Appeals and Hearings Workflow. ***Telligen has experience supporting the Agency during the appeals process.***

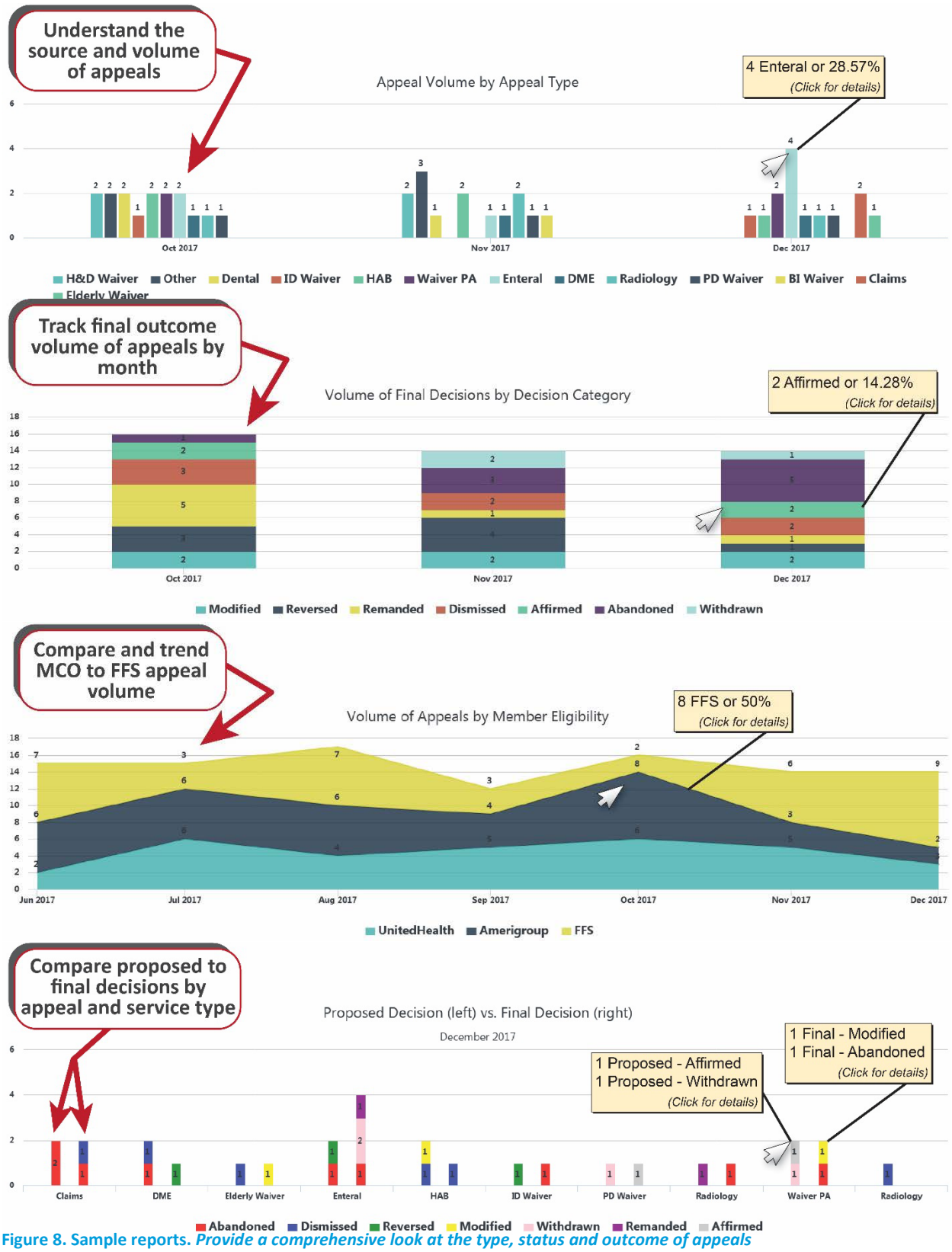


Figure 8. Sample reports. ***Provide a comprehensive look at the type, status and outcome of appeals***

We will report and analyze trends related to all appeal activity, including the outcomes of certain appeal types. Based on our analysis, our leadership team will provide recommend any needed changes in policy or processes to the Agency to ensure we collect the appropriate information. We will compare numbers in each appeal type to data from the prior year to identify trends. This will help to reduce the number of reversals when problem areas become apparent.

Our leaders understand the importance of monitoring trend areas related to appeal hearings. Our leadership team has presented recommendations to the Agency to address concerns identified during the appeal process.

Based on comments made by ALJs during the appeal process, Telligen and Agency leadership developed new language to update Iowa Administrative Code to require the use of the Core Standardized Assessment (CSA) forms for the level of care review process. Until the state updated the Iowa Administrative Code with the new language, our clinical staff obtained both the CSA and Physician Certification Form to support our LOC decisions and uploaded both to AIS for review by all parties involved in the appeal process. We also developed informational letters to provide direction on specific requirements related to the appropriate CSA to be used for determining LOC. Our leadership group kept the Medicaid Director apprised of activities throughout the process.

Recommendations have resulted in changes to the Iowa Administrative Code language for covered or non-covered services, as well as changes in program or service coverage. For example, the Agency instituted an updated psychological evaluation process to more accurately meet DSM-V criteria supported in the Iowa Administrative Code used during Intellectual Disability Waiver appeal hearings.

Telligen Internal Quality Improvement

Telligen makes efforts to ensure continuous quality improvement in our operational procedures by actively involving all team members responsible for appeals in discussions related to business process improvements. We created an appeals team comprised of team leads in all areas of our scope of work. These leaders meet monthly to discuss concerns and quality improvement strategies. One area identified in need of change was the appeal case summary. (It was lengthy and contained duplicative information.) Our leadership worked with the newly developed appeals team for the development and implementation of a new summary template that is easy to complete. The changes have also proved to be easier for members, providers and other appeal participants to follow. The changes allow transparency and more effective communication. This also reduces the time involved in developing the case summary and eliminates duplicative statements. In addition, our leadership team met with DIA personnel to identify and remediate gaps in communication related to the appeal process resulting in a leaner, more timely process.

We believe in this self-improvement process. It has improved operational efficiency, staff morale and member satisfaction. We look forward to continuing our collaborative appeal process with the Agency and using data to deliver services that are geared to meet Agency established goals.

We will provide this same high level of support and dedicated personnel to all appeal activity under the new QIO Services contract.

3. The Contractor shall provide medical expertise and necessary assistance in any stage of the appeal process concerning Contractor's findings that result in an appeal, including but not limited to:
a. Research issues as necessary;
b. Provide administrative support in preparing for and participating in appeals;
c. Provide written statements;
d. Provide expert testimony where appropriate to defend Agency decisions; and
e. Review ALJ decisions to determine if a Director's review of reversed decision is warranted. If warranted, prepare documentation for Director's review and submit within 10 days of receipt of the ALJ decision.

Our professional and clinical staff will assist the Agency in all stages of the appeal process by retaining subject matter experts in all areas defined in the scope of work. As complete and thorough documentation is critical to support our decisions, our review team will conduct research on each case by reviewing applicable state and federal requirements, and consulting with medical professionals, Agency personnel, case managers and providers as needed. Appeals are an important mechanism to ensure we make review decisions accurately based on current standards of care and in line with the Iowa Administrative Code.

We will provide administrative support in preparation for and participation in appeals by reviewing all appeal requests to determine which IME unit is responsible for the appeal. As noted previously, if the appeal is related to activity outside of the QIO Services scope of work, we will notify the appropriate IME unit of the appeal and provide all relevant documentation.

If the appeal is within our scope of work, our administrative support team will retrieve appeal documents and submit to the review coordinator (RC) who will complete the case summary.

We will research the case to validate that we made the correct decision. Often the request for appeal contains additional information that was sought but not received during the initial review process.

When an appeal request includes additional information, a physician reviewer reviews the requested service to determine if the new information alters the original decision. If the physician reviewer reverses the original denial decision, we inform the provider, member, member representative, ALJ and Agency staff in a written Dismissal Summary letter.

As part of the review process, we will provide written statements, including a case summary that outlines details of the case, to Medicaid members and their representative(s). The written statements will include applicable state and federal guidelines related to the appeal as well as detailed medical documentation to support our rationale for denial. We write our case summaries, as well as other documentation, in plain language so Medicaid members can understand our reason(s) for denial. Within 10 business days of the appeal notification, our administrative team will upload all documentation necessary to support our decision to AIS and mail copies to the Medicaid members and their representative(s). This will include the case summary, CSA, IAC reference(s), clinical criteria and PA forms.

We acknowledge it is our responsibility to provide expert testimony in respect to best practices, current standards of care, medical necessity, URAC guidelines, and the reason/rationale for the denial to defend the Agency's decision during appeal hearings. Paula Motsinger, our Medical and LTSS Operations

Manager and clinical team will review the file contents prior to our submission of appeal documentation to AIS. In the event the ALJ reverses the Agency's decision, Ms. Motsinger will review the digital hearing files to determine if it warrants a director review or staff need additional training. If we determine it warrants a director review, we will prepare a letter requesting a director review and submit it to the review committee within 10 days of receipt of an ALJ decision.

We have represented the Agency in managing the appeals process for more than 30 years. In FY17, our clinical staff provided 559 case summaries and represented the Agency in more than 472 hearings.

4.1.5 Quality Improvement and MCO Quality Oversight

For a QIO Service program that aligns with CMS Quality Strategy goals, it is important that the successful vendor's quality improvement efforts be member-centric. This means that team members should be proactive in identifying ways in which they can better deliver services to the Agency, improve program operations to minimize and mitigate health and safety risks to members, and ensure that members are always valued participants in decisions that affect their care.

Quality is synonymous with Telligen; it is a core value all Telligen team members and employee-owners embrace and practice. In the context of this scope of work, quality improvement means evaluating the efficiency, effectiveness, timeliness, quality, and accuracy of our work. We do this by capturing and monitoring internal metrics such as response time to address Agency requests, turnaround time for reviews, and our team members' ability to streamline processes that can improve operational efficiency. We also assess operational processes through reports and other indicators to identify opportunities for improvement.

Quality Mindset

- ✓ We played a key role in helping the Agency effectively conduct quality oversight of each MCO through the review of service plan reductions and CBCM ride-along activity
- ✓ Our professional staff have nearly 400 years of hands-on experience working with Medicaid members in the areas of HCBS/LTSS, case management and behavioral health.
- ✓ We have helped the Agency effectively manage and conduct quality oversight of home health and integrated health home programs.
- ✓ Since 2012, we have provided quality oversight and technical assistance to HCBS waiver and habilitation providers. Our collaboration with HCBS providers has resulted in increased compliance with regulations, as well as promotion of the health and safety of Medicaid's most vulnerable members.
- ✓ To help the Agency evaluate MCO performance, Telligen physicians evaluated MCO efforts documenting and collecting information associated with quality metric development. This ensured they were aligned with national standards and identified potential delivery issues.

When quality issues do arise, we address them quickly through ongoing training to help enhance knowledge and skills, as well as improve individual and organizational performance. Our goal is to seek challenges and address them quickly so they do not impact our ability to fulfill contract deliverables.

In addition to improving the quality of our own work, we have been tasked with overseeing MCO quality activities. This has involved continued collaboration with the Agency to improve our processes related to IDT Ride Along and Service Plan Reduction activity for MCO enrolled Medicaid members using Medicaid 1915(c) Waivers and 1915(i) State Plan Habilitation Services. Originally a CMS requirement as part of the

state's transition to managed care in 2016, the state asked us to lead this process. Our participation in the IDT Ride Along Activity ensures Medicaid members are offered the opportunity to participate in a person-centered process where their individual desires and outcomes are addressed. As part of this process, our experienced personnel participate in IDT meetings and monitor subsequent written person-centered services plans to ensure they are consistent with the services agreed upon during the IDT meetings. As part of the Service Plan Reduction activity, we review a representative sample of service plan reductions to determine if the decision to reduce services for Medicaid members is supported by the rationale provided.

Our work in this role has allowed us to strengthen relationships with the Agency and MCO leadership. In addition, we have helped MCOs understand the importance of person-centered planning and have seen improvements in the written service plans and subsequent documentation to support service reductions. Most importantly, it has provided opportunities for us to advocate for some of the state's most vulnerable Medicaid members.

In the following three sections, we describe our internal quality control (IQC) and continuous workflow analysis processes.

1. The Contractor shall implement quality improvement procedures that are based on proactive improvements rather than retroactive responses. The Contractor must understand the nature of and participate in quality improvement procedures that may occur in response to critical situations and shall assist in the planning and implementation of quality improvement procedures based on proactive improvement. Duties include but are not limited to:
a. Monitor the quality and accuracy of the Contractor's own work.

Continuous quality improvement is a key function of our overarching quality management process. It encourages our team members to frequently ask the questions "How are we doing?" and "Can we do it better?" By implementing these consistent checks, we can quickly and proactively address challenges that arise and ensure they have zero negative impacts to overall contract operations.

Telligen currently monitors the quality and accuracy of our work through our Internal Quality Control (IQC) program in six areas of our own work (Figure 9).

Figure 9. IQC Process. ***Our process evaluates our team members' work across our six focus areas***

Operations managers in each of the six areas review their team members' work using the following five critical questions as shown in Figure 10.

Figure 10. Five questions. ***Operations uses these five questions to evaluate team members' work as part of our IQC process.***

In addition to the evaluation questions, as well as peer-to-peer IQC reviews that address quality of review decisions, we recently implemented the use of daily dashboards on performance deliverables by to identify efficiencies and monitor compliance with timeliness. The dashboards identify the number of reviews being completed, as well as weekly and monthly reports on contract deliverables. If we identify any area of work that is not meeting contract requirements, operations managers meet as a group to discuss findings and identify process improvements. The results of the IQC are then shared by managers with their respective teams. Once the group-share is complete, the Medical and LTSS Operations Manager conducts a second level review with a focus on areas in need of improvement, including system changes and training modules for staff. This process has benefited our teams by ensuring a greater understanding of expectations related to our scope of work. Ensuring consistency between reviewers may also reduce appeals.

IQC is a crucial step in making sure we are meeting contract goals. By continually evaluating our teams' performance and identifying potential problem areas, we can positively impact our ability to meet the Agency's performance standards. ***We will continue to follow our IQC strategy as part of the new QIO Services contract to monitor quality and accuracy of our own work. In addition, we plan to expand our IQC in multiple areas, including PACE onsite review activity, Community Neurobehavioral Rehabilitation Services (CNRS) and Appeals to ensure the implementation of new processes is consistent with the needs of the Agency.***

Standardizing our IQC

✓ We recently updated our IQC process to increase consistency with IQC review activity, eliminate repetitiveness and reduce time required to complete IQC activities. Our IQC template with the five questions described in Figure 10 is applicable to each operation component in the scope of work.

b. Perform continuous workflow analysis to improve performance of Contractor functions and submit quarterly reports of the quality assurance activities, findings and corrective actions (if any) to the Agency electronically.

Continuous workflow analysis allows us to evaluate our processes, and modify or remove steps that cause errors or inefficiencies. This aligns with our quality management approach, and IQC programs, as it improves visibility into key processes at every point – allowing us to identify issues, develop solutions and improve efficiency throughout the contract.

Our process on this contract will include:

- **Performing continuous workflow analysis to improve the performance of our functions** – Our Account/Transition Manager and our Medical and LTSS Operations Manager will lead weekly lean process meetings with each team to evaluate current workflow, identify efficiencies and streamline improved performance of day-to-day functions. The goal is to identify opportunities for improving accuracy, efficiency and compliance with contract requirements.

  Discussion topics during the weekly meetings will include: (1) system and process review; (2) workflow statistics, as well as any problems or issues that teams have encountered; and (3) review the impact of activities or improvements that our teams have previously implemented.

  We expect all team members to contribute to the information we review in these meetings by logging issues or problems, as well as ideas for improvement and best practices. We have found that by engaging individuals who are closest to the work, we gain a more comprehensive understanding of specific tasks and processes, which allows us to pinpoint and address inefficiencies more quickly. For example, in one meeting, we determined HCBS nurse reviewers were documenting a significant amount of information that was not necessary for the review process. We ultimately eliminated the excessive and unnecessary documentation.

Identifying Efficiencies and Improving Workflow

- ✓ Developed and implemented algorithm to determine acuity tier for ID Waiver recipients
- ✓ Developed process to automate level of care information that expedites the LOC process
- ✓ Developed and implemented template for IQC, removing duplicative data
- ✓ Developed electronic review process for the inpatient psychiatric admissions and provides the state with direct access to decisions in MMIS
- ✓ Developed new template for State Fair Hearings, which reduced duplicative language and time to complete summaries by approximately 10 hours per week
- ✓ Developed consistent process for determining level of care and adhering to IQC, which has reduced the number of appeals, and improved consistency and quality in the review process
- ✓ Developed a medical library to house the most up-to-date, CAC-approved clinical criteria to ensure consistency for level of care across all teams
- ✓ Met with MCOs to review document submission approach and reduce submission time from weeks (and sometimes months) to several days
- ✓ Worked with Data Warehouse to interface ISIS with MQUIDS, which reduces the need for manual entry for level of care review, and allows the Agency to more easily compare member names and state IDs

- **Submitting quarterly reports of quality assurance (QA) activities, findings and corrective actions –** Managers will evaluate operational performance data from OnBase, MQUIDS, QPS and additional data sources weekly, paying specific attention to any trends or patterns that would necessitate more in-depth analysis and possible corrective action. Each month, program managers will submit all operational performance data to the Medical and LTSS Operations manager, who will aggregate the information into a quarterly report, which will address all contract performance measures. The report will also include: (1) a summary of all quality assurance activities performed during the quarter; (2) findings identified during the quarter, along with process changes resulting from the findings; and (3) any corrective actions implemented based on quality assurance data.

  We will provide this comprehensive report to the Agency each quarter in electronic format.

c. Provide the Agency with a description of any changes to the workflow for approval prior to implementation.

The Agency holds the largest view of the management of the Medicaid program and needs to be apprised of changes that could have far-reaching impacts. Should the need arise for us to modify an operational policy or workflow, we will provide the Agency with a description of the proposed change along with an explanation for why the change is needed and the benefits the change will provide. We will submit this information to the Agency for approval prior to implementation.

When changes arise, we will provide the Agency with the reason and rationale, as well as how the change will make the process more efficient, and potentially save costs. We will update the Agency as changes progress, as well as communicate any timelines associated with the changes. Once all changes are complete, we will update all operational procedures and desk guides.

When workflow changes arise under our current contract, we exceed expectations and promote overall efficiency for the Agency by communicating workflow changes to other impacted parties such as CORE and Data Warehouse – the latter because process changes sometime often involve IMPA, ISIS or OnBase. We have worked closely with the data warehouse to implement a process where providers can submit information electronically, e.g., care plans documents and those documents required for review activity, prior authorizations and claims, via the IMPA portal instead of faxing, which is laborious for the provider.

In another instance, we collaborated with another Data Warehouse and CORE to develop the coding processes on the back end of IMPA and ISIS so that the two applications can interface and work together, as well as with MQUIDS (to initiate reviews) and SIS Online. This eliminates manual data entry errors and facilitates transparency in our review process by enabling the Agency to view information in real time.

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.

As part of the person-centered planning process, Medicaid members must be provided the opportunity to make decisions regarding their care, including the reduction, suspension or termination of services. Decisions regarding their care must involve the interdisciplinary team and be identified within the person-centered plan of care. Currently, the Agency requires each MCO to submit a monthly AccQual A-15 report, which identifies reductions, suspensions or terminations of services for members utilizing HCBS Waivers and/or State Plan Habilitation Services. MCOs are also required to upload person-centered plans of care to IMPA for review.

AccQual A-15 Reporting

- ✓ Telligen played a key role in developing and implementing the current STC AccQual A-15 reporting process.
- ✓ Ongoing collaboration efforts continue with each MCO to identify and remediate risk areas for Medicaid members.
- ✓ Co-location provides ideal work environment for continuous quality improvement
- ✓ To date, Telligen has reviewed more than 600 care plan reductions.
- ✓ Current plans include the implementation of remediation efforts to ensure continuous quality improvement.

According to CMS' Special Terms and Conditions (STC) for Iowa's 1915(b) Waiver, Telligen will review a representative sample of the LTSS plans of care as submitted by each MCO for members enrolled in managed care who have had services reduced.

ii. Receive a monthly service plan reduction report from each of the MCOs documenting any reductions they have made in the past month;

As part of the review process, MCOs will send Telligen their monthly AccQual A-15 service plan reduction report, which documents all reductions, suspensions and terminations from the previous month. Within two business days of receipt, we will select a representative sample of care plans to be reviewed and submit the AccQual A-15 report, identifying the selected Medicaid members, to the Agency's Managed Care Bureau.

The Agency's Managed Care Bureau will share the representative sample with each MCO. After each MCO receives the AccQual A-15 report identifying the selected members, they will upload the most recent assessment of need, notice of action (NOA) and person-centered plan of care to IMPA. Each MCO will submit the report back to the MCO Bureau and include the rational for reduction, suspension or termination of services to be reviewed.

iii. Request additional information from a representative sample of these service plan reductions;

Prior to initiating the review, our senior review coordinator will review all documents in IMPA to ensure all supporting documentation is present. Required documentation includes a NOA, current core standardized (or department approved) assessment, and written person-centered care plan.

If additional information is needed, we will contact the appropriate MCO personnel, via secure email, to request the information be submitted within two business days. If the MCO does not submit the requested information within two business days, we will notify the Agency's Managed Care Bureau and request that they contact the MCO to request the information.

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.

Our approach to validate the reduction in services by the MCOs begins with comparing the written person-centered plan of care to the assessment results to ensure service needs identified within the assessment are included in the plan of care. We will also review the NOA to determine if the reduction, suspension or termination of services is appropriately identified within the NOA, to ensure that timely notice was provided to Medicaid members and their providers.

The third step in our process is to review the AccQual A-15 report and supporting documentation to determine if the rationale submitted by the MCO is consistent with the reduction, suspension or termination of services. We will determine if reductions, suspensions or terminations are permissible under state and federal laws, terms of the contracts between the MCO and DHS, and supported by best practices as determined by the Agency.

If, during the review process, we determine there are potential health and safety risks to the Medicaid member, we will communicate our concerns to the Agency in person within one business day and follow up with the MCO representative via conference call to communicate concerns the same day.

Following review of all supporting documentation, using criteria developed collaboratively with the Agency, we will determine whether the MCO submitted enough documentation to support their rational for reduction, suspension or termination of services. We will also determine if each MCO completed the AccQual A-15 report accurately and timely and include our findings in the report to the Agency.

Following a quality assurance review by leadership, we will submit the AccQual A-15 report to the Agency by the 10th business day of each month. The AccQual A-15 report will include potential health and safety risks for Medicaid members, recommendations for remediation and identified strength areas for each MCO.

As a value-added service, Telligen provides the following monthly report (Figure 11) to the Agency, identifying trends related to MCO care plan reductions as well as recommendations for continuous quality improvement. We will continue this value-added reporting process to support MCO quality improvement activities.

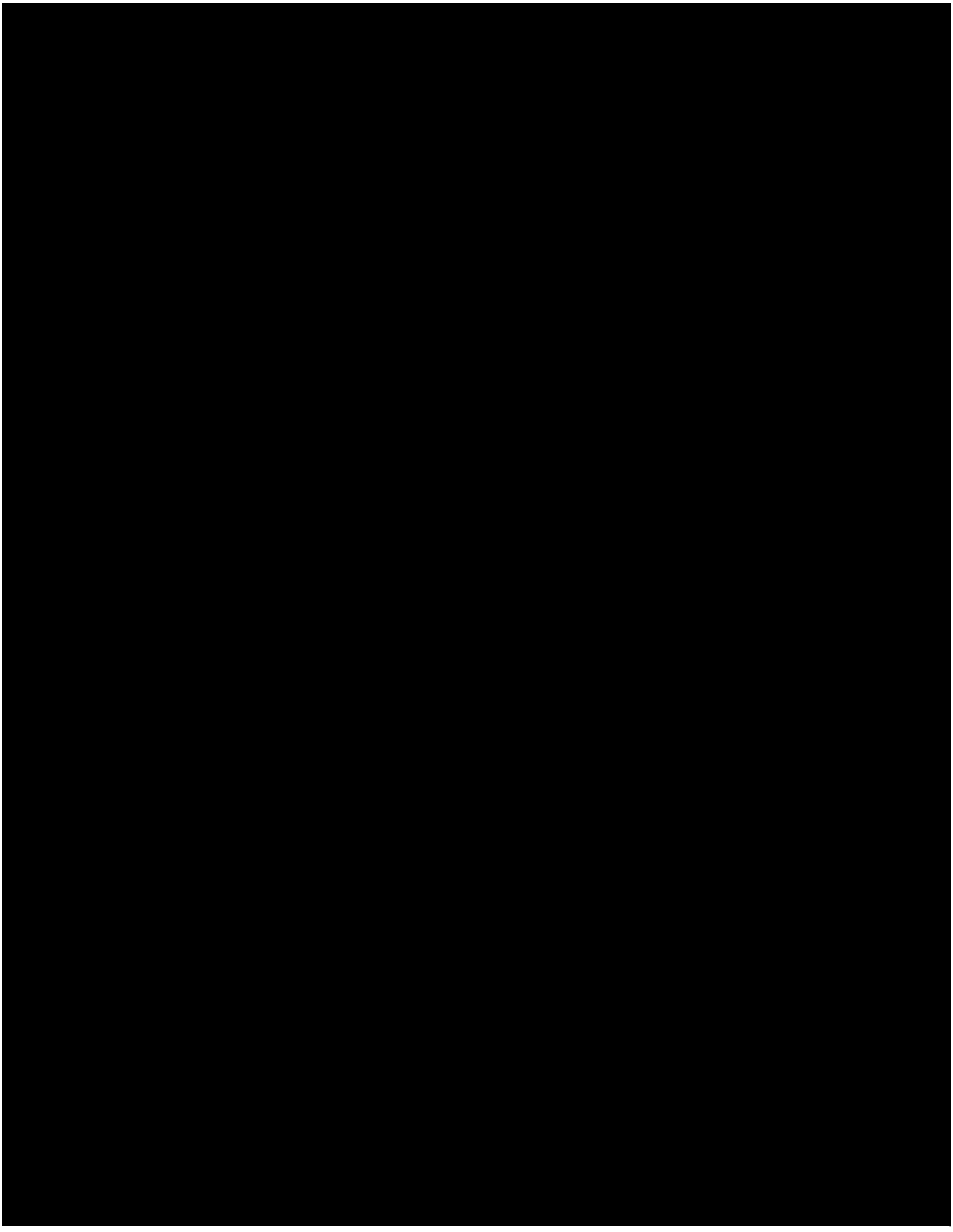


Figure 11. Monthly Report. ***Report identifies trends and recommendations for improvement***

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.

Person-centered planning is one of the most important components of waiver services. The person-centered planning process ensures that the member and the member's selected team have a voice in developing the service plan. HCBS waiver members are a vulnerable population and it is imperative that the members have a team assisting with advocacy and service planning.

The approach we have taken to the MCO IDT Ride Along is to ensure the components of person-centered planning are present during the IDT and include:

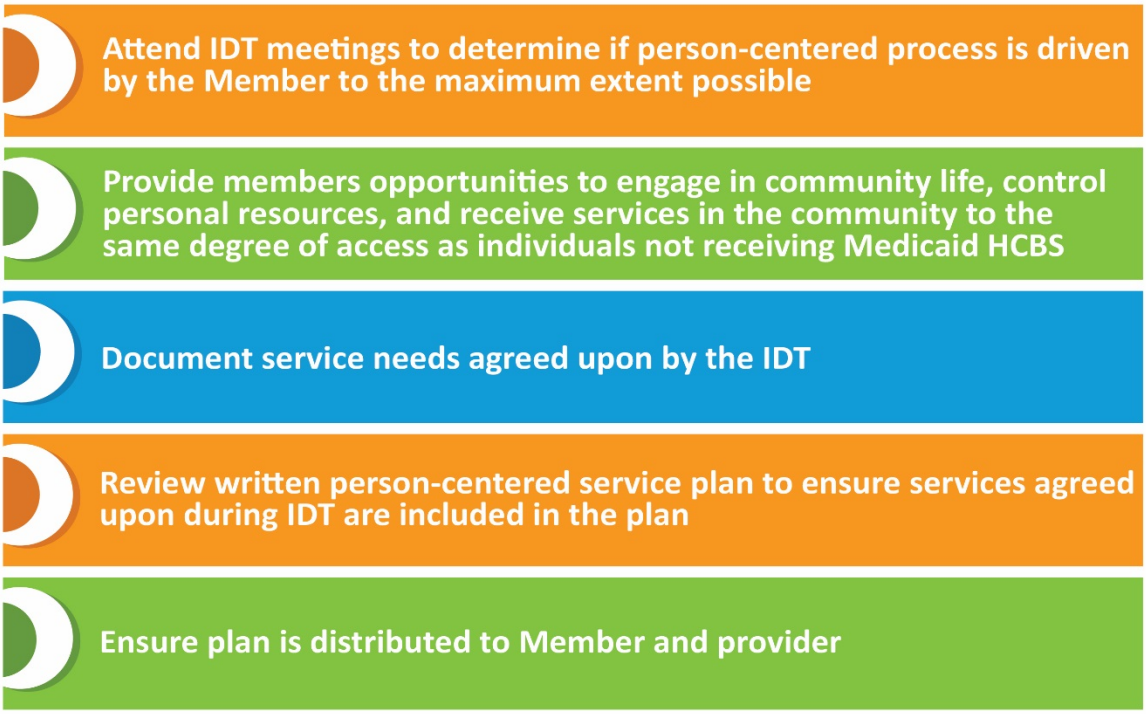


Figure 12. MCO IDT Ride Along. ***The process focuses on person-centered planning.***

Telligen worked with Agency policy staff and the Division of Mental Health and Disability Services (MHDS) to develop an Agency-approved tool to collect the data during the MCO IDT Ride Along. The following is the data collected by the tool.

Date:
MCO: Select
Reviewer: Specialist name
Date report completed:
Case Manager:
Community Based Case Manager:
CM/CBCM Contact information:
How long has this CBCM worked with the member?
Member State ID:
Provider Name:
Provider Contact:

Services the member will be receiving that were identified during the IDT meeting: ?

The following needs were addressed during the meeting:

Medical	Yes ☐	No ☐	
Behavioral	Yes ☐	No ☐	N/A ☐
Social	Yes ☐	No ☐	
Educational	Yes ☐	No ☐	N/A ☐
Housing	Yes ☐	No ☐	N/A ☐
Transportation	Yes ☐	No ☐	N/A ☐
Vocational	Yes ☐	No ☐	N/A ☐
Safety Plan	Yes ☐	No ☐	
Other Services:	Yes ☐	No ☐	

Comments:

Member's history was included:

Current Information	Yes ☐	No ☐	N/A ☐
Past information	Yes ☐	No ☐	N/A ☐
Social History	Yes ☐	No ☐	N/A ☐

Comments:

Information gathered from other sources:

Member	Present ☐	
Family members	Present ☐	Name(s)/Relationship
Medical providers	Present ☐	Name(s)
Social Workers	Present ☐	Name if different than above
Providers	Present ☐	Name(s)
Legally Authorized Representatives	Present ☐	Name(s)
Others	Present ☐	Name(s)

Comments:

Plan addressed the following needs:

Where to Live	Yes ☐	No ☐	N/A ☐
Where to work	Yes ☐	No ☐	N/A ☐
Relationships	Yes ☐	No ☐	
Adequate formal supports	Yes ☐	No ☐	
Adequate informal supports	Yes ☐	No ☐	
Safety Plan	Yes ☐	No ☐	
Physical Health Including diet, dentist etc.	Yes ☐	No ☐	
Behavioral Health inc. Mental Health and Substance Use Disorder	Yes ☐	No ☐	N/A ☐
Discharge plan	Yes ☐	No ☐	
Others:	Yes ☐	No ☐	

Comments:

The following guiding principles were evident:

Person centered planning	Yes ☐	No ☐
Olmstead	Yes ☐	No ☐
Strength based	Yes ☐	No ☐
Holistic approach incorporating spirituality, leisure, exercise etc.	Yes ☐	No ☐

Figure 13. Data Collection. ***Data collected through an Agency-approved tool***

We attend the member's scheduled MCO IDT and observe the Community Based Case Manager (CBCM) meeting with the member. We are there to assure the components of person-centered planning listed above are present. We verify that pertinent information such as medical, behavioral, social and holistic needs is addressed during the IDT.

Our approach to completing the work includes the steps in Figure 14.

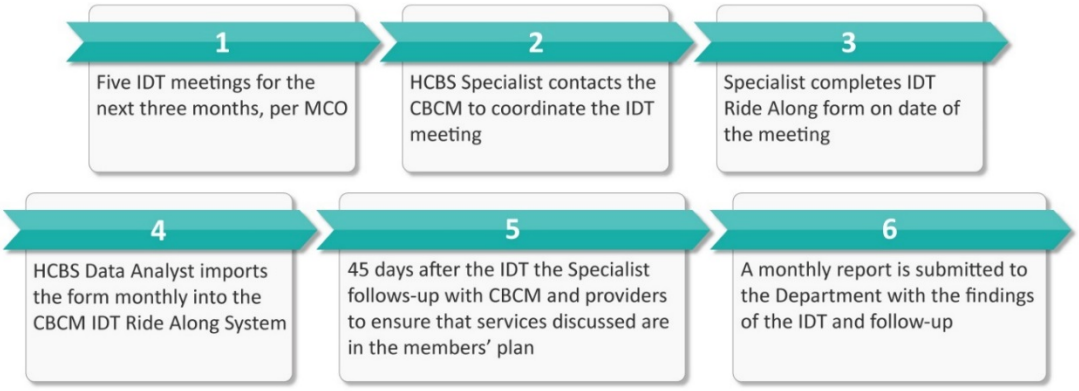


Figure 14. MCO IDT Ride Along Approach. ***Ride along provides check on person-centered planning.***

Value-added Service

In addition to meeting the requirements specified in the RFP, Telligen is also conducting follow-up reviews of each member's service plan from the MCO IDT Ride Along reviews. We want to ensure the agreed-upon services, as well as the number of units, are included in the service plan. Our process for doing this includes:

- Forty-five days after we attend the IDT, Telligen will contact the CBCM and request a copy of the member's person-centered service plan. The specialist will document on the MCO IDT follow up form whether all services discussed during the IDT Ride Along are included in the members person-centered service plan.
- The HCBS specialist will also follow up with the providers listed in the member's service plan to ensure they received a copy of the person-centered plan, assessment, and the CDAC agreement if applicable.
- We will complete a monthly report on the findings of both the initial IDT and the follow up, and then submit it to the Agency.

4.1.6 Performance Reporting and Corrective Actions

1. The Contractor shall submit monthly performance reports using an Agency-approved format, similar to the sample in Attachment 3.4, detailing all deliverables and performance measures that have been met or unmet during the month. This report shall be submitted with the monthly invoice.

Included with the monthly invoice, we will submit a performance and deliverables report electronically or as designated by the Agency. The report will include a detailed description of all activity related to performance and deliverables within the scope of work. The report will also outline areas where we

meet and exceed expectations. In the event we are unable to meet performance expectations, a detailed explanation, as well as a remediation plan, will be provided to the Agency.

As the current Medical Services and HCBS contractor, we have a proven track record of meeting or exceeding performance standards. As a trusted partner, we will continue to commit the necessary resources to ensure all performance standards are met timely and accurately.

Rick Riley, Account Manager and Paula Motsinger, Medical and LTSS Operations Manager will closely monitor all activities and deliverables to ensure performance measures are consistently met or exceeded. Ms. Motsinger and our IT staff will collaborate with other IME vendors to develop, enhance and maintain processes to query data within the current IME structure including QPS, OnBase, ISIS and MQUIDS to perform analysis that will produce data driven results.

2. The Contractor shall provide written notification to the Agency within two business days of discovery of any problems, concerns, or issues of non-compliance.

Using daily, weekly and monthly performance dashboards, we continuously measure our own performance. We identify opportunities for improvement based on our analysis of performance results and implement changes designed for improvement. We will rigorously apply this approach to ongoing performance monitoring and improvement to all contract activities. We will look for trends to identify developing patterns that may adversely impact our ability to meet performance expectations. We will address any problem trends immediately through process changes designed to reverse the trend and avoid a problem before it impacts our ability to meet expectations defined by the Agency. If we identify concerns, we will notify the Agency in writing via email, face-to-face discussion and provide reports within two business days of discovery. Included in the notification will be a recommendation and plan for business process improvements and remediation activities. We pride ourselves in our ability to anticipate and remediate problems related to our work.

3. The Contractor shall maintain records of such reports and other related communications issued in writing during the course of Contract performance.

Using the IME infrastructure, we will maintain records of all reports and related communications throughout the course of the contract in a secure location. The Agency will have full access to this information. We will store data we have extracted from Agency data bases to generate the QIO program and final reports in the Telligen folder located in the secure shared IME Universal and Medical Services drives for Agency visibility and retrieval. Additionally, we will follow the Agency's documentation policy for managing data and reports in support of the QIO Services program.

4. The Contract Owner has final authority to approve problem-resolution activities.

The values that drive Telligen as a leader in healthcare management also drive our commitment to continuous process and quality improvement. Based on more than 30 years' experience in both the Medical Services and HCBS scopes of work, our leaders will bring creative ideas for problem resolution to the Agency for final approval. We acknowledge the Agency has final authority to approve or reject all corrective actions we propose. If the Agency does not accept a proposed corrective action plan, we will collaborate with the Agency to develop an acceptable action plan.

5. The Agency's acceptance of a problem report shall not relieve the Contractor of any obligation under this Contract or waive any other remedy. The Agency's inability to identify the extent of a problem or the extent of damages incurred because of a problem shall not act as a waiver of performance or damages under this Contract.

