STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

PAGE	ORDER DATE
1 of 9	02/18/21
BUSINESS UNIT	BUYER
25710178	ROLAND, KEITH B

VENDOR NUMBER: 506501

VENDOR ADDRESS:

HEALTH SERVICES ADVISORY GROUP INC
3133 E CAMELBACK RD STE 300
PHOENIX AZ 85016-4544

DEPT OF HEALTH & HUMAN SVCS

CONTRACT NUMBER
93851 O4

THE CONTRACT PERIOD IS:

APRIL 01, 2021 THROUGH MARCH 31, 2024

THIS SERVICE CONTRACT HAS BEEN AMENDED PER THE FOLLOWING INFORMATION:

THIS CONTRACT IS NOT AN EXCLUSIVE CONTRACT TO FURNISH THE SERVICES SHOWN BELOW, AND DOES NOT PRECLUDE THE PURCHASE OF SIMILAR SERVICES FROM OTHER SOURCES.

THE STATE RESERVES THE RIGHT TO EXTEND THE PERIOD OF THIS CONTRACT BEYOND THE TERMINATION DATE WHEN MUTUALLY AGREEABLE TO THE VENDOR/CONTRACTOR AND THE STATE OF NEBRASKA.

Original/Bid Document 6303 Z1

Contract to supply and deliver for External Quality Reviews of the services included in the Managed Care Organizations (MCO) and Dental Benefits Manager (DBS) contracts to the State of Nebraska as per the attached specifications for a three (3) year period from date of award. The contract may be renewed for three (3) additional one (1) year periods when mutually agreeable to the vendor and the State of Nebraska. The State reserves the right to extend the period of this contract beyond the termination date when mutually agreeable to the vendor and the State of Nebraska.

Vendor Contact: Gretchen Thompson, MBA, CPHQ
Phone: (602) 801-6687
E-Mail: gthompson@hsag.com

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
1	EQR REPORT MCO: STATE - INITIAL TERM	99,384.7500	$	1.0000	99,384.75
2	EQR REPORT MCO : FEDERAL - INITIAL TERM $44,171.00 PER EQR REPORT (9 TOTAL)	298,154.2500	$	1.0000	298,154.25
3	EQR REPORT DBM: STATE - INITIAL TERM	33,128.2500	$	1.0000	33,128.25
4	EQR REPORT DBM: FEDERAL - INITIAL TERM	99,384.7500	$	1.0000	99,384.75

DocuSigned by:
Mary Ellen Dalton
5A6EBD2BF28E43D...
3/11/2021 | 17:28:22 EST
CONTRACTOR SIGNATURE

Kevin Bagley
EEF89D05BD264A5...
3/15/2021 | 09:46:23 CDT
AGENCY SIGNATURE

STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

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BUSINESS UNIT	BUYER
25710178	ROLAND, KEITH B

VENDOR NUMBER: 506501

CONTRACT NUMBER
93851 O4

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
	$44,171.00 PER EQR REPORT (3 TOTAL)				
5	VALIDATION OF PIPS REPORT MCO: STATE - INITIAL TERM	14,373.0000	$	1.0000	14,373.00
6	VALIDATION OF PIPS REPORT MCO : FEDERAL - INITIAL TERM	43,119.0000	$	1.0000	43,119.00
	$6,388.00 PER PIPS REPORT (9 TOTAL)				
7	VALIDATION OF PIPS REPORT DBM: STATE - INITIAL TERM	4,791.0000	$	1.0000	4,791.00
8	VALIDATION OF PIPS REPORT DBM: FEDERAL - INITIAL TERM	14,373.0000	$	1.0000	14,373.00
	$6,388.00 PER PIPS REPORT (3 TOTAL)				
9	VALIDATION OF PM REPORT MCO: STATE - INITIAL TERM	16,632.0000	$	1.0000	16,632.00
10	VALIDATION OF PM REPORT MCO : FEDERAL - INITIAL TERM	49,896.0000	$	1.0000	49,896.00
	$7,392.00 PER PM REPORT (9 TOTAL)				
11	VALIDATION OF PM REPORT DBM: STATE - INITIAL TERM	5,544.0000	$	1.0000	5,544.00
12	VALIDATION OF PM REPORT DBM: FEDERAL - INITIAL TERM	16,632.0000	$	1.0000	16,632.00
	$7,392.00 PER PM REPORT (3 TOTAL)				
13	VALIDATION OF NA REPORT MCO: STATE - INITIAL TERM	34,645.5000	$	1.0000	34,645.50
14	VALIDATION OF NA REPORT MCO : FEDERAL - INITIAL TERM	103,936.5000	$	1.0000	103,936.50
	$15,398.00 PER NA REPORT (9 TOTAL)				
15	VALIDATION OF NA REPORT DBM: STATE - INITIAL TERM	11,548.5000	$	1.0000	11,548.50

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STATE OF NEBRASKA SERVICE CONTRACT AMENDMENT

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25710178	ROLAND, KEITH B

VENDOR NUMBER: 506501

CONTRACT NUMBER
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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
16	VALIDATION OF NA REPORT DBM: FEDERAL - INITIAL TERM $15,398.00 PER NA REPORT (3 TOTAL)	34,645.5000	$	1.0000	34,645.50
17	TA AND CONSULTATION STATE - INITIAL TERM	13,050.0000	$	1.0000	13,050.00
18	TA AND CONSULTATION FEDERAL - INITIAL TERM $145.00 PER HOUR. ESTIMATED QUANTITY OF 120 HOURS PER YEAR IS SUBJECT TO ACTUAL UTILIZATION.	39,150.0000	$	1.0000	39,150.00
19	EQR REPORT MCO: STATE - RENEWAL 1	34,466.2500	$	1.0000	34,466.25
20	EQR REPORT MCO: FEDERAL - RENEWAL 1 $45,955.00 PER EQR REPORT (3 TOTAL)	103,398.7500	$	1.0000	103,398.75
21	EQR REPORT DBM: STATE - RENEWAL 1	11,488.7500	$	1.0000	11,488.75
22	EQR REPORT DBM: FEDERAL - RENEWAL 1 $45,955.00 PER EQR REPORT (1 TOTAL)	34,466.2500	$	1.0000	34,466.25
23	VALIDATION OF PIPS REPORT MCO: STATE - RENEWAL 1	4,984.5000	$	1.0000	4,984.50
24	VALIDATION OF PIPS REPORT MCO: FEDERAL - RENEWAL 1 $6,646.00 PER PIPS REPORT (3 TOTAL)	14,953.5000	$	1.0000	14,953.50
25	VALIDATION OF PIPS REPORT DBM: STATE - RENEWAL 1	1,661.5000	$	1.0000	1,661.50
26	VALIDATION OF PIPS REPORT DBM: FEDERAL - RENEWAL 1 $6,646.00 PER PIPS REPORT (1 TOTAL)	4,984.5000	$	1.0000	4,984.50

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25710178	ROLAND, KEITH B

VENDOR NUMBER: 506501

CONTRACT NUMBER
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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
27	VALIDATION OF PM REPORT MCO: STATE - RENEWAL 1	5,768.2500	$	1.0000	5,768.25
28	VALIDATION OF PM REPORT MCO: FEDERAL - RENEWAL 1 $7,691.00 PER PM REPORT (3 TOTAL)	17,304.7500	$	1.0000	17,304.75
29	VALIDATION OF PM REPORT DBM: STATE - RENEWAL 1	1,922.7500	$	1.0000	1,922.75
30	VALIDATION OF PM REPORT DBM: FEDERAL - RENEWAL 1 $7,691.00 PER PM REPORT (1 TOTAL)	5,768.2500	$	1.0000	5,768.25
31	VALIDATION OF NA REPORT MCO: STATE - RENEWAL 1	15,466.5000	$	1.0000	15,466.50
32	VALIDATION OF NA REPORT MCO: FEDERAL - RENEWAL 1 $20,622.00 PER NA REPORT (3 TOTAL)	46,399.5000	$	1.0000	46,399.50
33	VALIDATION OF NA REPORT DBM: STATE - RENEWAL 1	5,155.5000	$	1.0000	5,155.50
34	VALIDATION OF NA REPORT DBM: FEDERAL - RENEWAL 1 $20,622.00 PER NA REPORT (1 TOTAL)	15,466.5000	$	1.0000	15,466.50
35	TA AND CONSULTATION STATE - RENEWAL 1	4,530.0000	$	1.0000	4,530.00
36	TA AND CONSULTATION FEDERAL - RENEWAL 1 $151.00 PER HOUR. ESTIMATED QUANTITY OF 120 HOURS PER YEAR IS SUBJECT TO ACTUAL UTILIZATION.	13,590.0000	$	1.0000	13,590.00
37	EQR REPORT MCO: STATE - RENEWAL 2	35,155.5000	$	1.0000	35,155.50
38	EQR REPORT MCO: FEDERAL - RENEWAL 2	105,466.5000	$	1.0000	105,466.50