We acknowledge the Agency's acceptance of a problem report does not constitute a waiver of performance requirements or damages under the contract.

6. To the extent that Deficiencies are identified in the Contractor's performance and notwithstanding other remedies available under this Contract, the Agency may require the Contractor to develop and comply with a corrective action plan to resolve the Deficiencies, subject to Agency approval.

Our Internal Quality Control (IQC) process encourages all team members to monitor our business process and develop and execute strategies to become more efficient. Should any area of our performance fall below Agency-identified performance levels, we will develop a corrective action plan to address the performance gap and submit the plan to the Agency for approval. Through our IQC process, we will use quality improvement strategies to identify barriers in existing workflow processes and develop solutions to mitigate the barriers. If the proposed solution(s) does not improve performance, we will implement another solution, evaluate the impact, and document the results. We will report improvement and remediation steps relative to the corrective action plan to the Agency in timeframes defined by the Agency. We will continue to provide periodic updates to DHS regarding the identified problem and our corrective actions until we have resolved the deficiency.

4.1.7 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.

Prompt Response

- ✓ Telligen currently responds to requests within 24-48 hours
- ✓ Telligen promptly responds to RFIs for MCO related questions

Telligen will respond to all Agency requests including FOIA, RFIs, Open Records Act requests and miscellaneous requests within Agency-specified timeframes. We carefully evaluate the request to ensure we understand exactly what is being requested, query any needed data, interview any involved parties, compile results, review for QA, and present the results to the Agency. We have a unique ability to respond to the Agency's request within shorter timeframes than other vendors due to our institutional knowledge and established best practices.

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

We will respond to all Agency requests including FOIA, RFIs, Open Records Act requests and miscellaneous requests within Agency-specified timeframes. We carefully evaluate the request to

ensure we understand the request, query any needed data, interview any involved parties, compile results, review for QA and present the results to the Agency. We have a unique ability to respond to the Agency's request within shorter timeframes than other vendors due to our institutional knowledge and established procedures.

4.1.8 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 recognize the importance of accurate and timely communication to the Agency and communication with Medicaid members and their authorized representatives, as well as Agency staff, providers, facilities, and other IME vendors. We will staff, maintain and respond to inquiries we receive via centralized email mailboxes and toll-free lines for communication with Medicaid members and/or their authorized representatives, providers and facilities as needed to support all activities specified in the scope of work. This includes inquiries related to prior authorizations, claims, pharmacy, facilities, 1915(c) Waivers and 1915(i) State Plan HCBS, and both HCBS and non-HCBS providers.

As the current Medical Services contractor, we have established communication protocols that work well with the Agency. We proofread correspondence and email to assure accuracy prior to sending. Our staff uses scripts to address incoming and outgoing calls to providers and other stakeholders. We educate our staff regarding these protocols, and follow established processes and lines of communication with Medicaid members, authorized representatives, providers, facilities and other IME vendors.

Our staff may be reached by telephone, fax or e-mail during regular business hours, following the Agency holiday schedule. We will retrieve messages from the centralized, secure voicemail boxes throughout the day. Staff will respond to centralized email and voicemail boxes promptly and periodically throughout the business day. Staff will respond to provider and member questions, about the review process and/or status of admission or continued stay reviews within one business day. We presently exceed the contract expectation of two business days and will continue to do so.

Centralized voicemail and email boxes currently include, but are not limited to:

- Exception to Policy
- Appeals
- LTSS level of care including all waivers and facilities
- PACE
- Prior authorization
- HCBS
- Incident reporting
- Slot management

We will review all of these communications protocols and established lines of communication at the onset of the new contract. As necessary, we will work with the Agency and other vendors to ensure that our processes are collaborative and support the QIO functions. Our full leadership team will review all revisions to protocols and process and provide them to the Agency for approval prior to implementation.

2. The Contractor shall track and log communications within IME systems.

Telligen will log and maintain communication records within the IME systems including ISIS, OnBase, IMPA, MMIS and MQUIDS as required by the Agency.

3. The Contractor shall monitor the quality and accuracy of the Contractor's communications in accordance with the Agency-approved quality assurance plan.

We recognize the importance of quality and accurate communication for members and Agency stakeholders. We proofread all correspondence and email to assure accuracy prior to sending. Our staff uses scripts to address incoming and outgoing calls to providers and other stakeholders. We educate our staff regarding these protocols, and follow established processes and lines of communication with Medicaid members, authorized representatives, providers, facilities and other IME vendors. We will monitor the quality and accuracy of all communications through the audit activity included in our internal quality control process. Our leaders are dedicated to continuous quality improvement activities and work to ensure all staff are fully trained on all systems before working with members, authorized representatives, and providers.

4. The Contractor shall submit a report to the Agency on management of communications, to include timeliness and accuracy of responses, on a quarterly and annual basis.

Telligen will submit quarterly and annual reports to the Agency detailing communication efforts. We will submit timely reports that include aggregate data relative to the timeliness and accuracy of our responses, including telephone statistics on levels of incoming calls, abandonment levels and response levels. We will also proactively identify communication trends and provide recommendations for changes or enhancements based on those trends.

4.1.9 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 will not reference Telligen in any deliverables associated with the contract and will not mark them as confidential or proprietary.

4.2 TRANSITION (RFP 1.3.1.2)

4.2.1 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;

Transition Plan

[redacted]

[redacted]

Risk Management

As the incumbent contractor, we are aware of the operational, financial, and political challenges faced by the Agency. Our existing relationship with the Agency, combined with our long history of working with Iowa healthcare providers, will enable us to act quickly and appropriately in all situations. Our experience helps reduce the administrative and logistical problems that might otherwise occur.

[redacted]

Potential risks and our proposed treatment plans include:

Risks	Treatment Strategy	Treatment Plan
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

Table 5. Risk Management

We will also develop and maintain records of our performance and activities as required by state and federal regulations and the contract. We will provide the Agency, its representatives and designated state and federal auditors access to these records upon request.

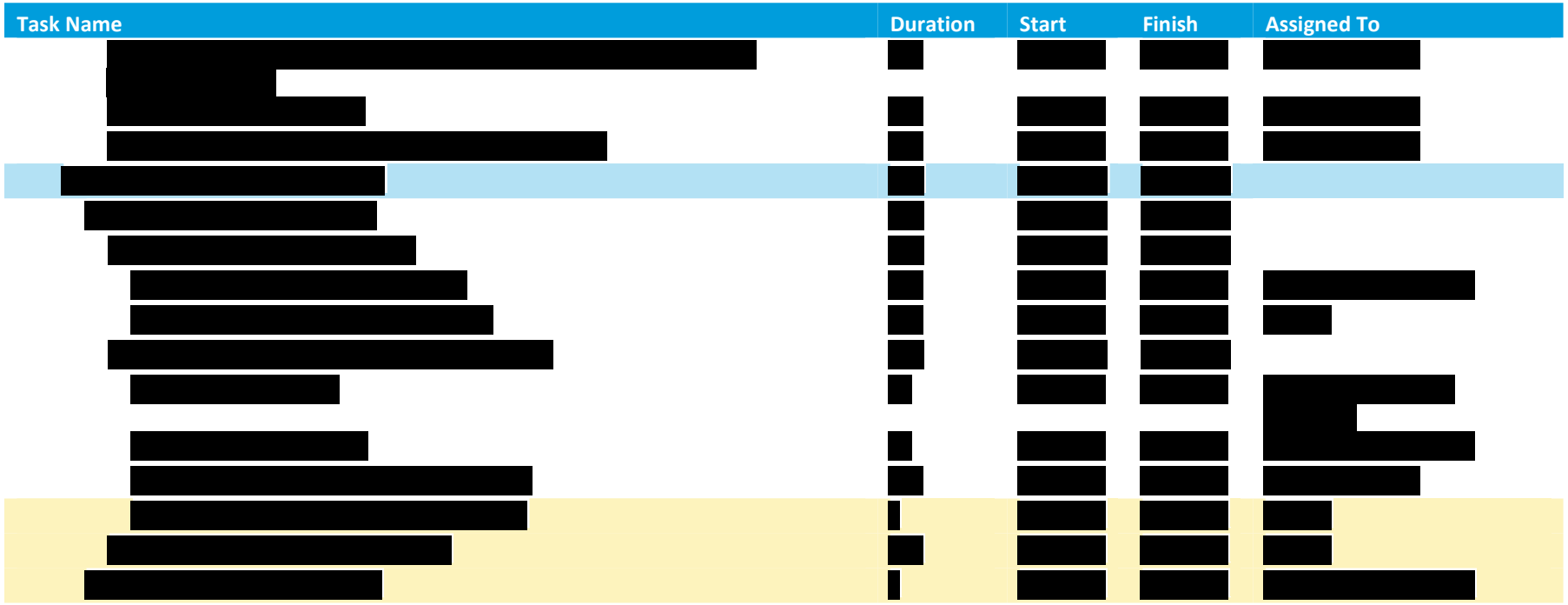
Project Plan

Our overall project plan, including each phase and relevant process groups, will address:

- Key deliverables
- Milestones
- Durations, predecessors and timelines

Transition Plan

The following chart provides our proposed transition plan for the implementation of the new QIO Services contract. We will make adjustments to plan activities or timelines as needed, based on discussions with Agency personnel during contract implementation.



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

Operations Plan

The following chart provides our proposed operations plan for conducting all key operational activities specified in the QIO Services scope of work. We will incorporate the program management approach discussed above to guide our performance during the operations phase. When dictated by changes in contract requirements or other circumstances that may affect performance or resources, the project manager will modify the operations project plan as needed to ensure continued success. As a part of our regular review process, we will assess and document lessons learned. From that feedback, we will make changes that will have a positive impact on operations.

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Task Name	Duration	Start	Finish	Assigned To
[redacted]				

Task Name	Duration	Start	Finish	Assigned To
[redacted]				

Task Name	Duration	Start	Finish	Assigned To
Log Provider Reviews, Complaints, Incidents, and Surveys as Outlined by the [redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]				[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
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[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Task Name	Duration	Start	Finish	Assigned To
[redacted]				

Task Name	Duration	Start	Finish	Assigned To
[redacted]				

During the operations phase, we will meet all performance standards and complete all required reports. We believe our current coordination with the Agency and MCO representatives is effective and we will continue to participate in all necessary activities to ensure that IME delivers quality service to its members and stakeholders.

We will continue to report all performance measures monthly, quarterly, and annually via report cards as directed by the Agency. We will also continue to monitor real-time data and information by collecting and reviewing interim measures to assess our progress. This strategy allows for early identification of problem areas and swift remedial action to have a positive impact on our performance.

c. A communications plan specifying expectations for all parties involved. This plan shall be developed in consultation with the Agency;

Communication

In consultation with the Agency, we will develop a communications plan specifying the expectations for all parties. Prior to implementation, we will consult with the Agency to develop a communications plan, which we will share with all team members and key stakeholders for review. This plan establishes several things, among them: (1) the way we will communicate, (2) communication frequency, and (3) which methods we will use to communicate with the Agency and other external stakeholders.

We will submit the final communications plan to the Agency for approval during the transition phase of the contract.

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.

Quality Assurance

The values that drive our leadership in healthcare management also drive our commitment to continuous process and quality improvement. We consistently measure our own performance, identify opportunities for improvement based on analysis of performance data and implement changes designed for improvement. This approach to ongoing performance monitoring and improvement will be rigorously applied to all activities included in the QIO Services contract.

During the program transition phase, we will submit a project work plan that details our quality monitoring and corrective action processes. During the operations phase, we will operate under this plan. The information below details our quality assurance and improvement programs.

Telligen Quality Assurance Program (Internal Quality Control (IQC) Plan)

[redacted]

- [redacted]

We will use standardized clinical and administrative performance measures when available. We will collaborate with the Agency on the final selection of the performance measures.

[redacted]

- [redacted]

,

[redacted]

.

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.

We currently provide monthly, quarterly and annual reports in consultation with the Agency. These reports include the use of standard naming conventions and we can easily revise them based on Agency recommendations. We will notify Agency staff via email, including the appropriate links, when we complete the reports and update them on SharePoint. The reporting plan also includes the intended internal and external stakeholders, frequency and due dates.

We will prepare the proposed reporting plan for the new QIO Services contract during the transition phase and submit it to the Agency for approval.

f. A training plan detailing, at minimum:
i. Training of Contractor staff in all systems, applications, and software that they will use.

[redacted]

We will develop our proposed training plan for the new QIO Services contract during the transition phase and will submit it to the Agency for approval.

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;

[redacted]

- [redacted]
- [redacted]
- [redacted]

[redacted]

- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]

[redacted]

[redacted]

[redacted].

We will also continue to provide the Agency with a published list of personnel to be contacted in the event of a potential or suspected security breach. This list will include names and all necessary contact information.

iii. Training of Contractor staff in operational procedures required to perform the Contractor's functions under the Contract.

All staff are fully trained and/or certified and/or licensed with the skills required to complete their day-to-day operational procedures. We will complete additional required training required for Medical Service review, and will identify ongoing needs for retraining, mentoring and coaching.

[redacted]

[redacted]

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.

We will continue to provide training for Agency employees and other Agency contractors as requested. (Please see Figure 15 as an example.) This training will be at no additional cost to the Agency.

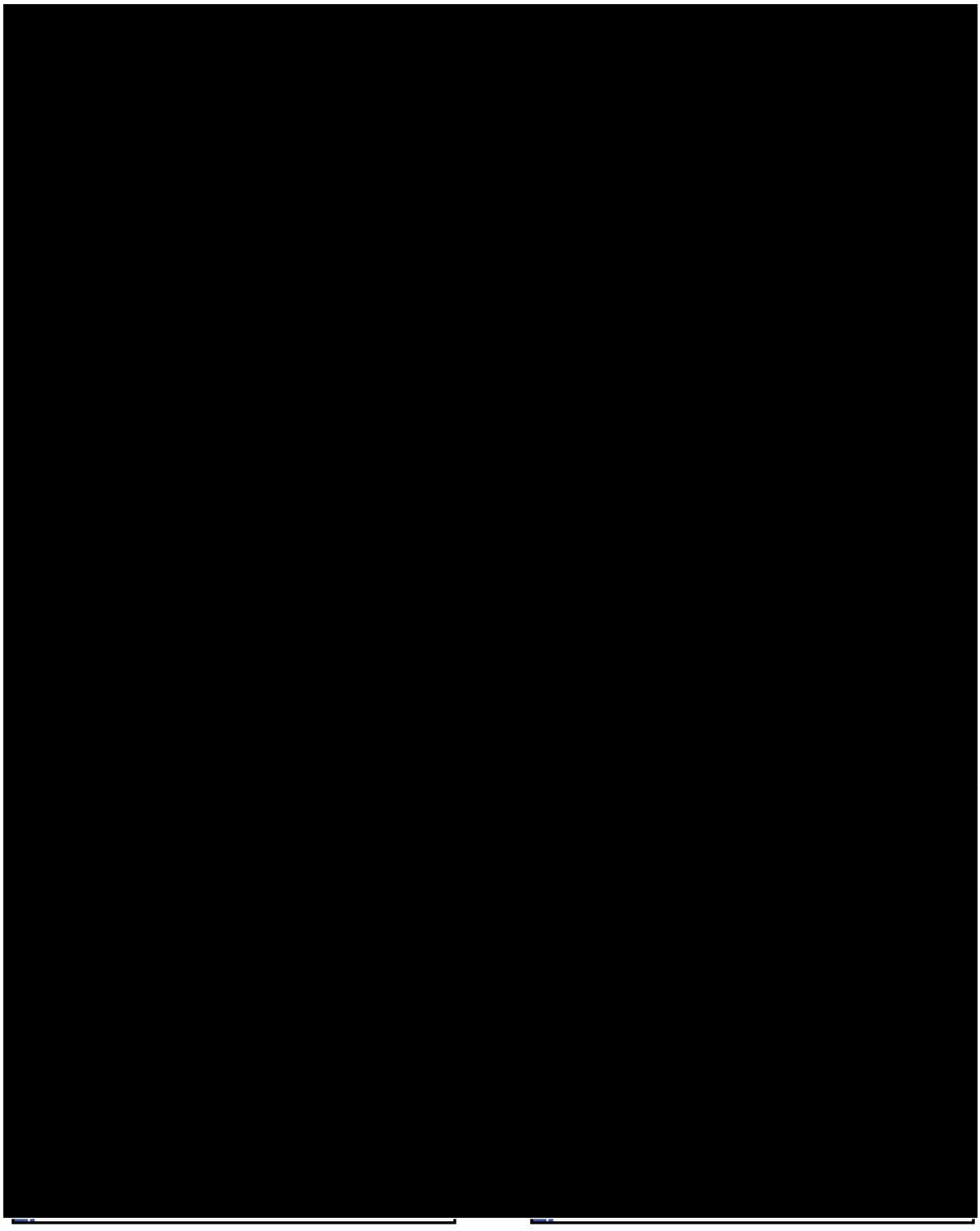

Figure 15. Sample Standard Operating Procedure Training. ***Training educates contractor and Agency staff on SOPs.***

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.
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 annually.

Procedure Manuals

We will continue to maintain detailed standard operating procedure manuals in the Agency-designate format. We will maintain the manuals on the IME universal drive. We review SOPs for necessary updates each quarter or more frequently when circumstances require changes, which this includes using version control to identify the most current documentation, including effective dates. We will forward any necessary procedure updates to the Agency for review and approval prior to finalizing the change. Once the Agency approves the change, we will place the manual on the IME universal drive or any other Agency-designated repository.

Our experienced medical experts will collaborate with other IME units to provide all information relevant to provider operations. Additionally, our experienced subject matter experts will develop and distributes all communication forms requested. This will include informational letters, emails, Agency website postings and any other Agency-requested documents.

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

[redacted].

4.2.2 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.

Because we have a long and established productive relationship with the Agency, and we are already co-located at the IME facility on Army Post Road, the Agency will benefit from a hassle-free and seamless transition, with no interruption in service to Medicaid members or providers. This also means the state will realize low implementation costs.

Since we are the current contractor, there will not be a need for us to review the turnover plan from a prior vendor. We will ensure that all activities needed to continue our operation align with the Agency's comprehensiveness readiness checklist and that all activities are Agency-approved and signed. This will include staff training and a review of the currently documented technical and operational requirement to ensure they meet and exceed Agency expectations.

We will collaborate with Agency staff to complete all operational readiness review activities specified in the scope of work. This will ensure all necessary work has been completed that will allow us to begin program operations following the end of the Transition period. Following completion of all readiness review activities, we will obtain written authorization from the Agency before beginning 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.

Since Telligen is the current contractor for this work, there will be no outgoing contractor involved in implementation of the new contract. We will work with the Agency to ensure we seamlessly incorporate any work in process at the end of the current contract into the work plans for the new contract.

4.3 MEDICAL AND LTSS OPERATIONS (RFP 1.3.1.3)

4.3.1 Medical Support

We are committed to improving the quality of care for Medicaid members. We know the importance of cost-effective, person-centered care. As an Iowa-based company, we have fostered a collaborative relationship with the Agency since 1979. As a QIO with considerable experience in all areas of this proposal, Telligen will provide support to the Agency for all QIO services specified in the scope of work.

As the current IME contractor for both Medical Services and HCBS, Telligen retains highly qualified clinical and professional staff to perform a multitude of activities including:

- Quality oversight of HCBS providers and case management entities
- Utilization management (PA, WPA, EPSDT, CNRS)
- MDS validation
- Claims pre-pay, provider claims inquiries
- Exceptions to policy
- Appeals
- LOC and NBA assessments
- Clinical Advisory Committee review of treatment modalities and medical policies

We recognize and understand the importance the medical and HCBS support functions provide for policy development and consulting for specific service areas on the Agency's behalf. As the QIO contractor, our highly-specialized staff will provide research-based recommendations relative to policies through our active involvement in work groups. Some examples of our historical involvement include:	
Shared Eligibility Workgroup (SEW): Development of slot management system and ISIS workflow updates	Kaizen workgroup: Identify gaps in managed care and FFS operations and implement quality improvement strategies
Clinical Advisory Committee (CAC): Review and update clinical criteria	***hawk**-i* CAC: provide clinical recommendations to board
Chapter 77: Collaborating with the Agency, we review and revise 441 IAC Chapter 77	Claims and Benefit (internal and MCO): Respond to questions from MCOs and to align payment methodologies and policies related to claims and billing
MCO On-Boarding and Operations: provide recommendations to MCO personnel for activities related to LOC, UM and Claims	Tiered Rates: Develop automation for tiered rates and assign acuity tiers
University of Iowa: Address claims and billing issues including claims adjudication	Electronic Visit Verification (EVV): Discuss implementation of EVV in Iowa
MFP "Where Are They Now": Develop process for surveying Medicaid MFP recipients	Incident and Complaint: Align process for FFS and MCO populations

Table 6. Telligen's work group involvement

4.3.1.1 Claims Pre-pay Reviews

The Contractor shall review FFS claims assigned by the Agency and make decisions on individual service claims that reflect current Iowa Medicaid policy. This includes but is not limited to:

a. Manually review claims that have been suspended within the MMIS for review to determine medical necessity or appropriateness and take appropriate action to adjudicate the claims;

b. Approve payment for all reasonable and necessary medical services and supplies;

c. Manually price claims when no current fee or payment exists for the service; and

d. Update IME data systems to reflect review outcomes.

Timely and accurate claim payment promotes quality service provision to Medicaid members. We will ensure we review and process all individual service claims in accordance with current Iowa Medicaid coverage policy.

Since the inception of Iowa Health Link, we have reviewed approximately 135,000 individual service claims annually.

Our experienced team of registered nurses and a certified professional coder complete the review process within 30 days of receipt of the claims from the Agency with a 99 percent accuracy rate.

Telligen's tested approach will result in payment approval of all reasonable and necessary medical services and supplies. In our manual review of claims that have been suspended within MMIS, we use the data sources that reflect current Iowa Medicaid policy: the Iowa Administrative Code (IAC), Medicaid Provider Manuals and Informational Letters. Due to the evolving nature of coverage policy, it is imperative that claim review staff have a vast knowledge of Medicaid coverage policy and receive timely notification of all policy changes. We update our team daily with any coverage policy changes affecting the review and processing of individual service claims.

Telligen's SFY17 Claim Support

- ✓ Claims are processed within 30 days with 99 percent accuracy rate
- ✓ Timely and comprehensive completion of quarterly and annual CPT_HCPCS code updates and annual ICD10 diagnosis and procedure code updates
- ✓ Trusted SME for IME/MCO Claims and Benefit Committee Meeting
- ✓ Support of Medicaid's most important provider, the University of Iowa, through bimonthly problem-solving calls
- ✓ Ongoing support for Provider Services' responses to providers
- ✓ Subject Matter Experts in response to MCO requests for claim processing guidance
- ✓ Collaborate with other IME vendors to develop fee schedules for procedure codes. This eliminates the need for manual pricing. Additionally, aligns MCO and IME FFS payment reimbursement and reduce provider abrasion
- ✓ Individualized approach to provider requests for information results in consistent and timely responses

Each of our claim review team members have at least 12 years of Medicaid experience, including the review of claims and entering individual claim decisions in MMIS. This experience promotes efficient use of time and consistent results in claim reviews.

We will review each claim using the appropriate administrative rules, coverage guidelines, medical necessity criteria, operational procedures, and desk guides.

We will also determine if the appropriate diagnosis and procedure codes are used, if the number of units billed is appropriate, or if there is any fragmenting of services. If claims history contains a claim that should not have paid or that contradicts the claim in review, we will submit internal credit adjustments for correct processing.

We will also review claims considered "special abstracts" we receive via OnBase from other IME vendors. These reviews are for members with retro eligibility. Our review coordinator calculates payment of the claim and, if needed, submits an internal gross adjustment to facilitate correct payment.

The pricing of multiple surgery claims is a manual process with the potential for a high rate of human error. Our team of review coordinators includes specialists in the pricing of multiple surgery claims, resulting in consistent accuracy. RCs can approve the service if documentation supports the service. We refer the cases the RC is not able to approve to our medical director or peer reviewer for final determination, including reason and rationale for the decision specific to the member's unique condition. Only the medical director or peer reviewer can issue a denial.

Telligen staff consistently consult with Provider Cost Audits and Rate Setting regarding the manual pricing of claims when no current Medicaid fee or payment exists. This collaboration helps provide consistent and accurate payments to Medicaid providers. When we identify a claim that requires assistance from Provider Cost Audits and Rate Setting, we send an email to Provider Cost Audits and Rate Setting identifying the claim and procedure or service that needs to be priced. When Provider Cost Audits and Rate Setting responds with the recommended pricing information, we proceed as recommended and note the fee to promote consistent pricing of future claims.

After we review claims, we will select the appropriate action in MMIS to either pay or deny the claim. When we deny a claim, we enter an appropriate denial message on the claim to give the provider the specific reason for the denial.

Our unique approach as a long-term partner for Iowa Medicaid includes identifying services that suspend for medical review to determine if these reviews are truly effective medical reviews or if medical review attention could be better focused on other types of services.

As we identify services that are either paid a very high percentage of the time or there is not a medical necessity concern, we make recommendations to the Agency to improve operational effectiveness. For example, we researched a vaccine procedure code that required medical necessity review and determined the service was not a medical necessity concern. Conversely, we identified an inpatient surgical procedure code that was not suspending for medical review and should have been due to a policy requirement of an acknowledgment of sterilization for the service. The Telligen team goes the extra step to improve the effectiveness of the Iowa Medicaid program.

4.3.1.2 Provider Claims Inquiries

Upon receipt of provider FFS claims inquiries, the Contractor shall

a. Review claims information and documentation, requesting additional information if needed;
b. Determine whether the service is payable;
c. Notify the provider of the outcome of the review; and
d. If the service is payable, the Contractor shall update the appropriate IME data systems.

We are dedicated to maintaining effective and useful interfaces with individual providers regarding medical policy questions and decisions on individual claims. When we receive the provider inquiry via OnBase workflow, we will review the information and documentation to ensure that needed information is present. If not, we will contact the provider to request specifically what is needed to complete the review.

Our experienced review staff know providers and their billing staff by name. Many providers have direct telephone numbers for the appropriate review staff who can assist them with their claims. Telligen's individualized approach results in providers receiving consistent and timely responses on their questions. We often initiate contact with providers during claim reviews when we note routine billing or documentation errors.

Upon receipt of needed information, we will determine if the service is payable, update MMIS or the appropriate IME data system and notify the provider of the outcome of the review. We track communication with providers through the OnBase provider inquiry workflow process.

We use keywords added to the provider inquiries that identify the type of inquiry. This has made the provider inquiry workflow more efficient and facilitates use of specialized reviewers for each type of inquiry which results in accurate and consistent responses and enhanced tracking of provider inquiries.

Our approach allows us to use the provider inquiry report to identify the volume of each type of inquiry received which can then be used to either provide broader provider education or MMIS enhancements.

When we provide a written response, we take the opportunity to provide education to assist the provider in obtaining future payment of services on the initial claim submission. We will also provide professional support to Medicaid providers regarding policy, prior authorizations and billing requirements. We provide oral instructions via telephone and written communication via e-mail to provider questions received.

When responding to providers, we will provide them with information to solve the specific issue at hand, and will also educate providers on how to prevent similar issues in the future. Our provider education goes further. We will also assist with informational letters regarding changes in policy, coverage of new services, and billing updates. Recently, we helped the Agency in write policy clarifications to provide formal guidance to the Managed Care Organizations regarding Medicaid Fee-for-Service reimbursement of same day multiple therapy units and laboratory venipuncture services.

Our approach to provider education is to use a variety of methods (one-on-one conversations, letters, conference calls, and group training) to ensure provider feedback and updates promote efficiency and accuracy.

With the wide variety and specialized services that the University of Iowa Hospitals provide, they often have issues that arise that are unique to them such as billing volume and unique services. To help these providers resolve these issues and to provide high quality customer service, we have collaborated with Provider Services and the Agency by participating in bimonthly (sometimes weekly) conference calls with the University of Iowa Hospitals. Our collaborative efforts have resulted in decreased volume of billing concerns, which has allowed us to readily identify any system issues that may be impacting this provider. We will continue our successful approach with the University of Iowa to ensure effective solutions to billing issues that may be unique to their institution.

Our proactive approach in working collaboratively with providers has helped increase the percentage of claims paid on initial submission and decrease the volume of provider billing errors.

4.3.1.3 Exceptions to policy (ETP)

The Contractor shall provide necessary assistance in the FFS ETP process, including but not limited to:
a. Log, track, and review ETP requests for the Bureau of Medical and Long-Term Services and Supports Policy;
b. When necessary, request additional information from the requestor;
c. Consult with Bureau policy staff and other IME Units as necessary;
d. Make recommendations for approval or denial of the request based on Agency policies and procedures, cost-effectiveness, medical necessity, and the availability of lower cost alternatives;
e. Prepare response letters for approval by Bureau staff and signature by the Medicaid Director; and
f. Submit a report of all Bureau ETPS to the Agency on a quarterly basis. This includes but is not limited to:
i. Requestor;
ii. Status;
iii. Disposition of request; and
iv. Analysis of ETP trends and recommendations for policy changes identified from ETP requests.

Exception to policy review is an effective means for the Agency to ensure Medicaid members receive necessary services in special situations and to guide the policy regarding standards of care. Our approach to review of service requests for policy exceptions begins by researching the purpose and effectiveness of the requested item or service. When needed, we will request additional information. Requests may include asking for information from the member's record, scientific research to support the provider's decision to ask for an exception, or pricing information to substantiate cost-effectiveness for the member and the Agency.

Our process will include consultation with Agency policy staff and other IME units as needed. We also consult with the appropriate medical professional in the best position to advise our team and the Agency. In addition to our internal medical director, we consult our external network of physicians and other medical professions in the appropriate field to lend further support to the review process. These experts provide feedback regarding medical necessity and effectiveness in achieving positive outcomes.

We also research pricing to identify the least costly manner for obtaining the item or service. We look for the availability of a lower cost item or service that is an effective alternative.

We will then carefully prepare a response letter for approval by Agency staff and signature by the Medicaid Director in compliance with all formatting requirements. We will send the review response as a recommendation to the Agency. We understand exceptions are granted at the complete discretion of the Medicaid Director after consideration of all relevant factors, including our review recommendations.

We provide a quarterly report to the Agency on all Exception to Policy reviews, including the name of the requestor, the ETP status, and the disposition of the request. We will analyze ETP data, including types of services with disposition, and include this analysis in our report to the Agency.

Experience counts: In SFY 17 Telligen reviewed approximately 900 Exceptions to Policy requests.

Our recommendations to the Agency included policy changes based on frequency of requests. We also inform the Agency of changes in practice patterns that have impacted requests for exceptions. An example of policy change resulting from our analysis was the movement of genetic laboratory testing from ETP to regular prior authorization, thereby increasing the efficiency of the Medicaid program.

4.3.1.4 Procedure and Diagnosis Codes

The Contractor shall provide professional and technical support to the Agency related to procedure and diagnosis codes. This includes but is not limited to:
a. Annually review ICD-10 diagnosis and surgical code and HCPCS updates;
b. Retrieve and review quarterly Medicaid National Correct Coding (NCCI) files and maintain accurate tracking of changes to NCCI guidelines;
c. Determine MMIS and policy impacts;
d. Update IME systems, as appropriate;
e. Answer MCO questions and review MCO documents related to billings, claims, and codes, as requested by the Agency; and
f. Participate as subject matter expert in meetings related to code updates and issues, as requested.

We are dedicated to updating IME data systems for consistency with industry standards relative to procedure and diagnosis codes. Accurate indicators in the MMIS Procedure, Drug, and Diagnosis (PDD) file significantly impact timely and consistent claims payment.

Our approach will be to continue working collaboratively with the Agency and all other IME vendors to ensure all system edits and MMIS indicators reflect current coverage policy. We will do that by annually reviewing ICD-10 diagnosis and surgical codes, HCPCS, and quarterly Medicaid National Correct Coding files.

Telligen has completed the annual update of codes for MMIS files since 2005 with 100 percent timeliness.

We will continue this successful process by accurately tracking all changes made within the file.

Our process includes contacting the Agency point of contact to retrieve the quarterly NCCI files from the RISSNET portal. We will review the quarterly NCCI files and maintain accurate tracking of changes to NCCI guidelines. Telligen will continue to collaborate among the Agency, IME vendors, and the Correct

Coding Initiative (CCI) vendor. The higher level of editing by the CCI vendor ensures Medicaid claims approved by the MMIS are appropriate for payment.

We will notify the Agency of any changes in the NCCI guidelines that conflict with Iowa Medicaid policy. This communication is important to ensure we follow NCCI guidelines. Proper notification of a conflict gives the Agency an opportunity to review and submit a request to the Centers for Medicare and Medicaid (CMS) for approval to deactivate NCCI edit(s).

The co-location of vendors has been a great advantage as Telligen staff have frequent conversations with Provider Cost Audits and Rate Setting personnel when performing the annual CPT and HCPCS code updates. When we have completed a preliminary review, and identified codes that will most likely be covered by Iowa Medicaid, we send Provider Cost Audits and Rate Setting the list of codes, so they can begin compiling fees for the new codes.

When we complete the extensive medical review of the new codes, we will collaborate with Provider Cost Audits and Rate Setting on any changes made to the preliminary listing of codes previously given and ensure all appropriate codes have a fee. On occasion, when CMS develops new procedure codes, fees cannot initially be established. However, we work to identify these codes as they become more established and then request Provider Cost Audits and Rate Setting to recommend fees to the Agency.

We have developed workflow processes to ensure consistency in the review process and to integrate collaboration with the Managed Care Organizations for consistency among the MCOs and FFS. We used our new review process effectively during our quarterly and annual CPT and HCPCS code updates, annual ICD-10-CM code updates and the update to the emergency diagnosis code list.

As part of our successful approach we will participate as subject matter experts and hold claims and benefit meetings with the Agency personnel and other IME vendors to further discuss the recommendation and answer any outstanding questions, ensuring the Agency has all information needed to make a fully informed decision on any recommended changes. We will also hold claims and benefit meetings with the Agency, MCOs and other IME vendors to discuss the decisions made at the internal claims and benefit meeting or to further discuss recommendations to provide consistency between managed care and FFS. We are engaged in all of Iowa Health Link interactions ensuring continuity of changes.

As the Medicare QIO for Iowa since 1984, we provide extra value to the Agency through regular meetings with the Medicare Carrier to exchange information and data that will assist in each organization's efforts to promote high quality care and appropriate utilization of services.

We maintain a formal written agreement with the Medicare carrier, which describes the administrative relationship between the organizations and specifies the type of information and data that will be shared.

We also ensure IME systems are up to date by submitting System Action Memos (SAMs) and Change Management Requests (CMRs) when needed. A SAM is requested for an update needed in any MMIS file and requires approval from the MMIS CORE vendor. A CMR, while similar to a SAM, is needed for hardcoded changes in the MMIS. CMR changes require medical and policy approval prior to production

by the MMIS CORE vendor. The Telligen team will collaborate with the Agency and other IME vendors to remediate system issues to ensure accurate MMIS claim adjudication including:

- Place of service and provider type discrepancies (SAM)
- Edits posting incorrectly (CMR)
- Updating service limitations (SAM)
- Adding new editing (CMR)

When changes are requested to a code, we not only review the noted changes, but we take the opportunity to provide a comprehensive review of the code or a range of codes, ensuring the accuracy of current MMIS indicators.

Our approach is to research each system issue thoroughly and discuss potential impacts with the Agency policy specialists and other appropriate IME vendors to ensure the best resolution is achieved for the Medicaid program. We then work with CORE systems staff to implement any needed changes to resolve the issue. We also communicate with the MCOs prior to any change that may affect the MCOs. Telligen will continue to be a collaborative partner by reviewing and responding to MCO questions and documents related to billing, claims, and codes.

Our process will include documenting updates made to medical codes through SAMs, CMRs, and annual Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), and International Classification of Diseases – 10th Revision – Clinical Modification (ICD-10-CM) code updates and emergent diagnosis code list updates.

When we are reviewing codes prior to updates being made, we document all research, collaboration, and discussions related to integrating the changes to preserve the background information of the reasons and rationale for changes made.

4.3.1.5 Clinical Advisory Committees (CAC)

a. Medical Assistance CAC

The Medical Assistance CAC provides a process for physician/provider intervention to promote quality care, member safety, cost effectiveness and positive physician/provider relations through discussion about Medicaid benefits and healthcare services.

In order to meet this requirement, the Contractor shall:

i. Provide medical support, coordination and facilitation for the Medical Assistance CAC. The committee members will represent all medical services providers. The committee will meet at a minimum quarterly and consist of seven to nine medical services providers. The Contractor's MMD will chair the Medical Assistance CAC. Payment for attendee pass-through costs shall be made as expenses are incurred as requested by the Agency, which include but are not limited to quarterly meeting costs and ad hoc committee meetings for clinical advisory committee member attendance.

ii. Submit a report summarizing activities of the Medical Assistance CAC to the Agency on an annual basis, within 90 days of the end of each State fiscal year.

The Medical Assistance Clinical Advisory Committee provides the Medicaid program the opportunity to ensure policies reflect current standards of care and that the program directly hears from practicing providers on key issues.

[redacted]

Telligen's CAC

✓ [redacted]

[redacted]

[redacted]

[redacted]

Telligen will recruit and maintain a committee of medical providers representing diverse specialties and localities from across the State of Iowa to review policies and clinical criteria to ensure access to safe and effective care. [redacted]

Figure 16 provides the names, specialties and years of service of the current IME CAC members.

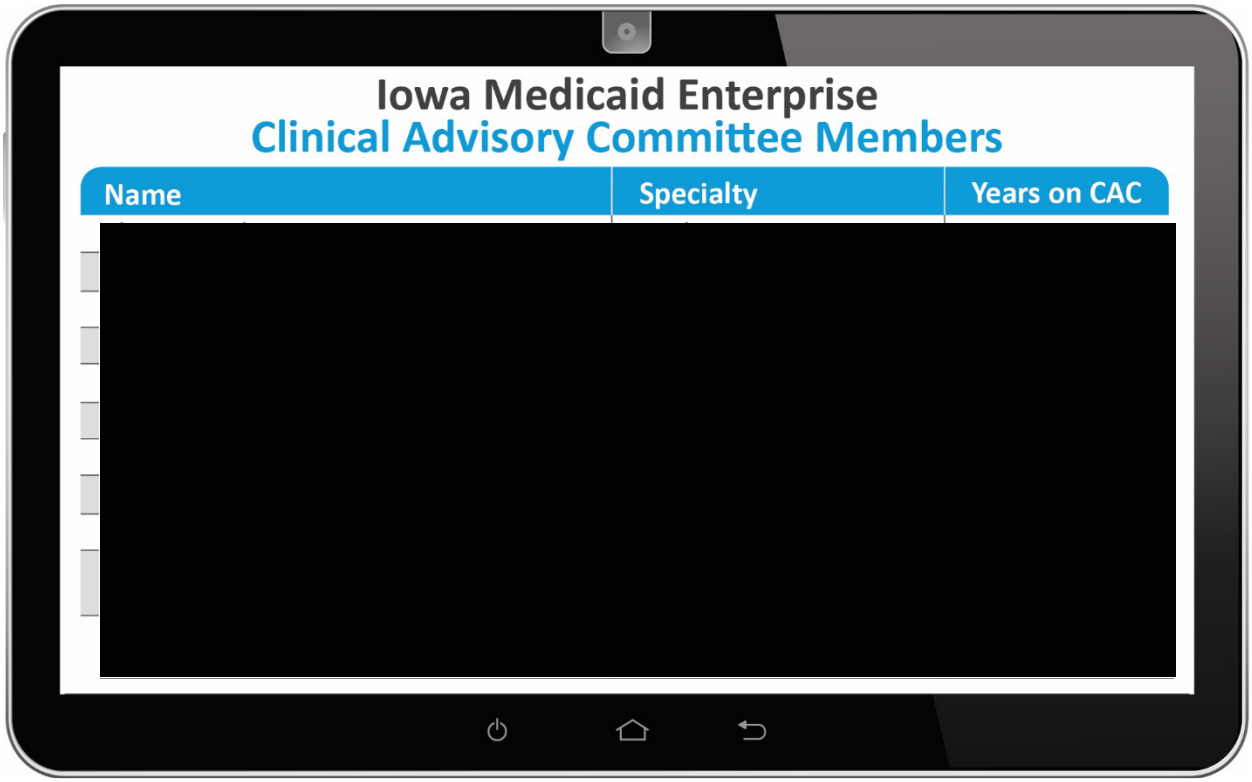

Figure 16. CAC Members. ***We credential each member of the CAC through our URAC-approved process.***

The committee will meet quarterly and report to the Iowa Medicaid Director in both the written minutes and at the Quality Committee meetings held jointly with the MCOs. We will bring urgent issues to the Medicaid Director. We will summarize the quarterly meeting minutes in an annual report we will submit to the Agency within 90 days of the end of the State fiscal year.

[redacted], will chair the committee. Included as nonvoting members of the CAC are the MCO chief medical officers or their physician designee. Their presence on the committee provides real time interaction between the providers and a high-level medical representative of the MCO. It also is an opportunity to disseminate best practice criteria in both directions. Our meeting format allows for issues regarding access and billing procedures to be discussed and resolved. Concerns and issues arising from this committee will be brought to the attention of the IME Director and Quality Committee.

As part of the Medicaid Assistance CAC process, [redacted] will be available and open to discuss concerns providers have in delivering medical care to Medicaid members. This will include responding to letters, phone calls and email correspondence. We encourage peer-to-peer conversations with providers to promote good will between the Agency and Iowa providers.

One Medical Assistance CAC tasks is to conduct an annual review of criteria to ensure they meet current clinical standards. Since IME implementation, we have partnered with the Agency to achieve well documented, research-based criteria. All criteria were developed from research of Medicare criteria,

other state Medicaid criteria, and other payors' criteria, along with collaboration with the Agency staff and CAC approval, assuring Medicaid criteria reflect current evidence-based practice standards.

Our URAC-approved process of criteria review supports national standards of care and best practices with respect to member safety, quality of care and cost.

We will review each set of criteria at least annually to reflect advances in medical science and national standards. We will also develop new criteria in conjunction with the Agency's Policy division as needed.

Medical Assistance CAC and Quality Committee members will participate in identifying key metrics and performance measures for evaluation and will participate in the analysis and review of data from FFS providers and MCOs. Specifically, we will evaluate CAHPS and HEDIS measures for use in the Iowa Medicaid program when the measures align with Agency priorities. We will also recommend additional measures that are meaningful for assessing quality. National standards will be identified and compared to State performance when they are available.

Our panel of peer reviewers forms ad hoc clinical advisory committees relative to specialized care of dentistry, orthodontia, physical therapy, speech therapy and behavioral health. These medical professionals review criteria covering their area of practice each year and are available to the Agency to respond to policy and coverage related questions ensuring Iowa Medicaid's program meets standards for specialized care.

We value the effective clinical partnership we have achieved with the Agency since 2005. We acknowledge that payment for CAC attendee pass-through costs will be made as expenses are incurred and include but are not limited to the costs of quarterly meetings and CAC member attendance.

b. hawk-i CAC
Iowa Code § 514I.5(7)(i) requires the hawk-i Board to "Establish and consult with a clinical advisory committee to make recommendations to the Board regarding the clinical aspects of the hawk-i program." This committee is made up of a variety of health care professionals.
In order to meet this requirement, the Contractor's MMD shall chair the hawk-i CAC and the Contractor shall:
i. Maintain a schedule of meetings. This includes identifying a location for the meeting and/or arranging for a conference call. Meetings shall be scheduled at least on a quarterly basis;
ii. Plan the agenda for the meetings;
iii. Record minutes of the meetings;
iv. Recruit committee members as needed; and
v. Be available to present recommendations from the committee to the hawk-i Board.

Our strategy in maintaining an effective ***hawk-i*** CAC is to recruit medical and/or dental providers with active practices, which focus on the population served by ***hawk-i*** insurance. Under the chairmanship of [redacted], the ***hawk-i*** CAC will review policies relevant to the pediatric population served, access to care, and assure members are receiving safe and appropriate care based on national guidelines. The ***hawk-i*** CAC will address key issues such as barriers to access along with clinical issues impacting the health of children as they arise.

We will schedule the ***hawk-i*** CAC meeting quarterly. We will facilitate the meeting or call, plan the agenda, record minutes from the meeting and provide the minutes to the Medicaid Director. [redacted] will present the CAC's recommendations to the ***hawk-i*** Board. We will exceed expectations by attending ***hawk-i*** Board meetings. We will also prepare and present an annual report of CAC activities to the ***hawk-i*** Board.

4.3.1.6 Minimum Data Set Support and Nursing Facility Case Mix Index

a. The Contractor shall provide support and technical assistance to the Agency related to any CMS updates to the Minimum Data Set (MDS) and Resource Utilization Group (RUG) scores, including participating in CMS calls on MDS and RUG development.
b. The Contractor shall develop and maintain RUG-based methodologies, subject to Agency approval.
c. The Contractor shall extract and maintain data from the national MDS database at CMS, to include maintaining appropriate data use agreements with CMS.
d. The Contractor shall calculate a nursing facility case mix index (CMI) and resident roster on a quarterly basis, ensuring roster rules are applied consistently from quarter to quarter.
e. The Contractor shall submit the CMI and resident roster to the IME Provider Cost Audit and Rate Setting (PCA) unit for quality assurance review, and incorporate any feedback prior to submitting the resident rosters to Iowa nursing facilities.
f. The Contractor shall communicate as necessary with nursing facility staff, to include providing help desk support services to Iowa nursing facilities, related to case mix index and RUG scores developed by the Contractor.

An effective Minimum Data Set and Case Mix approach ensures that Iowa's members served in nursing facilities are correctly evaluated for their medical and care needs and that Iowa's nursing facility providers are compensated in an equitable and transparent manner. As part of our approach we will provide support and technical assistance to the Agency related to CMS updates of the MDS and Resource Utilization Group (RUG) scores. We will actively participate in applicable CMS conference calls related to MDS and RUG development to ensure Iowa Medicaid's program remains current with national standards.

Subject to Agency approval, we will develop and maintain RUG-based systems, as well as extracting and preserving data from the national CMS MDS database, housed at Telligen. We will retain current data use agreements with CMS.

We will calculate a nursing facility case mix index (CMI) and resident roster on a quarterly basis, making sure roster rules are applied consistently each quarter. We will submit the CMI and resident roster to the IME Provider Cost Audit and Rate Setting unit for quality assurance review, incorporating any feedback prior to the timely distribution of the resident rosters to Iowa nursing facilities. Our support staff complete this quarterly mailing, and provide special handling to avoid the risk of a breach.

We will employ our collaborative methods when we deliver help desk support to Iowa Nursing Facilities requesting assistance with questions or issues related to MDS, CMI, or RUG scoring. *We have* ***created a YouTube Video Training session of this information to replace quarterly ICN sessions that were held in various locations throughout Iowa.*** Nursing facilities frequently tell us they "appreciate the knowledge-sharing and technical assistance from this specialized work."

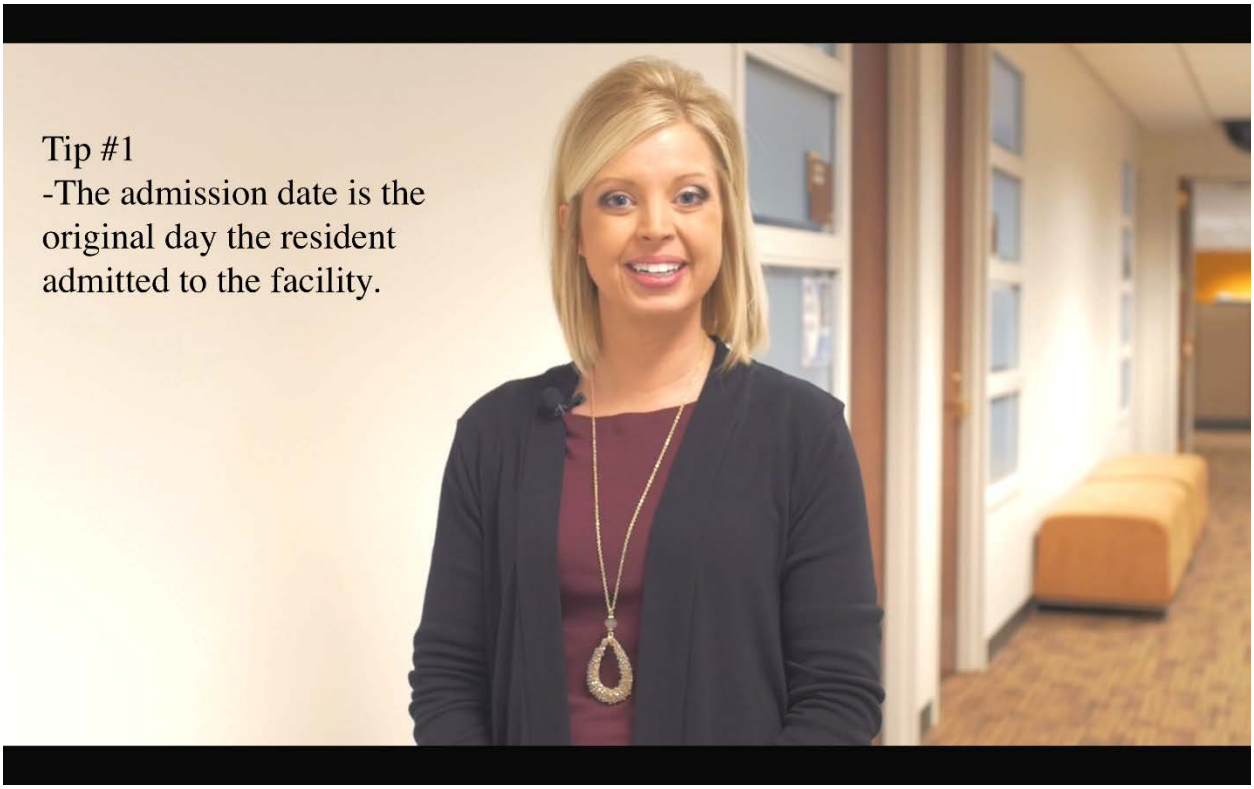

Figure 17. Video Training Session. ***YouTube videos give providers 24/7/365 access to training***

4.3.1.7 MDS Section "Q" Intake Calls

a. The Contractor shall receive calls from nursing facilities reporting a resident (regardless of pay source) who identifies he or she wants to talk with someone about the possibility of returning to the community.
b. Following the intake calls, Contractor shall refer residents to a Local Contact Agency (designated by the IME) for options counseling and possible transition planning.

Telligen is committed to promoting independence, as much as possible, and individual choice by members regarding where they receive their services. The MDS Section Q referrals are a means for members to pursue life in the community.

Our MDS certified nurse reviewers will oversee referral calls from nursing facilities requesting assistance with discharge planning as part of the MDS Section Q evaluation.

MDS Section Q Referral

- ✓ Telligen has managed all MDS Section Q Referrals for the State of Iowa since 2010
- ✓ Collaborated with Data Warehouse staff in 2016 to build efficiency and improved record-keeping by creating an ISIS-generated letter to be input at the time of the referral intake call

Regardless of the payor source, this referral process is available to all Nursing Facility residents who express a desire a to return to the community.

As part of our response to the Section Q referral, we will refer residents to the appropriate agency. The appropriate contact person for the referral will be dependent upon MCO or FFS enrollment status and is Agency directed. If a resident is enrolled with an MCO, our MDS certified nurse reviewers will collaborate with MCO personnel via email or telephone. If the resident is FFS enrolled, our MDS Certified Nurse Reviewers will collaborate with designated Agency personnel. This crucial step of the referral process triggers options counseling and transition planning to promote discharge from long-term facility placement to a more gratifying lifestyle for the member.

As part of the referral process, we send letters to nursing facilities, as well as to the designated contact personnel, formally notifying them of the MDS Section Q referral. We carefully proof and de-identify these letters of confidential information.

We provide technical assistance to nursing facility staff in circumstances when residents request to leave, however, due to health or safety concerns, this move would not be in their best interest. After discussion of the resident's condition and specific care needs, our MDS certified nurse reviewers may recommend use of the "skip" option found within the MDS Section Q.

Occasionally the discharge request is prompted by the Preadmission Screening and Resident Review (PASRR). Instead of handling this as a formal MDS Section Q referral, we identify this referral source in the Individualized Services Information System (ISIS), and as instructed by the Agency, we direct the nursing facility to ASCEND and LifeLongLinks.org for discharge planning assistance. We track all MDS Section Q referrals, including those prompted by the PASRR, and we have this information available for reporting to the Agency upon request.

Our team members are energized by our participation in this process. Successful examples of nursing facility residents benefiting from this referral activity includes, but is not limited to, those requiring handicap-accessible living arrangements or equipment, those with multiple medical or mental health needs, or a resident who wishes to transfer to a different county where the discharge planner is not familiar with available options within that area.

4.3.1.8 Payment Error Rate Measurement (PERM)

The Contractor shall provide support to the Agency during the CMS PERM project on a tri-annual basis, as requested. This includes but is not limited to:
a. Monitor the PERM website as requested for new claims to be added to the list of reviews.
b. Providing timely medical review on all cases that were identified by the auditors and assigned to the Contractor, to include:
i. Research claims information on MMIS; and
ii. Medical record review including coding verification, billing and unit validation, appropriate setting of services, medical necessity of procedures and hospital stays.
c. Provide findings from each of the medical reviews along with detailed explanation of agreement or disagreement with the PERM auditor's findings to the Agency.
d. Explain in detail any disputes with CMS findings to the Agency liaison with supporting rationale from the Iowa Administrative Code (IAC) and provider manuals.

Our approach to responding to the CMS PERM audits assists the Agency in ensuring the Iowa Medicaid program is following payment rules and avoids costly recoupment of funds. We will provide all resources

required to support the Agency through all cycles of the CMS PERM project. Our medical experts will complete timely review and document all cases identified by the auditor. This will include conducting comprehensive research of claims and medical record review including coding verification, billing and unit validation, appropriate setting of services and medical necessity of procedures and hospital stays. Telligen will document outcomes from medical reviews in conjunction with a detailed explanation of an agreement or disagreement of the auditor's findings. We will provide a comprehensive response and supporting documentation to the Agency liaison for any disputes with CMS findings.

We are experienced in collaborating with stakeholders related to all cycles of the CMS PERM project. Given the importance of identifying and reviewing improper payments, our experts provide responsive and comprehensive review of claims identified.

In our 10-year history of responding to PERM, we have consistently met all response timelines with complete and detailed findings.

4.3.1.9 Iowa Medicaid Policy Alignment

9. The Contractor shall ensure that Iowa Medicaid policies align with current and/or changing medical practices. This includes but is not limited to:
a. Advising the Agency on changes to evidence-based best practices, national and State trends, and federal policy changes;
b. Consulting the Agency on requested changes to Medicaid services, whether from the Agency, providers or other stakeholders. This responsibility includes drafting proposed policy clarifications or new policy regarding services covered under the Medicaid program; and
c. Providing the Agency with appropriate medical and professional expertise to evaluate any requests for new or unusual services or treatment modalities and their impact on current coverage policy.

It is important for the Iowa Medicaid program to align Medicaid policies with current and ever-changing medical practices to ensure members receive high quality care in a timely manner. Through research and collaboration with medical professionals, both internal and external consultants, we will use the most current clinical criteria and evidenced- based best practices to complete our work.

We are committed to researching the advances in medical science to assist the State of Iowa in delivering cost effective care to the citizens of Iowa. Changes to state and federal policy, as identified in the Iowa Code, Iowa Administrative Code (IAC), Code of Federal Regulations (CFR), and from directives from CMS, will be followed to assure the care delivered is consistent with the standards created by lawmakers. We will thoroughly research recommendations for policy changes with consideration of the advantages and disadvantages to the member population and to the state. We will consult with the Agency on any requested service changes we receive from providers or other stakeholders. As part of the process, we will draft the proposed change, clarification or new recommendations. Our experience in writing Informational Letters will support our efforts.

Our approach to assisting the Iowa program to remain up-to-date is for our medical staff to participate in the national forums advising Medicaid agencies across the country such as the Medicaid Medical Directors Learning Network, the Association of State and Territorial Health Officials, the

National Academy for State Health Policy, and other agencies assisting Medicaid programs with providing quality care to their members.

At the state level, we will actively work with the Agency to ensure our policies and procedures are in concert with the directives of the State in achieving the goals created by the governor and the Iowa legislature. We will seek and develop novel approaches to surmount the rising costs of medical care and services to provide cost efficient quality care in a restricted financial environment and draft them for Agency review.

Recommendations and major policy changes will be reviewed by the Medical Assistance CAC, ***hawk-i*** CAC or Maternal-Fetal Health Committee will review recommendations and major policy changes. We will ensure we use medical and professional expertise to evaluate any requests for new or unusual services or treatment modalities and their impact on current coverage policy and provide recommendations to Agency staff. Our professional panel representing numerous medical specialties as well as other types of providers (dental, therapies, behavioral health) will be available to assist with research and evaluation of these requests.

4.3.1.10 MCO Questions and Documents

10. The Contractor shall answer MCO questions and review MCO documents related to HEDIS measures, case management, clinical, medical, and general health policies and procedures, as requested by the Agency.

Our role is to be a resource to the Agency and to the MCOs. We will respond to all MCO questions and review MCO documents related to HEDIS measures, case management, clinical, medical and general health policies and procedures as requested by the Agency. We will respond to questions via secure email, SharePoint or in-person.

We will review documents the MCOs submit in an Agency-defined timeframe. We will recommend changes to the MCO proposals or plans based on our many years of experience with Iowa Medicaid and document recommendations in the Agency-defined format.

4.3.1.11 Professional Support to Medicaid Providers

11. The Contractor shall provide professional support to Medicaid providers regarding policy, prior authorization or billing requirements. This support may be in the form of oral instruction or written communication and must be documented in Agency data systems.

Our professional clinical and non-clinical staff including physicians, nurses, licensed mental health professionals and subject matter experts will be available to provide support to Medicaid providers regarding prior authorizations and billing requirements within our scope of work. Our claims review and prior authorization teams have established positive and open communication with providers. We initiate contact when we see that a specific provider appears to not understand correct submission procedures for either claims or authorizations. The support we provide will be either on the phone or in writing and we will document it in agency systems such as MMIS, OnBase and ISIS to ensure continuity of service. ***We're here to help.***

In a further effort to ensure that Medicaid stakeholders are informed, we will participate in Claims and Benefit meetings and collaborate with the University of Iowa to align billing practices and provide

technical assistance and professional support. We will provide written policy clarifications and complete informational letters related to our scope work.

4.3.1.12 Professional Support to the Agency

12. The Contractor shall provide professional and technical support to the Agency in responding to program reviews and audits.

Our approach to providing technical and professional support begins with interviewing the requestor to ensure our full understanding of the specific topic or need. What is the purpose and what are the goals of each review and audit? We then will draft the appropriate professionals on our team to work with Agency representatives to assure the outcome accomplishes exactly what is needed.

We will provide technical support to the Agency for all activities related to program reviews and audits. This will include, but not be limited to, CMS evidentiary reviews, waiver renewals and oversight of managed care.

4.3.1.13 Meeting Attendance

13. Contractor staff and/or consultants shall attend meetings with providers, MCOs, or other stakeholder groups in support of the Medicaid program, as requested by the Agency.

As an active partner in the Iowa Medicaid program, we will participate in all workgroups and attend meetings with providers, MCOs and other stakeholder groups as requested by the Agency. As the current contractor, we currently participate in MCO operations meetings, Health and Disability (HD) Advisory Committee Meetings, Claims and Benefit meetings and others to support the Medicaid program.

4.3.1.14 Certify New Outpatient Hospital Programs

14. The Contractor shall certify new outpatient hospital programs for appropriateness of Medicaid coverage and make recommendations to the Agency regarding appropriateness of new and/or existing programs, and determine criteria to be used regarding coverage for new and/or existing programs.

Our approach in certifying new hospital outpatient programs uses criteria outlined in Chapter E of the Acute Hospital Services manual. At the time a medical hospital provider applies for certification, we receive the referral from Provider Services and review the program requirements, program overview, objectives, policies and procedures regarding staffing, admission criteria, environment and documentation.

We will review certification requests for the following outpatient hospital programs:

- Cardiac rehabilitation
- Diabetic education
- Eating disorders
- Mental health
- Nutritional counseling

- Pain management
- Pulmonary rehabilitation

Based on the submitted documentation, we will issue a recommendation regarding the appropriateness of the program. If we are not able to approve the program, we will give the provider the opportunity to resubmit any missing information for our additional review. We will forward approvals to Provider Services to complete the certification process.

4.3.1.15 CMS 64.96 Report

15. The Contractor shall prepare, and submit to the Agency for approval, the CMS 64.96 Quarterly Report of Abortions, Hysterectomies and Sterilization, including supplemental worksheets relating to abortions and qualifications for federal funding.

Telligen will continue to support the Agency in its demonstration of abortion documentation compliance with CMS requirements. We will review all claims relating to hysterectomies, abortions, and sterilizations. Our review ensures consistent and accurate processing of these claims and that the sterilization consent form is completed in accordance with the IAC, or that the hysterectomy acknowledgement of sterilization is included with the claim as appropriate.

We understand the importance of accurately adjudicating all claims and we know that paid abortion claims must be appropriately reported for state or federal funding. We ensure all required documentation, including the abortion certificate, operative, ultrasound and pathology reports, lab results, consultation notes, and history and physical accompany the claim to support reimbursement for the services performed. Once all required documentation accompanies the claim, we refer the case to our Medicaid medical director to review and respond to the reason for the abortion. We will give all required documentation to the Agency to provide to the Governor's office. The claim will be adjudicated in accordance to the decision obtained from the Governor's office.

We will submit the Quarterly Report of Abortions for Agency approval. We understand the importance of accurately reporting state and federally funded abortions and that there is a financial impact to the State, including recoupment by the federal government, if abortions are reported incorrectly to CMS. We have taken steps to ensure all abortions are reported correctly by ensuring required documentation is included with the claim.

In addition to performing detailed reviews of suspended abortion claims ensuring all required documentation is included with the claim and compiling these claims for the quarterly abortion report, our approach includes a second review of paid claims using the Abortion COLD report. This facilitates additional review of claims potentially related to abortions that would need to be included on the Quarterly Abortion Report.

As part of the process, we will enter an indicator in MMIS identifying the abortion as a state- or federally-funded abortion which will then automatically post to the appropriate line on the CMS report. This process supports the Agency's budget analyst's ability to verify all abortion claims have been included accurately on the CMS report.

We will continue to provide the Quarterly Abortion Report to the Agency within five days of the end of the quarter. We have met or exceed the expected timeframes for reporting. Additionally, we facilitate the preparation of the Quarterly Report of Hysterectomies and Sterilizations as needed.

4.3.1.16 Assistance in Securing Grants

16. The Contractor shall assist the Agency in its efforts to secure grants as requested, and perform functions that are within the SOW of this Contract that fall under the grant.

We will provide the necessary resources to assist the Agency with all requests to secure grants, and we will perform functions that are within the Scope of Work of this contract that fall under the grant. Our experience includes assisting the Agency in two rounds of its application and successful awards for State Innovation Model grants.

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4.3.2 Utilization Management

4.3.2.1 Prior Authorizations (PA)

This section applies only to the FFS population.

a. Routine PAs.

The Contractor shall process PA requests for routine services to include but not limited to:

i. Audiology;
ii. Certain dental services, including orthodontia;
iii. Certain HCBS services, including CCO;
iv. Certain medical services;
v. Durable medical equipment (DME);
vi. Enteral;
vii. Home health;
viii. Surgical, including physician administered drugs and genetic testing; and
ix. Organ transplant services/related; and
x. Vision.

Prior Authorization (PA) of health services is an important means of managing the use of certain medical services and equipment provided to Iowa Medicaid Fee-For-Service (FFS) members. Our attention to detail helps to ensure access to appropriate medical care while meeting the Member's needs and controlling program costs. We will work closely with the Agency and other IME vendors to develop procedures and criteria for new PA review requests. Telligen will follow Agency Policy guidelines when performing the PA review process.

We will process PA requests for: audiology, dental, orthodontia, Home and Community Based Services (HCBS), Consumer Choice Options (CCO), medical services, durable medical equipment (DME), enteral nutritional supplements and supplies, home health services (through the EPSDT program) to the FFS population under 21 years of age, surgeries, medications administered in a clinical setting, genetic testing, organ transplants, and vision. Telligen will follow Agency-approved criteria for all PA procedures and processes.

Telligen PA Staff Contributions

- ✓ Medical Services PA staff made a smooth transition with the incorporation of Radiology reviews into the established routine PA review process.
- ✓ Medical Services PA staff transitioned MCO Medicaid members back into the FFS population seamlessly and within the Agency specified time frame when one MCO transitioned away from the Iowa Medicaid arena.
- ✓ The PA team was instrumental in confirming procedure and equipment codes requiring FFS PA review to ensure the MCO reviews encompassed the same codes.
- ✓ PA professional staff developed comparison spreadsheets for the WIC program indicating the nutritional supplements allowed through Iowa Medicaid and the unit fee schedule for each product.
- ✓ The Telligen PA team has 40 collective years of experience in PA review, including 3 Registered Nurse reviewers, 1 Licensed Practical Nurse, and a Dental Hygienist.

Our approach is to review the member's medical status to 1) Confirm medical need relative to criteria, 2) Evaluate the requested service or item for its ability to meet the member's medical need, and 3) Determine if the requested service is the least costly means of meeting the member need. We will

either approve the request, deny the request after physician or consultant review, or approve a modification of the request that meets the member's medical need but at a lower cost to the Medicaid program. Our team continuously looks for the most cost-effective means of meeting the medical need.

Figure 18 illustrates our efficient process.

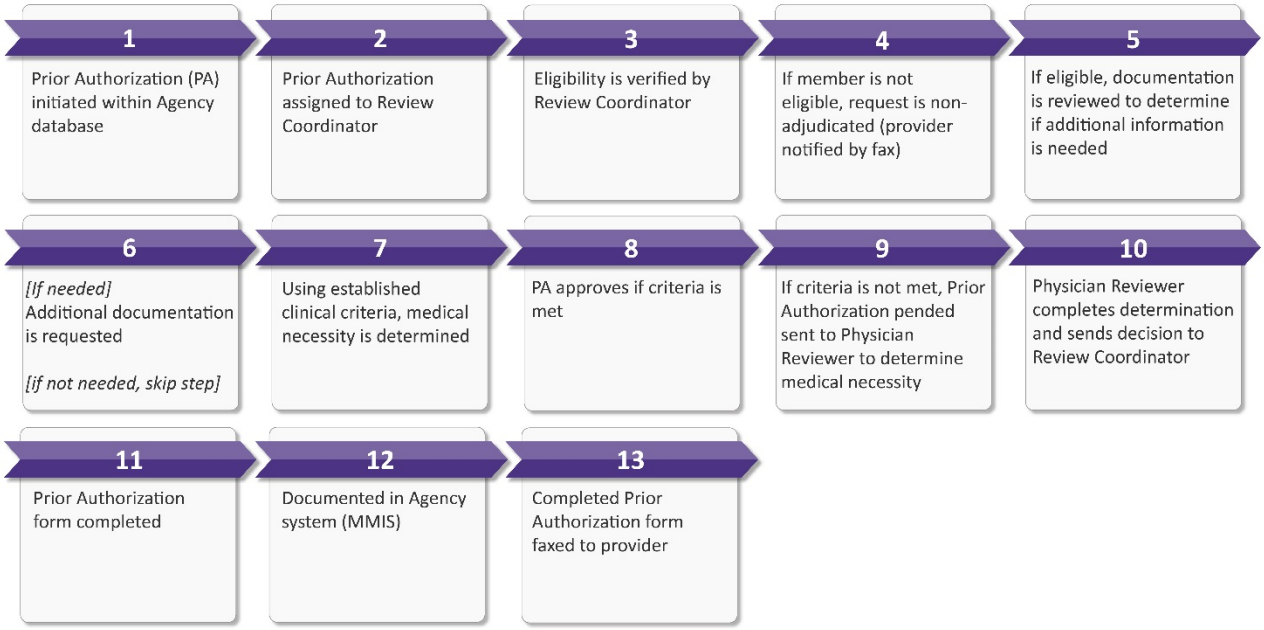

Figure 18. PA workflow. ***We worked closely with OnBase programmers to design an efficient workflow.***

As the Agency's partner, our PA review team will adopt additional services into the PA process as requested by the Agency to provide timely access to services and equipment for the members.

An example of our collaboration is our incorporation of a PA process for genetic testing to replace the ETP review process. The Telligen team researched the service and provided documentation to open genetic testing HCPCS code within MMIS to reflect a requirement for PA review and developed evidence-based criteria for the authorization. This successful process will continue to be available to the Agency to support smooth utilization management transitions in the future.

We will work to further build the file structure endeavoring to identify the services requiring PA prior to service delivery and payment. We will make recommendations while assisting in the review of proposed revisions. Timely adjudication of all PA requests will be ensured to assist in accurate claims processing while utilizing Agency approved policies and procedures.

We will consistently meet all PA objectives in a timely manner and will monitor PA trends to determine if changes are required.

b. Special PAs.
The Contractor shall process PA requests for the following special types of PAs:
i. Swing bed admissions and continued stays. Contractor duties include but are not limited to:
a) Determination of nursing facility or skilled nursing facility Level of Care;
b) Determination of appropriate number of days for authorization based on medical needs of the member;
c) Verification of swing-bed hospital provider efforts to locate appropriate alternative care within a 30-mile radius;
d) Necessary monitoring of swing bed providers to ensure active discharge planning is taking place; and
e) Special consideration for Iowa Wellness Plan Members, as they have different skilled nursing care benefits.

Swing Bed Oversight

- ✓ Telligen has completed hospital swing bed review activity since 2000.
- ✓ Expensive swing bed stays grew to as much as $4400 per day, or $1.6 million per year, per member

The purpose of this review is to ensure Critical Access Hospitals do not keep Swing Bed patients for extended periods of time while receiving high-dollar reimbursements for providing skilled nursing facility Level of Care that can be delivered in a nursing facility licensed to provide this care at a much lower rate. Prior to re-implementation of Swing Bed review, we found CAHs were keeping Medicaid members for Long-Term Care for two or more years without active discharge planning.

At the Agency's direction, each swing bed hospital stay will be allowed an automatic 14-day approval, before the formal swing bed review begins. This is permitted due to a large volume of reviews resulting from Medicare rehabilitation stays requiring only a couple weeks of skilled therapy, such as after a joint replacement surgery.

We will complete LOC review for all Admission and Continuing Stay Reviews for Medicaid Fee for Service (FFS) members using hospital swing beds and determine the appropriate number of days for that care. Medicaid members with managed care will be referred to their MCOs for these reviews. We will conduct evaluations based on CAC-approved criteria for Skilled Level of Care. If the member's care needs do not quality for Skilled Level of Care based on the criteria, we will send the case for physician review.

If the Medicaid member continues to meet criteria for Skilled Level of Care during concurrent review, our review coordinators will actively collaborate with hospital personnel working toward safe discharge planning, either back to the member's previous living status, or discharge to a lower level of care available to meet the member's care needs. Our staff will provide the hospital employees with a list of nursing facilities within a thirty-mile radius of the hospital to seek alternative placement. If it appears the hospital staff is not energetically pursuing discharge, RCs will take it upon themselves to contact facilities to inquire about bed availability, as well as the capability to meet specific care needs.

Telligen will exceed expectations by providing education and customer service to participating hospitals and by following up with the Swing Bed Hospital to ensure discharge has taken place. We maintain close communication with the Agency, especially when the length of stay in a Hospital Swing Bed becomes excessive and there is complexity with alternative placement.

We will make special consideration when a Medicaid member has coverage with the Iowa Health and Wellness Plan (IHAWP). This Affordable Care Act plan has a benefit limitation of only 120 days of Skilled Level of Care in a rolling calendar year. Our review coordinators will work within these limitations, determining the number of Skilled Level of Care days left of the benefit for each member, as well as educating hospital staff and instructing how to apply for regular Medicaid when the member's medical condition appears to have long-term care needs that cannot be met with this Medicaid plan.

After Swing Bed review had been suspended approximately seven years, Telligen began this work again in 2013. Working closely with Program Integrity and Provider Cost Audit to identify high-cost swing bed claims, Telligen began working on alternative placement for each case. Now discharge planning is assured for each Medicaid Member in a CAH swing bed.

Success Story

One success story involved transferring a member to a nursing facility within 10 miles of his home where his niece works.

The receiving facility reported they weaned him from a feeding tube, so that he could eat orally again.

The member and his family expressed much satisfaction with this move, having lived for over one year in an expensive hospital bed.

ii. Behavioral health services. The Contractor shall review criteria approved by the Agency to determine medical necessity and appropriateness for and duration of hospital or other facility stays (if applicable) for persons to receive services addressing behavioral health concerns. These services include but are not limited to:
a) Inpatient psychiatric hospitalization;
b) Residential behavioral health treatment; and
c) Psychiatric Medical Institute for Children (PMIC).

We will conduct behavioral health service reviews in accordance with all state and federal requirements. Our medical staff will review demographic and clinical documentation including diagnoses, service history, medication list and discharge plan to ensure members meet medical necessity criteria and the inpatient, residential or PMIC setting is appropriate to meet their needs.

In 2017, Telligen implemented a new electronic process for inpatient psychiatric hospitalization admissions which increased efficiency and received praise from hospital planners. Hospital personnel initiate the electronic process by completing a prior-authorization form, which is on the Agency's website. Once completed, we submit the PA form to our medical reviewer via secure email designated for the inpatient psychiatric hospitalization process. Our professional staff review the information

submitted for review, enter review information into MQUIDS, communicate the decision to the hospital in writing and enter the decision into MMIS.

iii. Community-based neurobehavioral rehabilitation services. The Contractor shall follow criteria set forth in Iowa Admin. Code r. 441- 78.56 to determine medical necessity for initial and subsequent community-based neurobehavioral rehabilitation services. This includes but is not limited to:
a) Review the provider's treatment plan and supporting documentation, and approve if the following conditions are met:
1) The plan conforms to the medical necessity requirements;
2) The plan is consistent with the written diagnosis and treatment recommendations;
3) The plan is sufficient in amount, duration, and scope to reasonably achieve its purpose;
4) The provider can demonstrate that the provider possesses the skills and resources necessary to implement the plan; and
5) The plan does not exceed 180 days in duration.

Community-Based Neurobehavioral Rehabilitation Services (CNRS) is a recent addition to the PA review process. We will review CNRS using criteria set forth in Iowa Administrative Code. We will determine medical necessity in accordance with criteria and approval of initial and continued stay for CNRS. Information required of the provider will include a proposed plan of care, a standardized comprehensive functional neurobehavioral assessment and medical documentation supporting the brain injury diagnosis and mental health diagnosis.

The PA process will include a review of the treatment plan determined by the provider in accordance with treatment codes H0019 or H2019. The plan of care will include the number of units to be approved under the appropriate code. The review will ensure the treatment plan specifically addresses the member's diagnosis and provides care plan goals specific to meeting the individual member's behavioral and mental health needs. The review will determine the amount, duration and scope of treatment is sufficient to achieve a positive outcome as demonstrated through the member's improved ability with coping skills and their ability to maintain independent living skills.

Telligen developed scoring tools called Functional Needs Assessment Tool (FNAST) and Medical Needs Assessment Tool (MNAST) forms that will be used to determine if the number of requested units is accurate to meet the members behavioral and mental healthcare needs. Using these Agency approved tools helps ensure that our responses are consistent, supported and transparent.