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25710178	ROLAND, KEITH B

VENDOR NUMBER: 506501

CONTRACT NUMBER
93851 O4

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
	$46,874.00 PER EQR REPORT (3 TOTAL)				
39	EQR REPORT DBM: STATE - RENEWAL 2	11,718.5000	$	1.0000	11,718.50
40	EQR REPORT DBM: FEDERAL - RENEWAL 2	35,155.5000	$	1.0000	35,155.50
	$46,874.00 PER EQR REPORT (1 TOTAL)				
41	VALIDATION OF PIPS REPORT MCO: STATE - RENEWAL 2	5,084.2500	$	1.0000	5,084.25
42	VALIDATION OF PIPS REPORT MCO: FEDERAL - RENEWAL 2	15,252.7500	$	1.0000	15,252.75
	$6,779.00 PER PIPS REPORT (3 TOTAL)				
43	VALIDATION OF PIPS REPORT DBM: STATE - RENEWAL 2	1,694.7500	$	1.0000	1,694.75
44	VALIDATION OF PIPS REPORT DBM: FEDERAL - RENEWAL 2	5,084.2500	$	1.0000	5,084.25
	$6,779.00 PER PIPS REPORT (1 TOTAL)				
45	VALIDATION OF PM REPORT MCO: STATE - RENEWAL 2	5,883.7500	$	1.0000	5,883.75
46	VALIDATION OF PM REPORT MCO: FEDERAL - RENEWAL 2	17,651.2500	$	1.0000	17,651.25
	$7,845.00 PER PM REPORT (3 TOTAL)				
47	VALIDATION OF PM REPORT DBM: STATE - RENEWAL 2	1,961.2500	$	1.0000	1,961.25
48	VALIDATION OF PM REPORT DBM: FEDERAL - RENEWAL 2	5,883.7500	$	1.0000	5,883.75
	$7,845.00 PER PM REPORT (1 TOTAL)				
49	VALIDATION OF NA REPORT MCO: STATE - RENEWAL 2	15,775.5000	$	1.0000	15,775.50

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25710178	ROLAND, KEITH B

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93851 O4

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
50	VALIDATION OF NA REPORT MCO: FEDERAL - RENEWAL 2 $21,034.00 PER NA REPORT (3 TOTAL)	47,326.5000	$	1.0000	47,326.50
51	VALIDATION OF NA REPORT DBM: STATE - RENEWAL 2	5,258.5000	$	1.0000	5,258.50
52	VALIDATION OF NA REPORT DBM: FEDERAL - RENEWAL 2 $21,034.00 PER NA REPORT (1 TOTAL)	15,775.5000	$	1.0000	15,775.50
53	TA AND CONSULTATION STATE - RENEWAL 2	4,620.0000	$	1.0000	4,620.00
54	TA AND CONSULTATION FEDERAL - RENEWAL 2 $154.00 PER HOUR. ESTIMATED QUANTITY OF 120 HOURS PER YEAR IS SUBJECT TO ACTUAL UTILIZATION.	13,860.0000	$	1.0000	13,860.00
55	EQR REPORT MCO: STATE - RENEWAL 3	35,858.2500	$	1.0000	35,858.25
56	EQR REPORT MCO: FEDERAL - RENEWAL 3 $47,811.00 PER EQR REPORT (3 TOTAL)	107,574.7500	$	1.0000	107,574.75
57	EQR REPORT DBM: STATE - RENEWAL 3	11,952.7500	$	1.0000	11,952.75
58	EQR REPORT DBM: FEDERAL - RENEWAL 3 $47,811.00 PER EQR REPORT (1 TOTAL)	35,858.2500	$	1.0000	35,858.25
59	VALIDATION OF PIPS REPORT MCO: STATE - RENEWAL 3	5,186.2500	$	1.0000	5,186.25
60	VALIDATION OF PIPS REPORT MCO: FEDERAL - RENEWAL 3 $6,915.00 PER PIPS REPORT (3 TOTAL)	15,558.7500	$	1.0000	15,558.75

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25710178	ROLAND, KEITH B

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CONTRACT NUMBER
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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
61	VALIDATION OF PIPS REPORT DBM: STATE - RENEWAL 3	1,728.7500	$	1.0000	1,728.75
62	VALIDATION OF PIPS REPORT DBM: FEDERAL - RENEWAL 3 $6,915.00 PER PIPS REPORT (1 TOTAL)	5,186.2500	$	1.0000	5,186.25
63	VALIDATION OF PM REPORT MCO: STATE - RENEWAL 3	6,001.5000	$	1.0000	6,001.50
64	VALIDATION OF PM REPORT MCO: FEDERAL - RENEWAL 3 $8,002.00 PER PM REPORT (3 TOTAL)	18,004.5000	$	1.0000	18,004.50
65	VALIDATION OF PM REPORT DBM: STATE - RENEWAL 3	2,000.5000	$	1.0000	2,000.50
66	VALIDATION OF PM REPORT DBM: FEDERAL - RENEWAL 3 $8,002.00 PER PM REPORT (1 TOTAL)	6,001.5000	$	1.0000	6,001.50
67	VALIDATION OF NA REPORT MCO: STATE - RENEWAL 3	16,091.2500	$	1.0000	16,091.25
68	VALIDATION OF NA REPORT MCO: FEDERAL - RENEWAL 3 $21,455.00 PER NA REPORT (3 TOTAL)	48,273.7500	$	1.0000	48,273.75
69	VALIDATION OF NA REPORT DBM: STATE - RENEWAL 3	5,363.7500	$	1.0000	5,363.75
70	VALIDATION OF NA REPORT DBM: FEDERAL - RENEWAL 3 $21,455.00 PER NA REPORT (1 TOTAL)	16,091.2500	$	1.0000	16,091.25
71	TA AND CONSULTATION STATE - RENEWAL 3	4,710.0000	$	1.0000	4,710.00
72	TA AND CONSULTATION FEDERAL - RENEWAL 3	14,130.0000	$	1.0000	14,130.00

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25710178	ROLAND, KEITH B

VENDOR NUMBER: 506501

CONTRACT NUMBER
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Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
	$157.00 PER HOUR. ESTIMATED QUANTITY OF 120 HOURS PER YEAR IS SUBJECT TO ACTUAL UTILIZATION.				
73	PROJECT DIRECTOR STATE	49.2500	$	1.0000	49.25
74	PROJECT DIRECTOR FEDERAL	147.7500	$	1.0000	147.75
	$197.00 PER HOUR. QUANTITY SUBJECT TO ACTUAL UTILIZATION.				
75	DIRECTOR, DSAA STATE	44.2500	$	1.0000	44.25
76	DIRECTOR, DSAA FEDERAL	132.7500	$	1.0000	132.75
	$177.00 PER HOUR. QUANTITY SUBJECT TO ACTUAL UTILIZATION.				
77	PROJECT MANAGER STATE	36.7500	$	1.0000	36.75
78	PROJECT MANAGER FEDERAL	110.2500	$	1.0000	110.25
	$147.00 PER HOUR. QUANTITY SUBJECT TO ACTUAL UTILIZATION.				
79	SENIOR ANALYST STATE	31.7500	$	1.0000	31.75
80	SENIOR ANALYST FEDERAL	95.2500	$	1.0000	95.25
	$127.00 PER HOUR. QUANTITY SUBJECT TO ACTUAL UTILIZATION.				
81	ANALYST STATE	26.7500	$	1.0000	26.75
82	ANALYST FEDERAL	80.2500	$	1.0000	80.25
	$107.00 PER HOUR. QUANTITY SUBJECT TO ACTUAL UTILIZATION.				
83	ANALYTICS COORDINATOR STATE	19.2500	$	1.0000	19.25

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25710178	ROLAND, KEITH B

VENDOR NUMBER: 506501

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93851 O4

Line	Description	Quantity	Unit of Measure	Unit Price	Extended Price
84	ANALYTICS COORDINATOR FEDERAL	57.7500	$	1.0000	57.75

$77.00 PER HOUR. QUANTITY SUBJECT TO ACTUAL UTILIZATION.

Total Order **1,979,176.00**

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INITIALS

Technical Proposal

Response to
Request for Proposal
RFP 6303 Z1

State of Nebraska Department of Health and Human Services

External Quality Reviews

October 30, 2020
2:00 pm Central Time

Health Services Advisory Group, Inc. • 3133 East Camelback Road, Suite 100 • Phoenix, Arizona 85016
Phone: 602.801.6600 • Fax: 602.801.6051

HSAG HEALTH SERVICES ADVISORY GROUP

October 30, 2020

Keith Roland
Department of Health and Human Services
301 Centennial Mall S.
Lincoln, NE 68509

RE: Response to Request for Proposal for External Quality Reviews; Solicitation Number: RFP 6303 Z1

Dear Mr. Roland:

Health Services Advisory Group, Inc. (HSAG) is pleased to submit this response to the above-mentioned solicitation for consideration by the Nebraska Department of Health and Human Services.

The enclosed response demonstrates HSAG's skills, resources, experience and commitment to serve Nebraska as the external quality review organization (EQRO) of contracted managed care organizations (MCOs) and the Dental Benefits Manager (DBM).

HSAG is the largest, most experienced EQRO in the nation serving state Medicaid Agencies. We have expert staff who have years of experience working with Medicaid programs. We are knowledgeable about all of the CMS mandatory and optional EQRO requirements and are ready to begin work upon contract award. Moreover, we offer innovative solutions and best practices that promote improvements in healthcare for Medicaid populations. We would be honored to work with you in your state and share a high performing, sustainable partnership.

HSAG acknowledges receipt of Addendum One – Revised Schedule of Events dated 06/26/2020, Addendum Two – Questions and Answers, Addendum Three – Revised Schedule of Events dated 07/07/2020, Addendum Four – Questions and Answers dated 09/17/2020, and Addendum Four – Remote Bid Opening dated 10/26/2020.

I am the company representative authorized to bind the organization. Please do not hesitate to contact me if you have any questions or require clarification. I can be reached at 602.801.6701 or mdalton@hsag.com.