Through our review of the documentation provided, we will assure the provider has the professional skills and resources necessary to implement the treatment plan. Finally, we will support approval of all medically necessary care plans for a time frame up to 180 days.

iv. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT). The Contractor shall review criteria approved by the Agency to determine medical necessity for EPSDT private duty nursing and personal care services. In addition to processing PAs, the Contractor shall conduct care promotion activities to include but not limited to:
a) Collaborate with an interdisciplinary team, as requested, for care conferences when a decrease in the approved number of hours occurs. The interdisciplinary team reviews the options available to assist the family in maintaining their special needs member in the home.
b) Provide a monthly electronic PA summary, including PAs on file for the next 6 months of authorized services, to the University of Iowa Child Health Specialty Clinic (CHSC) for their clients.

To improve the health status of vulnerable Medicaid members from birth through age 21, Telligen will provide medical expertise and assistance at every stage of the Early Periodic Screening, Diagnostic, and Treatment (EPSDT) prior authorization process. A nurse review coordinator will review documentation to determine medical necessity of private duty nursing and/or personal care services provided by home health aides to ensure the member's home care needs are met.

Our nurse reviewer will collaborate with an interdisciplinary team consisting of the member's parent(s) or guardian, case manager and the private duty nursing agency staff during a care conference in the event the requested number of hours are decreased through the review process. The care conference will allow the team to come to an agreement on the number of hours needed to adequately meet the member's needs.

We have found the care conference process often helps the family in understanding the options available to assist with maintaining their child with special needs in their home.

We will provide a monthly electronic summary of all PAs to the University of Iowa Child Health Specialty Clinic. Team members are sent timely alerts through reports derived from the electronic summary to assist in the decision-making process supporting the child's care needs.

Telligen has 12 years of experience reviewing requests for EPSTD private duty nursing and personal care service requests with Agency approved criteria. Our team monitors safety indicators for these children with high needs. As part of our approach the nurse reviewer will track issues found in the documentation that may affect the member's quality of care or may be putting the child's safety at risk. As an example of our quality review, we recently submitted a report to Agency Policy staff and the Program Integrity unit at IME when documentation was found indicating an incident was noted multiple times, revealing questionable activity and placing the child at risk for exposure to extreme outdoor temperatures.

v. Facility short-stays. Contractor duties include but are not limited to:
a) Conduct reviews to identify short-stay approvals for members seeking admission to a Nursing Facility (NF), Skilled Nursing Facility (SNF), ICF/ID, Nursing Facility for the Mentally Ill (NF/MI), Inpatient Psychiatric Hospital, or PMIC when the prior living arrangement was a community setting.
b) Conduct reviews for continued stay to ensure that facility placement is for the shortest duration possible, allowing members who choose to return to the community to do so at the earliest possible opportunity.

Our approach in conducting reviews for facility short stays is to ensure placement is planned for the shortest duration possible allowing the member to return to the community at the earliest opportunity.

Discharge planning begins upon admission and is a part of the medical necessity review especially if a member's medical condition improves.

Our review coordinators will complete the Level of Care review for institutionalized-based care in a Nursing Facility (NF), Skilled Nursing Facility (SNF), ICF/ID, Nursing Facility for the Mentally Ill (NF/MI), Inpatient Psychiatric Hospital, or PMIC facility. The review coordinator will take into consideration the length of stay, and whether the possibility exists for the member to return to their previous living arrangement.

At the time of the admission review, we determine if the member is enrolled in managed care. We refer the facilities to the MCOs for ongoing review if the member does not discharge within the initial 30 days of the facility stay. We actively follow length of stays for FFS members through concurrent review.

Review coordinators will limit initial authorizations for institutional-based care to thirty days following discharge from a hospital if the member previously lived in a community-based setting. If the member has not discharged before the end of thirty days, we request information pertaining to the member's progress since admission and updated discharge planning at the Continued Stay Review. Our processes are directed at supporting member choice and promoting return of the individual to the community at the earliest possible opportunity.

vi. High-tech imaging (such as MRI, MRA, CT, and PET) for radiology services, except in hospital and emergency room settings. The Contractor shall perform the medical review process for high-tech imaging that target variation in practice, promote cost-effective clinical decision making and increase the safety of Iowa Medicaid members.

Unnecessary exposure to high-tech imaging is a safety concern now addressed through oversight of a prior authorization process. We implemented this oversight in collaboration with the Agency to improve patient safety and reduce costs.

We will perform reviews for radiology services to ensure Medicaid FFS members receive adequate medical treatment for medical problems requiring radiologic imaging in a timely manner. We review the high-tech imaging process for radiology services in settings other than a hospital or emergency room using the process described in section 4.3.2.1.a. The PA team will collaborate with the Agency to ensure we receive all requests through IMPA, the electronic submission system. This will include the creation of informational letters educating providers of the IMPA transmission process.

The team will work with providers to ensure the Agency approved PA forms are completed accurately and are submitted with all clinical information pertaining to the requested procedure. Radiology services include MRIs, MRAs, CT scans and PET scans. The review nurses will collaborate with providers to ensure providers understand requests can be submitted using a single HCPC code or a family of codes.

Qualified nursing staff will review all documentation submitted to determine if they can approve the procedure using Agency approved McKesson radiology criteria. If we require additional documentation, the nurse will submit a request, in writing, to the provider. When documentation does not meet established Agency approved criteria, the PA and all documentation will be pended to a physician reviewer for a determination. Only physicians have the authority to deny services.

In the event the radiologic service is denied, the provider will be allowed a peer-to-peer consultation, when requested. The following workflow outlines this process:

If the original denial decision is reversed, the nurse reviewer will modify the original PA form to reflect approval of services. We will send the form to the provider electronically to pursue performance of the requested service.

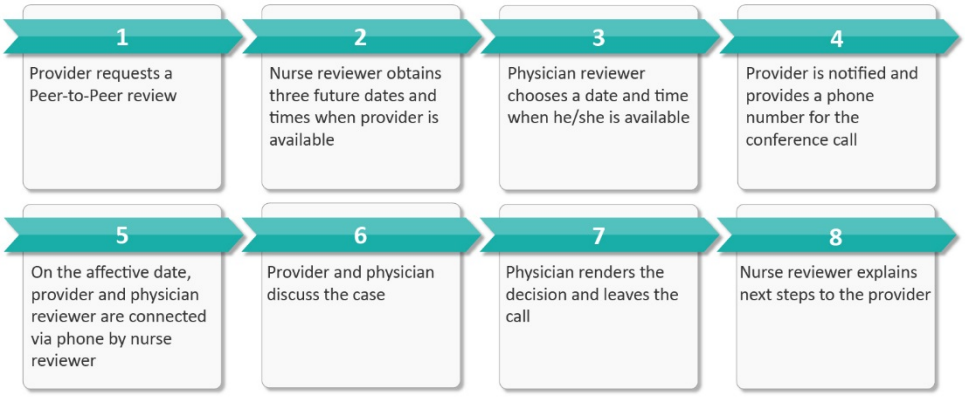

Figure 19. ***Telligen's URAC informed peer-to-peer consultation increases provider access and satisfaction while ensuring members receive medically necessary services.***

c. The Contractor shall provide timely review of all PA requests in accordance with Iowa Admin. Code r. 441-79.9 and the conditions for payment as established in Iowa Admin. Code ch. 441-78 to determine whether the service to be provided is medically necessary and appropriate, determine whether the service should be approved, denied, or modified, and (if approved) determine an approved duration, as required.

Timely review is essential to ensuring Medicaid members receive medically necessary services in accordance with Iowa Administrative Code 441-79.9 and conditions for payment as listed in IAC 441-78. In addition to the Iowa Administrative code, we also use Agency-approved criteria. Upon receipt of all information, our professional nursing staff will review all PA requests to determine if services requested are medically necessary and appropriate. Within an Agency established timeframe, we will notify the provider requesting the PA of our decision, which will include an authorized date-of-service and duration time-frame.

Our process allows for timely receipt of additional information from the provider, if requested. This also allows adequate time to render a fair decision and allow the member to receive the requested service in a reasonable time-frame. When a PA is pended for physician review, we will assure the PA determination is rendered within an Agency established time frame.

Modifications can be made when a PA request includes multiple units of any specific service or product. Modifications of units are determined based on member's individual needs and on the maximum number of units allowed by the Agency as found through research of the service or product code used in the PA request. The provider will be informed of any reductions in units by a statement entered on the PA form during the review process.

d. The Contractor shall request additional PA documentation, as necessary. If additional documentation is not received within 45 days of initial request, the Contractor shall issue a technical denial no earlier than day 45 but no later than 60 days of initial request.

Some PAs require requests for additional information to complete a thorough review and providers must be allowed adequate time to provide that information. In the event the documentation is lacking enough information to support medical necessity of the requested service(s), the review staff will send a letter requesting the missing information to the provider requesting the service(s). We will pend the PA request for 45 days awaiting receipt of additional information. If we do not receive the information within that 45-day time frame, but not more than 60 days from initial receipt, we will issue a technical denial decision. Our successful approach is guided through timers we requested within the OnBase workflow that prompts our team to complete follow up requests for information and technical denials in a timely manner.

e. For any PA requests for which a decision has not been reached within 60 days of request, the Contractor shall:
i. Automatically approve the PA request, per Iowa Admin. Code r. 441-79.8(7)"b"; and
ii. Report immediately to the Agency in writing the reason for inaction.

Telligen will assure the PA determination will be rendered within 60 days of the pend date. If we do not receive information by the 45th pended day, we will technically deny the review before 60 days have passed. Timers within OnBase guide this process. We will base our technical denials on the reason that we did not receive adequate information within the timeframe needed to render a medical necessity decision, supported by Iowa Administrative Code.

We will use an established timing method to ensure we address all PAs that are outstanding at 53 days prior to 60 days. We will technically deny all PAs still pending the receipt of additional information before the end of the 60-days.

We will automatically approve any outstanding pended PAs beyond 60 days according to Agency policies. A system is in place to assure that no PAs fall into the category of being automatically approved. The timers within the workflow process allow staff to determine if the PA can be completed with a review decision or technically denied for lack of adequate documentation to render that decision. The agency will be notified, in writing, of any PAs that are automatically approved due to being pended longer than 60 days.

f. The Contractor may approve, but cannot deny, a PA request without first referring it to a peer consultant.

While our professional review coordinators may approve PA requests, we will provide professional medical staff to perform PA reviews as directed by the Agency, including a full time medical director, registered nurses and peer reviewers with recognized credentials. We will maintain a physician review panel comprised of licensed board-certified practicing physicians and professionals. In doing so, we will ensure all PAs requiring peer review are given consideration by the correct peer.

Telligen has 46 consulting peer reviewers covering general/family practice, internal medicine, surgery, psychology/psychiatry, orthopedics, optometry/ophthalmology, orthodontia, dental, obstetrics, anesthesiology, otolaryngology, critical care, pulmonary services, therapists, audiology, gastroenterology, neurology, vascular medicine, and organ transplants. We credential each peer consultant using a URAC approved process.

Only peer consultants will be allowed to render denials other than technical denials. The peer consultants will base their denial decisions on a review of all documentation submitted for review with the PA requests. The peer consultant will provide written rationale of the decision based on clinical expertise and medical knowledge while staying consistent with Iowa Administrative Code.

Our peer consultants' decisions will be rendered within 15 business days from the date we received the PA request. Through FY17, Telligen has 100 percent compliance with this process and often exceeds Agency expectations.

g. When a PA request is denied or modified, the Contractor shall send a copy of the Request for Prior Authorization form(s) to the provider and produce and send notice of decision (NOD) to the Member and provider, on Agency-approved forms, to include but not limited to the following information:
i. The reason and the circumstances for the adverse action;
ii. The appropriate section of the Iowa Administrative Code;
iii. Information as to the specific reason for the denial that Members would understand as the basis for denial; and
iv. Member appeal rights.

Providers and members are entitled to clear information about the reason a requested service was denied or modified. Notices of Decision (NOD) are important tools to educate providers and members regarding program requirements. We will issue an NOD to the provider for all cases involving a denied or modified PA and fax the notification to the provider. The nurse reviewer will enter the denied information from the PA form into the agency PA billing verification system to generate a formal NOD, which we will send by mail to the member.

We will include the reason and rationale for all NODs issued for adverse decisions and will reference the appropriate Iowa Administrative Code supporting each denied or modified determination. The information will be shared with Medicaid members and providers revealing the specific reason for denial, and to enhance understanding of that reason. We will include Information regarding the member's right to appeal in the NOD. We will send a copy of the PA form and the NOD to the member

and provider for all cases resulting in an adverse decision. The NOD will also provide the appropriate IAC citation supporting the denied decision.

h. When a PA request is approved, the Contractor shall send a copy of the Request for Prior Authorization form(s) to the provider with the PA decision.

We will send a copy of approved Request for Authorization form to the provider requesting the service. The PA form will include information and any special instructions involving how reimbursement is calculated (in the absence of a pre-determined fee schedule), if the number of units requested is modified, along with r any information pertinent to the processing of the PA service claim. For enteral nutritional supplements, the form will include the calculation used to determine the number of units approved, especially in the event the member receives nutritional supplements through the Women, Infants and Children's (WIC) program.

i. The Contractor shall maintain PA files, to include but not limited to:
i. Maintain detailed audit trail reports of all changes to PA records, indicating date of last change, ID of the person making the change, and information changed for each PA record;
ii. Maintain PA requests and supporting documentation in the Agency workflow management system. Hardcopy requests and documentation will be imaged by the Agency-approved system contractor and be made available to the Contractor electronically; and
iii. Update Agency data systems with outcomes of PA decisions.

Detailed audit trails ensure transparency of a program supported by public funds. Telligen will maintain a detailed audit trail of all changes made to PA records. All information will indicate the date changes are made and will include an Agency established numerical ID of the staff responsible for the change. Documentation will be provided in the system providing the reason for all changes.

We will maintain all PA requests and supporting documentation in the Agency approved workflow management system. When hardcopy requests are required for the PA review process, they will be accessed through the same electronic workflow system.

As a part of the review process, the Agency data systems will be updated with PA review decisions. Telligen will work with the data system management unit to ensure these updates are completed.

We will work with IME units to ensure timely and accurate claims processing for cases involving PA reviews.

j. The Contractor shall track, trend and analyze services requiring prior authorization and report recommendations for policy changes to the Agency as requested.

Our PA team will submit a monthly report documenting the timeliness of PAs, the volume of requests received and completed, the rate of denial, the number of ALJ reversed decisions, and the reasons for decision reversal. Our approach to trending services requiring prior authorization will rely not only on our analysis of this monthly report but also our tracking of questions or concerns raised by Medicaid providers involving the PA process. Our analysis will also be informed by our routine review of criteria and our interactions with the Clinical Advisory Committee and our staff participation in conferences including the Medicaid Medical Directors Learning Network.

We will provide recommendations for prior authorization policy changes to the Agency. As an example, we recently proposed a reduction in the number of dental crowns allowed per member per year with a potential cost savings of approximately $200,000 annually.

k. The Contractor shall submit a report of HCBS PA activities that occurred the previous month, with fiscal year-to-date totals, analysis of trends, and recommendations for improvements (including internal quality improvements) to the Agency on a monthly basis.

Paula Motsinger, Medical and LTSS Operations Manager, will meet with the HCBS PA team monthly to review developing trends, discuss quality improvement strategies, and help develop quality improvement initiatives. Using data from OnBase, we will compile and submit a monthly report on HCBS PA activities. The report will include analysis of trend areas, monthly and fiscal year-to-date totals, and recommendations for improvements. The reports will also address internal quality improvement recommendations including the need for system, staffing or process changes. We will submit all reports electronically via secure email or placed on the secure drive for review by the Agency.

4.3.2.2 Level of Care and Needs Based Eligibility Assessment Reviews for LTSS

a. The Contractor shall perform the following types of Level of Care (LOC) and needs based eligibility assessment (NBA) reviews for the LTSS programs and populations identified:
i. Initial LOC Review, for all applicants or Members (FFS and MCO) upon admission or when accessing HCBS waiver program, facility (NF, SNF, ICF/ID, and PMIC), and PACE (regardless of funding source) services for the first time;
ii. Continued Stay Review (LOC-CSR), for HCBS waiver program, facility, and PACE services, annually or when there is a significant change in the Member's needs for the following populations:
a) All FFS Members;
b) Any MCO Member where the MCO determines the LOC has changed; and
c) All PACE members, regardless of funding source (i.e., FFS, MCO, Medicare, and private payer).
iii. Initial NBA Review for all applicants or Members (FFS and MCO) requesting Medicaid funding for Habilitation services for the first time;
iv. Continued Stay Review (NBA-CSR) for Habilitation services, annually or when there is a significant change in the Member's needs for the following populations:
a) All FFS Members; and
b) Any MCO Member where the MCO determines the NBA has changed.

We have been conducting Level of Care (LOC) reviews for 39 years. Our dedication to continuous quality improvement has brought consistency and uniformity to the LOC and Needs Based Assessment process for Medicaid members utilizing 1915(c) Waivers and 1915(i) State Plan HCBS. Our review processes include an objective approach to determining medical necessity for each member based on their functional ability and their medical, psychological, and mental health condition.

We are committed to the ongoing process and future collaboration with the Agency to ensure the integrity of the LTSS programs.

We conducted listening sessions throughout the state for each waiver program and supported the Agency in its determination the interRAI suite of assessments was a comprehensive tool that provided information to complete the level of care review. We use the interRAI assessment for each remaining waiver program as the Supports Intensity Scale had previously been selected for persons with intellectual and developmental disability. Additionally, our LTSS team reviewed each assessment tool

and prepared guidelines for assessors to ensure they were capturing needed information to determine LOC based on Iowa's specific criteria.

The assessments provide in-person validation of the member's functional ability and contain multiple indicators of the member's cognitive and emotional status. Our approach is to thoroughly review the needs based assessment and to match key indicators on the assessment with each criterion of Iowa Medicaid's LTSS program. Telligen will perform Level of Care (LOC) and needs-based eligibility assessment (NBA) reviews for the LTSS programs identified:

- Initial LOC Review, for all applicants (FFS and MCO) upon admission or when accessing HCBS waiver program and facility (NF, SNF, ICF/ID, PMIC, and PACE) services for the first time;
- Continued Stay Review (LOC-CSR), for HCBS waiver program, facility and PACE services annually or when there is a significant change in the applicant's needs for the following populations:
  - All FFS members
  - Any MCO Member where the MCO determines the LOC has changed.
  - All PACE members
- Initial NBA Review for all applicants or members (FFS and MCO) requesting Medicaid funding for Habilitation services for the first time;
- Continued Stay Review (NBA-CSR) for Habilitation services, annually or when there is a significant change in the Member's needs for the following populations:
  - All FFS members
  - Any MCO Member where the MCO determines the NBA has changed.

b. The Contractor shall begin LOC and NBA reviews once request is received via ISIS workflow milestone, certification form, or core standardized assessment submittal.

We will begin the LOC and NBA reviews once we receive a request. Initial and continued stay level of care reviews are initiated through ISIS workflow milestone, a fax certification form from providers and/or case managers, or the submission of a core standardized assessment.

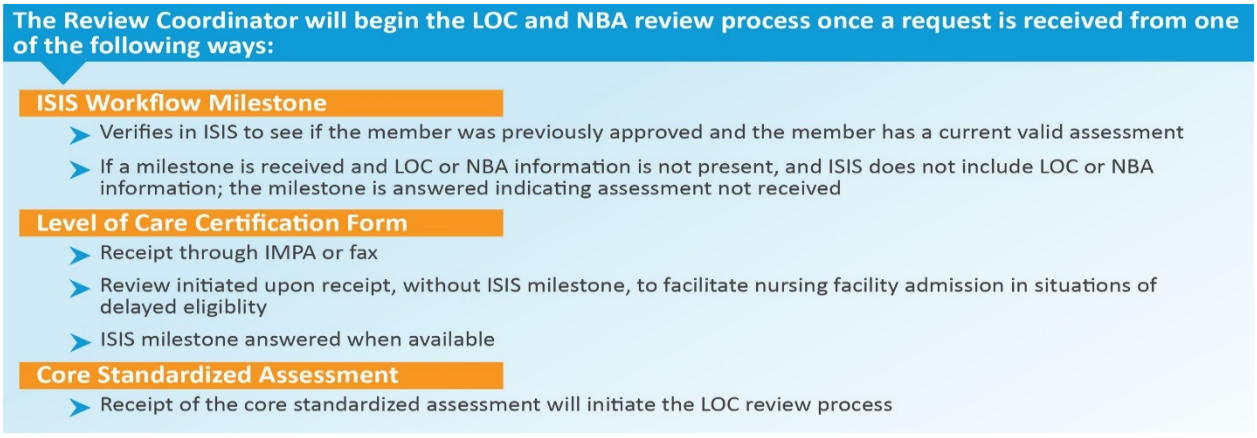

Figure 20. LOC and NBA review process.

Our experienced team will manage intake of new medical records received daily and quickly move these to review coordinators for all programs. Whether the records are faxed or uploaded to IMPA, they are received by our team electronically in OnBase. Our successful process has key components to ensure timeliness and thorough responses:

- Support staff schedules are aligned for continuous coverage of logging, keywording, and assigning documents
- Staff have easy access to Review Coordinators for any needed clarification and to respond to an urgent request
- Appeal requests are handled with priority
- Review Coordinators complete daily workloads assignments in OnBase and ISIS queues
- Review Coordinators check queues throughout the day
- Management staff monitors workloads and a daily reporting dashboard

Our LOC and NBA review team members work together closely and help one another when workloads are heavy or when a reviewer has additional responsibilities or meetings.

c. The Contractor shall accept documentation for LOC and NBA review from the Member's physician, provider, case manager, MCO, and/or core standardized assessment (CSA) vendor. The Contractor shall request additional information, as necessary.

We will accept documentation for LOC and NBA reviews from the member's physician, provider, case manager, MCO, and/or the core standardized assessment vendor throughout the level of care review process. We also use previously submitted information stored in State systems to avoid unnecessary requests and duplication of information previously received.

If the review coordinator determines additional information is required to complete the medical necessity review for waivers, nursing facilities, PACE, out-of-state facilities, PMIC, ICF/ID, and mental health institutes (MHI), we contact the appropriate individual by telephone, e-mail, and/or letter to gather information needed to complete the review. Also, the review coordinator will enter an electronic note into ISIS documenting the request. The ISIS milestone process will prompt the case manager that additional information is required to complete the review for the FFS population who are assigned a CM/SW.

Having all information available during the review process increases the accuracy of the review, maintains program integrity, and allows for prompt initiation of services for the member. We will only request information necessary to complete the review.

Our review coordinator will request additional information if she identifies a discrepancy in the medical record and/or needs further clarification to make an appropriate and informed LOC decision based on the member's care needs. All review documents received will be scanned and stored in OnBase workflow for easy retrieval or to support appeal requests. Examples of additional information requested may include but not limited to:

- Physician clinic notes

- History and Physical
- Laboratory results
- Tests and procedures
- Medication list
- Diagnoses list
- Psychiatric evaluation

Review coordinators will document demographic and clinical information obtained in each review in OnBase or MQUIDS system as appropriate to the type of review. Clinical documentation will include diagnoses, service history, medication list, functional limitations that meet level of care criteria, approval or peer review outcomes, appeal data, any other information to support the level of care decision, and the next review date. The clinical documentation in MQUIDS is a record of all services received by the member and is a database from which reports can be generated.

d. The Contractor shall ensure LOC and NBA reviews are based on an objective and accurate evaluation of the individuals' needs. Based on these reviews, the Contractor shall:
i. Determine whether LOC and NBA criteria are met in accordance with all State and federal requirements based on information provided;
ii. Approve or deny LOC or NBA requests, in accordance with criteria and within timeframes established by the Agency;
iii. If services are approved, review service plan. If changes to the service plan are necessary, notify the case manager, as required;
iv. Document LOC and NBA decisions within Agency data systems; and
v. Produce and send notice of decision (NOD) to the Member, physician, provider, case manager, and/or facility, per Agency requirements.

We will ensure LOC and NBA reviews are based on objective and accurate evaluation of the applicants' needs and approve or deny in accordance with criteria and authority given Peer Reviewers by the Agency.

Using established criteria ensures we complete reviews consistently and objectively within each program and completing the review in a timely fashion ensures the member does not have a delay in starting services.

Review coordinators will use established physician-approved criteria that the CAC reviews annually. This ensures we complete reviews consistently and objectively for each program. The criteria are established on evidenced-based standards and accommodations for the Iowa Administrative Code (IAC) as it relates to the application of the criteria, as required. We will follow all state and federal standards such as unique coverage rules for IHAWP members.

Our objective evaluation includes the following areas:

- Functional ability
- Psychosocial well-being
- Communication and vision
- Skin condition
- Continence
- Disease diagnoses
- Treatments and procedures
- Social supports
- Cognitive status
- Mood and behavior
- Mobility
- Pulmonary status
- Nutrition
- Health conditions
- Medications
- Environmental assessments

Our review coordinators will complete level of care (LOC) and needs based assessment (NBA) reviews on admission to the programs within two days following receipt of the information needed to make a determination. They will complete continued stay reviews within five days following receipt of the necessary information. They will complete the annual continued stay review more frequently if a member has a change in condition or the original level of care was approved for less than one year. Reviews approved for less than one year are determined by medical condition and medical necessity.

We will update MQUIDS, OnBase, ISIS, and MMIS (when appropriate) with the results of the LOC and NBA review. We will scan and store all review documents in OnBase workflow for easy retrieval. All documentation becomes historical data and is available for review by the Agency.

We will initiate the LOC in ISIS and complete milestones on each member during the review process. We will enter it into ISIS, along with the approved LOC for which the member is eligible. We will complete for each member effective dates with timely NODs with a denial or lower LOC decision.

We will use both ISIS and MMIS to determine if there is managed care involvement for the member. Facility, LOC and NBA reviews are prompted by ISIS or with the submission of the level of care certification form or appropriate core standardized assessment. We will not delay the nursing facility level of care review, waiting for Medicaid eligibility in ISIS, since Medicaid eligibility can be a moving target, especially as a member moves back and forth between Medicare and Medicaid coverage.

Telligen follows the best business practice of completing the review as soon as possible within guidelines, then completing ISIS when the milestone becomes available.

Our team members are available to talk with members and families as questions arise regarding level of care processes and outcomes. We know it's important to understand the member's unique condition and needs. We will approve all requests that meet criteria and program guidelines. Figure 21 illustrates our workflow for LOC and NBA reviews.

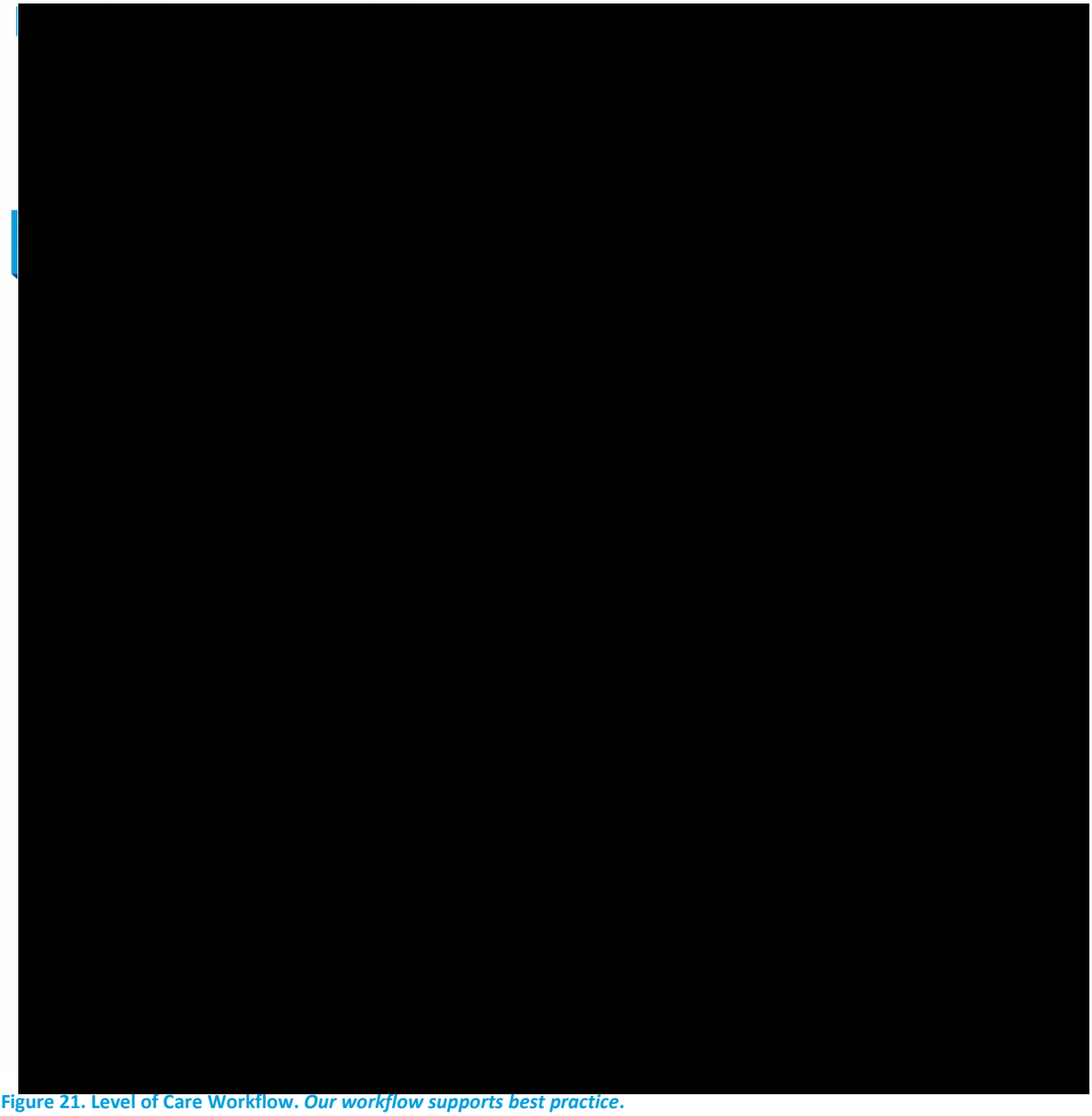

Figure 21. Level of Care Workflow. *Our workflow supports best practice*.

When we approve the request, we will review the service plan to ensure it is adequate to meet the member's needs. If changes to the service plan are necessary, we will notify the case manager via ISIS.

If our review coordinator cannot approve Level of Care based on criteria, the review will be referred to a physician reviewer or medical director. If a denial decision is made by the physician reviewer or medical director, the Review Coordinator will enter the denial rationale, including the IAC reference, into ISIS which will provide notification to the care manager and IMW who are responsible for mailing NODs. In addition, the Review Coordinator will notify the MCO via email and include the reason and denial rationale in relation to the IAC.

Our review coordinators will document demographic and clinical information obtained in each review in the MQUIDS application system. Clinical documentation will include diagnoses, service history, medication list, functional limitations that meet level of care criteria, approval or peer review outcomes, appeal data, any other information to support the level of care decision, and next review date. The clinical documentation in MQUIDS is a record of all services received by the member and is a database from which reports can be generated.

e. The Contractor shall submit a quarterly report to the Agency on applicants and Members approved and denied for LTSS based on LOC and NBA determinations, using Agency-approved criteria.

We will complete quarterly reports on the outcomes of LTSS and NBA reviews and submit them to the Agency within specified timeframes. The reports will display each type of review completed and the outcome of the review, by category. Our management team will work collaboratively with the Agency to determine if enhancements are requested and will revise reporting templates accordingly.

4.3.2.3 Tiered Rates

The Contractor shall assist the Agency in determining payment tiers for supported community living services, residential-based supported community living services, day habilitation services, and adult day care services provided under the Intellectual Disabilities (ID) waiver. Duties include but are not limited to:

a. Determine acuity tiers based on the results of the SIS assessment tool;

b. Assign acuity tiers based on mathematically valid processes;

c. Assign tiers to all new applicants or Members (FFS and MCO) requesting Medicaid funding for ID waiver services for the first time; and

d. Assign tiers annually or when there is a significant change in the Member's needs for the following populations:

i. All FFS Members; and

ii. Any MCO Member where the MCO determines the Level of Care has changed.

In 2017, Telligen leaders collaborated with the Agency and other IME vendors to develop a process for assigning tiered rates for Medicaid members using supported community living (SCL) services, residential-based supported community living services (RBSCL), day habilitation services, and adult day care services through the Intellectual Disability (ID) waiver. We will again employ our successful approach under the new QIO Services contract.

[redacted] Medical LTSS Operations Manager and [redacted], Biostatistician, will work closely with the American Association of Intellectual Developmental Disabilities (AAIDD)'s technology solutions partner (AJ Boggs) and Agency personnel to develop an automated process to assign acuity tiers. The process involves transferring the raw results of the SIS assessment tool to IME, applying the IME algorithm against the results to calculate the acuity tier, saving the acuity tier to electronic review records, and notifying Telligen reviewers of the update. The algorithm used to calculate the acuity tier will use criteria identified in Iowa Administrative Code for supported community living services, residential-based supported community living services, day habilitation services, and adult day care services provided under the Intellectual Disabilities (ID) waiver applied against scores from specified sections of the SIS.

Following the review process, Telligen reviewers will assign acuity tiers based on a mathematically valid process for all new applicants for FFS and MCO enrolled Medicaid Members requesting Medicaid funding for ID waiver services for the first time. We will enter the acuity tier into ISIS at the same time we enter the assessment dates.

During the CSR process, we will assign acuity tiers annually or when there is a notable change in the member's needs for the full FFS population. We will update acuity tiers for Medicaid Members enrolled in managed care if the MCO determines the LOC has changed.

We will continue to collaborate with the Agency on all activities related to tiered rates.

4.3.2.4 Quality Reviews

The Contractor shall conduct quality reviews in accordance with all State and federal requirements, as approved by the Agency. Duties include but are not limited to:
a. HCBS Waiver and Habilitation Program Evidentiary Reviews
i. Coordinate the reviews with other IME Units and Agency staff.
ii. Review assessed needs, medical necessity, person-centered care planning, effective services delivered timely, and discharge plans. The review shall determine whether:
a) Services are individualized and reflect member's preferences and needs.
b) Services are implemented as planned and produce the desired results.
c) Members are safe and secure.
d) Members are free to exercise their rights.
e) Services strive to improve quality outcomes for members.
iii. Provide results of these reviews to the Agency for approval, prepared in accordance with the Agency's HCBS evidentiary materials guidelines, as approved by CMS.
iv. Provide a written review findings report to the Agency, to include recommendations for enhancements, corrective actions, or both, within 30 business days of completion of the quality reviews, subject to Agency approval.

To assist the state with reporting CMS Assurances related to Iowa's 1915(c) Waivers and HCBS 1915(i) State Plan HCBS (Habilitation) programs, Telligen will conduct quality reviews in accordance with all applicable state and federal requirements.

The QA process will require coordination with other IME vendors including CORE and Data Warehouse. The State's Data Warehouse Unit will initiate the process and pull a representative sample of Medicaid members monthly from ISIS. The representative sample will be sent to Telligen to initiate the review process.

To begin our review process, we will send a letter to the targeted case manager (TCM) and HCBS provider(s) requesting the department approved assessment, person-centered service plan, provider(s) plan and daily service documentation for a specified timeframe.

Case managers and providers will submit documentation to compete the Quality Review process via IMPA. The documentation will be imported to OnBase by CORE and dropped to an appropriate work queue. Our team of clinical and professional staff will review the documentation to ensure compliance with State and Federal requirements and national best-practices. Each quality component will be

addressed on an electronic quality review tool in OnBase. This review tool will allow CMS evidentiary components to be scored, aggregated and shared with the Agency monthly on the Quality Assurance Report.

Following receipt of documentation, our staff will review the documentation to determine if all documentation is compliant with state and federal requirements. We will request additional information from the TCM, CM or provider(s) via letter if needed.

Following the review process, if any quality measurement does not meet applicable state and federal requirements we will request the TCM, CM, or SW to update the service plan to meet the requirements and submit an updated service plan. If we do not receive a response to the request for an updated service plan from the TCM, CM, or SW after 30 calendar days, we will send a second request letter to the TCM, CM, or SW and their supervisor requesting an updated service plan.

We will share the scored quality tool with providers to provide transparency of the review outcome and to facilitate education regarding quality of services. We also highlight comments to help providers remediate areas that need improvement.

The outcome of the quality review, including the rationale, will be displayed in a quality tool and mailed to the TCM, CM/SW, and provider(s) within 30 calendar days of receipt of all information. We will report aggregate results of quality reviews to the Agency as needed for CMS Evidentiary requests.

We complete HCBS Waiver and Habilitation Program evidentiary reviews and address the following CMS Sub-Assurances:

- **Level of Care** - to ensure Medicaid members are assigned the appropriate LOC to meet their needs
- **Service Planning** – to ensure the person-centered services plan is developed and implemented and ensure that the applicant and/or guardian participated and included in the decision-making and development of the service plan
- **Health and Welfare** – to ensure safety and welfare needs are met
- **Qualified Providers** – to ensure providers initially and continually meet required licensure/certification standards

To address the CMS sub-assurances, the written person-centered service plan, Agency approved assessment, and daily service documentation will be reviewed to ensure the following:

- Service plan is individualized and addresses the Member's assessed health and safety risks
- Service plan identifies Member's preferences, including choice of provider(s)
- Service plan addresses personal goals and desired outcomes
- Service plan addresses Member's rights and responsibilities
- Service plan contains a plan for emergencies and supports available to the member in the event of an emergency

- Service plan includes all providers, amount of services, funding source and is signed by Member or representative
- Consumer choice option (CCO) offered in the plan
- Services are implemented as identified in the service plan and produce the desired outcomes
- Evidence of team communication regarding services coordinated by the TCM or CM/SW
- Discharge planning where applicable

To ensure we collect the member's input regarding his services, we will complete Individual Participant Experience Surveys (IPES) with Members included in the representative sample. We will complete IPES telephonically unless the member, TCM, CM or representative indicates a preference for in-person completion of the tool.

Health and safety concerns will also be addressed through the review of incidents and complaints pulled from IMPA.

We will collaborate with the Agency to develop a reporting mechanism to fulfill their requirements. As an enhancement, we suggest that a monthly report of completed QA reviews, including the waiver program and remediated review outcomes, could be submitted along with current monthly deliverables.

In SFY 17, the Telligen leadership team was an in integral part of a workgroup to develop new state evidentiary performance measures addressing CMS Assurances for HCBS.

b. Community-based Neurobehavioral Rehabilitation Services (CNRS) Quality Reviews.
i. All CNRS providers shall be reviewed over a randomized three year cycle.
ii. Review risk-based service needs, medical necessity, person-centered care planning, effective services delivered timely, and discharge plans to determine whether:
a) Members have a need for assistance
b) Members have a qualifying brain injury diagnosis co-occurring with a DSM-V diagnosis
c) Members have a standardized comprehensive neurobehavioral assessment documenting the member's need for services
d) Members treatment plans are individualized and reflect the members needs
e) Services are implemented as planned and produce the desired results.
f) CNRS staff delivering or supervising direct service to the members meet the training criteria in rule.
iii. Coordinate the reviews with other IME Units and Agency staff.
iv. Provide a written review findings report of the quality review to the Agency, to include recommendations for enhancements, corrective actions, or both, within 30 business days of completion of the quality reviews, subject to Agency approval.
v. Forward a copy of the report to the provider once approved.

We are committed to helping the Agency provide neurobehavioral rehabilitation services to adults with brain injury and co-occurring mental health diagnosis as an alternative to costly out-of-state facility-based neurobehavioral rehabilitation, hospitalization, institutionalization, incarceration, or homelessness.

Our approach will support the Agency's efforts to return applicants to Iowa for neuro-rehabilitation services as an alternative to costly out-of-state services if they can receive needed services closer to home. We will work closely with appropriate subject matter experts to develop a process that aligns with other practices of the Agency.

We will conduct Community-based Neurobehavioral Rehabilitation Services (CNRS) quality reviews for adults with brain injury and co-occurring mental health diagnosis based on State and federal guidelines. Quality reviews will be conducted on all CNRS providers to evaluate the appropriateness of placement and to ensure services are meeting the treatment needs of the Member.

We will conduct quality review for all facilities the first year and conduct follow-up reviews over a randomized three-year cycle. We will create and maintain an electronic master file relative to the sample and use a Telligen statistician to develop a process for determining a statistically valid sample for the three-year cycle.

Our approach to this important work will include developing a comprehensive Inspection of Care database to record all review activity when conducting the quality review. This process will then be consistent with other quality inspections.

We will review the current medical records for all Members in the facility at the time of the onsite visit. The areas we will review include:

- Risk-based service needs
- Medical necessity and medical need for assistance
- Medical documentation supporting a qualifying diagnosis co-occurring with a DSM-V diagnosis
- Standardized comprehensive neurobehavioral assessment documenting member's need for services
- Person-centered care planning – individualized, measurable and reflect member's needs. We will review the treatment plan to determine whether:
    - The treatment plan is consistent with the written diagnosis and treatment recommendations made by a licensed medical professional that is a licensed neuropsychologist or neurologist, M.D., or D.O.
    - The treatment plan is sufficient in amount, duration, and scope to reasonably achieve its purpose
    - The provider can demonstrate that the provider possesses the skills and resources necessary to implement the plan
    - For continued stays, the Review Coordinator will review and determine if the member continues to meet medical necessity and will review the medical records for:
        - Current treatment plan
        - The treatment summary detailing the member's response to treatment during the previous approval period. We may approve a subsequent neurobehavioral rehabilitation

treatment plan that conforms to the conditions of medical necessity and conditions of continued treatment in rule

- Effective services delivered timely – implemented as planned and produce the desired results
- Discharge plans are addressed
- Member observation will be completed at time of onsite review
- CNRS direct care and supervising staff employment records pertaining to training will be reviewed to ensure training criteria per rule is met

We will coordinate quality reviews and conduct them based on Agency direction. We will network with other IME Units as needed to complete a comprehensive review and ensure that all applicants receive services based on their individual needs.

We will provide a report of the review findings to the Agency within 30 days of completing the onsite quality review. The report will include any recommendations for enhancements, and/or corrective actions. We will send the report to the provider subject to Agency approval.

If a corrective action is warranted, the facility will be informed on the individual member Inspection of Care results. If an immediate threat to the member's health and/or safety is present, the manager will act as directed by the Agency.

Facilities will have no more than 30 days from the date of the letter to address/correct the concerns by responding in writing detailing steps they are taking to address them. The corrective action plan from the facility must include:

- Date of the onsite visit
- Name of the member
- Member SID
- Item(s) cited in the report to be corrected by Inspection of Care tool number
- Explicit steps the facility has taken to correct the problem
- Planned steps undertaken to sustain change
- Date by which correction will be completed
- Staff responsible for the action plan

Once we receive the Correction Action Plan (CAP) from the facility, the review coordinator who conducted the onsite visit will review and approve, unless there are concerns. If the RC notes concerns, the manager will review each CAP with the Agency. If a returned CAP is unacceptable, we will notify the facility in writing of necessary steps to correct. If further action is required to satisfy the CAP, we will request direction from the Agency.

4.3.2.5 Minimum Data Set Validation Reviews

The Contractor shall conduct annual MDS validation reviews of a minimum of 25 percent or approximately 110 of the current Iowa certified nursing facilities, to include but not limited to:

a. Ensure every facility has been reviewed at least once within each four year period.

b. Ensure facilities currently identified as being at-risk and those with the highest MDS error rates from the previous State fiscal year are given priority for reviews.

c. For each facility reviewed, conduct MDS validation on 25 percent, or a minimum of five, whichever is higher, of the Medicaid residents.

d. MDS validation reviews may be conducted remotely as desk reviews or on-site, if deemed necessary based on the complexity and professional opinion of the reviewer.

e. Ensure a minimum inter-rater reliability of 95 percent.

f. The validation review will utilize all pertinent information, including the MDS, the member's medical record, and interviews with facility staff.

g. Conduct exit conference with the nursing facility administrative staff to identify inconsistencies found in the MDS fields utilized for RUGs III classifications. The exit conference shall include MDS assessment with patterns of errors, areas that need improvement, staff education and training needs, and notice of when the final report will be sent to the facility.

h. Confirm Pre-Admission Screening and Resident Review (PASRR) was complete and appropriate documentation is included in the member's medical record.

i. Provide formal written report of the MDS validation process to the facility.

j. Notify the Agency if a nursing facility's error rate is greater than the established threshold or questionable patterns of coding or transmission are noticed.

k. Submit reports of MDS validation review activity and findings to the Agency on a quarterly basis.

The Minimum Data Set is a core set of screening, clinical and functional status elements, including common definitions and coding categories which form the foundation of the comprehensive assessment for all residents of long term care facilities certified in Medicaid or Medicare. Coding of the MDS directly relates to facility reimbursement for Medicaid residents. This important validation process identifies MDS items coded in error, as well as identifying omitted MDS items and is an integral part of the quality assurance process for accurate payment to nursing facilities.

We successfully changed the MDS validation work in 2017 to an offsite desk review, compared to reviews that have historically been completed onsite. While there were a few nursing facilities still completed onsite based on necessity, the majority were completed offsite saving travel time and expense. We created system updates to accommodate this work as an offsite review, to support all necessary data collection, as well as reporting to the nursing facilities and to the Agency.

Our approach begins with requesting specific medical records required for the MDS Validation based on RUG scores of each Medicaid resident selected. We give the facility options to supply the records by uploading the documents into IMPA, faxing the records to Telligen, or mailing the records using the U.S. Postal Service at the facility's expense. Several nursing facilities have allowed us access to their electronic health records for the brief time needed to complete the validation. This proves to be the most efficient mode for our reviewers, as well as the nursing facilities.

Our validation review uses all pertinent information needed to identify clinical characteristics and functional abilities of the resident, including the MDS, the medical record, and interviews with facility staff. Major RUG Categories include:

- Rehabilitation
- Extensive services
- Special care
- Clinically complex
- Residents receiving complex clinical care or with conditions requiring changes
- Impaired cognition
- Behavior problems
- Reduced physical functioning

For each facility, we will perform MDS Validation on 25 percent of the Medicaid residents, or a minimum of five, whichever is higher.

Our tested process to ensure a minimum inter-rater reliability of 95 percent includes dual review on a statistically valid sample by two different review coordinators. If we find any discrepancies, we discuss the reasons and arrive at a resolution that ensures ongoing consistency.

In addition to 25 percent of the nursing facilities, which is approximately 110 facilities, we will also complete MDS Validation for all facilities on the No-Admit List. This list includes nursing facilities considered at-risk based on issues found on DIA surveys. Nursing facilities that had higher inconsistencies found with previous validation work are also included with the next scheduled review. We record this data and track the four-year cycle of validation reviews for each nursing facility.

As an important part of our process, we schedule an exit conference with the nursing facility administrative staff when we complete the MDS validation review. At this time, we provide recommendations to improve documentation when we identify inconsistencies between the medical record and the MDS coding. We design our collaborative feedback to reduce future errors and increase the accuracy of MDS coding. The information we share during the exit conference will include pattern of error, areas that need improvement, as well as staff education and training needs. We will send a final written report to the nursing facility within thirty days of the exit conference.

Telligen exceeds expectations by collecting data related to Quality Measures to provide high-level overview for tracking trends and potential risks to nursing facility residents who may be receiving sub-standard care.

As requested by the Agency, our MDS review coordinators confirm compliance of the Pre-Admission Screening and Resident Review (PASRR), as well as monitoring for supporting PASRR documentation with each validation. As a quality review, we note falls, skin breakdown, and dysphasia. We follow-up with nursing facility staff as to whether appropriate care planning is found for each identified item.

We will inform the Agency if a nursing facility rate is greater than the established threshold or questionable patterns of coding are noticed. Any nursing facility with an error rate greater than 25 percent of the expected threshold will have their sampling increased by an additional 25 percent and the Agency will be notified of the increase.

We will submit quarterly report to the Agency documenting MDS Validation review activity and findings.

Although this is not requested by the Agency, we recognize the importance of having staff MDS-Certified. This ensures our reviewers are equipped with knowledge and authority when working with nursing facilities. All Telligen staff also have long-term care experience as clinical nurses. One staff member is additionally dementia-certified. All three review coordinators have valuable proficiency as they all have previous experience working as MDS coordinators in nursing facilities.

4.3.2.6 Utilization Reviews (URs)

For the entire Medicaid population, the Contractor shall conduct UR activity in accordance with 42 CFR Part 456. Contractor duties include but are not limited to:
a. Facilities.
For ICF/ID, NF/MI, PMIC, and Mental Health Institute (MHI) facilities, evaluate the appropriateness of placement and that services are meeting the treatment needs of the member, to include but not limited to:
i. Conduct an annual on-site review of current medical records for and observe members in the facility at the time of the onsite visit.
ii. Provide a written review findings report of the UR results to the facility, to include recommendations for enhancements, corrective actions, or both, within 30 business days of completion of the review.
iii. Report aggregate findings to the Agency on a quarterly basis.

Telligen behavioral health review coordinators will conduct an annual onsite review at all ICFID, NFMI, PMIC, and MHI facilities where eligible Medicaid members reside. We schedule these reviews within 10-12 months from the date of the previous years' onsite visit. Using tools we created from 42 CFR Part 456 requirements, we will review eligible Medicaid members at each annual onsite visit. Our behavioral health review coordinators will review medical records to ensure services are meeting the needs of the member. We will also complete an observation of each member at the time of the review.

Following the onsite visit, we will send the facility a completed, individualized tool for each member, as well as aggregated results, within 30 business days of review completion. The tool will tell them the outcome of each review criterion. The individualized tool may contain recommendations for enhancements or corrective actions for each member reviewed. We will provide aggregated review results to the Agency on a quarterly basis. Our staff will work collaboratively with Agency staff to ensure the aggregated results contain sufficient data to meet Agency needs.

When scoring reveals serious concerns with treatment plan or treatment progress, we will initiate a request for corrective action. The facility has 30 days to respond with a plan to correct identified deficits. We will inform the Agency when facilities fail to cooperate with the corrective action plan. We will also provide the facility report to the Agency. Results of the reviews conducted monthly are aggregated and provided to the Agency for their review of relative strengths or concerns.

b. Hospitals.
For hospitals, evaluate utilization control processes to assess their comprehensiveness and verify their completion. Duties include but are not limited to:
i. Conduct a triennial desk review of hospital utilization control process documentation.
ii. Notify the provider of the review results, including any identified deficiencies. This letter will be sent to each CAH within three business days following review completion.
iii. Provide a written review findings report of the UR results to the Agency, to include recommendations for enhancements, corrective actions, or both, within 30 business days of completion of the review.
iv. Report aggregate findings to the Agency on a quarterly basis.

We will continue to complete a triennial desk review of hospital utilization control processes in accordance with Code of Federal Regulations (CFR) part 485, Subpart F, Sections 485.635 through 485.641 for Iowa critical access hospitals (CAH), and to Federal requirements defined in CFR 42, Part 456, Subpart C for Iowa acute hospitals.

We have established triennial schedules to ensure timely reviews; CAH review 2009 (baseline), 2011, 2014, 2017 and 2020, etc.; and acute hospital review 2009 (baseline), 2012, 2015, 2018 and 2021.

We developed individual scoring tools from the appropriate regulations for both acute and CAHs. In addition, we created a database to house the results from the tools, which we also use as a tracking mechanism for documentation we have received. The IME mailroom scans all documentation and makes it available through OnBase. As we receive documentation from the facility, we review the submitted documentation within 30 days of receipt and score each component as appropriate on the tool.

During this review, we will report any deficiencies in the documentation to the facility. If documentation is not located for any regulation, we will call the facility to obtain the missing information. If necessary, we will review with Agency policy staff and implement corrective actions for any hospital found to be lacking in most of the reviewed categories.

Within three business days of completion of the desk review, we will send a tool to each hospital that recites each regulation and how the facility scored. We will also provide a findings report to the Agency that includes recommendations for enhancements or corrective actions within 30 business days of review completion.

We will submit an aggregate report to the Agency on a quarterly basis that displays each hospital's aggregated totals for each section of the tool. We will collaborate with the Agency to develop additional reporting as necessary.

4.4 Quality Oversight Operations for HCBS Waiver, MFP, and Habilitation Programs (RFP 1.3.1.4)

4.4.1 General Requirements

For requirements listed in Section 1.3.1.4, the Contractor shall:

1. HCBS Quality Assurance and Quality Improvement Recommendations. Duties include but are not limited to:

a. Identify improvements to the technical and functional requirements of the HCBS waiver continuous quality improvement (CQI) process.

b. Make recommendations to the Agency that identify system improvements and best practices in quality assurance and quality improvement within the HCBS waiver, Habilitation and MFP programs.

c. Recommendations shall be based upon trending and analysis of data collected from Contractor functions.

d. Collaborate with other IME Units to make recommendations to the Agency that recommend policy revisions based on identified quality indicators.

e. Report findings to the Agency on a quarterly and annual basis.

Quality assurance and continuous quality improvement (CQI) are integral components of our overall management strategy and approach for HCBS waiver, MFP, and Habilitation programs. Telligen will evaluate and monitor processes, programs, and procedures to ensure technical and functional quality in all stages of the work cycle.

HCBS Reporting and Collaboration

- ✓ Developed Quarterly Waiver Snapshot report
- ✓ Developed and implemented new Self-assessment process in collaboration with Program Integrity
- ✓ Collaborated with Provider Services to update HCBS provider accreditation information in ISIS
- ✓ Collaborated with Policy to review and revise 441 IAC Chapter 77

Evaluation and monitoring involves analyzing data, collaborating with other IME units, and maintaining current knowledge of state and federal guidelines to provide recommendations to the Agency. Ongoing collaboration with IME vendors, Agency personnel and HCBS providers will be an integral part of our daily work processes to recommend, develop and implement quality improvement initiatives. Telligen will actively monitor policies and procedures to identify process improvements on a cyclical basis.

We will identify quality assurance and quality improvement strategies based on trends found during the data analysis process, collaboration with other IME units, and changes to state and federal regulations. We will present recommendations and detailed reports to the Agency weekly, monthly, quarterly and annually. The goal of quality assurance and quality improvement is to ensure Medicaid members receive high-quality services and supports in a cost-efficient environment.

2. HCBS Website. Duties include but are not limited to:
a. Provide rule hyperlinks that explain processes related to provider quality oversight.
b. Provide an updated list of provider training schedules.
c. Provide updated list of staff to include the Program Supervisors and all Specialists with county assignments, a telephone number, and email address.
d. Establish, develop and maintain a continuous FAQ link containing information approved by the Agency SMEs.
e. Provide all other information, to be determined by the Agency, on a timely basis.
f. Contractor shall update Agency-approved HCBS waiver dashboard on a monthly basis.
g. Report activities to the Agency on a monthly, quarterly, and annual basis.

The role of the HCBS unit is to complete review activity and offer technical assistance to Medicaid members, HCBS providers and stakeholders. The HCBS website provides contacts, links to Iowa Administrative Code, and training for providers and stakeholders. It is important for members, providers and stakeholders to know where to find resources regarding services. Telligen will ensure that the HCBS webpage on the Department of Human Services Iowa Medicaid webpage is current. We will monitor links and provide updates as information changes through collaboration with Agency personnel. We will ensure the website includes an updated list of provider training schedules and other important training announcements. In addition, all previous training sessions that are relevant and conform to current procedures and requirements, will be maintained on the website for continued provider use.

We will ensure there is a current HCBS Specialist Map, identifying roles of individual team members, their assigned counties and their contact information, on the Agency's website.

We will actively monitor and manage a FAQ link, which will contain HSBC topics and is approved by the Agency's SME's.

We will develop and provide the Agency with monthly, quarterly, annual and ad hoc reports as requested. We will also develop reporting based on information that has been identified as beneficial to the Agency.

We will complete the HCBS dashboard, Contract Deliverable, HCBS Quality Assurance, and an Annual report as requested by the Agency. The Agency-approved dashboard will include an overall summary of HCBS activity. We will provide this report to the Agency monthly. The Contract Deliverables report will demonstrate compliance with all HCBS requirements in the scope of work and additional tasks completed by the HCBS unit. We will provide this report to the Agency quarterly. The HCBS Quality Assurance report will include HCBS evidentiary performance measures for both the fee-for-service and managed care populations. We will share this report, including trend analysis and proposed changes, with the Agency during the quarterly Quality Assurance Committee meetings. We will also submit the annual report, summarizing all work our HCBS completed in the previous fiscal year, to the Agency.

Telligen has been instrumental in the development and implementation of data driven reports to meet and exceed Agency expectations.

Our statistician recognized the need to analyze fiscal trends related to Iowa's 1915 (c) Waivers and took the initiative to develop a quarterly Waiver Snapshot Report. The quarterly Waiver Snapshot report identifies demographic and financial information for each HCBS waiver. Policy staff have used this report to help them manage their waivers. Since we developed this report, the Agency has requested this report on a quarterly basis.

3. Administrative Support. Duties include but are not limited to:
a. Complete any clerical and administrative functions associated with program administration of services, as assigned by the Agency.
b. Prepare for and assist the Agency with audits/renewals and reviews related to the provider quality assurance oversight data.
c. Resolve billing problems.
d. Assist with SOP and provider manual updates.
e. Maintain a resource guide.
f. Review and determine approval for assigned applications for new HCBS providers, to include but not limited to:
i. Review to ensure applications are complete;
ii. Send notification to providers of the requirements and documents needed for becoming a Medicaid HCBS waiver provider;
iii. Conduct a desk review of provider application and documentation to determine if application can be approved; and
iv. Notify IME Provider Services unit, as applicable.
g. Provide assistance to providers and field staff on specified program issues as approved by the Agency.
h. Work with the Agency and other IME Units on identified issues.
i. Report activities to the Agency on a quarterly and annual basis.

We will support the HCBS program through administrative tasks that ensure the smooth functioning of the HCBS program and support HCBS providers in serving Medicaid members. Our administrative staff will schedule meetings, take meeting minutes, and develop agendas for agency meetings as requested. Currently, our administrative staff schedule and coordinate agency meetings, request agenda items, take meeting minutes, and distribute meeting minutes to attendees.

Administrative staff, including Dr. Krushat, Biostatistician, will prepare and participate in quality assurance oversight of the data gathered from the HCBS team. Shannon Miller, HCBS Operations Manager and Dr. Krushat will present HCBS quality oversight data to the Agency monthly. Recommendations are made regarding the information based on the findings. Telligen participates in the CMS Evidentiary development and gathers the data required for the CMS Evidentiary reporting. We have recently begun including MCO CMS evidentiary information in the Quality Assurance Quarterly Report to assist the Agency in meeting the CMS Quarterly review standard.

We will provide administrative support to help the Agency resolve, track and monitor all outside billing as needed.

Our administrative staff will maintain and update all standard operating procedures on a regularly scheduled basis or as we implement changes. Ms. Miller will assign policies and procedures for update to all team members based on their expertise.

Our administrative support staff will maintain an Operational Procedure and a desk guide which will include resources for all aspects of their work. Information on scheduling webinars, sending ISIS blasts and all support duties including mailing letters will have clear processes outlined.

Our administrative staff will assist in the updating of the provider manual and any other provider materials as requested by the agency.

Our administrative staff will initially review all provider applications to ensure applications are complete.

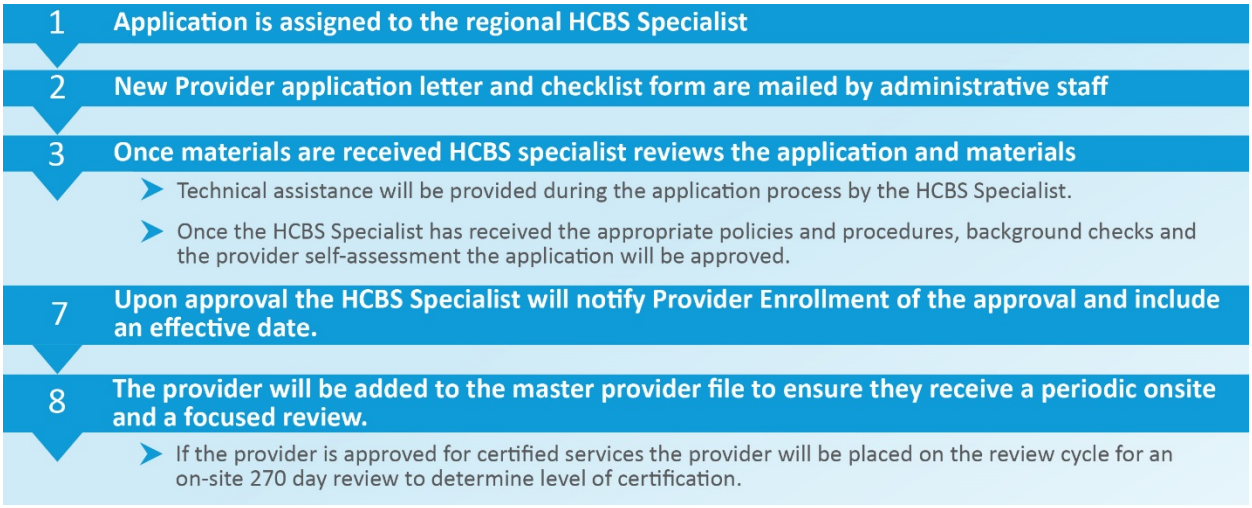

Figure 22. Administrative support process. ***We will continue to provide assistance for HCBS provider applications.***

Telligen administrative support staff will assist and inform providers and field staff on specified program issues as approved by the Agency. Administrative support staff may communicate via email, telephonically or through an ISIS blast at the Agency's request. Administrative support staff will also ensure that field staff receives any emails issued by the Agency. Administrative staff will assist the Agency with any other IME units with Identified issues.

Quarterly and annually, we will report all administrative staff duties through the Quarterly Contract deliverables report.

4. Provider Training. Duties include but are not limited to:
a. Develop and conduct training in collaboration with the Agency's MCOs;
b. Various methods of training dissemination including web-enabled training for providers as approved by the Agency.
c. Interpretation, clarification, and guidance on procedural expectations of State and Federal regulations and administrative code, as well as industry accepted standards for best practice.
d. Focus areas based on HCBS quality assurance processes and supported by Contractor data analysis, subject to Agency approval.
e. Coordinate with other IME Units to develop and deliver provider training tools and reference materials.
f. Identify system improvements and best practices in provider training.
g. Report activities to the Agency on a quarterly and annual basis.

The goal of technical assistance and training is to increase providers' compliance with state and federal requirements for quality on deficiencies identified during provider periodic reviews. Quality deficiencies may be identified in one or more of the following areas:

- Fiscal accountability
- Training requirements
- Policies and procedures
- Quality improvement plans

Training

- ✓ Provided incident and complaint training as a webinar readily available for providers to revisit
- ✓ Provider self-assessment training webinar posted to the DHS website to eliminate travel
- ✓ Completed 12,933 instances of technical assistance in the past five years

A well-trained provider community facilitates effective services that promote independence and Member choice and meeting CMS required assurances. Telligen will collaborate with the MCOs in identifying areas requiring training, the development and completion of that training.

Telligen successfully collaborated with all three MCOs on the new Critical Incident Report form and developed and conducted a joint training with all three MCOs.

Via monthly collaboration with the MCOs will continue to identify provider areas of concern, which will help us identify additional training needs. We recognize the importance of the holistic view of each provider in ensuring quality services are being provided. The HCBS MCO monthly meeting will allow the HCBS staff to be aware of any issues providers may be having with the MCOs and incorporate that information into reports, onsite visits and technical assistance.

At least quarterly, our on-site HCBS data analyst analyzes the Periodic Review data for specific trends of deficiencies to establish baselines and determine necessary training and outreach activities. Based on identified trends, we develop training and present it to providers on specific topics. We submit and will continue to submit all provider training to the Agency for approval prior to the training occurring. We will continue to provide training sessions in a multifaceted way to ensure training is available for all providers (Figure 23).

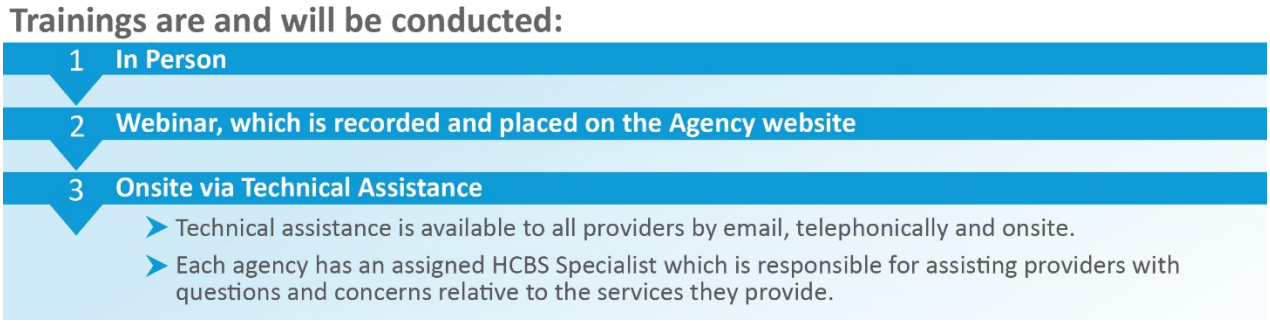

Figure 23. Training methods. ***A variety of training methods makes it easier for providers to participate.***

We will collaborate with other IME units in developing training content and materials. We will continue to assist with updating the provider manual, Program Integrity CMS review, updating Iowa Administrative Code, and the development of various state transition plan materials to assist with provider education. Telligen continues to focus on providing training in the most effective and efficient manor to providers by continuously reviewing the process and making updates and changes.

We will report all HCBS activity to the Agency via the Week in Review, quarterly reporting and annual reporting.

5. Log all provider reviews, complaints, incidents, and surveys into the current Agency electronic tracking database, to include discovery, remediation, and improvement activities. Duties include but are not limited to:
a. Associated data shall be stored for no less than ten (10) years.
b. Data shall undergo internal quality checks by the Contractor to mitigate data entry errors.
c. Present an internal quality assurance analysis to the Agency on a quarterly and annual basis.

Telligen will use QualAssure Performance System (QPS) for provider reviews. All aspects of the provider reviews are maintained in this system including discovery, remediation and improvement activities.

Electronic Tracking
✓ Developed QPS
✓ Developed Internal Quality Control database
✓ Developed HCBS Unit Dashboard

Telligen has successfully completed all HCBS review activity for over five years for the Agency. All information is stored appropriately and available for reporting needs as required.

In addition, we will submit and store all review materials in OnBase from the initial review letter to the final compliance letter per our current process. OnBase will house the review reports along with QPS to ensure the records are maintained for no less than 10 years. [redacted] and the HCBS team lead review all findings and subsequent reports prior to approval for internal quality control. We also verify all data through the quarterly reporting process via [redacted] We complete IQC on all HCBS activity to ensure we enter data accurately. We will develop and provide a quarterly and annual Internal Quality Assurance Analysis to the Agency.

Figure 24. Performance Report. ***Performance metrics are an important component of our IQC.***

6. Provide statistically valid and reliable processes to include but not limited to:
a. Samples, reviews, tools, and techniques shall be evaluated for statistical validation and reliability.
b. 100% of processes should be included in all relevant SOPs and maintained at an annual basis to ensure accuracy.

[redacted] will use a simple random sampling method to identify sample sizes and help determine the review cycle. Unless otherwise identified, we will base all sample sizes on a 95 percent confidence level with a five percent margin of error. [redacted] will calculate sample sizes for IPES surveys, member file reviews and IQC reviews. He will develop sample size calculators to ensure the representative sample is available for each population being measured. He will also use a random sampling method to determine when providers will receive a review.

Relevant SOPs will include sampling methodology to ensure that the samples are developed in a consistent manner. Our biostatistician has knowledge of different sampling techniques and will apply the best fit technique for the measured population.

4.4.2 HCBS Provider Reviews

1. The Contractor shall conduct the following types of reviews for HCBS waiver and Habilitation programs:
a. Periodic Reviews. Duties include but are not limited to:
i. 100% of enrolled providers are reviewed over a randomized five-year cycle. Periodic reviews may be completed in a combination of desk review or onsite visits, depending on the level of provider intervention required.
ii. Reviews shall always include, but are not limited to, review of member documentation, policies and procedures, employee records, and financial statements.
iii. Verify the accuracy of the provider's self-assessment by reviewing evidence of the implementation of required policies and procedures.
iv. Periodic review tool(s) shall be approved by the Agency on an annual basis.

We developed a master provider file to ensure that 100 percent of providers receive a periodic review on a five-year cycle when providing services requiring quality assurance oversight. We will maintain a Master Provider File to include all HCBS enrolled providers identifying available services, deemed status, certification date, and additional pertinent information.

Provider Reviews completed through SFY17

- ✓ Completed 707 Periodic and Certification Reviews
- ✓ Completed 465 Focused Reviews
- ✓ Completed 183 Targeted Reviews
- ✓ Completed 163 Chapter. 24 Reviews
- ✓ Completed 2,432 Provider Self-Assessments

Over the past six years, Telligen has built a strong relationship with providers. We ensure the emphasis is on education and collaboration rather than a punitive process. Our goal is to ensure each provider understands the rules, regulations and best practices to deliver high quality services to the members they serve.

Each periodic review will involve an onsite visit to the provider agency. During the periodic onsite review, the review team will conduct an entrance interview with the Agency advising them of what to expect during the onsite. During the onsite visit, our staff will review the provider's policy and procedure manuals, employee records, training programs, financial statements, Member documentation, and verify the accuracy of the provider's self-assessment. Using the QPS review checklist, the HCBS specialist will capture the periodic review findings and the provider's self-assessment response to verify the accuracy of the provider's report submitted through the annual self-assessment process.

After the onsite periodic review, the HCBS specialist will conduct an exit interview with the provider identifying the preliminary findings. We may provide technical assistance during the exit interview and will document it in the review findings report.

We strongly emphasize to the provider during the exit interview that they can reach out to their specialist at any time for technical assistance.

We will work closely with the Agency when changes to the periodic review tool are necessary and obtain approval prior to implementing any changes.

b. Focused Desk Reviews. Duties include but are not limited to:
i. 100% of enrolled providers are reviewed over a randomized five year cycle. Focused reviews may be completed in a combination of desk review or onsite visits, depending on the level of provider intervention required.
ii. Areas of focus are determined by the Agency, based on CMS quality framework, HCBS settings requirements, and other trends.
iii. Reviews may include, but are not limited to, review of member documentation, policies and procedures, employee records, and financial statements.
iv. Verify the accuracy of the provider's self-assessment by reviewing evidence of the implementation of required policies and procedures.
v. Focused review tool(s) shall be approved by the Agency on an annual basis.
vi. Present an internal quality assurance analysis to the Agency on a monthly, quarterly, and annual basis.

The HCBS Unit will analyze data obtained through the various review activities and make recommendations regarding the next years focused review topic. The Agency will make the final determination on the focused review topic annually.

The focused desk review will include a review of policies and procedures relative to the topic, service documentation, personnel records and financial statements. The annual provider self-assessment will also be reviewed to ensure accuracy.

Once we determine the topic for the focused review, Ms. Miller will develop a tool to submit to the Agency for approval. We will not use the focused review tool until we receive Agency approval.

The focused review process will follow the periodic review process as far as timelines, tracking, corrective action, and compliance. We will gather and present to the Agency monthly, quarterly and annual internal quality assurance reports.

Exceeding Expectations

While the RFP requests information relative to a focused desk review, we have been completing onsite focused reviews in partnership with the Agency. We have modified the current focused desk review process to support the Statewide Transition Plan. Our current focused review model includes an HCBS specialist dedicated solely to the focused review process to ensure compliance and support providers in their efforts to meet requirements in the CMS Final Settings Rule. We modified and updated the focused review tool in QPS to reflect the CMS Final Settings Rule relative to person-centered planning and settings.

All 153 nonresidential HCBS providers are receiving an onsite visit to evaluate compliance with the CMS Final Settings Rule.

The onsite visit includes a review of policies and procedures, provider self-assessment accuracy, service documentation and personnel files and an onsite visit to each service location. HCBS staff works closely with Agency Policy staff meeting bi-weekly to ensure compliance with the Statewide Transition Plan. We offer extensive technical assistance to providers to support their compliance with CMS final rule. We will

continue to monitor compliance with the Statewide Transition Plan through all avenues of quality oversight including the provider self-assessment, periodic, certification and focused review activity.

c. Targeted Reviews. Duties include but are not limited to:
i. Review shall be initiated as a result of concerns arising from a desk review, complaint, incident, or Agency referral.
ii. Reviews shall include investigation of the targeted issue or concern. Areas of reviews may include, but are not limited to, review of member documentation, policies and procedures, employee records, incident reports, member survey and financial statements.
iii. Verify the accuracy of the provider's self-assessment by reviewing evidence of the implementation of required policies and procedures.
iv. Conduct provider targeted reviews as desk reviews unless circumstances rise to level that requires an onsite review.
v. The Contractor shall provide technical assistance and training to providers to demonstrate increased provider compliance of targeted review areas, to include but not limited to:
a) Analyze and trend areas of deficiency in MCO and FFS each quarter and provide appropriate aggregate outreach to providers on a quarterly or annual basis.
b) Document activities performed to enhance provider understanding of State and Federal rules, laws, and regulations as well as industry accepted standards for best practice.
c) Report findings to the Agency on a quarterly and annual basis.
vi. Present an internal quality assurance analysis to the Agency on a monthly, quarterly, and annual basis.

Our HCBS incident and complaint specialist will open a targeted review in response to complaints, incidents, and other noted concerns found during a desk or onsite review and in response to Agency referrals. We complete an initial assessment of incidents and complaints within two business days of receipt of the incident or complaint. We will complete initial screening within two business days of receipt of the incident or complaint. If we identify an imminent risk, we will take immediate action to contact the case manager or the community based case manager and any other appropriate authority to ensure the member's safety. After the initial screening for imminent risk and data entry of the complaint, incident or referral, we will complete a second level screening to investigate the identified concern. Agency-approved criteria will identify the topics for targeted reviews. Likely topics for targeted reviews will include, at a minimum, the following:

- Member safety concerns and risks
- Provider misinterpretation of laws and rules
- Provider negligence
- Misuse of Medicaid procedures or resources

We will discuss incidents and complaints involving health and safety concerns with the Agency to determine if an onsite review is necessary. We investigate non-urgent concerns through a desk review. We request records from the identified provider and, as appropriate, from the respective case manager or community based case manager. While focused on the identified concern from the complaint, incident or referral, we complete a thorough review that includes all member documentation, incident reports, Member surveys, provider policies and procedures, employee records and financial statements as needed related to the identified concern. We also complete a review and validation of the provider

self-assessment responses to confirm the existence of evidence supporting the provider responses. We will complete all Targeted Review reports within the Agency-specified time frames. We will collect all targeted review activity in the Incident and Complaint system for tracking and internal quality control purposes.

We provide technical assistance as part of the targeted review process in areas that may not require a corrective action. Our incident and complaint specialist will make best practice recommendations in the review report. We monitor incident reports daily for FFS. Quarterly, we aggregate FFS and MCO incident report data, and then analyze it to identify trends in reporting. Trends may relate to specific types of errors in the reporting process, or similar incident reports within a specific agency. The incident and complaint specialist will evaluate the data with the data analyst. Because of this information, we either develop a comprehensive training for all providers or conduct outreach to the specific provider, as well as a targeted review.