Sincerely,

Mary Ellen Dalton

Mary Ellen Dalton, PhD, MBA, RN
President and Chief Executive Officer

3133 East Camelback Road, Suite 100, Phoenix, AZ 85016-4545 | Phone: 602.801.6600 | Fax: 602.801.6051 | www.hsag.com

Table of Contents

List of Acronyms

List of Acronyms

ACOs	Accountable Care Organizations
ADHD	Attention-Deficit Hyperactivity Disorder
AHRQ	Agency for Healthcare Research and Quality
AMA	American Medical Association
AMP	Align. Measure. Perform.
BBA	Balanced Budget Act of 1997
BHOs	Behavioral Health Organizations
CAHPS	Consumer Effectiveness Data and Information Set
CAP	Corrective Action Plan
CASS	Coding Accuracy Support System
CCC	Children with Chronic Conditions
CFR	Code of Federal Regulations
CHCA	Certified HEDIS Compliance Auditor
CHIP	Children's Health Insurance Program
CME	Continuing Medical Education
CMS	Centers for Medicare & Medicaid Services
CPHQ	Certified Professional in Healthcare Quality
DBM	Dental Benefits Manager
DHHS	State of Nebraska, Department of Health and Human Services
DSAA	Data Science & Advance Analytics
ECHO	Experience of Care and Health Outcomes
EDV	Encounter Data Validation
EPSDT	Early and Periodic, Screening, Diagnostic and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
ESRD	End-Stage Renal Disease
FFS	Fee for Service
HCBS	Home and Community Based Services
HEDIS	Healthcare Effectiveness Data and Information Set
HIPAA	Health Insurance Portability and Accountability Act of 1996
HITECH	Health Information Technology for Economic and Clinical Health Act
HSAG	Health Services Advisory Group, Inc.
IDIQ	Indefinite Delivery Indefinite Quality
IDSS	Interactive Data Submission System
IMPROVE	Implement Medicaid Programs for the Reduction of Avoidable Visits to the ED

ISCAT	Information Systems Capabilities Assessment Tool
IT	Information Technology
LTSS	Long-Term Services and Supports
MAC	Medicaid and CHIP
MCEs	Managed Care Entities
MCOs	Managed Care Organizations
MIDS	Measure and Instrument Development and Support
MRR	Medical Record Review
MOC	Maintenance of Certification
NAV	Network Adequacy Validation
NCQA	National Committee for Quality Assurance
NQF	National Quality Forum
NQIIC	Network of Quality Improvement and Innovation Contracts
PAHP	Prepaid Ambulatory Health Plan
PCCM	Primary Care Case Management
PCP	Primary Care Providers
PDF	Portable Document Format
PDSA	Plan-Do-Study-Act
PHI	Protected Health Information
PIHPs	Prepaid Inpatient Health Plans
PIP	Performance Improvement Projects
PMCP	Performance Measure Calculation Platform
PMV	Performance Measure Validation
PSRO	Professional Services Review Organization
QAPI	Quality Assessment and Performance Improvement
QAPIP	Quality Assessment and Performance Improvement Program
QAT	Quality Assurance Team
QI	Quality Improvement
QIN-QIO	Quality Innovation Network-Quality Improvement Organization
QIO	Quality Improvement Organization
QRS	Quality Rating System
RAEs	Regional Accountable Entities
RCCOs	Regional Care Coordination Organizations
RFP	Request for Proposal
Roadmap	Record of Administration, Data Management, and Processes
RRT	Rate Reporting Template
S&CS	State & Corporate Services

SAFE	Secure Access File Exchange
SME	Subject Matter Expert
TA	Technical Assistance
TANF	Temporary Assistance for Needy Families
TEPs	Technical Expert Panels
USPS	United States Postal Service

Original Request for Proposal for Contractual Services Form

REQUEST FOR PROPOSAL FOR CONTRACTUAL SERVICES FORM

By signing this Request for Proposal for Contractual Services form, the contractor guarantees compliance with the procedures stated in this Solicitation, and agrees to the terms and conditions unless otherwise indicated in writing and certifies that contractor maintains a drug free work place.

CONTRACTOR MUST COMPLETE THE FOLLOWING

Per Nebraska's Transparency in Government Procurement Act, Neb. Rev Stat § 73-603 DAS is required to collect statistical information regarding the number of contracts awarded to Nebraska Contractors. This information is for statistical purposes only and will not be considered for contract award purposes.

_____ NEBRASKA CONTRACTOR AFFIDAVIT: Bidder hereby attests that bidder is a Nebraska Contractor. "Nebraska Contractor" shall mean any bidder who has maintained a bona fide place of business and at least one employee within this state for at least the six (6) months immediately preceding the posting date of this Solicitation.

_____ I hereby certify that I am a Resident disabled veteran or business located in a designated enterprise zone in accordance with Neb. Rev. Stat. § 73-107 and wish to have preference, if applicable, considered in the award of this contract.

_____ I hereby certify that I am a blind person licensed by the Commission for the Blind & Visually Impaired in accordance with Neb. Rev. Stat. §71-8611 and wish to have preference considered in the award of this contract.

FORM MUST BE SIGNED USING AN INDELIBLE METHOD (NOT ELECTRONICALLY)

FIRM:	Health Services Advisory Group, Inc. (HSAG)
COMPLETE ADDRESS:	3133 East Camelback Road, Suite 100, Phoenix, Arizona 85016
TELEPHONE NUMBER:	602.801.6701
FAX NUMBER:	602.665.6169
DATE:	10/26/2020
SIGNATURE:	Mary Ellen Dalton
TYPED NAME & TITLE OF SIGNER:	Mary Ellen Dalton, PhD, MBA, RN; President and Chief Executive Officer

Form A—Contractor Proposal Point of Contact

Form A
Contractor Proposal Point of Contact
Request for Proposal Number 6303 Z1

Form A should be completed and submitted with each response to this solicitation. This is intended to provide the State with information on the contractor's name and address, and the specific person(s) who are responsible for preparation of the contractor's response.

Preparation of Response Contact Information	
Contractor Name:	Health Services Advisory Group, Inc. (HSAG)
Contractor Address:	3133 East Camelback Road, Suite 100 Phoenix, Arizona 85016
Contact Person & Title:	Gretchen Thompson, MBA, CPHQ; Chief Operating Officer, State & Corporate Services
E-mail Address:	gthompson@hsag.com
Telephone Number (Office):	602.801.6687
Telephone Number (Cellular):	602.317.6224
Fax Number:	602.665.6169

Each contractor should also designate a specific contact person who will be responsible for responding to the State if any clarifications of the contractor's response should become necessary. This will also be the person who the State contacts to set up a presentation/demonstration, if required.

Communication with the State Contact Information	
Contractor Name:	Health Services Advisory Group, Inc. (HSAG)
Contractor Address:	3133 East Camelback Road, Suite 100 Phoenix, Arizona 85016
Contact Person & Title:	Gretchen Thompson, MBA, CPHQ; Chief Operating Officer, State & Corporate Services
E-mail Address:	gthompson@hsag.com
Telephone Number (Office):	602.801.6687
Telephone Number (Cellular):	602.317.6224
Fax Number:	602.665.6169

Corporate Overview

Technical Proposal

Health Services Advisory Group, Inc. (HSAG), is providing information to the State of Nebraska, Department of Health and Human Services (DHHS) regarding Request for Proposal for Contractual Services Number 6303 Z1, External Quality Reviews (EQR) of contracted managed care organizations (MCOs) and a Dental Benefits Manager (DBM), by first stating the proposal issue in the blue box followed by the HSAG response.

1. Corporate Overview

a. Contractor Identification and Information

The contractor should provide the full company or corporate name, address of the company's headquarters, entity organization (corporation, partnership, proprietorship), state in which the contractor is incorporated or otherwise organized to do business, year in which the contractor first organized to do business and whether the name and form of organization has changed since first organized.

Corporate Name: **Health Services Advisory Group, Inc. (HSAG)**

Address of headquarters: **3133 E. Camelback Rd., Suite 100, Phoenix, AZ 85016**

Entity organization: **Corporation**

State of incorporation: **Arizona**

Year organized to do business: **1982**

Name change: **None**

b. Financial Statements

The contractor should provide financial statements applicable to the firm. If publicly held, the contractor should provide a copy of the corporation's most recent audited financial reports and statements, and the name, address, and telephone number of the fiscally responsible representative of the contractor's financial or banking organization.

If the contractor is not a publicly held corporation, either the reports and statements required of a publicly held corporation, or a description of the organization, including size, longevity, client base, areas of specialization and expertise, and any other pertinent information, should be submitted in such a manner that proposal evaluators may reasonably formulate a determination about the stability and financial strength of the organization. Additionally, a non-publicly held firm should provide a banking reference.

The contractor must disclose any and all judgments, pending or expected litigation, or other real or potential financial reversals, which might materially affect the viability or stability of the organization, or state that no such condition is known to exist.

The State may elect to use a third party to conduct credit checks as part of the corporate overview evaluation.

HSAG is a privately held corporation established in 1979. Appendix 1: Audited Financial Statements, contains HSAG's most recent audited financial statements. For fiscal year 2019, HSAG's combined revenues were $114.6 million, giving it the financial strength to maintain the activities and obligations of a contract resulting from an award from the State of Nebraska. HSAG's financial statements are prepared by a certified public accountant and HSAG follows Generally Accepted Accounting Principles. HSAG's financial strength is a result of its ability to balance growth and working capital. The company's sound financial status has provided the solid base upon which it has expanded the number and size of awarded contracts. HSAG has access to a line of credit with a maximum borrowing base of $7.0 million, and its working capital ratio has been well above industry norms for the last several years. HSAG has held a longstanding relationship with Wells Fargo Bank. Appendix 2: Banking Reference, contains HSAG's banking reference.

HSAG does not have any judgments, pending or expected litigation, or other real or potential financial reversals, which might materially affect the viability or stability of the organization.

Overview of HSAG

HSAG was established in 1979 by a group of medical professionals whose mutual goal was to make a positive difference in health care quality. HSAG originally began as a professional services review organization (PSRO) reviewing Medicare hospitalizations for quality and utilization in the northern half of Arizona. The PSRO program subsequently was modified to focus on quality improvement and HSAG became a Centers for Medicare & Medicaid (CMS) quality improvement organization (QIO) for Arizona in 1984. In 2003, HSAG became the QIO for Florida and in 2008, it became the QIO for California. In July 2014, CMS regionalized the QIO program through competitive bidding and awarded HSAG the largest Quality Innovation Network-Quality Improvement Organization (QIN-QIO) contract in the nation, with a region comprising Arizona, California, Florida, Ohio, and the U.S. Virgin Islands.

In 2019, CMS again restructured its health care improvement initiatives and awarded HSAG a Network of Quality Improvement and Innovation Contractors (NQIIC) Indefinite Delivery Indefinite Quantity (IDIQ) contract from February 1, 2019, through January 31, 2024. The purpose of this contract is to procure expert health care quality improvement services to support quality improvement efforts across settings and programs for maximum impact in health care and value to taxpayers. The NQIIC IDIQ includes statutorily required QIN-QIO work (Sections 1152-1154 of the Social Security Act), statutorily required End-Stage Renal Disease (ESRD) network work (under Section 1881), hospital-focused large-scale improvement work, clinician-focused technical assistance work, and other quality improvement efforts. Under this contract, HSAG functions as the QIN-QIO for Arizona and California, representing approximately 7.5 million of the nation's Medicare beneficiaries. For documentation related to HSAG's QIN-QIO designation, see Appendix 3: QIN-QIO Documentation.

When the Balanced Budget Act (BBA) of 1997 implemented federal independent quality review requirements, HSAG began evaluating Medicaid health care quality, timeliness, and accessibility of services as an external quality review organization (EQRO) for state Medicaid agencies. HSAG is now the largest EQRO in the country, with current contracts to provide EQR or EQR-related activities in 16 states: Arizona, California, Colorado, Florida, Georgia, Hawaii, Illinois, Iowa, Michigan, Nevada, New Hampshire, Oregon, Tennessee, Utah, Vermont, and Virginia. Collectively, these states enroll more than 36 million Medicaid enrollees who represent approximately 45 percent of the nation's Medicaid population.

In 1995, HSAG began to develop health outcomes expertise with audits, surveys, and assessment tools that included patient-reported health status, quality of life, and satisfaction. HSAG quickly became a leader in the field by designing and conducting scientifically sound quality-of-life and outcomes studies, as well as collecting, analyzing, and reporting data for federal and state agencies, managed care health plans, hospitals and academic medical centers, and private sector health care companies. HSAG's extensive expertise enables it to integrate patient experience of care and other evaluation results efficiently and effectively with findings from related quality improvement activities to achieve performance improvement. Today, as a National Committee for Quality Assurance (NCQA)-licensed organization and an NCQA-certified Healthcare Effectiveness Data and Information Set (HEDIS®)[1] survey vendor for the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[2], HSAG provides an array of health care audit services as well as member and provider surveys. For documentation related to HSAG's NCQA designations, see Appendix 4: Licensing and Certifications.

HSAG also is an ESRD network contractor under CMS, serving four regions composed of 15 states and territories that serve approximately 20 percent of the nation's dialysis population.

c. Change of Ownership

If any change in ownership or control of the company is anticipated during the twelve (12) months following the proposal due date, the contractor should describe the circumstances of such change and indicate when the change will likely occur. Any change of ownership to an awarded contractor(s) will require notification to the State.

HSAG does not anticipate either a change in ownership or in control of the company during the 12 months following the proposal due date. Additionally, HSAG understands that any change of ownership to an awarded contractor requires notification to the State.

[1] HEDIS® is a registered trademark of NCQA

[2] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ)

d. Office Location

The contractor's office location responsible for performance pursuant to an award of a contract with the State of Nebraska should be identified.

The location of the office responsible for performing the duties outlined in the contract with the State is 3133 East Camelback Road, Suite 100, Phoenix, AZ 85016.

e. Relationships with the State

The contractor should describe any dealings with the State over the previous ten (10) years. If the organization, its predecessor, or any Party named in the contractor's proposal response has contracted with the State, the contractor should identify the contract number(s) and/or any other information available to identify such contract(s). If no such contracts exist, so declare.

HSAG has not had any dealings with the State of Nebraska over the previous 10 years.

f. Contractor's Employee Relations to State

If any Party named in the contractor's proposal response is or was an employee of the State within the past sixty (60) months, identify the individual(s) by name, State agency with whom employed, job title or position held with the State, and separation date. If no such relationship exists or has existed, so declare.

If any employee of any agency of the State of Nebraska is employed by the contractor or is a Subcontractor to the contractor, as of the due date for proposal submission, identify all such persons by name, position held with the contractor, and position held with the State (including job title and agency). Describe the responsibilities of such persons within the proposing organization. If, after review of this information by the State, it is determined that a conflict of interest exists or may exist, the contractor may be disqualified from further consideration in this proposal. If no such relationship exists, so declare.

There are no parties named in HSAG's proposal response who were or are employees of the State within the past 60 months.

g. Contract Performance

If the contractor or any proposed Subcontractor has had a contract terminated for default during the past ten (10) years, all such instances must be described as required below. Termination for default is defined as a notice to stop performance delivery due to the contractor's non-performance or poor performance, and the issue was either not litigated due to inaction on the part of the contractor or litigated and such litigation determined the contractor to be in default.

It is mandatory that the contractor submit full details of all termination for default experienced during the past ten (10) years, including the other Party's name, address, and telephone number. The response to this section must present the contractor's position on the matter. The State will evaluate the facts and will score the contractor's proposal accordingly. If no such termination for default has been experienced by the contractor in the past ten (10) years, so declare.

If at any time during the past ten (10) years, the contractor has had a contract terminated for convenience, non-performance, non-allocation of funds, or any other reason, describe fully all circumstances surrounding such termination, including the name and address of the other contracting Party.

HSAG has never had a contract terminated for default. HSAG also does not intend to subcontract any of the proposed work included under the project requirements of this contract. If HSAG determines it is necessary to use subcontractors for any future work that DHHS requests, HSAG will obtain DHHS' review and approval. HSAG will ensure that any subcontractors it uses to perform work under the Nebraska contract will not have had any contracts terminated for default within the last 10 years.

h. Summary of Contractor's Corporate Experience

The contractor should provide a summary matrix listing the contractor's previous projects similar to this solicitation in size, scope, and complexity. The State will use no more than three (3) narrative project descriptions submitted by the contractor during its evaluation of the proposal.

The contractor should address the following:
i. Provide narrative descriptions to highlight the similarities between the contractor's experience and this solicitation. These descriptions should include:

a) The time period of the project;
b) The scheduled and actual completion dates;
c) The Contractor's responsibilities;
d) For reference purposes, a customer name (including the name of a contact person, a current telephone number, a facsimile number, and e-mail address); and
e) Each project description should identify whether the work was performed as the prime Contractor or as a Subcontractor. If a contractor performed as the prime Contractor, the description should provide the originally scheduled completion date and budget, as well as the actual (or currently planned) completion date and actual (or currently planned) budget.

ii. Contractor and Subcontractor(s) experience should be listed separately. Narrative descriptions submitted for Subcontractors should be specifically identified as Subcontractor projects.

iii. If the work was performed as a Subcontractor, the narrative description should identify the same information as requested for the Contractors above. In addition, Subcontractors should identify what share of contract costs, project responsibilities, and time period were performed as a Subcontractor.

i. Contractor's Experience

HSAG is the largest and most experienced EQRO in the country, with current contracts to provide EQR or EQR-related activities in 16 states. A matrix of HSAG's EQR contracted states and the activities within the past five consecutive years is provided in Table 1: HSAG EQR Experience Matrix.

Table 1: HSAG EQR Experience Matrix

State and Contracting Agency	Years ♦	Mandatory EQR Activities					Optional EQR Activities							Other		
		Compliance Review	Validation of Performance Measures	Validation of Performance Improvement Projects (PIPs)	Validation of Network Adequacy	Annual EQR Technical Report	Validation of Encounter Data	Validation/Implementation of Member and Provider Surveys	Calculation of Performance Measures	Implementation of PIPs	Focused Studies	Quality Rating System/ Consumer Report Card	Technical Assistance and Training	Readiness Reviews and Additional Monitoring Activities	Quality Strategy Development/ Review, Evaluation, Revision	Stakeholder Meetings
Arizona Arizona Health Care Cost Containment System (AHCCCS)	**Present:** 1/1/2019-12/31/2023 **Past:** 9/21/1999-3/31/2019				•	•		•	•							
California California Department of Health Care Services (DHCS) Managed Care Quality and Monitoring Division	**Present:** 9/1/2020-6/30/2023 **Past:** 9/1/2008-8/31/2020		•	•	•	•	•	•			•		•			•
Colorado Colorado Department of Health Care Policy and Financing (DHCPF)	**Present:** 7/1/2018-6/30/2023 **Past:** 3/1/2001-6/30/2018	•	•	•	•	•	•	•	•				•	•		
Florida Florida Agency for Health Care Administration (AHCA)	**Present:** 7/1/2013-6/30/2021 **Past:** 5/1/2006-6/30/2013	•*	•	•	•	•	•	•**					•			•
Georgia Georgia Department of Community Health (DCH)	**Present:** 2/1/2019-6/30/2023 **Past:** 7/1/2008-1/31/2019	•	•	•		•				•			•			•
Hawaii Hawaii Department of Human Services (DHS), Med–QUEST Division (MQD)	**Present:** 1/1/2016-12/31/2021 **Past:** 7/1/2001-12/31/2015	•	•	•		•	•	•					•			
Illinois Illinois Department of Healthcare and Family Services (HFS)	**Present:** 3/13/2019-3/12/2029 **Past:** 8/29/2002-12/27/2018	•	•	•	•	•	•	•			•	•	•	•	•	
Iowa Iowa Medicaid Enterprise (IME), Iowa Department of Human Services	**Present:** 1/1/2016-12/31/2021 **Past:** N/A	•	•	•	•	•	•	•	•		•	•		•		