Quarterly and annually, we document and report all training and technical assistance to the Agency.

d. Certification Reviews of Enrolled Providers. Duties include but are not limited to:
i. Certification reviews shall be conducted within the program mandated timeframe found in Iowa Admin. Code ch. 441-77.
ii. Reviews include, but are not limited to, policies and procedures, staff training, and employee records.
iii. Verify the accuracy of the provider's self-assessment by reviewing evidence of the implementation of required policies and procedures.
iv. Develop certification tool(s) and review on an annual basis.
v. Submit certification tool(s) to the Agency for approval on an annual basis.
vi. The Contractor shall provide technical assistance and training to providers to demonstrate increased provider compliance on certification onsite reviews to include but not limited to:
a) Analyze and trend areas of deficiency each quarter and provide appropriate aggregate outreach to providers on a quarterly or annual basis;
b) Document activities performed to enhance provider understanding of State and Federal rules, laws, and regulations as well as industry accepted standards for best practice; and
c) Report findings to the Agency on a quarterly and annual basis.
vii. Present an internal quality assurance analysis to the Agency on a monthly, quarterly, and annual basis.

Shannon Miller, HCBS Operations Manager will maintain and use the Master Provider File to identify HCBS providers requiring HCBS certification. We will base the cycle of certification on the provider's previous level of certification. HCBS issues certification levels per specific requirements as described in IAC 441-77.

We will complete certification reviews onsite at the provider agency location. During the onsite review, our HCBS staff will conduct an entrance interview with the agency advising them of what to expect during the review.

Telligen is dedicated to improving the quality of HCBS providers as evidenced by the increase in three-year certifications following the implementation of the contract in 2012.

The certification process will include a review of policies and procedures, service documentation, Member files, and personnel files. The provider's responses to the provider self-assessment will be verified and recorded into the QPS review checklist. Evidence that the provider is following their policies and procedures and documentation that supports the provider's responses to the provider self-assessment are recorded into the review checklist as well.

Telligen assisted in the development of the onsite certification review tool. The Agency approved the QPS checklist and we will submit it for approval any time we make changes.

We use an Agency-approved certification scoring tool and outlined in IAC 441-77 to determine the provider's level of certification.

We will offer technical assistance to the provider throughout the review process and at any other time the provider may have questions. The HCBS Specialist will work with the provider throughout the review process to ensure the provider has all assistance needed. All technical assistance is logged within QPS to document assistance given to the provider.

At the end of the certification review, we conduct an exit interview to share preliminary results with the provider. We will submit the certification findings review report to the provider within 15 business days of Agency approval. During the CAP and compliance process the HCBS Specialists are available for technical support to the provider.

All certification findings will be reported to the Agency on a quarterly and annual basis.

We complete IQC activities on a sample of our team's reviews. Typically, we determine sample based on a 95 percent confidence level with a five percent margin of error. IQC activities may result in additional training based on results. We will submit IQC results to the Agency monthly, quarterly and annually.

e. Chapter 24/HCBS Waiver Provider Onsite Reviews. The Contractor shall collaborate with the Agency's Division of Mental Health and Disability Services (MHDS) to provide quality oversight of providers of Iowa Admin. Code ch. 441-24 services, also known as Chapter 24 providers, and HCBS waiver services. The Contractor shall manage, monitor, and follow-up on collaborative on-site reviews to include but not limited to:
i. Conduct Chapter 24/HCBS reviews:
a) Upon request, enrolled Chapter 24/HCBS waiver providers are reviewed onsite within the program mandated timeframe.
b) Reviews shall always include, but are not limited to, review of member documentation, policies and procedures, employee records, and financial statements.
c) Verify the accuracy of the provider's self-assessment by reviewing evidence of the implementation of required policies and procedures.
d) Periodic review tool(s) shall be approved by the Agency on an annual basis.
e) Report totals of Chapter 24/HCBS reviews on a monthly, quarterly, and annual basis.
ii. Provide technical assistance and training to providers to demonstrate increased provider compliance on Chapter 24/HCBS onsite reviews to include but not limited to:
a) Analyze and trend areas of deficiency and provide appropriate aggregate outreach to providers on a quarterly and annual basis.
b) Document activities performed to enhance provider understanding of State and Federal rules, laws, and regulations as well as industry accepted standards for best practice.
c) Report findings to the Agency on a quarterly and annual basis.
iii. Collaborate with the MHDS to include but not limited to:
a) Attend meetings to discuss progress on reviews.
b) Coordinate scheduled reviews.
c) Discuss and collaborate on all rule revisions and implementation that are necessary.
d) Report activities to the Agency on a quarterly and annual basis.

Telligen will coordinate with the Division of Mental Health and Disability Services (MHDS) for providers which have an IAC Chapter 24 accreditation as well as being an enrolled HCBS provider. Telligen will maintain a Master Provider File to include all HCBS enrolled providers identifying a Chapter 24 accreditation. Prior to the review taking place, the specialist will collaborate with MHDS to inform them of the review and invite them to participate in the review process. The HCBS specialist will send out the review notification to the provider and include the Chapter 24 Staff Training and Experience Chart, the Division of MHDS Application and Letter of Agreement. At the time the review materials are received administrative staff will upload the completed Staff Training and Experience Chart, the Division of MHDS Application and Letter of Agreement to the HCBS MHDS Share Point site.

We will complete Chapter 24/HCBS waiver provider reviews onsite at the provider agency location. During the onsite review, the HCBS unit will conduct an entrance interview with the provider advising them of what to expect during the review.

The onsite review process will include a review of policies and procedures, service documentation, Member files, and personnel files. The provider's responses to the provider self-assessment will be verified and recorded into the QPS review checklist. Evidence that the provider is following their policies and procedures and documentation that supports the provider's responses to the provider self-assessment are recorded into the review checklist as well.

We helped develop the onsite periodic review tool. The Agency approves the QPS checklist and will do so at any time as we make changes.

We will include all Chapter 24 review totals in the Contract Deliverables report on a quarterly basis.

We will offer technical assistance to the provider throughout the review process and at any other time the provider may have questions. The HCBS Specialist will work with the provider throughout the review process to ensure the provider has all necessary assistance. We document all technical assistance to the provider within QPS. At the end of the certification review, we conduct an exit interview and share preliminary results with the provider.

We will submit the certification findings review report to the provider within 15 business days of Agency approval. During the CAP and compliance process the HCBS Specialists is available for technical support to the provider.

We will use aggregate review findings to determine quarterly training and provider outreach.

Quarterly and annually, we will report all review findings to the Agency through the Contract Deliverables and Quality Assurance reports.

Telligen will participate in HCBS MHDS meetings to share information and collaborate in the review process, discuss provider issues, and assist with deeming providers. Once we have completed the certification review, we will place a completed copy in the SharePoint folder, which will also include:

- Completed QPS review report
- Copy of the certification letter
- Copy of the providers submitted corrective action plan
- Copy of the CAP accepted letter

We will report all Chapter 24 activities to the Agency through the Contract Deliverables and Quality Assurance reports quarterly and annually.

f. Provider Self-Assessment Reviews. The Contractor shall review completed provider annual self-assessments to ensure full completion and compliance to include but not limited to:
i. Ensure that providers are complying with quality self-assessment requirements defined in State and Federal laws, rules, and regulations as well as industry accepted standards for best practice.
ii. Review and revise self-assessment tool(s) on an annual basis and attain approval by the Agency.
iii. Publish the self-assessment tool, as approved by the Agency, and a publicly communicate a deadline for submission on the HCBS website.
iv. Ensure that 100% of enrolled providers submit an annual self-assessment.
v. Report findings to the Agency on a monthly, quarterly, and annual basis.

Telligen approaches all review activity as an educational relationship with providers, beginning with the self-assessment through the Periodic, Certification, Focused and Targeted reviews. It is the HCBS Quality Assurance team's responsibility to support and assist HCBS providers so they may provide the best possible care to members.

A strong collaborat[redacted] will work with the Agency in updating the Provider Self-Assessment tool on an annual basis. We will publish the approved Provider Self-Assessment tool to the Agency website along with an FAQ and provider training. We will send an informational letter to all providers via IMPA identifying the location of the Provider Self-Assessment tool, the FAQ location and the due date of the Provider Self-Assessment. Included in the informational letter will be a link to the HCBS Specialist map and listing of regional specialists by county.

We will monitor all HCBS providers who required to submit a Provider Self-Assessment via the HCBS Provider Self-Assessment SharePoint to ensure receipt and approval of the self-assessment. Telligen will provide technical assistance to providers regarding the self-assessment to support the accurate completion of the Provider Self-Assessment.

We will use a master provider file to track all providers required to submit a Provider Self-Assessment. In instances where HCBS is unsuccessful in obtaining a completed Provider Self-Assessment, [redacted] will work with other Agency units to ensure that we are following Iowa Administrative Code. HCBS has developed a process with Program Integrity to issue sanctions to providers who have not submitted the Provider Self-Assessment after the due date and when no response to the HCBS specialist's inquiries has been made.

2. Unless otherwise specified in the section above, the Contractor shall collaborate with the Agency's Managed Care Organizations (MCOs) to provide technical assistance and training to providers to demonstrate increased provider compliance on reviews to include but not limited to:
a. Analyze and trend areas of deficiencies and provide appropriate aggregate outreach to providers on a quarterly basis.

[redacted], HCBS Operations Manager will work with the MCO account managers and MCO personnel to facilitate an HCBS MCO provider issue meeting. The meeting will identify providers which require additional training or education related to quality concerns.

By identifying provider issues and concerns through the HCBS MCO provider meeting and by collecting incident data, we can identify additional training needs. Telligen will collaborate with MCOs in the outreach to providers for training and technical assistance.

We currently receive data from MCOs for encounter data, incident data and IPES data. The Data Analyst completes waiver snapshot reports with the encounter data and provides these to Agency policy staff. We analyze the incident data to identify provider incident trends across the MCO and the FFS population. This analysis also initiates more with the MCO and the provider for education and possibly a corrective action through a targeted review.

b. Document activities performed to enhance provider understanding of State and Federal rules, laws, and regulations as well as industry accepted standards for best practice.

We will document all technical assistance and review activity to enhance provider understanding of State and Federal rules in QPS and or the Incident and Complaint Database. Daily, we document technical assistance, identified by provider, in the system. HCBS Staff will monitor the HCBS QA, HCBS Waiver, HCBS IR, and HCBS Waiver slot mailboxes for the Agency. We document all technical assistance provided through these emails in QPS by provider or individual to document the education we provided.

We capture all onsite review activity through QPS. If during the onsite review process a specialist identifies the provider is using best practices, we make a note in the review report acknowledging the provider's dedication to quality services by using best practices.

c. Report findings to the Agency on a monthly, quarterly, and annual basis.

Analyzing and reviewing on-site findings allow us to determine the areas which need additional attention. The findings also highlight the improvement providers have made over the last several years. The goal of the findings reports is to identify training-need areas, focus review topics and to give an overview to the Agency of their current waiver providers. We will submit monthly, quarterly and annual reports to the Agency relative to MCO collaboration. Telligen developed and currently completes a monthly IDT Ride Along report, which we also include in the quarterly reports. In addition, we include the MCO incident reports in the Quarterly Quality Assurance report as well. We will develop a monthly report of all information relative to MCO collaboration.

3. The Contractor shall submit all reports of provider reviews to include but not limited to:
a. Findings report shall articulate when deficiencies are found and relevant correlations to State and Federal rule, law, and regulation as well as industry accepted standards for best practice.
b. Report findings to the Agency on a monthly, quarterly, and annual basis, in an Agency-approved format.

We complete a findings report for all onsite review activity, which includes our evaluation of provider compliance with the Provider Self-Assessment, policy review, evidence evaluation, and whether a corrective action is required. When we identify necessary corrective action, the HCBS Specialist will identify the specifics of the CAP comments section of the review report. Currently, Telligen reports findings related to review activity to the Agency on a quarterly and annual basis. We will also develop and submit a monthly report to the Agency.

4. The Contractor shall initiate development of corrective action plans (CAPs) with providers who have policy, procedure, and outcome deficiencies based off reviews, to include but not limited to:
a. CAP initiation shall occur simultaneously with review findings report.
b. Provide education and assistance when areas of compliance are not clearly established such that the provider can attain a plan for achievable success within the timeframe preceding the follow-up compliance review.
c. Review and approve CAPs to come into compliance with IAC standards at a 100% level.
d. The review and approval process shall be based on established protocols approved by the Agency.
e. Subsequent correspondence with providers shall be in a format approved by the Agency.
f. Report findings to the Agency on a monthly, quarterly, and annual basis.

The HCBS review findings report identifies the areas with deficiencies and initiates the CAP. During the on-site review, we will discuss these areas with the provider, and offer technical assistance. Our HCBS specialist also advises the provider during the exit counseling to reach out should there be additional questions or an area of the report that they do not understand upon receipt. Once we receive the CAP, our HCBS specialist has 15 business days to review the information and determine whether the CAP is accepted, partially accepted or not accepted. We will provide additional technical assistance in cases of partial or non-acceptance. We will submit an Agency-approved letter to the provider indicating the

results of the CAP submission. We will report all data relative to the corrective action plan process to the Agency monthly, quarterly and annually.

5. The Contractor shall conduct a follow up compliance review to ensure that the provider has implemented policies and procedures agreed upon in the approved CAP, and report findings to the Agency on a monthly, quarterly, and annual basis.

Our HCBS specialist will initiate a compliance review within 45 days of the CAP acceptance letter in an Agency-approved letter. Once we receive the compliance materials, the specialist will review the material and determine whether the compliance can be accepted, partially accepted or not accepted within 15 business days of receipt of the material. We will offer additional technical assistance in cases of partial or non-acceptance. We will submit an Agency-approved letter to the provider indicating the results of the compliance submission. We will report all data relative to the compliance process to the Agency on a monthly, quarterly and annually.

4.4.3 HCBS Waiver, Habilitation and MFP Provider Complaints

This Section applies to the FFS population, except where MCO reporting indicates there are providers with similar complaints open with multiple MCOs. If there is a systemic issue with a provider, the Contractor shall request more information from the provider and follow-up as described below.

1. The Contractor shall handle complaints in a manner consistent with the Agency to include but not limited to:

a. Ensure complaints have an initial assessment completed within three (3) business days and the resulting action(s) will be in accordance with HCBS waiver, Habilitation, and MFP program policies, procedures and State and Federal rules, laws, and regulations.

b. Resulting action (e.g. investigation, closure, or referral) shall be logged and reported to the Agency.

c. Initiate fact-finding correspondence with relevant parties and correspondence within two business days of initial assessment.

d. Correspondence with all parties shall be in a format approved by the Agency.

e. Report findings to the Agency on a monthly, quarterly, and annual basis.

A complaint is a statement of dissatisfaction. It is important to provide prompt and thorough attention to complaints to ensure member health and safety as well as quality of life and services. Our incident and complaint specialist will review all complaints received.

Incident and Complaints Completed Through SFY17

- ✓ Completed 929 Complaints
- ✓ Reviewed 40,196 Incidents
- ✓ Completed 183 Targeted Reviews

Telligen collaborated with all three Managed Care Organizations to update and implement a universal Incident Report Form.

We collaborated with all three Managed Care Organizations to create and present an updated Incident Reporting training for all providers

After the initial screening for imminent risk and the data entry of the complaint, the HCBS Incident and Complaint Specialist will complete a second level screening to investigate the identified concern, including but not limited to:

- Member safety concerns and risks
- Provider misinterpretation of laws and rules
- Provider negligence
- Misuse of Medicaid procedures or resources

Figure 25. Complaint process. ***We will document all complaint activity***

We will gather information from all relative parties and log it in the Incident and Complaint database. We will send an Agency-approved letter to the provider advising them of the complaint and requesting material relative to the complaint. Depending on the information received, we may close the complaint or open a targeted review.

Telligen has developed a process for coordinating complaints between the appropriate MCO to ensure complaints are addressed.

We will report all complaints to the Agency within the Contract Deliverables quarterly report and in the annual report.

2. The Contractor shall conduct investigations of complaints when determined necessary in initial assessment to include but not limited to:
a. Notify the Agency and the applicable provider if it is determined during the initial assessment that an investigation is necessary.
b. Correspondence with the provider shall be in a format approved by the Agency.
c. Correspondence and associated data shall be logged within an electronic database.
d. Report findings to the Agency on a monthly, quarterly, and annual basis.

HCBS waiver members are a vulnerable population and it is our job to ensure their safety. In cases of complaints or abuse allegations it is our responsibility to identify why the issue occurred, ensure remediation and assist the provider in developing a process that will eliminate reoccurrence.

The HCBS Specialist will contact the provider and other parties related to the complaint. An Agency approved letter will be sent to the provider requesting information relative to the complaint. Depending on the information received the complaint may be closed or after discussion with the Agency may turn into a Targeted review.

If the complaint requires a Targeted review the provider will receive an Agency approved findings letter requesting a corrective action plan. All correspondence will be approved by the Agency prior to being sent to the provider. Once we receive an acceptable corrective action plan, we will mail a CAP accepted letter within 15 business days. We will initiate a compliance review within 45 business days of the CAP acceptance. We will document all correspondence and activity in Incident and Complaint database.

We will report all findings to the Agency monthly, quarterly and annually.

3. The Contractor shall make written recommendations to the Agency related to complaint management to include but not limited to:
a. Recommendations identify system improvements and best practices in complaint management.
b. Collaborate with other IME Units to recommend policy revisions based on identified quality indicators.
c. Report recommendations to the Agency on a quarterly and annual basis.

We are responsible for the health and safety of a vulnerable population. Identifying system improvements and best practices will assist in maintaining member safety and the prevention of health and safety concerns. Telligen will make recommendations regarding complaint management based on the data collected during the incident and complaint process. Telligen collaborates with program integrity, the Department of Human Services Dependent Adult Abuse unit, and the incident and complaint units within the MCOs. We will continue to work with all IME units to improve and better process complaints.

We have also conducted HCBS MCO meetings to share information regarding incidents and complaints and to foster a holistic view of provider agencies.

4.4.4 HCBS Waiver, Habilitation and MFP Provider Incident Reporting Management

This Section applies to the FFS population, except where MCO reporting indicates there are providers with similar incidents open with multiple MCOs. If there is a systemic issue with a provider, the Contractor shall request more information from the provider and follow-up as described below.

1. The Contractor shall ensure that HCBS waiver, Habilitation and MFP providers are complying with incident reporting requirements to include but not limited to:

a. Provide education and assistance when it is discovered that providers are not adhering or are misinterpreting requirements or industry accepted standards for best practice.

b. Identify trend areas of deficiency each quarter and provide training or outreach to clarify requirements.

c. Document activities performed to enhance provider understanding of State and Federal rules, laws, and regulations as well as industry accepted standards for best practice.

d. Report findings to the Agency on a quarterly and annual basis.

Our HCBS incident and complaint specialist will review all incidents received via Iowa Medicaid Portal Access (IMPA) daily. We review the incidents to ensure the provider is following incident reporting requirements in IAC 441-77. We provide technical assistance to providers when IAC requirements are not met.

Incident and Complaints Completed Through SFY17
✓ Reviewed 929 Complaints
✓ Reviewed 40,196 Incidents
✓ Completed 183 Targeted Reviews

We focus on a preventative approach when it comes to incidents; and having a solid foundation in policies, procedures and training assists in managing the reoccurrence of the same incident.

We document and analyze technical assistance to identify trends and possible training opportunities. We will report all findings to the Agency on a quarterly and annual basis.

2. The Contractor shall ensure that providers are submitting incident reports into the Iowa Medicaid Portal Access (IMPA) system on a timely basis to include but not limited to:

a. For incidents that are faxed/mailed to the Agency, the Contractor shall follow up with provider to remind them of the IMPA requirement.

b. Provide training or outreach to providers who are not submitting incident reports within the mandated timeframe.

c. Initiate contact with the provider to remediate the rate of untimely submission upon discovery of provider submitting incidents in IMPA outside the mandated timeframe.

d. Report findings to the Agency on a quarterly and annual basis.

Our HCBS incident and complaint specialist will review all incidents that we receive via IMPA each day. We review incidents to ensure the provider is following incident reporting requirements in IAC 441-77. We provide technical assistance to provider agencies when IAC requirements are not met.

In addition, our HCBS Incident and Complaint specialist monitors both OnBase for faxed incident reports and the HCBSIR mailbox daily to ensure all incidents are recorded and reviewed promptly. The HCBS specialist provides technical assistance, which includes sending the provider IL 1119, which alerts them to the requirement of submitting the incident via IMPA.

In cases where the provider is having issues with submitting the incident via IMPA, our HCBS specialist will troubleshoot errors with the provider. All incident reports that we receive outside of the required timeframes trigger a follow-up from the incident and complaint specialist. We provide training and outreach technical assistance along with the rule reference related to incident reporting requirements and documented in our systems.

We document all technical assistance in the technical assistance portion of QPS. We will report all findings to the Agency quarterly and annually.

3. The Contractor shall complete targeted reviews of providers based on incident reports to include but not limited to:
a. Health and welfare of an individual or individuals appears to be at risk, either presently or in the future.
b. Immediately notify the Agency and the case manager or service worker.
c. Notify the provider in advance of the review unless it is determined that the individual is in immediate jeopardy.
d. Associated correspondence shall be in a format approved by the Agency.
e. Report findings to the Agency on a monthly, quarterly, and annual basis.

Our HCBS incident and complaint specialist may initiate a targeted review based on an incident report received in IMPA. The HCBS incident and complaint specialist will send an Agency approved letter requesting additional information related to the incident. Upon receiving the requested information, the specialist may determine that the provider's policies and procedures, training or interpretation of laws and rules need to be remediated. We send an Agency-approved letter to the provider requesting that a CAP be submitted. Once we receive the acceptable CAP, we will mail an acceptance letter within 15 business days. We will initiate a compliance review within 45 business days of the CAP acceptance. We will also document all activity will be documented in the Incident and Complaint Database.

Telligen views the targeted review process as an opportunity to educate and support the provider so they may deliver the highest quality services to their members.

We will report all findings to the Agency monthly, quarterly and annually.

4. The Contractor shall meet with the Agency staff to review the previous period's major incidents to include but not limited to:
a. Report the discovery, remediation and improvement activities for flagged incident reports.
b. Provide monthly, quarterly and annual reports with statistical analysis and trending of aggregate incident data as well as detailed information on the discovery and remediation associated with flagged incident reports.
c. Provide evaluate a statistically valid sample at a 95% confidence level to identify error rate of data entry for provider submitted reports.
d. Report findings to the Agency on a monthly, quarterly, and annual basis, in an Agency-approved format.

[redacted], HCBS Operations Manager will meet with the Agency monthly to review the incident data. [redacted], Biostatistician will evaluate a statistically valid sample at a 95 percent confidence level to identify the data entry error rate for provider submitted incident reports.

Telligen currently combines and analyzes the FFS incident reports with the incident data provided by the MCOs to track and analyze incidents trends. In cases where the data reflects a trend the Incident and Complaint specialist reaches out to the provider. In these cases, additional information is requested. Our review of the information will determine if a targeted review is necessary.

We will complete monthly, quarterly and annual incident reporting that includes the tracking and trend analysis of FFS and MCO incidents.

We will provide monthly, quarterly and annual incident information including targeted reviews to the Agency.

5. The Contractor shall make written recommendations to the Agency related to incident reporting to include but not limited to:
a. Recommendations identify improvements and best practices in incident report management.
b. Collaborate with other IME Units to recommend policy revisions based on identified quality indicators.
c. Report recommendations to the Agency on a quarterly and annual basis.

Incident management helps ensure the safety of members. In support, we will make recommendations on improvements and best practices for incident management.

We plan to broaden the Incident and Complaint process to include analyzing claims data with incident reports received. We will update policies and procedures to implement the new process that will examine emergency room visits with submitted incident reports to ensure incidents are submitted appropriately.

We will collaborate with Agency policy staff and other IME units to implement and modify processes and change policy to better support quality measures and best practices.

We will report recommendations to the Agency monthly, quarterly and annually.

4.4.5 HCBS Waiver and Habilitation Member Surveys

This section applies only to the FFS population.

1. The Contractor shall manage, monitor and maintain the Iowa Participant Experience Survey (IPES) or redesigned tool to include but not limited to:
a. Tool examines the experience of program members.
b. Areas of member experience examined include, but are not limited to: satisfaction, safety, service utilization, choice, and dignity.
c. Revisions or newly developed components of the survey tool must be approved by the Agency and statistically validated.
d. Provide initial and ongoing training to contract staff on reliable interviewing techniques for the member survey tool being used.
e. Ensure representative samples of members are interviewed each period at a 95% confidence level.
f. Work with other units in the Agency to ensure representative sample.
g. Report findings to the Agency on a monthly, quarterly, and annual basis.

Member Surveys Completed Through SFY 17

- ✓ Completed 2,211 IPES Surveys
- ✓ Completed 641 MFP Surveys
- ✓ Assisted the Agency in MFP tool development
- ✓ Developed reporting to highlight the MFP program

We will use the approved Iowa Participant Experience Survey (IPES) to interview members. Prior to completing the interview, administrative support staff will mail a letter to the case manager or the community based case manager, which requests member-specific information. We use the information from the case manager to identify who we should interview (member or guardian), the type of interview (telephonically or in person), the time of day, and any special interests the member may have. The interview is important in ensuring that needs are being met and services provided appropriately. The interview also allows the member to have a voice in the delivery of their services. During the IPES survey the member is asked about their services, the staff and the agencies providing the services. The specialist also listens to any other comments or concerns the Member, or their representative may have regarding services or quality of life.

While there are specific criteria resulting in a flag letter, the HCBS specialist will also assist the Member with any issues identified during the interview.

We understand we are a representative of the Agency and when we identify a concern or issue, we are responsible for acting and assisting the member to remediate the issue, regardless of whether a flag letter is required.

Our HCBS specialists will review the case manager letter prior to making contact to ensure we know of any special needs the Member has but also any topic they might enjoy discussing to “break the ice.” The interview will include questions which address the member’s satisfaction, safety, services, choice, and dignity. We will use only Agency-approved tools. We will work with the state on a three-year cycle to ensure a 95 percent confidence level is pulled for each FFS waiver population.

We will submit all IPES findings to the Agency on a monthly, quarterly and annual basis.

2. The Contractor shall develop appropriate and universal follow up for responses that are flagged to include but not limited to:
a. Established per design of the member survey tool and as approved by the Agency.
b. 100% of flagged responses shall be remediated with a case manager or service worker within the 15 business days.
c. Document the discovery, remediation and improvement associated with flagged responses in an electronic database, or equivalent.
d. Develop communication strategies with case managers and service workers to ensure improvement of the quality of life and services for members interviewed.
e. Report findings to the Agency on a quarterly and annual basis.

The IPES database documents the areas where we have identified a flag. We send an Agency-approved IPES flag letter to the case manager and the case manager's supervisor identifying the specific flags identified during the interview. The flag letter identifies the specific issues discussed during the interview and gives the case manager 30 days to submit a written remediation plan to the HSBC specialist. We monitor remediation to ensure that we receive a response in cases where the case manager did not respond, so that we can notify policy staff of the issue. We remediate 100 percent of the flagged responses with the case manager within 15 business days. The goal is to ensure the issues are remediated for the member as soon as possible, and ensure that the case manager is made aware of any issue the member may be having.

We will report all flagged IPES responses to the Agency on quarterly and annually.

3. The Contractor shall make written recommendations to the Agency related to member surveys to include but not limited to:
a. Recommendations identify system improvements and best practices in member surveys.
b. Collaborate with other IME Units to recommend policy revisions based on identified quality indicators.
c. Identify trends in member survey responses that could be used to drive systemic policy changes and improvements
d. Data shall be derived from a centralized database, or equivalent, such that it can undergo replication for future reports.
e. Report recommendations to the Agency on a quarterly and annual basis.

We gather the information obtained during the IPES survey to analyze and identify trends. Telligen will make recommendations to the Agency and or other Agency units as needed based on the analyzed data. We will also analyze IPES data to identify whether program changes are needed based on the number of people who respond similarly.

We can analyze all data that we gather to identify whether additional training or outreach is required in a specific area based on Member feedback. Telligen developed an IPES database that allows direct data entry during the IPES survey, which allows us to pull data and analyze queries.

We will report all recommendations to the Agency quarterly and annually.

4.4.6 MFP Surveys

This scope of work will cease on March 31, 2020.

1. The Contractor shall manage, monitor and maintain the MFP participant survey or redesigned tool to include but not limited to:

a. Tool approved by the Agency and CMS examines the quality of life of MFP participants in all areas designated by federal funding requirements. Revisions or newly developed components of the survey tool must be approved by the Agency and statistically validated.

b. Provide initial and ongoing training to contract staff on reliable interviewing techniques for the member survey tool being used.

c. Interview MFP participants at a 100% level.

d. Collaborate with other units in the Agency to ensure representative sample.

e. Report findings to the Agency on a monthly, quarterly, and annual basis.

The Money Follows the Person (MFP) program assists individuals living in a facility to receive additional funding to move into the community. Last year it was determined that the MFP grant was coming to an end.

Shannon Miller, HCBS Operations Manager worked with the MFP program manager and the MFP partnership members to develop a tool to evaluate where the members are now after completing the MFP program.

We are currently using an Agency-approved tool.

Prior to us completing the MFP interview, our administrative support staff mail out a letter to the case manager or the community-based case manager requesting member-specific information. We use the information from the case manager to identify whom we should interview (Member or guardian), how (telephonically or in person), time of day, and any of the member's special interests. This interview is important to ensure needs are being met and services provided appropriately. The interview also provides the member an opportunity to have a voice in the interview. We use a complete list of members who have participated in the MFP program to ensure we interview 100 percent of members. Currently, we pull and review 30 members using the oldest end date as a filter. We determined the 30 members per month criterion based on the number of total MFP members and the Agency time frame for completion of the "Where are they now?" survey. We complete a monthly, quarterly and annual report for the Agency.

[redacted], HCBS Operations Manager and our senior manager also participate and present at the MFP Partnership meetings. For example, [redacted] presented on the MFP population that transitioned from institutional care to the community as part of a "where are they now" survey.

We acknowledge the importance of reaching out to members to gather information regarding the success of the MFP program. Understanding how the program supports this vulnerable population in the community provides data to either continue the program if offered or allow MCOs to implement or use some of the information to better support more individuals in the community.

2. The Contractor shall develop appropriate and universal follow up for MFP survey responses that are flagged to include but not limited to:
a. Established per design of the MFP survey tool and as approved by the Agency.
b. 100% of flagged responses shall be remediated with a transition specialist within 15 business days.
c. Document the discovery, remediation and improvement associated with flagged responses in an electronic database, or equivalent.
d. Develop communication strategies with transition specialists to ensure improvement of the quality of life and services for members interviewed.
e. Report findings to the Agency on a quarterly and annual basis.

As we previously described, [redacted] collaborated with the MFP program manager and other MFP stakeholders in developing the Agency-approved survey tool.

The HCBS specialist notifies [redacted] of any information either received or seen during the interview that may elicit a flag for the member. We then send out an Agency-approved MFP flag letter to the MFP program manager, case manager and the case manager's supervisor identifying the specific flags noted during the interview. The flag letter identifies the specific issues discussed during the interview and gives the case manager 30 days to submit a written remediation plan to the HCBS specialist. We monitor remediation to ensure that we receive a response is received. When the case manager does not respond, we notify Agency policy staff of the issue. We remediate 100 percent of the flagged responses with the case manager within 15 business days.

While there are specific criteria resulting in a flag letter, the HCBS specialist will also assist the member with any issues identified during the interview.

We report all flagged MFP to the Agency quarterly and annually.

3. The Contractor shall make written recommendations to the Agency related to MFP surveys to include but not limited to:
a. Recommendations identify system improvements and best practices in MFP surveys.
b. Collaborate with other IME Units to recommend policy revisions based on identified quality indicators.
c. Identify trends in member survey responses that could be used to drive systemic policy changes and improvements
d. Data shall be derived from a centralized database, or equivalent, such that it can undergo replication for future reports.
e. Report recommendations to the Agency on a quarterly and annual basis.

The information we obtain during the MFP survey is gathered and analyzed to identify trends. We will make recommendations to the Agency and or other IME units as needed based on the analyzed data. The goal of the MFP "Where are they Now" survey is to have data to support the effectiveness of the program. Data supporting the program will allow for the state to apply for the grant again should it be available but also allow the state to provide the data to the MCOs as a possible program model.

We will report all recommendations to the Agency quarterly and annually.

4.4.7 HCBS Waiver Slot Management

1. The Contractor shall assign one full-time HCBS Slot Manager and one fully trained backup to assist the Agency with management and release of waiver slots to include but not limited to:

Slot Management
✓ Helped develop WISE
✓ Developed waiver snapshots
✓ Maintains all slot data
✓ Manages the waiver slot email

The slot manager must have a working knowledge of the entire slot process at both a program and individual level. This will include an in-depth knowledge of the slot process, the available programs, and specific program rules. The Slot Manager will be able to provide clear program summaries to program managers and to assist members, guardians, parents and case managers during any step of the slot process. The slot manager will be available to assist in person, over the phone, and through email at any time during business hours. The Slot manager will be the first point of contact for many members, guardians, parents and case managers when questions or concerns arise. The slot manager's focus will be to assist members during the slot process and provide them with accurate information in a timely manner.

In addition to supporting program managers and assisting members in the slot process, the slot manager will also maintain all individual slot data. Individual slot data includes; demographic information, application date, status of application, and a historical summary of activity. We will maintain data via an online database that is directly linked to the case manager's individual updates. The slot manager will monitor data integrity throughout the system. If the slot manager finds that data integrity is compromised, he/she will troubleshoot, notify the appropriate personnel, and correct the issue. The slot manager will maintain a back-up database that he/she can use if issues should arise. We will update the backup weekly. We will use the data from the slot database in summaries provided to program managers. These summaries will provide program managers with essential information in determining the overall status of the slot program, the number of slot releases which can occur, and when releases should take place.

The slot manager will also be responsible for monitoring the waitlist and status' of other specially funded programs.

There are special slots for three of the waivers,

- Intellectual Disability(ID), Brain Injury (BI), and Child Mental Health (CMH) waivers.
- The slot manager will monitor the Money Follows the Person (MFP), Reserved Capacity Slot (RCS), Brain Injury Community Based Neurobehavioral Services (BI-CNRS-RCS), and Intellectual Disability Residential Based Supported Community Living (ID-RB-SCL).

The slot manager will monitor the availability of these slots and report to the Agency on the status.

a. Allocate slots based on waiver funding allocation and wait list characteristics.

We allocate slots in two ways: using the attrition guidelines or based on specific funding.

Monthly, the slot manager uses the attrition guidelines to identify the number of members who no longer have access to their assigned slot. We use these guidelines to identify when a member no longer

meets eligibility criteria. Once we identify these members, we notify the Agency of the number of slots that closed by waiver type. The Agency uses this information to determine if an attrition release is required. If the Agency determines a slot release is required, then the Agency will develop a release plan and submit it to the slot manager. The slot manager allocates slots according to the release plan.

We also allocate slots based on additional state funding When this occurs, the program manager informs the slot manager of the release plan. The slot manager then allocates the slow according to the release plan.

b. Meet with Agency staff as necessary to determine distribution strategy and discuss status.

The slot manager and [redacted] will meet with the Agency on a weekly basis or a schedule identified by the Agency to discuss any concerns or identified issues. At the time of the meeting the slot manager and [redacted] will also propose any quality improvement ideas or issue resolution at this time. In the case of an emergent issue in relation to slot management the [redacted] and the slot manager will notify the identified Agency Staff immediately.

c. Publish funding allocations on the website within 10 business days of the end of the reporting period.

The slot manager will complete a monthly slot waiting list report to be published to the state website within 10 business days. In addition to this report, we will also create an Internal Monthly Slot and waiting list report, which we will send to program managers. The Internal Monthly Slot and Waiting List Report will break down the slots in process in more detail for the Agency. We will send all slot reports through an IQC process prior to submitting them to the Agency.

d. Published status format must be accessible to the public and formatted as approved by the Agency.

The slot manager will work with the Agency web master to ensure the slot report is in the appropriate format to be published. We have been successful working with Agency staff to have the Monthly Public Waiting List Report published within 10 business days.

e. Report waiver slot and wait list data to the Agency on a monthly, quarterly, and annual basis.

The slot manager has worked with the Agency to design and streamline all slot reporting activities. We current produce 16 reports on a weekly and monthly basis. Weekly reports provide the Agency leadership with an overview of slot activity. Slot activity for each waiver includes the number of persons at each step in the slot process, the number of slots which are currently being used compared to the CMS and fiscal maximums, and the next application date for each waiver with a wait list. We provide weekly reports to each MCO to communicate where members are in the slot process. Monthly, we complete a 12-month historical analysis to identify trends that occur within each waiver. We also post a monthly report the Agency website to identify slot activity for the public.

The slot manager will collaborate with the Agency to revise or develop new reports as necessary. The slot manager will also make report recommendations based on trends seen in current and historical data and knowledge of the program.

f. Ad hoc reporting, upon Agency request.

Daily, the slot manager will compile reports for the Agency on an ad-hoc basis at the Agency's request. An example of an Ad Hoc report would be one that identifies all Members who are currently pending on the waitlist. We make any ad hoc report request a priority and to ensure we meet the Agency's deadline.

4.5 POPULATION HEALTH IMPROVEMENT SPECIAL PROJECTS (RFP 1.3.1.5)

4.5.1 Program of All Inclusive Care for the Elderly (PACE)

The Contractor shall support Agency PACE activities based on requirements set forth in 42 CFR, Part 460, to include but not limited to:

1. The Contractor shall operate a quality assurance and compliance monitoring plan for the PACE providers in accordance with 42 CFR, Part 460, to include but not limited to:
a. Operate a quality assurance and compliance monitoring plan for PACE providers.
b. In cooperation with CMS and the Agency for newly established PACE programs, provide adequate staff to complete the initial technical assistance review.
c. Conduct at least one unscheduled quality review on site annually utilizing the quality review process developed by CMS.
d. In cooperation with CMS and the Agency, participate with adequate staff in the annual reviews of the PACE organization during the three-year trial period and biannually thereafter.
e. Conduct an initial exit conference with the PACE organization for the preliminary outcomes of the review.
f. Utilizing the CMS format, submit a written report on the findings of the quality assurance and compliance monitoring of PACE providers, as well as recommendations and any corrective actions, to the Agency within 30 business days of completion of the review.
g. Monitor and follow up to ensure corrective actions are implemented.