State and Contracting Agency	Years ♦	Mandatory EQR Activities					Optional EQR Activities							Other		
		Compliance Review	Validation of Performance Measures	Validation of Performance Improvement Projects (PIPs)	Validation of Network Adequacy	Annual EQR Technical Report	Validation of Encounter Data	Validation/Implementation of Member and Provider Surveys	Calculation of Performance Measures	Implementation of PIPs	Focused Studies	Quality Rating System/ Consumer Report Card	Technical Assistance and Training	Readiness Reviews and Additional Monitoring Activities	Quality Strategy Development/ Review, Evaluation, Revision	Stakeholder Meetings
Michigan(Behavioral Health) Michigan Department of Health and Human Services (MDHHS) Behavioral Health and Developmental Disabilities Administration (BHDDA) Division of Quality Management and Planning	**Present:** 10/1/2019-9/30/2027 **Past:** 7/1/2004-9/30/2019***	•	•	•		•		•					•			
Michigan(Physical Health) Michigan Department of Health and Human Services (MDHHS) Managed Care Plan Division	**Present:** 10/1/2019-9/30/2027 **Past:** 9/18/2004-9/30/2019***	•	•	•	•	•		•				•	•			
Nevada Nevada Division of Health Care Financing and Policy (DHCFP)	**Present:** 7/1/2018-6/30/2024 **Past:** 7/1/1999-6/30/2018	•	•	•	•	•	•	•	•				•	•	•	
New Hampshire New Hampshire Department of Health and Human Services (DHHS)	**Present:** 7/1/2019-6/30/2026 **Past:** 8/14/2013-6/30/2019	•	•	•	•	•	•	•	•		•				•	•
Oregon Oregon Health Authority (OHA), Health Systems Division	**Present:** 7/1/2018-6/30/2025 **Past:** N/A	•	•	•	•	•							•	•		
Tennessee Tennessee Bureau of TennCare (HSAG is a subcontractor to the EQRO, Qsource)	**Present:** 10/1/2020-9/30/2025 **Past:** 10/1/2005-9/30/2020	•	•		•											
Utah Utah, Department of Health (UDOH)	**Present:** 1/1/2018-12/31/2020 **Past:** 9/1/2014-6/30/2018 1/1/2005-12/31/2007	•	•	•	•	•							•			
Vermont Vermont Agency of Human Services (AHS)	**Present:** 2/15/2016-12/31/2021 **Past:** 11/15/2007-2/14/2016	•	•	•		•										

State and Contracting Agency	Years ♦	Mandatory EQR Activities					Optional EQR Activities							Other		
		Compliance Review	Validation of Performance Measures	Validation of Performance Improvement Projects (PIPs)	Validation of Network Adequacy	Annual EQR Technical Report	Validation of Encounter Data	Validation/Implementation of Member and Provider Surveys	Calculation of Performance Measures	Implementation of PIPs	Focused Studies	Quality Rating System/Consumer Report Card	Technical Assistance and Training	Readiness Reviews and Additional Monitoring Activities	Quality Strategy Development/ Review, Evaluation, Revision	Stakeholder Meetings
Virginia Virginia Department of Medical Assistance Services (DMAS)	**Present:** 2/1/2015-1/31/2021 **Past:** N/A	•	•	•	•	•	•	•	•		•	•	•	•	•	

♦ The dates shown include optional contract years
* HSAG created the electronic compliance review tool the state used to conduct the reviews.
** HSAG developed the tool that the state required the health plans to use when administering provider surveys.
*** Michigan combined the EQRO contracts (Physical Health, Behavioral Health and Developmental Disabilities Administration) in 2019.

The descriptions in Tables 2a and 2b: HSAG EQR Experience as a Prime Contractor, highlight the similarities between HSAG's experience and the tasks outlined in this RFP.

Each project description includes the following:

- The duration or time period of the contract
- The scheduled and actual completion dates of the contract
- A description of HSAG's responsibilities for the contract
- The customer's name, contact person's name, address, phone number, and email address

Specifically, Table 2a includes the project narrative descriptions of the EQRO contracts for the Iowa Medicaid Enterprise, Iowa Department of Human Services; Nevada Division of Health Care Financing and Policy; and the New Hampshire Department of Health and Human Services, Office of Medicaid Business and Policy, as they are most similar to Nebraska's Medicaid programs and the EQRO scope of work. These current contracts with state Medicaid agencies can attest to HSAG's qualifications and performance as an EQRO, as well as the agencies' satisfaction with the services provided. These selected state contracts most closely align with DHHS' programs, enrollee populations, requested EQR services, and/or goals. For example:

- Iowa – HSAG has served as Iowa's EQRO since the state transitioned to managed care in 2016. Iowa currently contracts with two MCOs to coordinate acute care and long-term services and supports for nearly 680,000 Medicaid enrollees in managed

care. Iowa also maintains a carve out dental program, contracting with two dental prepaid ambulatory health plans (PAHPs).

- Nevada – HSAG has served as the state's trusted EQRO for more than 20 years. As part of its tenure, HSAG has provided EQR services for Nevada's managed care program, primary care case management program, dental carve out managed care program, and the fee for services (FFS) program. Currently, Nevada contracts with three MCOs and one dental PAHP to coordinate the care and services for more than 460,000 Medicaid enrollees served in managed care.
- New Hampshire – HSAG has served as New Hampshire's EQRO since it transitioned to managed care in 2013. New Hampshire currently contracts with three MCOs to coordinate care and services for more than 190,000 Medicaid enrollees in managed care. HSAG worked with New Hampshire as it expanded Medicaid eligibility and transitioned Medicaid expansion recipients in and out of managed care.

For each of these states, HSAG served as the prime contractor.

Table 2a: HSAG EQR Experience as a Prime Contractor (Iowa, Nevada, and New Hampshire)

Iowa External Quality Review Services Profile - HSAG Prime Contractor	
Name of Agency/ Address:	Iowa Medicaid Enterprise, Iowa Department of Human Services 611 5th Avenue Des Moines, Iowa, 50309-1610
Contact(s):	Jason Holst, BSW—Quality Improvement Analyst (515) 974-3070 Fax: Not available jholst@dhs.state.ia.us
Duration of the Contract:	Current: 1/1/2016–12/31/2021 Prior: N/A
Active/Closed:	Active
Scheduled Date for Completion:	12/31/2021
Actual Completion Date:	Contract still ongoing
Total Value:	$1,785,606
Description of EQR Services Performed for Medicaid Managed Care	
Since 2016, HSAG has served as the EQRO for the State of Iowa and has performed mandatory and optional EQR services for the Iowa Department of Human Services. HSAG conducts various mandatory and optional EQR activities with four managed care entities (two MCOs and two dental PAHPs). These activities include the following:	
CMS MANDATORY EQR ACTIVITIES PERFORMED DURING THE REQUESTED EXPERIENCE PERIOD:	
Compliance Reviews HSAG assesses compliance with Medicaid managed care regulations set forth in 42 CFR §438—Managed Care Subpart D and the quality assessment and performance improvement requirements described in 42 CFR §438.330, and it performs an annual review of each MCO and, starting in 2018, each PAHP. This includes pre-on-site and on-site reviews, analysis of findings, production of reports that describe each plan's strengths and weaknesses, and recommendations to improve the quality of health care services the plan provides. *Validation of Performance Measures* HSAG conducts performance measure validation (PMV) audits of state-defined measures to validate the accuracy and completeness of the performance measure rates reported by MCOs and, beginning in 2018, performance measures reported by dental PAHPs. HSAG conducts PMV activities following the CMS protocols and the NCQA HEDIS PMV process. The PMV activity includes pre-on-site, on-site, and post-on-site activities. HSAG uses the Information Systems Capabilities and Assessment Tool required in CMS Protocol 2 to obtain information from the respective MCOs and dental PAHPs regarding their data systems. HSAG prepares plan-specific PMV reports, documenting the validation findings. Based on all validation activities, the validation team determines the audit result for the performance measures. In 2018, HSAG developed state-specific performance measures and specifications to measure MCOs' performance related to care management activities for persons enrolled in home and community-based service (HCBS) waiver programs and enrolled in managed care. The performance measures were based on contractual and federal requirements for care management. *Validation of Performance Improvement Projects (PIPs)* Beginning in 2016 for the MCOs and 2018 for the dental PAHPs, HSAG validates PIPs for MCOs and PAHPs to ensure that each entity conducts PIPs in a manner consistent with CMS protocols, industry best practices, and	

Iowa External Quality Review Services Profile - HSAG Prime Contractor

the requirements set forth in federal regulations. HSAG evaluates the soundness and results of the PIPs the plans implement, and it produces plan-specific reports. The reports encompass HSAG's findings from the PIP validation activities, recommendations to improve the validity of the PIP processes and, as applicable, performance on the measures.

Validation of Network Adequacy

HSAG is contracted to analyze the provider network files from each MCO annually and, starting in 2018, the dental PAHPs. This includes tracking the geographic distribution of providers and hospitals compared to the number of enrollees served. HSAG also conducts secret shopper surveys to determine accessibility of providers.

Annual EQR Technical Report

HSAG aggregates and analyzes the data it obtains from each state-defined EQR activity conducted during the contract year to draw conclusions about the quality, timeliness, and accessibility of care and services that each MCO and each dental PAHP provides to members. Dental PAHP EQR activities began in 2018. The annual technical report includes plan-specific results and aggregate comparative results related to activities. HSAG also assesses the strengths and weaknesses of each plan regarding the quality of health care provided to participants. The technical report assists the state in evaluating the strengths and weaknesses of the managed care program and assists the Iowa program to better target its activities in areas where further quality improvements are needed.

CMS OPTIONAL EQR ACTIVITIES PERFORMED DURING THE REQUESTED EXPERIENCE PERIOD:

Validation of Encounter Data

HSAG conducts an annual validation of encounter data that each MCO and each dental PAHP submits to the state. HSAG uses the CMS protocol to determine the accuracy and completeness of encounter data and prepares an annual encounter data validation report. Dental PAHP EQR activities began in 2018.

Administration/Validation of Member and Provider Surveys

DHS contracted with HSAG to perform a review and validation of the MCOs' Enrollee and Provider Surveys, specifically the Iowa Participant Experience Survey (IPES). The MCOs were required to administer the IPES to members in the HCBS program and were given the freedom to modify the survey, as needed. The IPES instrument is a customized survey instrument that used the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) HCBS survey as a guideline. HSAG validated findings of the MCOs' IPES administration.

Calculation of Performance Measures

HSAG worked collaboratively with DHS to select and calculate an array of performance measures that reflected the MCOs' overall performance.

Focused Studies

In 2017, HSAG initiated a focused study related to the MCOs' person-centered care planning process. The focused study included pre-on-site and on-site activities. HSAG used the results to assist DHS in creating performance measures focused on person-centered care planning, which enabled DHS to monitor the future performance of MCOs related to the care-planning measures.

In 2018, at the request of Iowa Medicaid Enterprise, HSAG provided project management for a focused study review of Iowa Medicaid long-term services and supports claims. The focused study activities included developing sampling protocols and data formats, sample selection, review of claims for payment accuracy, and report generation. The report was completed in 2019.

Iowa External Quality Review Services Profile - HSAG Prime Contractor
Quality Rating System/Consumer Report Card In collaboration with DHS, HSAG developed an MCO report card to measure each MCO's performance compared to state-established benchmarks/performance standards.
OTHER ACTIVITIES PERFORMED DURING THE REQUESTED EXPERIENCE PERIOD:
1915(b) Waiver Independent Assessment In applying for a 1915(b) waiver, a Medicaid agency must document in the waiver request and maintain data regarding the cost-effectiveness of the project; the effect of the project on the accessibility and quality of services; and the anticipated impact of the project on the state's Medicaid program. Further, pursuant to Section 2111(B) of the State Medicaid Manual, states must arrange for an independent evaluation or assessment of their waiver program and submit the findings when renewing their waiver programs. DHS contracted with HSAG in SFY 2020 to complete an independent assessment of the Iowa High Quality Healthcare Initiative Waiver. As part of this assessment, HSAG analyzes and concludes within a written report whether access, quality, and cost effectiveness are better than, equal to, or worse than before the waiver. HSAG also provides recommendations for actions that DHS can undertake to improve the health care received through the Iowa MCOs. *Readiness Reviews* In 2019, HSAG conducted a readiness review of an MCO to verify that the entity had an appropriate operational structure to oversee Medicaid covered services and comply with state and federal requirements and the MCO contract. HSAG also conducted an information systems capability assessment, which included a review of the MCO's data management processes and procedures to collect and integrate medical, financial, member, and provider information encompassing clinical and service-related data to determine the extent to which the MCO's information system supported the production of valid and reliable state performance measures and the capacity to manage the health care of the MCO's beneficiaries. The readiness review consisted of desk reviews and an on-site review. HSAG developed program-specific assessment documents to validate readiness review and drafted its findings in a readiness review report to the state. It included identifying MCO deficiencies and developing a remediation plan as a result of the review. HSAG followed up on identified issues and reviewed and documented the status of the MCOs' resolutions from the remediation plan for the state. HSAG submitted a final report to the state as part of the readiness review process.

Nevada External Quality Review Services Profile - HSAG Prime Contractor	
Name of Agency/ Address:	Nevada Division of Health Care Financing and Policy (DHCFP) 1100 East Williams Street, Suite 101 Carson City, Nevada, 89701
Contact(s):	Theresa Carsten—Social Services Chief III (775) 684-3655 Fax: Not available theresa.carsten@dhcfp.nv.gov
Duration of the Contract:	Current: 7/1/2018–6/30/2024 Prior: 7/1/1999–6/30/2018
Active/Closed:	Active
Scheduled Date for Completion:	6/30/2024
Actual Completion Date:	Contract still ongoing
Total Value:	$2,962,597

Description of EQR Services Performed for Medicaid Managed Care

Since 1999, HSAG has served as the EQRO for the State of Nevada and has performed mandatory and optional EQR services for DHCFP. For the most current contract, HSAG conducts various mandatory and optional EQR activities with four managed care entities (three MCOs and one DBA). These activities include the following:

CMS MANDATORY EQR ACTIVITIES PERFORMED DURING THE REQUESTED EXPERIENCE PERIOD:

Compliance Reviews

Annually, HSAG conducts compliance reviews of each MCO and the dental benefit administrator's (DBA's) internal quality assurance program (IQAP) to assess compliance with state and federal regulations. HSAG produces a plan-specific report of findings and recommendations to improve the structure and operations of each plan's managed care delivery system. The IQAP compliance review also includes a follow-up on corrective actions resulting from previous IQAP reviews. Compliance reviews of the DBA began in 2019.

HSAG performed a compliance review of the care management organization's (CMO's) vendor for the Health Care Guidance Program (HCGP). This included reviewing the CMO's comprehensive care coordination program and ensuring there were procedures to assess care coordination needs of the fee-for-service population enrolled in the HCGP. HSAG also verified that the CMO vendor appropriately operationalized the CMO's contractual elements.

Validation of Performance Measures

HSAG performs annual HEDIS compliance audits of MCOs and produces a plan-specific and comparative summary in the annual EQR technical report. Since 2019, HSAG validates performance measures for the DBA and produces a DBA-specific report.

HSAG validates the CMO non-pay-for-performance (non-P4P) measures. The CMO coordinated care for Nevada's high-risk, high-needs enrollees in HCGP, the FFS program. As part of the validation process, HSAG assesses the information system for processing claims and validates performance measures the CMO vendor is required to report for the FFS population.

Validation of Performance Improvement Projects (PIPs)

HSAG validates PIPs by applying the most current CMS protocols to a rapid-cycle improvement approach. HSAG evaluates the soundness and results of the PIPs the MCOs and DBA implement. The DBA serves as a dental prepaid ambulatory health plan (PAHP) and HSAG began validating DBA PIPs in 2019. HSAG produces plan-

Nevada External Quality Review Services Profile - HSAG Prime Contractor

specific reports and recommendations based on the PIPs' outcomes, and it facilitates technical assistance for each MCO's and the DBA's PIPs on behalf of the State.

Validation of Network Adequacy

HSAG completes an annual validation of each MCO's and the DBA's network adequacy at the request of DHCFP.

HSAG conducted a review of the MCOs' networks, which included geoaccess analysis and a secret shopper survey. This review was to verify that MCOs and the FFS program had adequate capacity and appointment availability to serve the Medicaid population in Nevada.

Annual EQR Technical Report

Annually, HSAG prepares a detailed annual EQR technical report in accordance with 42 CFR §438.358. The report describes how the data from all oversight activities were aggregated and analyzed and how conclusions were drawn as to the quality, timeliness, and access to the care the DHCFP-contracted MCOs and the DBA provided. The report includes objectives, technical methods of data collection and analysis, a description of data obtained, and conclusions drawn from the data.

Additionally, the technical report includes an assessment of each managed care entity's (MCE's) strengths and weaknesses with respect to the quality, timeliness, and access to healthcare services provided to Medicaid recipients; recommendations for improving the quality of healthcare that each MCE provides; and an assessment of the degree to which each MCE has effectively addressed the recommendations for quality improvement EQRO made during the previous year's review processes. Further, the report contains the annual evaluation of the DHCFP quality improvement program (QIP) and the MCEs' achievement of the goals and objectives documented in the DHCFP QIP description. The Nevada EQR Technical Report includes information for activities performed for MCOs. Since SFY 2018, the report has included information about the dental prepaid ambulatory health plan (PAHP). Information about the state's primary care case management (PCCM) program was included in the report for the following years SFY 2016, SFY 2017, and SFY 2018.

CMS OPTIONAL EQR ACTIVITIES PERFORMED DURING THE REQUESTED EXPERIENCE PERIOD:

Validation of Encounter Data

HSAG performed encounter data validation, which included an information systems capabilities assessment, encounter data analyses, and a record review to determine the timeliness, completeness, and accuracy of each MCE's encounter data.

Administration/Validation of Member and Provider Surveys

HSAG administered CAHPS® surveys for the FFS population to receive input from members about their services for the DHCFP's Access Monitoring Review Plan.

Calculation of Performance Measures

HSAG calculated nine administrative HEDIS measures for the DHCFP's fee-for-service program. The performance measure rates were used as part of DHCFP's Access Monitoring Review Plan.

Quality Rating System/Consumer Report Card

HSAG performs an annual evaluation of the Nevada DHCFP State Quality Assessment and Performance Improvement Strategy to evaluate the completeness and effectiveness of the strategy and determine the extent to which DHCFP, in concert with its contracted MCEs, have implemented the methods described in the quality strategy to assess MCE compliance with CMS quality standards and improve the healthcare delivery and health outcomes of the Medicaid population.

HSAG performs an annual evaluation of the Nevada DHCFP Statewide Quality Strategy to evaluate the completeness and effectiveness of the strategy and determine the extent to which DHCFP, in concert with its

Nevada External Quality Review Services Profile - HSAG Prime Contractor
contracted managed care entities (MCEs) have implemented the methods described in the quality strategy to assess compliance with CMS quality standards and improve the healthcare delivery and health outcomes of the Medicaid population. *Technical Assistance and Training* HSAG provides MCEs with technical assistance to address Medicaid managed care, contract compliance, and EQRO mandatory and optional activities. This includes tool development, training and technical assistance in collaboration with DHCFP and MCEs. HSAG performs additional consultative services or technical assistance related to EQR activities for DHCFP. It also has provided guidance in RFP development to procure other vendors for the State and has worked with DHCFP to submit deliverables in response to CMS requests.
OTHER ACTIVITIES PERFORMED DURING THE REQUESTED EXPERIENCE PERIOD:
1115 Research and Demonstration Waiver Evaluation Design Plan HSAG provided 1115 research and demonstration waiver consulting in the areas of 1115 demonstration evaluation design plan and 1115 demonstration quality strategy development and implementation. *1915(b) Waiver Independent Assessment* HSAG provided an independent assessment of the quality and access portion of the overall 1915(b) waiver independent for the dental prepaid ambulatory health plan (PAHP) program. *Readiness Reviews* HSAG performed readiness reviews of MCOs and the DBA to verify that each entity had an appropriate operational structure to oversee Medicaid covered services to members, as outlined in 42 CFR §438.66(d)(1). The readiness review also included an assessment of each MCO's and the DBA's information system and its capabilities to accept electronic eligibility and enrollment feeds from DHCFP, process claims, and generate encounters as required by the contract. *Quality Strategy Development/Revision/Evaluation* HSAG performs an annual evaluation of the Nevada DHCFP State Quality Assessment and Performance Improvement Strategy to evaluate the completeness and effectiveness of the strategy and determine the extent to which DHCFP, in concert with its contracted MCEs, have implemented the methods described in the quality strategy to assess MCE compliance with CMS quality standards and improve the healthcare delivery and health outcomes of the Medicaid population.