As part of our QA oversight process, we will support all Agency PACE activities relative to requirements established in 42 CFR, Part 460. The PACE organization supports the all-inclusive care of Iowa's elderly population to provide comprehensive medical and social services to certain frail, community-dwelling elderly individuals in effort to meet their care needs outside of a facility environment.

Actively Involved in Special Projects

- ✓ Developed a new onsite review process and reporting tool
- ✓ Participated in performing four onsite readiness reviews for new PACE organizations
- ✓ Dr. Smith, Medicaid Medical Director is highly involved in the review of medical documentation if concerns are identified

We will work with the Agency to provide compliance monitoring and quality assurance oversight of the PACE organizations currently located in Iowa.

Our review coordinators performing this work are specifically trained with knowledge of the PACE Program. This enables them to complete necessary onsite audit reviews, including state readiness reviews, providing technical assistance to newly-established PACE sites, unscheduled annual CMS quality

reviews, and scheduled annual quality reviews required during the three-year trial period and biannually thereafter. We will collaborate with the Agency to determine the appropriate number of staff needed for each onsite, as well as any other requirements, or the need for additional onsite reviews. We will provide for travel and overnight accommodations for staff for each visit conducted.

Playing an active role in assisting the Agency, we will participate in exit conferences concluding each onsite review conveying preliminary outcomes of the audit to the PACE organization. Following this, a written report will be composed and submitted to the PACE organization and to CMS within 30 business days of the onsite review. Following the CMS format, the report will provide detailed findings, including recommendations and any corrective actions necessary based on quality assurance and compliance monitoring. We will provide ongoing follow-up and oversight for each PACE organization. We will ensure corrective action plans are prepared and implemented if indicated.

PACE Level of Care Reviews are handled similar to nursing facility reviews, as the participant's medical condition needs to be considered like that of a nursing facility resident.

Our staff will ensure a quality assurance plan is in place to address the use of services. There are many special considerations for this review that apply based on the PACE model that provides all-inclusive care and functions like a small managed care organization:

- PACE Level of Care Certification Form, in conjunction with an Addendum Form, is submitted by the PACE organization for review and applied to the same ASE Criteria used for Nursing Facility (NF), also known as, Intermediate (ICF), Level of Care
- Admission and annual Continuing Stay Reviews are performed within performance standards of two business days for admission reviews and five business days for continued stay reviews, following our receipt of the information
- Specific Deemed Eligibility Criteria has been developed to apply to Continuing Stay Reviews when the participant's condition remains unchanged from the last review
- Physician (peer) Review and the Appeal process is used when the participant's medical condition does not meet qualifications of established Criteria
- Financial Eligibility must be established using Individualized Services Information System (ISIS), prior to initiating a PACE review. Close communication is made with the PACE organization to coordinate both the medical and the financial pieces of the review
- Established monthly cut-off dates play a part in the timeliness of a PACE review, as PACE services can only be initiated at the beginning of the month following the month of approval

Telligen works directly with the Agency PACE Policy Staff, and has developed strong, professional working relationships with all the PACE organizations in Iowa. Our involvement, expertise, and years of experience with this program have been beneficial, as exemplified, in the following ways:

- We originated and developed the Addendum Form with the Agency's approval to help obtain all details needed for PACE review. This has eliminated the need for back- and-forth communication with the PACE organizations to gather specific information requiring clarification, and it facilitates the Physician Review

- We initiated the concept of One-on-One Training with PACE Admission Coordinators in 2017 to improve the review process. We have documented this training and use it reference and follow-up as needed, such as for PACE staff turnover
- Telligen has been instrumental in supporting the Agency with changes to the 2017 CMS Audit process, which allocates additional responsibility to the state-level. We have invested much effort into collaborating with the Agency to plan a new approach to on-site compliance visits, as well as designing new survey tools, and revising Reporting and Notification Forms to rise to the level of this need. We completed two onsite compliance audits in 2017 using this new CMS format
- Under the Agency's direction, our RCs independently performed two technical assistance on-site compliance visits in 2017. One example includes investigating a complaint against a PACE organization pertaining to poor communication regarding a PACE participant residing in a nursing facility.
- Telligen participates with the Agency in performing State Readiness onsite reviews whenever there is a new PACE organization. Our expertise, specifically toward clinical observation, is valued, as well as contribution to the oversight survey of the new facility and evaluation of the PACE Center's Policies and Procedure
- Our medical directors are actively involved with providing physician input, as they attend and present at meetings with PACE staff, perform medical record review at the request of the Agency or CMS to include medical necessity, safety, or assessment of a grievance or Appeal, including participating in Appeal hearings with ALJs, as well as closely communicating with Review Coordinators in all aspects of the PACE Review. The medical directors recently helped revise standardized wording of the PACE Agreement, while developing Deemed Eligibility and Safety criteria. This important document is contained within Agency Contracts of all PACE organizations
- We review all accounts of Level Two submissions, which involves required reporting from the PACE organizations of injuries, accidents, or mishaps occurring to PACE participants. Telligen extends professional insight to the incident descriptions, referring to our Medical Directors as needed, as well as record-keeping of all reported incidents
- Our RCs communicate and follow-up any concerns to the Agency and to CMS. We note and report to the Agency any evidence suggesting the PACE provider is not delivering appropriate care or following PACE rules and regulations
- Our RCs respond quickly to Agency or CMS requests for review of circumstances when a PACE organization requests denial of enrollment, or there is an involuntary disenrollment to the program; as concerns arise regarding the motive of the request, or safety of the PACE participant. Incorporating professional advice from our medical directors, RCs offer medical expertise and recommendations to the Agency, as well as communication to the PACE organization relating to safety of the PACE participant

Our review coordinators join in PACE conference calls on state and national levels to stay informed of trends and issues. They also monitor CMS interaction through the Health Plan Management System (HPMS) to learn information such as reporting or marketing submissions.

4.5.2 Health Homes

The Contractor shall support Agency Health Home initiatives based on provisions within the Affordable Care Act of 2010 and Iowa Medicaid State plan, to include but not limited to:
1. Health Home Coordinator
a. Provide quality oversight of Health Home programs and remain flexible with program design.
b. Keep current and advise the Agency regarding any innovative best practices to Health Home models including but not limited to, medical, dental, behavioral and LTSS, or related issues.
c. Maintain and facilitate ongoing primary stakeholder understanding and buy-in on Health Home programs.
d. Provide guidance and education necessary to engage potential Health Home clinics.
e. Maintain the interface for reimbursement and incentive methodology to ensure care coordination and quality of care are part of the Health Home programs.
f. Develop performance indicators to identify effective Health Homes for incentive payments.
g. Develop a plan to monitor new Health Home programs screening and assessment outcomes.
h. Facilitate evaluation of Health Home programs and CMS quality measure reporting.
i. Answer MCO questions and review MCO documents related to Health Home programs, as requested by the Agency.
j. Provide reports to the Agency monthly on Health Home activities and annually on Health Home savings.

Telligen will provide an experienced and knowledgeable Health Home Coordinator to support the Agency Health Home initiatives based on the provisions within the Affordable Care Act of 2010 and the Iowa Medicaid State plan. The Health Home Coordinator will:

- Provide project management consultation to IME Leadership on health home delivery models, including researching other state approaches to health home and managed care
- Represent the Agency as a main contact for health homes practitioners and associations
- Onboard new health homes
- Maintain managed care organization member data and health home enrollment file
- Facilitate monthly meetings with managed care organizations which include, but not limited to the following deliverables:
  - Webinar training on Health Home specific topics
  - Health Home evaluations including onsite and desk reviews
  - Establish Health Home quality incentives and benchmark
- With the direction of the IME public policy staff, resolve provider issues related to habilitation, claims and other concerns
- Evaluate University of Iowa Public Policy reports on health homes and review with the Agency to gain sign off in preparation for reports to be published
- Using the results from University of Iowa Public Policy analysis, report health home quality measures to CMS

- Review the reporting requirements identified by the Managed Care Bureau and identify gaps in reporting on health homes by the managed care organizations
- Monitor the development and implementation of health home services to ensure the requirements of the state plan amendments for Chronic Conditions and Integrated Health Homes meet the expectations of the state. Address any issues with IME Leadership and issue corrective action plans if needed.
- Create and execute a plan to ensure MCO Health Home activities are meeting the requirements of the state SPAs for Chronic Condition and Integrated Health Homes
- Provide monthly reports to the Agency on Health Home activities and annually on Health Home savings

Health Home Enrollment Monthly Report						
	HH Type	**Amerigroup**	**AmeriHealth**	**UHC**	**FFS**	**Total**
Adult	Chronic Condition Health Home	1,635	1,391	1,400		4,426
Child	Chronic Condition Health Home	447	402	422		1,271
Total	**Chronic Condition HH**	**2,082**	**1,793**	**1,822**	**88**	**5,785**
Adult	Integrated HH	4,953	5,791	3,472	181	14,397
Child	Integrated HH	3,254	3,530	2,293	265	9,342
Total	**Integrated HH**	**8,207**	**9,321**	**5,765**	**446**	**23,739**

Amerigroup	**Adult**	**Child**	**Senior**	**Grand Total**
Chronic Condition HH	1,425	447	210	2,082
Integrated HH	4,822	3,254	131	8,207
Grand Total	**6,247**	**3,701**	**341**	**10,289**
AmeriHealth *(contract ended November 2017)*				
Chronic Condition HH	1,124	402	267	1,793
Integrated HH	5,663	3,530	128	9,321
Grand Total	**6,787**	**3,932**	**395**	**11,114**
UnitedHealthcare				
Chronic Condition HH	1,243	447	132	1,822
Integrated HH	3,398	2,293	74	5,765
Grand Total	**4,641**	**2,740**	**206**	**7,587**

Table 7. Health Home Enrollment Monthly Report

4.5.3 Health Information Technology for Economic and Clinical Health (HITECH or HIT)

The Contractor shall support Agency HIT activities based on provisions in the American Recovery and Reinvestment Act (ARRA) and in compliance with Federal regulations outlined in 42 CFR 495. Contractor duties include but are not limited to the following:

1. HIT Coordinator

a. Research, plan and oversee the HIT project, including initiatives supporting the meaningful use of health information exchange and coordination with the Iowa Health Information Network (IHIN), HIT Planning activities related to Iowa's Round Two SIM Testing grant, and integration of the Meaningful Use program into the MACRA Quality Payment Program.

b. Contribute to the definition of incentive payment strategies for Medicaid EHR incentive payment program and other value based payment strategies by recommending HIT platforms to support those payments. Duties include but are not limited to:

i. Recommend strategies to leverage the availability of clinical data to promote efficiencies and improve clinical outcomes as identified through SIM HIT planning activities.

ii. Recommend strategies to capture quality metrics for the purposes of measuring meaningful use of electronic health records, health/medical home performance monitoring, federal reporting, Medicaid Value Based Payment programs, or other Medicaid program for evaluation purposes.

iii. Identify connection points between the health information exchange and the MMIS system for administrative efficiencies and program evaluation.

c. Support and track projects related to Health Information Technology as directed by the Agency. Duties include but are not limited to:

i. Ensure weekly status reports regarding HIT project(s) status, items completed, work planned for the next week (including meetings), outstanding action items and issues are provided to the agency

ii. Schedule and facilitate monthly status meetings with the project steering team and Provider Services Unit Manager.

iii. Manage the continuing development of the HIT plan as directed by the Agency, including initiatives identified from HIT planning workgroups.

iv. Review and update annually the State Medicaid Health Information Technology Plan (SMHP) to allow Iowa Medicaid to leverage technology to improve quality outcomes and manage the growing costs of health care delivery.

v. Update the HIT I-APD annually and as needed, to support State HIT efforts identified through SIM.

vi. Provide HIT I-IAPD budget planning and tracking to support to the Agency.

vii. Provide consolidated project tracking and reporting for all Health Information Technology projects.

d. Ensure privacy and security in expanding the availability of health information exchange.

e. Represent the Agency in discussions with stakeholders.

f. Participate in planning and execution of statewide provider assessment as directed by the Agency.

g. Participate in the Iowa e-Health advisory council, SIM HIT planning workgroups, and other workgroups as directed by the Agency.

h. Represent Iowa Medicaid Enterprise in presentations and workshops related to Health Information Technology as directed by the Agency, including HIT planning workgroups.

[redacted] will serve as the HIT Coordinator and has supported the IME HIT projects for more than three years. She will support Agency HIT activities based on provisions in the American Recovery and Reinvestment Act (ARRA) and in compliance with Federal regulations outlined in 42 CFR 495.

We will formally coordinate with IDPH and IHIN, and through scheduled leadership meetings, joint committees and workgroups to ensure regular communication, coordinated strategies, and optimal progress.

[redacted] will support the five major components of Iowa's SMHP HIT Roadmap:

- Support adoption of electronic health records
- Support health information exchange
- Expand the availability of health records
- Support medical homes
- Meaningful use of exchanged information
- Capture quality measures data

We will build on our experience to develop quality reporting capabilities, ensure the accuracy and validity of the data, and coordinate activities with other data reporting programs currently active in the state.

Under Agency direction, we will participate in the development of the Iowa Medicaid HIT plan. We will align our activities with other HIT and HIE efforts in the state to effectively and efficiently combine the expertise and resources available to support the Agency's HIT plan. We will devote dedicated resources to this effort and build upon the Agency's existing HIT infrastructure and staff expertise to ensure success in achieving the goals of the HIT plan.

Telligen will represent the Agency in discussions with Iowa stakeholders regarding the development of a State HIT plan. We have represented the Agency on the Medical Home Task Force, the HIT/HIE task force, and several other statewide initiatives and have collaborated with other state agencies, provider groups, commercial payers, and medical associations on various projects involving HIT and HIE. Telligen experts will continue to participate in State HIT planning activities as requested by the Agency.

Telligen understands and adheres to all rules and policies related to the confidentiality and security of Medicaid member protected health information. We have extensive experience in this area resulting from our work in the national Health Information Security and Privacy Collaborative (HISPC). Under this program, Iowa's governor designate Telligen to represent the state. Program goals were to identify ways to increase the exchange of clinical information among healthcare providers while protecting the privacy and security of the information.

We build privacy protections into all Telligen data policies and procedures and will be used to ensure the privacy of Medicaid members in all recommendations made to the Agency.

We developed and deployed a provider incentive program for the Oklahoma Medicaid agency as part of our contract to operate a Health Management Program for Medicaid members in that state. Our staff

have participated in numerous CMS initiatives regarding the development of clinical performance measures used in provider incentive programs. In addition, we have the contract with CMS to operate the Quality Payment Program (QPP) Small, Underserved and Rural Support services in Iowa to provide outreach, guidance and technical assistance to clinicians in solo or small practices (15 or fewer) to promote successful HIT adoption, optimization and delivery system reform activities to transition to the new Quality Payment Program. We also won the CMS national contract for the QPP Merit-based Incentive Payment System Customer Program Support and Service Center (QPP MIPS). Telligen is responsible for providing customer support services to participating QPP MIPS clinicians, including maintaining a dedicated help desk, conducting training and outreach, creating dynamic content, and spreading program knowledge. These two contracts provide Telligen with additional expertise and knowledge to share with the HIT Coordinator and support the Agency's HIT programs.

We have experience developing and executing provider assessments of HIT use. We conducted the first statewide assessment of physician adoption of electronic health records in 2006. Several stakeholder organizations used the data to develop future HIT deployment strategies. More recently, we worked with IDPH to design an assessment tool to collect current information about the rate of HIT adoption by Iowa providers. We will use our expertise to assist the Agency in planning and executing statewide provider assessments that may be needed as part of the Medicaid HIT plan.

HIT Coordinator

[redacted] will provide the project management oversight to the entire EHR incentive program which includes the PIPP system software development life cycle, developing requirements for enhancements, system issues tracking, user acceptance testing, and specification reviews for regulation updates; the pre-payment audit process, post-payment audit process, provider outreach, SMHP updates, IAPD updates, regulations impacting the program, and other systems communication issues, as well as attending many CMS meetings and events.

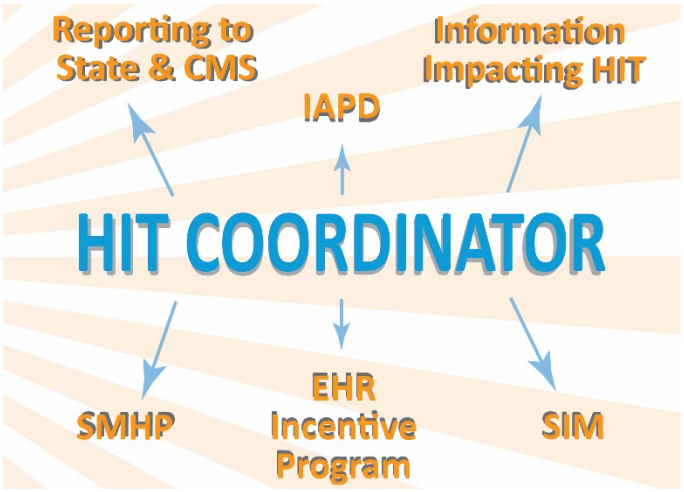

Figure 26. HIT Coordinator responsibilities. ***Performs as the "hub" for Health Information Technology activity across the state.***

[redacted] Agency showing where EHR adoption opportunities for eligible providers in Iowa are available. Due to this reporting, the Agency chose Telligen to perform outreach, education and assistance to dental providers, as this provider type was out of scope with the original REC. The effort was coordinated with another Telligen resource, from the former HIT Regional Extension Center. She worked with IME's dental policy person, dental MCOs, communications, the Iowa Dental Association and others to promote the EHR program to dentists. Educational materials and webinars were posted to the DHS website and informational letters were sent to the providers, as well as working with the IDA and dental MCOs to post to their newsletters, websites,

and blogs. This was a coordinated effort in conjunction with the "Last Chance 2016" effort to encourage eligible providers, such as dentists to participate in the program.

[redacted] will attend informational webinars pertaining to the MACRA/MIPS/QPP programs to assist in aligning efforts and providing guidance to providers with EHR incentive program questions, as the Medicare EHR incentive program sunsets, yet the Medicaid EHR incentive program runs through program year 2021.

[redacted] will keep apprised of the Office of the National Coordinator for Health Information Technology's HealthIT.gov website and resources available there along with other resources for providers participating in the EHR incentive program. She will participate in CMS's Community of Practice calls for Auditing, Meaningful Use, Clinical Quality Measures, Performance Progress, Health Information Exchange, Public Health and Medicaid, as well as the All States call and CMS Regional Office Meetings.

[redacted] will submit quarterly reports to CMS using CMS's prescribed process, as well as a quarterly report compiled by the PIPP team, which contains attestation data for meaningful use measures and clinical quality measures submitted by providers for each program year. She will provide annual and as needed updates to the HIT IAPD and work with IHIN, IDPH and others as needed for other updates. She will also work with CMS to answer questions and get clarification around the HITECH 90/10 funding opportunities for design, development and implementation.

[redacted] will participate in e-Health Advisory Council Meetings, the IHIN Technical Workgroup, attend IHIN board meetings, and holds a bi-weekly HIT Synergy Meeting which includes IHC, IHIN, IDPH, and IME, so HIT efforts remain coordinated and unduplicated, and communication among partners occurs. She maintains a weekly status meeting with the project steering committee, and provides weekly HIT status updates. She also assists as needed in other policy areas such as the Managed Care Bureau for the quality plan updates.

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2. HIT Advisor
a. Support and track projects related to Health Information Technology as directed by the Agency that includes:
i. Direct provider outreach for incoming and outbound calls for EHR incentive program inquiries.
ii. Review and resolve EHR incentive application questions from the pre-payment auditors (escalated issues).
iii. Provide direction and training to EHR pre-payment auditors.
iv. Coordinate and resolve EHR incentive payment issues.
v. Support the Agency's EHR incentive payment system's queue progress per incentive year, including prioritization of tickets, testing releases, and identifying bugs that need action.
vi. Research CMS updates impacting the EHR incentive program and develop training for the pre-payment auditors, system changes, updates to regulatory authority (SMHP addendum, SMHP), and reworking processes for pre- and post-payment auditors.
vii. Recreate and solidify processes for pre- and post-payment auditors, and correlating system enhancements or updates needed.
b. Support the HIT Coordinator in compiling weekly status reports regarding HIT project(s) status, items completed, work planned for the next week (including meetings), outstanding action items and issues
c. Participate in regular status meetings with the project steering team and Provider Services Unit Manager.
d. Assist the HIT Coordinator in reviewing and developing updates to the SMHP and IAPD documents and monthly and quarterly updates to CMS to support the EHR Incentive Payment Program.

[redacted] monitor the EHR incentive pre-payment activities, provide outreach to providers and hospitals, and answer pre-payment auditor questions. She has supported the IME HIT programs for the past year and has several years of experience leading the transition to Meaningful Use and Quality Payment Program for hospitals and clinicians as well as an expert on several EHRs. [redacted] will serve as a dedicated resource to oversee EHR incentive program activities and provide outreach to providers and hospital participants. [redacted] will also support [redacted], HIT Coordinator. She oversees the PIPP system software development life cycle including issues, enhancements, and performs user acceptance testing to ensure the software meets the requirements prior to production release. [redacted] monitors post payment audit progress, and reviews and approves the post-payment auditor documents. She also tracks post-payment provider adjustments and recoupments and communicates with program integrity and ensures the MMIS and PIPP systems correctly reflect the adjustments.

Many outreach and PIPP system update efforts have focused on eligible hospitals who attested for program year 2016. As CMS announced last spring they will no longer perform meaningful use post payment audits for hospitals beginning in 2015, a new screen to collect the meaningful use documents was designed and implemented into the PIPP system. [redacted] outreach efforts to hospitals have focused on educating the hospitals as to what documents they will need to provide to pass the pre-payment audit process as well as calculating patient volume. She has been reviewing the meaningful use documents for eligible hospitals to ensure they are acceptable prior to passing onto the pre-payment auditors to continue the process. Where discrepancies have been found she uses the national level repository (since all hospitals must first attest with Medicare) to assist the hospitals in resolving the

meaningful use reporting issues and errors. She has also ensured that the aggregate payment calculations and three-year distribution are correct prior to issuing the payments.

[redacted] will continue to hold weekly status meetings with the pre-payment auditors, and bi-weekly status meetings with the PIPP system team, as well as bi-weekly post-payment auditor meetings. She will continue to hold regular coaching, training, and issue resolution meetings with the two pre-payment auditors to ensure barriers are removed and incentive payment progress to providers continues until the program year is complete.

She will monitor payment progress against the EHR incentive program funding request for the quarter to ensure payments are within the projected budget amount. She monitors the PIPP system queue status and progress prior to closing out each program year, and runs reports and provides guidance to the pre-payment auditors to assist in the progression.

[redacted] will attend all CMS Community of Practice calls, All-States calls, CMS Regional Office calls, and other webinars pertaining to the EHR incentive program.

She will continue to perform outreach to providers who have participated in the Medicaid EHR incentive program; encouraging return participation until providers have received all six incentive payments. She will continue to monitor attestation statuses to maximize incentive payments to providers and encourage meaningful use of EHRs. Other outreach to providers includes communications distributed through the PIPP system, informational letters, and website updates.

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3. EHR Pre-payment Auditor(s)
a. Assist in the implementation of the EHR Incentive Payment Program at the direction of the HIT Coordinator.
b. Assist in the implementation of systems and process modifications to support paying provider incentives for the adoption and meaningful use of certified technology at the direction of the HIT Coordinator.
c. Monitor provider adoption of electronic health records.
d. Research barriers to EHR adoption.
e. Assist in outreach to providers to encourage them to adopt and meaningfully use electronic health records.
f. Educate providers on the EHR incentive payment program.
g. Communicate with providers regarding status of their EHR application.
h. Provide application instructions to providers, including directing them to the CMS registration and attestation system.
i. Process first and second quality review of provider applications for the EHR incentives in a timely manner.
j. Retrieving the necessary data from the EHR incentive payment system for the HIT Coordinator and assisting with analysis. Data includes but is not limited to:
i. Performance data;
ii. Number of providers applying for incentives from the system;
iii. Number of payments made, total dollars distributed, broken down by provider type from the system; and
iv. Average length of time from application to payment from the system.
k. Support the HIT Coordinator in compiling weekly status reports regarding HIT project(s) status, items completed, work planned for the next week (including meetings), outstanding action items and issues

We will provide two qualified EHR Pre-payment Auditors.

[redacted], HIT Advisor and [redacted], HIT Coordinator will ensure the prepayment auditors perform outreach by phone calls and emails to providers and to monitor queue statuses to move providers from review to payment complete.

[redacted] and [redacted] will continue to work directly with the pre-payment auditors to train and assist them in their processes and to achieve better performance and program knowledge. We will encourage active participation in process improvements and to achieve a good understanding of the patient volume reports, one of the rigorous and complex auditing duties.

The EHR Prepayment auditors will:

- Complete timely, accurate reviews of provider attestations in a consistent manner
- Actively participate in status meetings, training activities for rules impacting the EHR incentive program, PIPP system bug logging, suggest PIPP system enhancements, communicate attestation issues, identify trends with provider attestations, and meaningful use reporting issues
- Process attestations and communicate as needed with providers

- Build appropriate EHR files within the MMIS system so the incentive payments can be processed appropriately to the providers or payee based on the attestation information
- Follow the process guide and templates to perform consistent audits prior to issuing payment
- Run Medicaid claims count and detailed claims reports and reconcile with the patient volume attestation, and use the trust but verify methodology established within the SMHP
- Use CMS specification sheets and FAQs in the review process and to communicate with providers
- Store auditing documents appropriately per incentive program year and use templates for patient volume audits
- Upload documentation to the PIPP system audit screen and enter required data fields appropriately
- Educate providers on program rules and attestation expectations to meet the requirements for receiving an incentive payment when they identify deficiencies during the attestation review
- Monitor their queues for timely reviews and complete tasks as assigned
- Monitor the EHR incentives mailbox and provide timely responses to provider inquiries regarding the program or attestation questions. Escalate issues as needed to the HIT Advisor and Coordinator

4.6 TURNOVER PHASE (RFP 1.3.1.6)

Within this final phase of the Contract, the Contractor turns over operations to a new contractor near the end of the Contract term. This phase is activated when the Agency enters into a contract with a new entity (such as a newly awarded contractor) and begins the process of transferring responsibility for operations to that entity.
Once the turnover phase begins, the Contractor shall:
A. Fully cooperate with the Agency and new entity.
B. Develop and comply with a turnover plan detailing the activities necessary to transfer responsibility for operations to the new entity.

If, at the end of the contract term, the work is awarded to another contractor, we will cooperate fully with the Agency and the new contractor to assure a smooth transition. As part of this phase, we will develop and execute a turnover plan detailing the activities necessary to successfully transfer operational responsibilities to the new contractor.

The plan will include all information requested by the Agency and at a minimum, the following elements:

- Roles and responsibilities of the Telligen turnover team
- A milestone chart detailing the resources, timelines and stages of transition from the date that the successor assumes sole responsibility for the work
- Plans to communicate and cooperate with the successor
- Proposed approach to transition technical support to the successor

- Transfer of all relevant information to ensure successful transition of operational activities including:
  - Data in a file extract of all utilization reviews and quality reviews
  - Clinical information necessary for ongoing management of services
  - Operation support documents
  - Outstanding issues and tasks
  - Contact and communication material

During the turnover phase, we will work to ensure services to members are not disrupted and the change to the successor is transparent. We will continue to meet performance expectations during the turnover phase

4.7 PERFORMANCE MEASURES (RFP 1.3.2)

4.7.1 General Requirements

1. The Contractor shall respond to email or telephone inquiries from Members, authorized representatives, providers, or facilities within two business days of receipt.

As the current Medical Services and HCBS contractor, we have met or exceeded performance standards of our current contract and are committed to continuing high-quality work for the Agency. Our professional staff have extensive knowledge of state and federal guidelines related to our work. We will provide accurate and timely communication to Medicaid members, authorized representatives and providers. Our staff will monitor email, call center lines and individual telephone lines and respond to all inquiries within two business days as expected by the Agency.

2. The Contractor shall participate in 100% of assigned appeal hearings.

Our medical and professional staff, including internal and external consultants, currently and effectively manage this process and will continue to represent the Agency in 100 percent of appeal hearings related to our scope of work. We have, and will maintain, a specialized appeals unit responsible for representing the Agency in appeal hearings.

All appeals outside our scope of work will be assigned to the appropriate unit. We will communicate appeal information, including hearing date and supporting documentation, to the appropriate IME unit and Agency personnel responsible for the program.

4.7.2 Transition

1. The Contractor shall submit transition and operations plans to the Agency for approval within 15 business days after execution of this Contract, unless specified otherwise. The Contractor shall receive final approval no later than 10 business days after first submission.

We will submit our final transition and operations plans for approval within 15 business days after execution of the Contract, unless specified otherwise. We have provided drafts of these plans in Section 4.2.1 of our proposal.

2. The Contractor shall submit the communications, quality assurance, reporting, and training plans to the Agency for approval within 20 business days after execution of this Contract. The Contractor shall receive final approval no later than 10 business days after first submission.

As a QIO, quality assurance is a major component of our work. A continuous quality improvement focus is part of our organizational culture. We pride ourselves on building proactive improvement into all operations. As the current contractor, we have met or exceeded expectations for communications, quality assurance, reporting and training our staff.

We will communicate with the Agency via telephone, secure email, IMPA, ISIS, OnBase and MMIS. We will communicate with Medicaid members, authorized representatives and providers via secure telephone, email, fax and mail.

We have fully trained professional clinical and non-clinical staff who will perform all aspects of the work identified within the proposal. We will also full train all new employees prior to them completing work independently. We have an extensive IQC process and will continue to monitor the quality of work of our staff. Our more experienced staff will mentor new employees, which supports our efforts to retain high-quality, professional staff.

Within 20 business days following execution of the contract, we will submit all changes to our communication, quality assurance, reporting and training plans to the Agency review and approval.

3. The Contractor shall submit SOPs to the Agency for approval within 25 business days after the execution of this Contract. The Contractor shall receive final approval no later than 10 business days after first submission. The Contractor shall document all SOP changes within 30 calendar days of the change.

As the current contractor for this scope of work, we have completed updates to our SOPs annually or within 30 days following any changes. We will continue to meet this standard under the new contract. We will submit all current SOPs to the Agency within 25 business days following execution of the contract, unless the Agency specifies otherwise.

4.7.3 Medical Support

1. Provider Claims Inquiries.
a. The Contractor shall notify providers within five business days of receipt of a claims inquiry with missing or incomplete information.
b. The Contractor shall send the final determination letter on a claims inquiry to the provider within 10 business days of receipt of complete documentation.

We receive provider inquiries via OnBase when claims are denied. Within five business days of receipt of the claims inquiry, we will respond to the provider with a detailed explanation of benefits (EOB) and, if required, request additional information to process the claim.

Within 10 business days of the receipt of all information, we will make a final determination and notify the provider.

2. ETPs.
a. The Contractor shall provide ETP recommendations to Bureau staff within eight business days of receipt unless additional information is requested.
b. The Contractor shall request additional information, if needed, within two business days of ETP receipt.
c. The Contractor shall complete 95 percent of ETP determinations within 10 business days of receipt of complete information, and 100 percent within 20 business days.

Our professional staff will provide ETP recommendations to Agency staff within eight business days of receipt unless additional information is requested. If we need additional information, we will request it within two business days of receipt.

We will complete 95 percent of ETP determinations within 10 business days of receipt of complete information and 100 percent within 20 business days.

3. PERM.
a. The Contractor shall complete medical record reviews for the PERM project within 10 business days of receipt of records, to include physician review if required.

Our professional staff will complete medical record reviews for the PERM project within 10 business days of the receipt of all documentation.

4.7.4 Utilization Management

1. HCBS PAs:
a. The Contractor shall review and communicate decisions on 100 percent of HCBS PAs within two business days of requests of initial service plans once all required materials are received.
b. The Contractor shall review and communicate decisions within five business days of requests for reassessments of service plans once all required materials are received.
c. The Contractor shall arrange for peer-to-peer conversations, as requested, within one business day of request.

The timely and effective review of HCBS prior authorizations are critical to determining the quality of care that members receive, as well as ensuring that they are receiving medically necessary services that do not exceed the Iowa Administrative Code 1915 (c) waiver cap. Telligen understands the importance of ensuring members receive the services needed but also understands the importance of appropriate use of Agency dollars.

Case managers submit their requests for HCBS services in ISIS. When a request requires our review, the file is submitted via IMPA and enters our OnBase work queue. If the request is for an initial stay, we will complete all review activity within two business days (five business days for continued stay reviews).

All PA documents should include a Certificate of Medical Necessity Form to request a waiver prior authorization (WPA) for an initial service plan for CDAC, Pre-Vocational Services, Assistive Devices, or Home and Vehicle Modification. All supporting documentation identified on the form is received via the Iowa Medicaid Portal Access (IMPA) system. The Waiver Prior Authorization (WPA) support staff will keyword the information and assign the review to a senior review coordinator. Once review coordinators receive the information, they have two business days to complete the review. If additional

information is needed, the RC will send a letter to the provider, requesting additional information within 14 calendar days. Once we receive all required and requested information, the RC will have two business days to complete the review process, which includes a decision (approved, denied, modified), and completion of the workflow in ISIS. This process notifies the case manager of the decision and allows them to send out a Notice of Decision (NOD) to the appropriate parties (Figure 27).

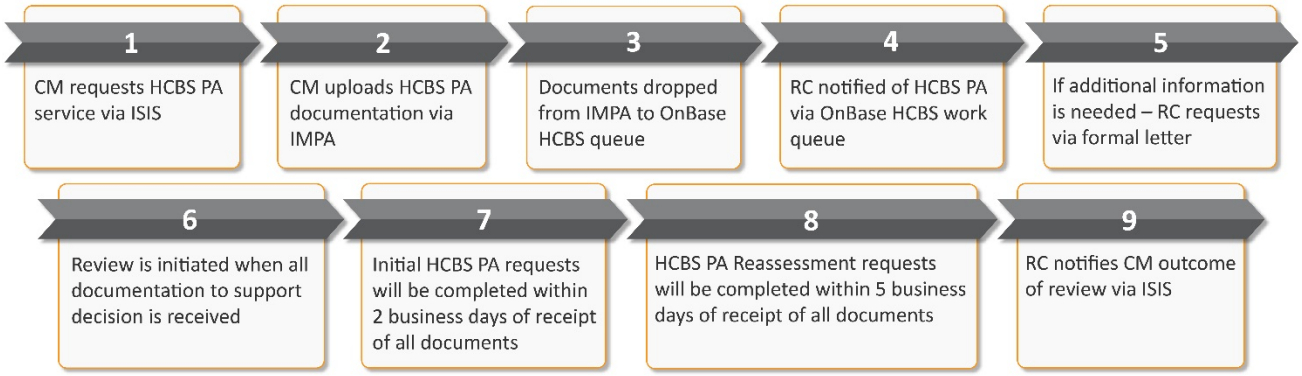

Figure 27. C*ompleting HCBS prior authorizations in a timely and efficient manner allows members to receive immediate access to necessary services.*

We receive a Certificate of Medical Necessity Form to request a WPA for reassessment of service plan for CDAC, Pre-Vocational Services, Assistive Devices, or Home and Vehicle Modification, along with all supporting documentation identified on the form, via IMPA. Like the HCBS prior authorization process depicted in Figure 27, WPA support staff will keyword the information and assign the case to a review coordinator. Once review coordinators receive the information, they have five business days to complete the review. If we require additional information, the RC will send a letter requesting additional information from the provider within 14 calendar days. Once we receive all the required and requested information, the RC will have five business days to complete the review, offer a decision (approved, denied, modified), and complete the workflow in ISIS. This process notifies the case manager of the decision and allows them to send out an NOD to the appropriate parties.

We understand the importance of working collaboratively with HCBS providers and Medicaid members to ensure they receive medically necessary services. Telligen initiated the provision of the peer-to-peer conversation in 2009. If a member or their representative disagrees with a review decision, we will arrange a peer-to-peer conversation between the member (or their representative) and our personnel within one business day of the request. Following this conversation, we may update the medical services determination if indicated.

2. Medical PAs:
a. The Contractor shall review and communicate decisions on 95 percent of Medical PA requests not requiring physician review within 10 business days of initial receipt, and 100 percent within 15 business days of initial receipt.
b. The Contractor shall review and communicate decisions on 95 percent of Medical PA requests requiring physician review within 15 business days of initial receipt, and 100 percent within 20 business days of initial receipt.
c. For those Medical PA requests for which additional information has been requested and not received, the Contractor shall review and communicate decisions for 95 percent of the PAs no earlier than 45 calendar days from initial receipt (to allow time for receipt of the requested information) and no later than 60 calendar days of initial receipt, and complete 100 percent within 60 calendar days of initial receipt.
d. For urgent PA requests, the Contractor shall review and communicate decisions within 72 hours from receipt of the request.

The timely and effective review of PAs is critical in determining the quality of care that members receive, as well as ensuring that they are receiving medically necessary services that do not exceed the Iowa Administrative Code 1915 (c) waiver cap. Telligen understands the importance of ensuring members receive the services needed but also understands the importance of appropriate use of Agency dollars.

The PA team will meet performance standards by processing, completing, and communicating review decisions within 10 business days of receipt of the requests not requiring physician review, no less than 95 percent of the time. In keeping with this strategy, we will process, complete, and communicate review decisions 100 percent of the time within 15 days of initial receipt of information for cases not requiring physician review. Because the system time and date stamps incoming documentation, we can use this information to monitor performance of our team members and ensure we are meeting contract deliverables.