New Hampshire External Quality Review Services Profile - HSAG Prime Contractor	
Name of Agency/ Address:	New Hampshire Department of Health and Human Services (DHHS), Office of Medicaid Business and Policy (OMBP), 129 Pleasant Street Concord, New Hampshire, 03301-3857
Contact(s):	Patrick McGowan, MS, CPHQ - Medicaid Quality Program Administrator, Bureau of Quality Management (603) 271-9534 Fax: Not available Patrick.McGowan@dhhs.nh.gov
Duration of the Contract:	Current: 7/1/2019-6/30/2026 Prior: 8/14/2013-6/30/2019
Active/Closed:	Active
Scheduled Date for Completion:	6/30/2026
Actual Completion Date:	Contract still ongoing
Total Value:	$2,464,200

Description of EQR Services Performed for Medicaid Managed Care

HSAG was selected in 2013 as New Hampshire's first external quality review organization (EQRO) and performs external quality review (EQR) services for DHHS. The New Hampshire MCOs coordinated care for the Medicaid expansion population in 2015 and again in 2019, which is now referred to as the Granite Advantage Program. With the implementation of its 1915(b) waiver in February 2016, the duals (Medicare/Medicaid) became a mandatory population to be included in the NH Medicaid Care Management Program.

CMS MANDATORY EQR ACTIVITIES PERFORMED DURING THE REQUESTED EXPERIENCE PERIOD:

Compliance Reviews

HSAG conducts annual on-site compliance monitoring activities. In the first year of the contract, HSAG conducted a complete compliance review of all federal and state requirements, and in subsequent years, HSAG conducted a review of one-third of the federal and state requirements.

Validation of Performance Measures

HSAG conducts performance measure validation (PMV) audits of state-defined measures to validate the accuracy and completeness of the performance measure rates. HSAG conducts PMV activities following the CMS EQR Protocol 2: Validation of Performance Measures, and the NCQA HEDIS PMV process. The PMV activity includes pre-on-site, on-site, and post-on-site activities. HSAG uses the information systems capabilities and assessment tool (ISCAT) required in CMS Protocol 2 to obtain information from the managed care organizations (MCOs) regarding their data systems. The customized ISCAT questionnaire covers data collection, system edits, data completeness studies, data transfer and integration, and measure calculation and reporting. HSAG also uses a document review template; an issue tracking forms; a site visit agenda; an interview guide; a data completeness and accuracy query list; a source code review findings report; medical record review validation policies and procedures; and a findings report, primary source verification results report, and file and rate review spreadsheets as part of the PMV process. HSAG prepares a PMV report for each MCO, documenting the validation findings. Based on all validation activities, the validation team determines the audit result for the performance measures.

Validation of Performance Improvement Projects (PIPs)

HSAG validates up to four PIPs for each MCO with topics the MCOs have chosen. One topic for each MCO includes the behavioral health population.

New Hampshire External Quality Review Services Profile - HSAG Prime Contractor
Validation of Network Adequacy From 2015 through 2018, HSAG completed access analysis reports for the FFS population. In 2019, HSAG conducted two secret shopper studies of provider offices to ensure access to care by the Medicaid care management members. *Annual EQR Technical Report* HSAG prepares the EQR technical report in accordance with 42 CFR §438.358. It describes how HSAG aggregated and analyzed the data from all EQR activities and how the conclusions were drawn as to the quality, timeliness, and access to care the MCOs provided. The report includes objectives, technical methods of data collection and analysis, and a description of data obtained, and conclusions drawn, from the data. Additionally, the technical report includes an assessment of the MCOs' strengths and weaknesses with respect to the quality, timeliness, and access to healthcare services; recommendations for improving performance related to these same aspects of healthcare services; and an assessment of the degree to which the MCOs have effectively addressed the recommendations for quality improvement the EQRO made during the previous year's review processes.
CMS OPTIONAL EQR ACTIVITIES PERFORMED DURING THE REQUESTED EXPERIENCE PERIOD:
Validation of Encounter Data HSAG performs encounter data validation to include developing and implementing an encounter data quality reporting system (EDQRS) to evaluate the quality of encounter data files the MCOs have submitted. The EDQRS is designed to import, store, and review incoming encounter data and generate automated, weekly validation reports for New Hampshire. *Administration/Validation of Member and Provider Surveys* HSAG administers and validates consumer, provider, and member surveys of quality of care. Activities include administering the CAHPS survey to the Medicaid population, creating a provider survey, conducting Secret Shopper surveys with providers, and developing a behavioral health member survey for the MCOs to administer. HSAG convenes focus groups and semi-structured interviews of Medicaid managed care members each year to obtain feedback concerning members' experiences with care in the Medicaid program. In 2014 HSAG conducted a statewide CAHPS survey for the adult and child FFS populations. In 2015, HSAG conducted a statewide CAHPS survey for the adult FFS population. *Calculation of Performance Measures* HSAG calculates DHHS-developed performance measures for the Medicaid care management program. *Focused Studies* HSAG develops annual quality studies to include topics that DHHS has chosen. Past studies have included an assessment of the prior authorization systems in the MCOs and the fee-for-service Medicaid program, and a review of the care management systems and processes the MCOs used. Focused study topics have included, prior authorizations (2015), care management (2016), behavioral health member survey (2017), information technology review (2018), and provider surveys (2019).
OTHER ACTIVITIES PERFORMED DURING THE REQUESTED EXPERIENCE PERIOD:
Developing 1115 Waiver Evaluation Plan and Implementing the 1115 Evaluation HSAG developed an 1115 Waiver evaluation plan for the New Hampshire Health Protection Program to submit to CMS for approval in 2015 and conducts the 1115 Waiver Premium Assistance Program evaluation (2016 to present).

New Hampshire External Quality Review Services Profile - HSAG Prime Contractor
Quality Strategy Development/Revision/Evaluation HSAG assists DHHS annually in evaluating the state's quality strategy by providing recommendations to the state and MCOs on developing and updating a statewide quality strategy, meeting CMS requirements, and harmonizing with the National Quality Strategy. *Stakeholder Meetings* HSAG conducted three ""Lunch and Learn"" sessions for DHHS staff on topics of interest related to EQR activities. HSAG plans an annual meeting for the MCO and DHHS staff members that includes nationally recognized speakers on topics relevant to the New Hampshire Medicaid Care Management Program.

Table 2b: HSAG EQR Experience as a Prime Contractor (All Other States)

Arizona External Quality Review Services Profile - HSAG Prime Contractor	
Name of Agency/ Address:	Arizona Health Care Cost Containment System (AHCCCS) 801 E. Jefferson Street Phoenix, Arizona, 85034
Contact(s):	Jamie Robin, RN, BSN, MPC - Quality Improvement Manager (602) 417-4717 Fax: Not available jamie.robin@azahcccs.gov
Duration of the Contract:	Current: 1/1/2019-12/31/2023 Prior: 9/21/1999-3/31/2019
Active/Closed:	Active
Scheduled Date for Completion:	12/31/2023
Actual Completion Date:	Contract still ongoing
Total Value:	$3,521,907
Description of EQR Services Performed for Medicaid Managed Care	
Since 1999, HSAG has performed external quality review (EQR) services for AHCCCS, which includes the following activities:	
CMS MANDATORY EQR ACTIVITIES PERFORMED DURING THE REQUESTED EXPERIENCE PERIOD:	
Validation of Network Adequacy HSAG conducts various activities supporting the validation and analysis of AHCCCS' subcontracted health plans to ensure compliance with time and distance standards as well as preparing for the CMS network reporting requirements. Specifically, HSAG conducts quarterly validation of the health plan network time and distance submissions, and it prepares reports to CMS regarding network adequacy and the availability and accessibility of covered services with the health plan contracts. *Annual EQR Technical Report* HSAG prepares four detailed EQR technical reports for each AHCCCS line of business (acute care, long-term care, behavioral health, and Children's Rehabilitative Services [CRS]), as required in the current contract scope of work. The technical reports describe the way the data from all oversight activities, in accordance with 42 CFR §438.358, were aggregated and analyzed, and how conclusions were drawn as to the quality, timeliness, and access to care furnished by AHCCCS-contracted MCOs.	
CMS OPTIONAL EQR ACTIVITIES PERFORMED DURING THE REQUESTED EXPERIENCE PERIOD:	
Administration/Validation of Member and Provider Surveys HSAG conducts Consumer Assessment Healthcare Providers and Systems (CAHPS®) surveys for adults and children enrolled in the state's Medicaid programs. This includes acute care plans, CHIP members covered under AHCCCS' KidsCare program, children with special needs who receive services through CRS and, since 2013, individuals who have been determined to have a serious mental illness. In 2016-17, HSAG conducted a CAHPS survey of adults and children enrolled in acute care, children enrolled in CRS, and adults enrolled in the Mercy Maricopa Integrated Care (Mercy Maricopa) program. In 2018, HSAG conducted CAHPS for the American Indian Health Program and KidsCare. In 2019, HSAG conducted an annual CAHPS survey for KidsCare. For 2020, HSAG is conducting its annual Kids Care CAHPS survey as well as a CAHPS surveys for the AHCCCS Complete Care, Seriously Mentally Ill, and American Indian Health Program populations.	