We will maintain Agency time limits for all PAs requiring physician review, ensuring decisions are rendered and communicated within 15 business days of receipt no less than 95 percent of the time and 100 percent of the time within 20 business days. Again, PAs will be pended when additional information is required to complete the review process.

When we must request additional information, we will pend the PA for no less than 45 days to allow the provider adequate time to return all required documentation. Our team will review and communicate PA decisions for no less than 95 percent of the pended PAs, no earlier than 45 calendar days from initial receipt. Staff will complete 100 percent of pended PA decisions prior to 60 calendar days of initial receipt. When the information is not received within the 60-day time frame, a technical denial decision will be made based on insufficient documentation to support a medical necessity decision.

We will review, process and complete all PA requests marked urgent by the provider within 72 hours of receipt of the request. We will also communicate review determinations within 72 hours of receipt. Email alerts will flag urgent requests, which will allow our team members adequate time to process the information and communicate the review decision.

3. LOC and NBA Reviews:
a. The Contractor shall complete 95 percent of Initial LOC and NBA determinations within two business days of receipt of complete information, and 100 percent within five business days.
b. The Contractor shall complete 95 percent of LOC-CSR and NBA-CSR determinations within five business days of receipt of complete information, and 100 percent within ten business days.

We have routinely completed level of care determinations for admission reviews within two business days 95 percent of the time and within five business days 100 percent of the time. In addition, we have maintained timeliness with completion of continued stay level of care determinations. Telligen is committed to continuing the same level of performance.

Telligen will complete Initial LOC and NBA determinations for FFS and MCO population within two business days of receiving complete information needed to conduct the review. The SRC will complete the level of care review and issue a decision regarding approval or denial of LOC and NBA determinations. Once we have completed our review, the review coordinator will enter the approval or denial decision into ISIS. This will allow us to document the information in the NOD, and then send to the Member and provider.

Telligen will complete LOC-CSR and NBA-CSR determinations for FFS population or MCO-affiliated members when the MCO has requested a LOC review, within five business days of receiving complete information needed to conduct the review. The SRC will complete the level of care review and issue a decision regarding approval or denial of LOC and NBA determinations. Once we have completed the review, the SRC will enter the approval or denial decision into ISIS. This will allow us to document the information in the NOD, and then send to the Member and provider. For MCO members, the SRC will send approval and denial notification via email to the MCO contact. If the LOC or NBA review results in a denial, the SRC will include the physician reviewer/medical director reason for the denial decision.

4. Utilization Reviews:
a. The Contractor shall conduct annual onsite UR facility visits between months 10 and 12 months following the prior year visit.
b. The Contractor shall conduct UR hospital desk review every three years for each hospital.
c. The Contractor shall complete desk review of hospital utilization control process within 25 business days following receipt of submitted documentation.
d. The Contractor shall submit written UR findings report to the Agency within 30 business days of completion of each review.

We will conduct an annual onsite review of each facility and complete subsequent reviews within 10 to 12 months after the previous review to ensure compliance with 42 CFR 456. We will track these reviews annually, and we will plan all reviews to allow for schedule adjustments when necessary and to ensure compliance with 42 CFR Part 456.

Every three years, we will conduct a desk review of the utilization control process for each hospital. We will perform the desk review process within 25 business days following our receipt of the hospital's documentation.

Within 30 business days of our completion of the review, we will submit a written UR findings report to the Agency.

4.7.5 HCBS Quality Oversight Operations

1. The Contractor shall submit provider review findings reports to the Agency within 15 business days of the review, and to the provider within 15 business days of Agency approval.

We will submit all provider review findings to the Agency within 15 business days of the last date of the review. Prior to submitting to the Agency, the HCBS team lead or HCBS operations manager will review the report for quality and content.

Once the Agency approves the report, we will send the review findings report to the provider within 15 business days. We will use QPS for the review findings report management of Periodic, Certification and Focused review activity. We will monitor all timelines through QPS to ensure compliance with contract deliverables.

2. Provider Review, Incident, Complaint, and Survey Logs:
a. The Contractor shall log data at an entry rate of error not to exceed 5%.
b. The Contractor shall log 90% of data within two business days of activity.

We will enter all data into the Complaint and Incident database and maintain a data entry error rate that does not exceed five percent. We will input all information received, technical assistance provided, and correspondence into the database within two business days of the activity.

3. HCBS Incidents and Complaints:
a. The Contractor shall complete initial assessments within 3 business days.
b. The Contractor shall initiate fact-finding correspondence with relevant parties within 2 days of initial assessment.

We will review information received either from an IMPA Incident report, Rejected Intake Dependent Adult Abuse report or the Incident and Complaint form upon receipt. We will follow policies, procedures and decision trees to determine the course of action to be taken. If additional information is required, we will request additional information from the pertinent parties.

We will complete all initial assessments within three business days with a request for additional information occurring within two business days of the initial assessment.

4. CAPS:
a. The Contractor shall initiate CAPs within 30 business days of review.
b. The Contractor shall review and make determinations on CAPS within 15 business days of initial submission.
c. The Contractor shall conduct a compliance review within 60 business days after CAP is approved.

We will initiate the corrective action plan within 30 business days of completion of our review. We will review the corrective action plan and make determinations within 15 business days of its initial submission.

We will initiate all compliance reviews for all review types within 45 business days to account for letter approval and mailing times to ensure the review is initiated prior to 60 business days. We will use QPS to track timeliness for Periodic, Certification and Focused reviews. The Complaint and Incident database will track all timelines for incidents and complaints.

4.7.6 PACE

1. The Contractor shall submit the written PACE findings report to the Agency within 30 business days of completion of the review.

Our PACE Specialist will complete a written findings report detailing areas of deficiency and expectations related to CAP activity and submit to the operations manager within 15 business days of the exit conference. Our operations manager will review the report for quality and content and submit the final report to the Agency within 30 business days of the exit conference.

4.7.7 HIT

1. The Contractor shall participate in 100% of HIT project status meetings.
2. The Contractor shall complete first reviews of applications within two business days.
3. The Contractor shall complete second reviews of applications within two business days.
4. The Contractor shall review applications with 100% accuracy prior to incentive payment disbursement.
5. The Contractor shall respond to all emails or calls to providers within two business days on technical questions, status of applications and the incentive program in general.

[redacted] stakeholders. They also prepare agendas and status updates to discuss with meeting attendees for the HIT and Prepay Status meetings. Policy contributes input on the cadence of the meetings, including requests to cancel or reschedule the meetings. The current regularly occurring meetings include HIT Status Meeting, Pre-Pay Status Meeting, Post Pay Status Meeting and PIPP Status Meeting. [redacted] and/or [redacted] participate in 100 percent of the meetings.

For this contract, Telligen will:

- Participate in 100 percent of HIT project status meetings
- Complete first reviews of applications within two business days
- Complete second reviews of applications within two business days
- Review applications with 100-percent accuracy prior to incentive payment reimbursement
- Respond to all emails or calls to providers within two business days on technical questions, status of applications and the incentive program in general

4.7.8 Reporting

1. The Contractor shall deliver accurate and timely reports to the Agency. All submitted reports shall be concise, free from typographical and grammatical errors, and come to logical conclusions.
2. Unless otherwise specified, the Contractor shall provide all identified reports in an Agency-approved format and in accordance with timeframes established in the Agency-approved reporting plan.
3. The Contractor shall submit reports within the timeframes established in the Agency-approved reporting plan and according to the following schedule, unless otherwise specified within the Agency-approved reporting plan:
a. Weekly reports: within two business days of end of reporting period;
b. Monthly reports: within ten business days of end of reporting period;
c. Quarterly reports: within fifteen business days of end of reporting period;
d. Annual reports: within twenty business days of end of reporting period; and
e. Ad hoc reports: within two business days of request, unless otherwise specified.
4. For those reports that will be released to external stakeholders, and other special reports as identified within the reporting plan, the Contractor shall:
a. Submit a draft to the Agency for review 30 calendar days prior to the release date.
b. Receive final approval of the report no later than 14 days after first submittal.

Telligen will provide the Agency with information about our activities through required reports, open communication, and regular meetings with Agency staff. We will meet all performance standards and complete all required reports within the prescribed timeframes. We believe our current collaboration with policy staff is effective, and we will continue to participate in all necessary activities to ensure that Telligen delivers quality reporting that is concise, error-free and responsive to Agency needs.

We currently report all performance measures requested by the Agency in daily, monthly, quarterly and/or annual timeframes via established reporting formats developed in collaboration with Agency staff. Telligen will analyze performance data and suggest revised report content and formats following discussions with Agency staff. We will quickly develop new reporting formats as requested by the Agency.

We will provide management reports at required intervals, as well as in response to ad hoc requests within two business days. Reports may include the timeliness of review outcomes, the volume of requests received and completed, the rate of denial, and the number of overturned decisions and the reasons for the reversal. As appropriate, scheduled and ad hoc reports will include recommendations for changes that would improve review processes and provide more useful information to the Agency.

We will establish and monitor baseline measurements over time for each performance measure. We will analyze performance data as the Agency requires. We will look for trends to identify developing patterns that may adversely impact our ability to meet performance standards. We will address any problem trends immediately through process changes designed to reverse the trend and avoid a problem before it impacts our ability to meet the Agency's expectations.

For reports to be released to external stakeholders, we will develop draft versions of the reports and submit them to the Agency for review 30 calendar days prior to their planned release date. To ensure

timely release of the report, our staff will follow up with Agency staff if we have not received a response within 14 calendar days following submission of the draft document.

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5 TELLIGEN'S BACKGROUND (RFP 3.2.5)

5.1 EXPERIENCE (RFP 3.2.5.1)

The bidder shall provide the following information regarding the organization's experience:
3.2.5.1.1 Level of technical experience in providing the types of services sought by the RFP.

Since 1979, the Iowa Department of Human Services has contracted with Telligen for utilization management, quality improvement, and special project services involving recipients of medical assistance. The Agency's confidence in our sustained ability to produce desired outcomes has been supported by being awarded increased program responsibility over the past 39 years. Examples include Rehabilitative Treatment Service authorization in 1998, Disease Management for Diabetes and Adult Rehabilitation Options in 2003 and a significant expansion of the Recipient Health Education Program also in 2003.

Unmatched IME Medical Services/HCBS Experience

- ✓ 39-years as Iowa Medicaid utilization management, quality improvement and special projects vendor
- ✓ Five years as successful Iowa Medicaid HCBS vendor
- ✓ Collaborated with and supported transition to managed care organizations

We know Iowa Medicaid Medical Services

Since 2005, Telligen has held the Medical Services contract. We deliver leading-edge solutions to improving quality and utilization management to IME. Additionally, our medical professionals collaborated, planned and supported the implementation of the managed care organizations.

Under our Medical Services contract, we have identified and promoted best practices that resulted in measurable cost avoidance to the state. Over the last four state fiscal years, the total cost avoidance was $143 million.

In 2010, we implemented a waiver prior authorization program to ensure medically necessary HCBS. In FY 2014, savings from this program totaled $6.5 million.

In 2010, we added High Tech Radiology prior authorization reviews.

In 2016, in response to the CMS Special Terms and Conditions, we began MCO Quality Oversight in Iowa. Iowa In-Patient Psychiatric admission reviews also began in 2016.

In 2017, the Iowa Minimum Data Set (MDS) validation was added back into our contract. It had been removed in 2016, when the Managed Care Organizations moved into Iowa.

We know HCBS

In 2012, we began working with more than 700 Iowa HCBS providers to improve the quality of services provided to members. Providers receiving quality reviews and technical assistance demonstrated the following results:

- 133 percent increase in deficiency-free reviews
- 28 percent increase in providers achieving maximum certification of three years

We conduct level of care determinations for all seven waiver programs, ICF/ID and nursing facilities, in addition to making non-financial eligibility determinations for persons with mental illness to determine federal and state eligibility requirements are met.

In Colorado, we have worked with the Department of Health Care Policy and Financing to conduct onsite review and monitoring of HCBS providers to ensure compliance with the CMS Settings Final Rule. In Maryland, we work with the state Medicaid agency to conduct prior authorizations and continuing service authorizations for seven different HCBS waiver populations. We also complete in-home assessments used to determine eligibility for the previously noted waiver programs.

We know the technology

For the past 12 years we have worked with the Agency to develop, use and maintain its systems. We worked with the Division of Data Management to develop the Medicaid Quality Utilization Information Data System and QualAssure Performance System. In the past six months, we have worked with DDM on over 100 system changes for MQUIDS and QPS. We have the flexibility and processes in place to quickly respond to the Agency's changing needs and priorities.

3.2.5.1.2 Description of all services similar to those sought by this RFP that the bidder has provided to other businesses or governmental entities within the last twenty-four (24) months.
For each similar service, provide a matrix detailing:
A. Project title;
B. Project role (primary contractor or subcontractor);
C. Name of client agency or business;
D. General description of the scope of work;
E. Start and end dates of contract for services as originally entered into between the parties;
F. If the contract was terminated for any reason before completion of all obligations under the contract provisions, detail the reason(s) for the termination;
G. Contract value;
H. Whether the services were provided timely and within budget;
I. Any damages, penalties, disincentives assessed, or payments withheld, or anything of value traded or given up by the bidder that were valued at or above $500,000. Include the estimated cost assessed against the bidder for the incident with the details of the occurrence;
J. List administrative or regulatory proceedings or adjudicated matters related to this service to which the bidder has been a party; and
K. Contact information for the client's project manager including address, telephone number, and electronic mail address.

The following matrixes provide details on similar services we have provided for the Maryland, Colorado, Idaho and Oklahoma Medicaid programs.

A. Project title	Level of Need Determinations and Assessments
B. Project role	Prime contractor
C. Name of client agency or business	[redacted])
D. General description of the scope of work	
	[redacted]
E. Start and end dates of contract	[redacted]
F. Reason(s) for termination	Not applicable
G. Contract value	[redacted]
H. Services provided timely and within budget?	Yes
I. Any damages, penalties, disincentives assessed, or payments withheld	None
J. Administrative or regulatory proceedings or adjudicated matters	None
K. Contact information	[redacted]

A. Project title	[redacted]
B. Project role	Prime contractor
C. Name of client agency or business	[redacted])
D. General description of the scope of work	

[redacted]

- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]

[redacted]

[redacted]

E. Start and end dates of contract	[redacted]
F. Reason(s) for termination	Not applicable
G. Contract value	[redacted]
H. Services provided timely and within budget?	Yes

I. Any damages, penalties, disincentives assessed, or payments withheld	None
J. Administrative or regulatory proceedings or adjudicated matters	None
K. Contact information	[redacted]

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A. Project title	[redacted]
B. Project role	Prime contractor
C. Name of client agency or business	[redacted]
D. General description of the scope of work	
[redacted]	
E. Start and end dates of contract	[redacted]
F. Reason(s) for termination	Not applicable
G. Contract value	[redacted]
H. Services provided timely and within budget?	Yes
I. Any damages, penalties, disincentives assessed, or payments withheld	None
J. Administrative or regulatory proceedings or adjudicated matters	None
K. Contact information	[redacted]

A. Project title	[redacted]
B. Project role	Prime contractor
C. Name of client agency or business	[redacted]
D. General description of the scope of work	
	[redacted]
E. Start and end dates of contract	[redacted]
F. Reason(s) for termination	Not applicable
G. Contract value	[redacted]
H. Services provided timely and within budget?	Yes
I. Any damages, penalties, disincentives assessed, or payments withheld	None
J. Administrative or regulatory proceedings or adjudicated matters	None
K. Contact information	[redacted]

A. Project title	External Quality Review
B. Project role	Prime contractor
C. Name of client agency or business	[redacted]
D. General description of the scope of work	
[redacted]	
E. Start and end dates of contract	[redacted]
F. Reason(s) for termination	Not applicable
G. Contract value	[redacted]
H. Services provided timely and within budget?	Yes
I. Any damages, penalties, disincentives assessed, or payments withheld	None
J. Administrative or regulatory proceedings or adjudicated matters	None
K. Contact information	[redacted]

A. Project title	[redacted]
B. Project role	Prime contractor
C. Name of client agency or business	[redacted]
D. General description of the scope of work	
	[redacted]
E. Start and end dates of contract	[redacted]
F. Reason(s) for termination	Not applicable
G. Contract value	[redacted]
H. Services provided timely and within budget?	Yes
I. Any damages, penalties, disincentives assessed, or payments withheld	None
J. Administrative or regulatory proceedings or adjudicated matters	None

K. Contact information	[redacted]

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A. Project title	Onsite Monitoring of HCBS Providers
B. Project role	Prime contractor
C. Name of client agency or business	[redacted]
D. General description of the scope of work	
[redacted]	[redacted]
F. Reason(s) for termination	Not applicable
G. Contract value	[redacted]
H. Services provided timely and within budget?	Yes
I. Any damages, penalties, disincentives assessed, or payments withheld	None
J. Administrative or regulatory proceedings or adjudicated matters	None
K. Contact information	[redacted]

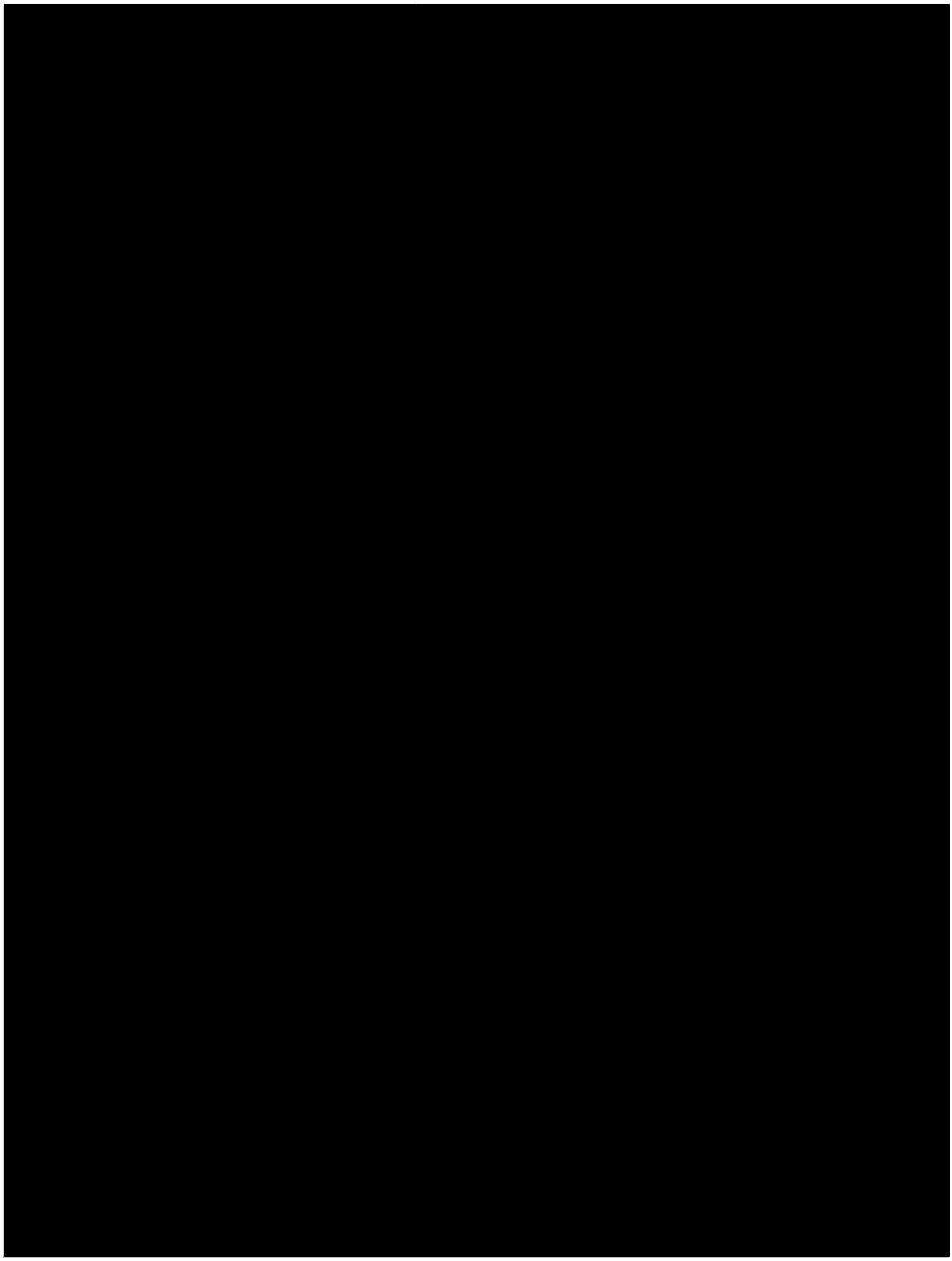
3.2.5.1.3 List any details of whether the bidder or any owners, officers, primary partners, staff providing services or any owners, officers, primary partners, or staff providing services of any subcontractor who may be involved with providing the services sought in this RFP, have ever had a founded child or dependent adult abuse report, or been convicted of a felony.

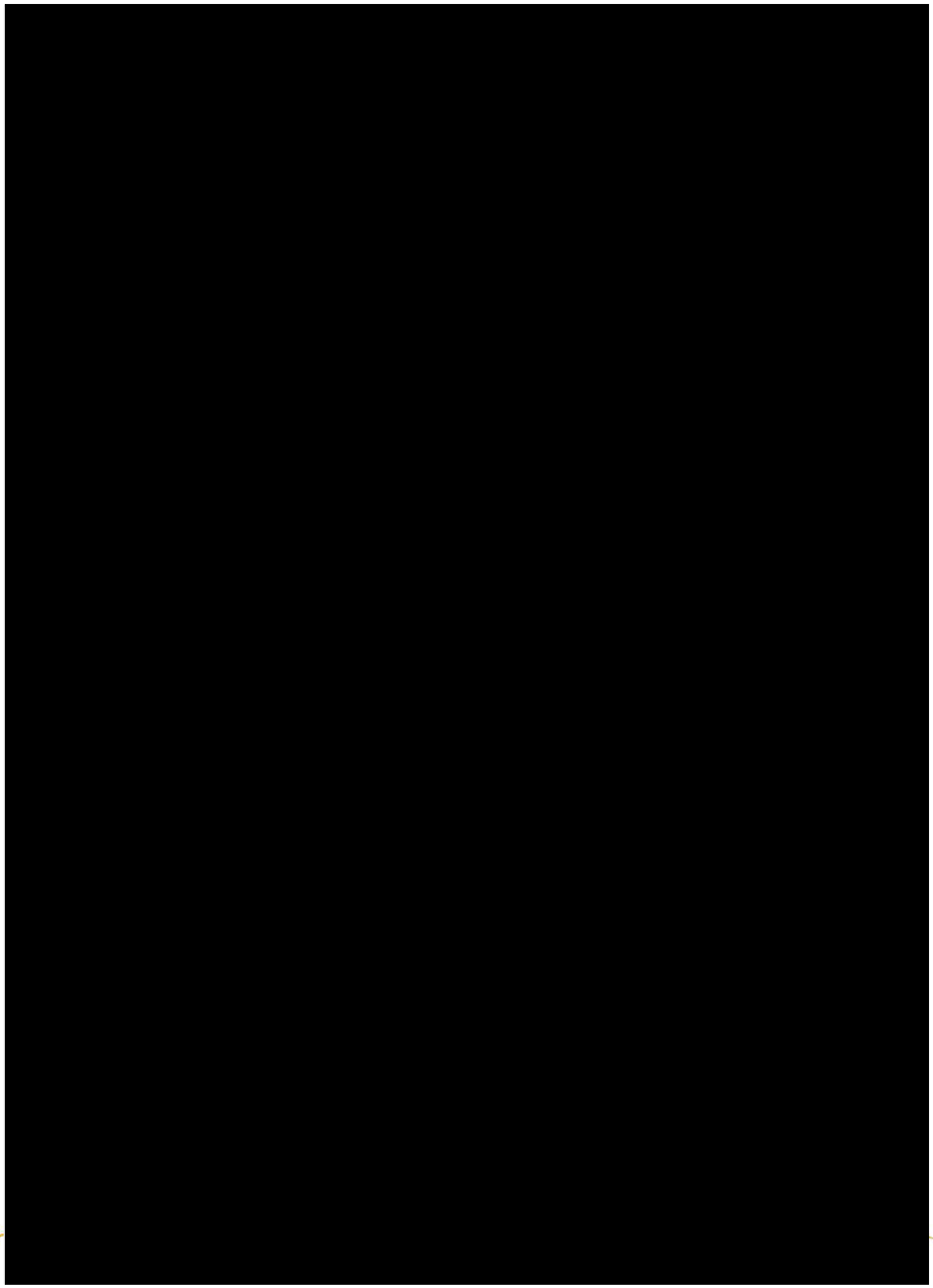
No Telligen owner, officer, primary partner or staff providing services sought in this RFP, has ever had a founded child or dependent adult abuse report, or been convicted of a felony.

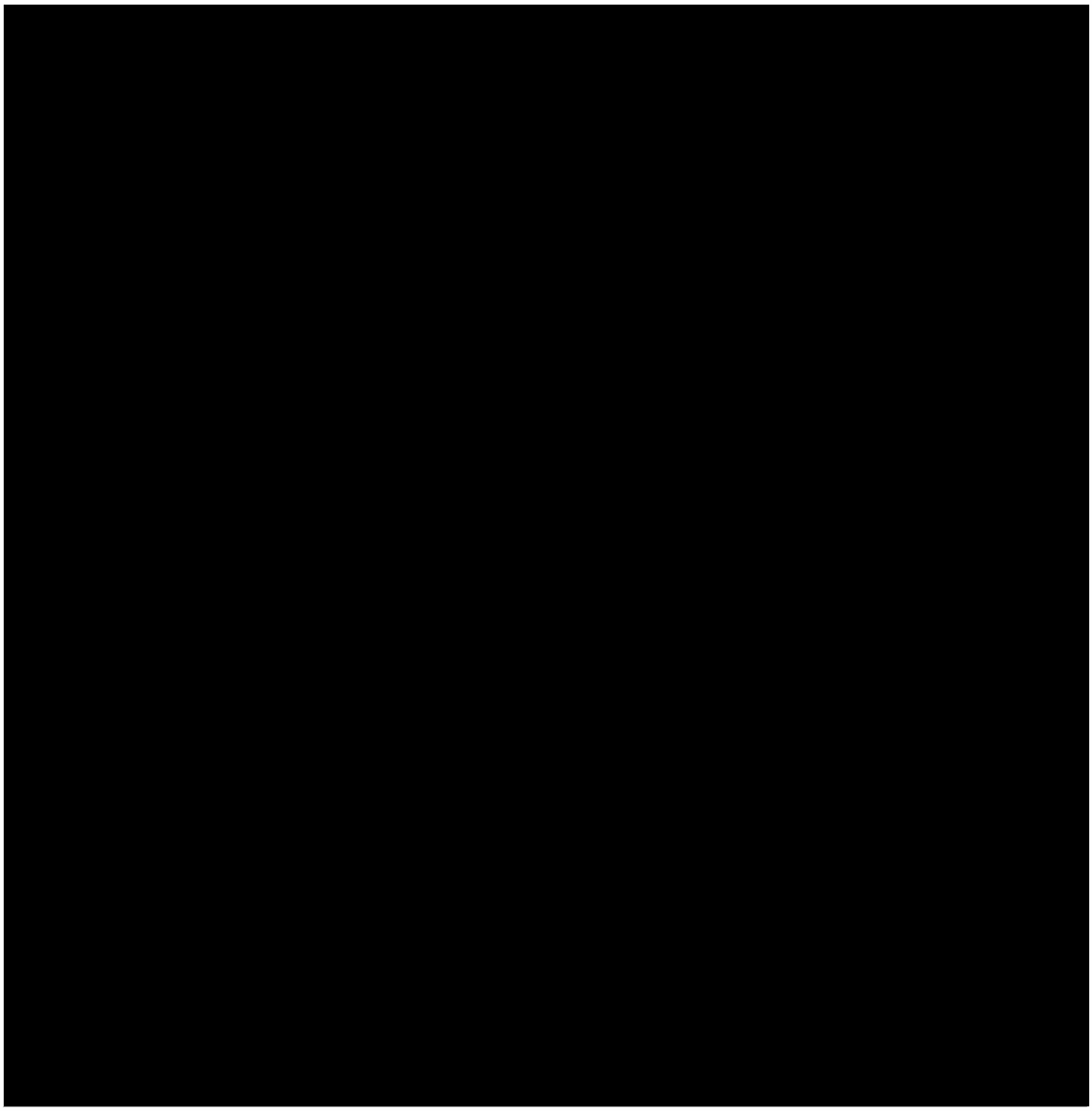
3.2.5.1.4 Letters of reference from three (3) of the bidder's previous clients knowledgeable of the bidder's performance in providing services similar to those sought in this RFP, including a contact person, telephone number, and electronic mail address for each reference. It is preferred that letters of reference are provided for services that were procured in a competitive environment. Persons who are currently employed by the Agency are not eligible to be references.

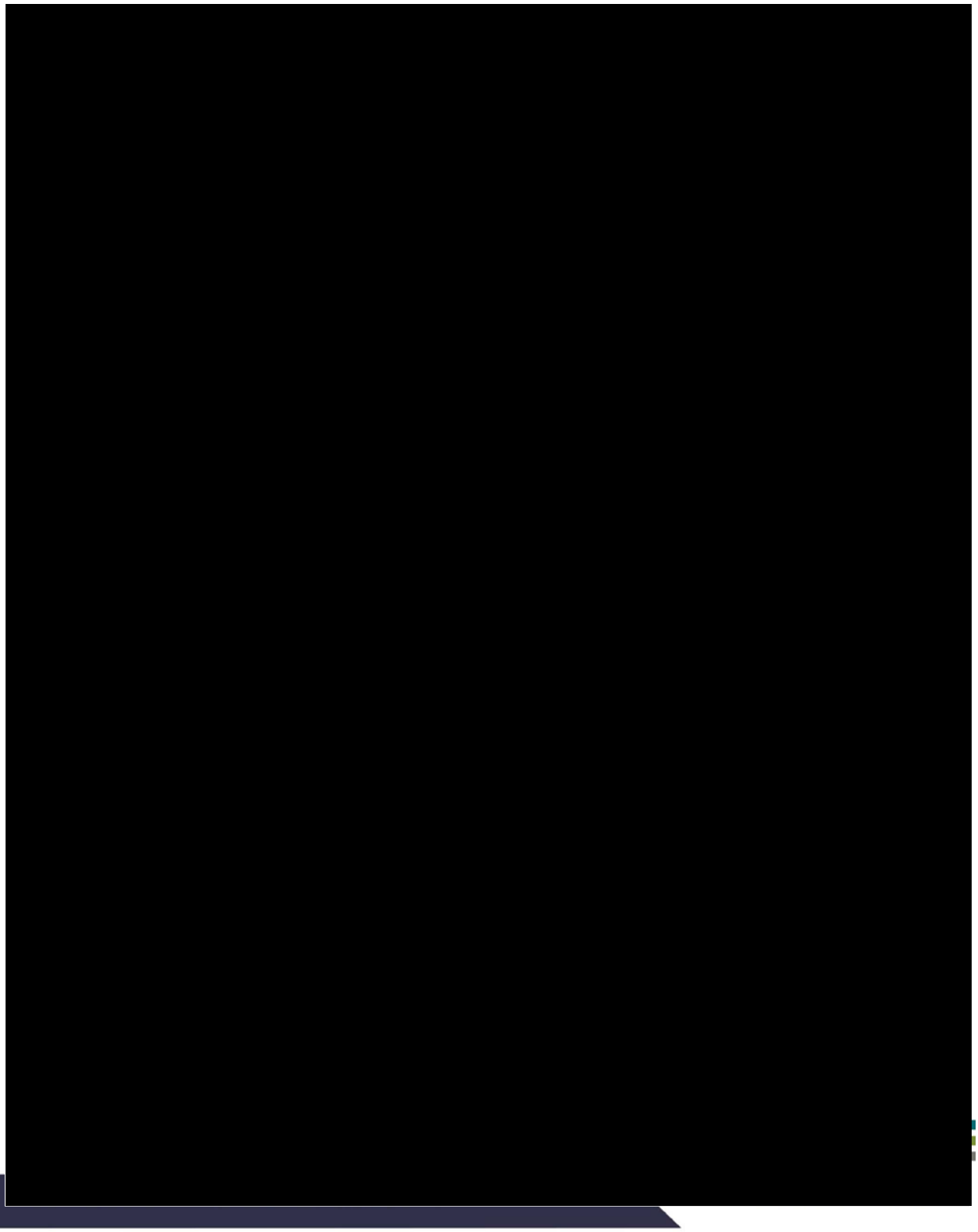
In the following pages we have provided letters of reference from the following:

[redacted]









3.2.5.1.5 Description of experience managing subcontractors, if the bidder proposes to use subcontractors.

We are not proposing the use of subcontractors.

This space intentionally left blank

5.2 PERSONNEL (RFP 3.2.5.2)

The bidder shall provide the following information regarding personnel:

5.2.1 Tables of Organization

Illustrate the lines of authority in two tables:

- ***One showing overall operations***

The following organizational chart illustrates the lines of authority of our overall operations.

Experienced Leaders

- ✓ Key personnel exceed RFP requirements
- ✓ Management team brings institutional knowledge of working in FFS and managed care environments
- ✓ Telligen team understands and has worked extensively with state and federal guidelines for waiver programs

[redacted]

[redacted] will provide executive leadership for this contract with [redacted] reporting directly to her. [redacted] has over 35 years in leadership roles including 25 years with the Iowa Medicaid contracts. This includes medical services, HCBS and CSA contracts. This experience includes successfully leading Telligen's efforts in the initial 2004 transition to the IME model and enhancing our continued partnership with the Agency in delivery of this effective model.

- ***One showing staff who will provide services under the RFP, listing the total number of proposed staff, specifying key personnel, other supervisors, and field staff.***

The following organizational chart identifies the Telligen personnel who will provide the services specified in the QIO Services scope of work. The chart includes the total number of proposed staff and identifies key personnel, supervisory personnel and field staff.

Figure 29. Project organization

5.2.2 Information About Project Manager and Key Project Personnel

- ***Include names and credentials for the project manager and any additional key project personnel who will be involved in providing services sought by this RFP. Include resumes for these personnel. The resumes shall include: name, education, and years of experience and employment history, particularly as it relates to the scope of services specified herein. Resumes shall also include the percentage of time the person would be specifically dedicated to this project, if the bidder is selected as the successful bidder. Resumes should not include social security numbers.***
- ***Include the project manager's experience managing subcontractor staff if the bidder proposes to use subcontractors.***
- ***Include the percentage of time the project manager and key project personnel will devote to this project on a monthly basis.***

Key Personnel	Credentials	% of Time on Project/Month
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted] Health and Human Services	✓ [redacted]

Key Personnel	Credentials	% of Time on Project/Month
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	✓

Table 8. Key Personnel credentials and time commitment

We are not proposing the use of subcontractors.

All key personnel will continue to be located in the Iowa Medicaid Enterprise office.

We have an experienced, qualified team

The key personnel described above will have the support of a QIO Services for Iowa Medicaid team with 400+ years of combined experience. They will also have the support of our corporate staff located in our West Des Moines headquarters.

- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- Our staff includes the following degrees and certifications:

Certifications			
[redacted]			
[redacted]			
[redacted]			
[redacted]			
[redacted]			
[redacted]			
[redacted]			
[redacted]			
[redacted]			
[redacted]			

Table 9. Telligen staff certifications

Degrees			
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]		

Table 10. Telligen staff degrees

Our staff also has experience with a wide range of committees and stakeholders:

Clinical Advisory Committee	IME and University of Iowa claims review committee
***hawk*-I** committee	Brain Injury diagnostic and criteria committee
Maternal fetal health	MHDS IME meeting
Iowa collaborative statewide task forces	IACP Meeting
Statewide HIV task force	Account manager meeting
Statewide Hepatitis C	Verscend correct coding initiative vendor
Medical directors network	System Eligibility Workgroup
MCO Quality committee	Lean Committee
Internal Quality control committee	Analytics committee
Electronic Visit Verification	Pediatric Home Health Committee
State Innovation model committee	IME MCO Incident and Complaint committee
HD Advisory committee	WISE meetings
MFP partnership meeting	State system work flow meetings
Program Integrity	MCO analytics meeting
Quality Assurance	Electronic Health Records advisory meetings
MCO HCBS provider meeting	I-HIN Technical work group
Long Term Care Policy Meeting	Culture Club committee
Medical Services and Policy committee for Long term care	IME Social Club Committee
Internal Claims and Benefit meeting	Statewide Transition Plan Meeting
IME and MCO claims and benefit meetings	Various CMS calls related to HCBS

Table 11. Telligen committee involvement

We provide subject matter expertise in collaboration with the Agency, CORE, Program Integrity, Member Services, Provider Enrollment, Provider Services and Provider Cost Audit.

Our Long-Term Care, PACE and MDS validation subject matter experts are located across Iowa to monitor compliance with Code of Federal Regulation 456. Our review coordinators specialize in non-financial eligibility and medical necessity.

Our Long-Term Care waiver team includes nurses, licensed social workers and Qualified Intellectual Disabilities Professionals (QIDP) with extensive behavioral health experience.

We strategically locate HCBS specialists across Iowa to ensure timely and quality review of HCBS providers. Each of these specialists are subject matter experts on state and federal regulations related to quality oversight.

Our claims team has a highly seasoned staff experienced in the research and adjudication of claims in accordance with IME policy and CMS directives. The team has years of experience in updating and cross walking CPT, ICD-10, and HCPCS codes.

Our appeals team is made up of seasoned individuals with experience representing the Agency in thousands of State Fair Appeal Hearings.

The team responsible for completing prior authorization reviews has experience with all types of medical and dental services and products. This includes but is not limited to physician administered medications, surgeries and durable medical equipment for the Medicaid population.

Our QIO Services team is exceptionally qualified but can also count on the support of a large corporate support staff with a wide range of experience and qualifications.