Arizona External Quality Review Services Profile - HSAG Prime Contractor
Calculation of Performance Measures HSAG calculates performance measure rates for the state's lines of business, including acute care, long-term care, behavioral health, and CRS. HSAG evaluates performance measures in the areas of care for children, care for women, behavioral health, care for chronic conditions, and access to care. Additionally, HSAG evaluates outcome measures in the areas of asthma, COPD, diabetes, and heart failure, as well as utilization measures monitoring emergency department utilization, inpatient utilization, mental health utilization, and 30-day readmission rates.

California External Quality Review Services Profile - HSAG Prime Contractor	
Name of Agency/ Address:	California Department of Health Care Services (DHCS) Managed Care Quality and Monitoring Division 1501 Capitol Avenue Sacramento, California, 95814
Contact(s):	Dana Durham - Policy and Medical Monitoring Branch, Chief (916) 345-8209 Fax: Not available dana.durham@dhcs.ca.gov
	Anna Lee Amarnath, MD, MPH - Medical Program Consultant, Medical Quality & Oversight Section, Chief (916) 345-8211 Fax: Not available annalee.amarnath@dhcs.ca.gov
Duration of the Contract:	Current: 9/1/2020-6/30/2023 Prior: 9/1/2008-8/31/2020
Active/Closed:	Active
Scheduled Date for Completion:	6/30/2023
Actual Completion Date:	Contract still ongoing
Total Value:	$29,872,000
Description of EQR Services Performed for Medicaid Managed Care	
HSAG has held the EQRO contract since 2008 and performs the following EQR services:	
CMS MANDATORY EQR ACTIVITIES PERFORMED DURING THE REQUESTED EXPERIENCE PERIOD:	

Validation of Performance Measures

HSAG provides DHCS with input on performance measure selection and performs on-site audits for the DHCS Medi-Cal managed care program's selected HEDIS, non-HEDIS, and DHCS-developed performance measures. HSAG provides technical assistance to 29 Medi-Cal managed care health plans (MCPs) throughout the audit process and produces preliminary and final plan-specific audit reports for each MCP. For MCPs that also serve the managed long-term services and supports (MLTSS) population, HSAG validates required performance measures reported for the Medi-Cal-only MLTSS population. HSAG creates analytic rate spreadsheets for all required performance measures that show trending and comparative analyses by county and at the aggregate level.

Validation of Performance Improvement Projects (PIPs)

Consistent with CMS protocols, HSAG performs PIP validation reviews of two PIPs for each of the Medi-Cal managed care plans (MCMC plans); and assists DHCS in determining the PIP topics. HSAG produces quarterly PIP status reports that provide validation results, PIP outcomes, a summary of technical assistance to MCMC plans, and recommendations to DHCS and the MCMC plans. HSAG also provides technical assistance and consultation to DHCS and the MCMC plans on the rapid-cycle PIP process to increase the opportunity for desired PIP outcomes. In addition, HSAG developed a Rapid Cycle PIP Guide for MCMC plans that provides information on how to design a methodologically sound PIP, along with detailed instructions on required PIP documentation. The guide meets CMS protocols.

Validation of Network Adequacy

Since 2017, HSAG has conducted timely access analyses to help DHCS assess the extent to which MCPs are meeting the wait time standards for select appointment types. Quarterly, HSAG receives provider data from DHCS

and selects sample providers for each MCP based on the appointment types on which DHCS wants HSAG to focus for that quarter. HSAG then conducts telephone surveys for each sample provider to inquire about appointment availability.

HSAG collaborated with DHCS to develop the survey script. HSAG and its vendor conduct trainings to ensure the survey questions are administered consistently across all providers. Finally, HSAG developed an interactive quarterly report in Excel that enables DHCS to assess individual MCP performance, compare performance across MCPs, and assess statewide rates for each measure.

Additionally, HSAG reports information related to MCPs' alternative access standards to ensure that the MCPs' provider networks are adequate to deliver services to Medi-Cal members. HSAG uses data that DHCS provides to analyze various reporting elements defined by California Welfare and Institute Code §14197.05.

HSAG also reports information related to the experience of members placed in skilled nursing facilities/intermediate care facilities and the distance that these individuals are placed from their residences. HSAG developed a methodology to assess this information and worked with DHCS to obtain the necessary data and conduct the analyses.

Annual EQR Technical Report

HSAG produces plan-specific performance evaluation reports and an annual technical report to meet the federal requirements outlined in 42 CFR §438.364. The plan-specific reports present plan-specific data for MCMC plans and analyses for all activities, summarize areas of strength and opportunities for improvement, and provide an assessment of each MCMC plan's performance in providing quality, accessible, and timely healthcare services to Medi-Cal members. HSAG also provides plan-specific recommendations in each report and an assessment of the degree to which each MCMC plan has addressed the recommendations from the previous year. The annual technical report provides aggregated results and analyses for all activities across all MCMC plans, an assessment of strengths and opportunities for improvement across all MCMC plans, and an assessment of the MCMC plans' performance in providing quality, accessible, and timely healthcare services to Medi-Cal members. HSAG includes recommendations for DHCS and an assessment of the degree to which DHCS has addressed the recommendations from the previous year.

CMS OPTIONAL EQR ACTIVITIES PERFORMED DURING THE REQUESTED EXPERIENCE PERIOD:

Validation of Encounter Data

HSAG conducts encounter data validation studies that include administrative encounter data and medical record reviews. HSAG produces plan-specific and aggregate reports that summarize the findings and include recommendations for DHCS and the MCPs to ensure accurate, complete, and timely encounter data. As needed, HSAG provides DHCS with technical assistance regarding encounter data quality and completeness. HSAG has produced an encounter data improvement guide for the MCPs that highlights the procedures and practices of MCPs with high encounter data quality. The guide provides useful tips and improvement strategies for MCPs that seek to improve encounter data quality and accuracy.

Administration/Validation of Member and Provider Surveys

HSAG administers CAHPS surveys to the Medi-Cal managed care adult and child populations, as well as to the Children's Health Insurance Program population. The surveys are in English and Spanish. HSAG conducts demographic analyses on the results and produces reports that include results and analyses at the MCP, county, and statewide levels.

Focused Studies

HSAG conducts clinical and nonclinical focused studies on areas of special interest to DHCS. The following are examples of topics for which HSAG has conducted focused studies: Quality Improvement for Selected Topics in

California External Quality Review Services Profile - HSAG Prime Contractor
Maternal and Child Health; Quality Improvement in Rural Communities; Validation of DHCS' Methodology for Calculating Performance Measures; Health Disparities Analysis; MCP Quality Teams Structures and Functions; Medi-Cal Only MLTSS Population; Developmental Screening; Long-Acting Reversible Contraceptive Utilization; Tobacco Cessation; Opioids; Creation of Analytic Rate Spreadsheets. *Technical Assistance and Training* HSAG provides DHCS and the MCPs with technical assistance related to required performance measures for which there are opportunities for improvement. In addition to MCP-specific technical assistance, HSAG facilitates quarterly collaborative discussions with the MCPs around DHCS priority topic areas. HSAG provides instructive information on rapid-cycle quality improvement tools and facilitates the sharing of successful quality improvement efforts, challenges, and lessons learned among MCPs.
OTHER ACTIVITIES PERFORMED DURING THE REQUESTED EXPERIENCE PERIOD:
Stakeholder Meetings *Annual Quality Improvement Conference* HSAG, in partnership with DHCS, plans and conducts an annual quality improvement conference with the goal of presenting up-to-date, practical information to MCPs, state staff members, and other key stakeholders regarding quality improvement issues and best practices as they affect the managed care environment. HSAG ensures the conference includes opportunities for skill building and for participants to share how they intend to use the information learned at the conference to improve the healthcare services for Medi-Cal members.

Colorado External Quality Review Services Profile - HSAG Prime Contractor	
Name of Agency/ Address:	Colorado Department of Health Care Policy and Financing (DHCPF) 1570 Grant Street Denver, Colorado, 80203
Contact(s):	Jerry Ware, Quality and Compliance Specialist/Contract Administrator - Office of Cost Control and Quality Improvement (303) 866-2335 Fax: Not available jerry.ware@state.co.us
	Curt Curnow, Quality and Health Improvement Section Manager - Office of Cost Control and Quality Improvement (303) 866-5879 Fax: Not available curt.curnow@state.com.us
Duration of the Contract:	Current: 7/1/2018-6/30/2023 Prior: 3/1/2001-6/30/2018
Active/Closed:	Active
Scheduled Date for Completion:	6/30/2023
Actual Completion Date:	Contract still ongoing
Total Value:	$12,994,198

Description of EQR Services Performed for Medicaid Managed Care

HSAG has contracted with Colorado for CAHPS and HEDIS work since 2001 and has been the uninterrupted EQRO since 2004, performing mandatory and optional EQR services for DHCPF. In spring of 2011, Colorado developed its Accountable Care Collaborative (ACC) Program. Central to the program, Colorado chose seven regional collaborative care organizations (RCCOs) to administer the program in the RCCOs' respective regions. The next iteration of the collaborative (ACC Phase II) seeks to leverage the proven successes of Colorado's ACC program to enhance Colorado's Medicaid member and provider experiences. In November 2017, DHCPF announced the awards for seven regional accountable entity (RAE) contracts to replace the seven RCCOs and five behavioral health organizations (BHOs) to implement the second phase of its ACC program. Colorado's RAEs are primary care case management (PCCM) entities with additional behavioral health PIHP responsibilities. HSAG conducts all mandatory and several optional EQR activities for the RAEs.

CMS MANDATORY EQR ACTIVITIES PERFORMED DURING THE REQUESTED EXPERIENCE PERIOD:

Compliance Reviews

HSAG has conducted annual on-site compliance monitoring reviews since 2004 for Colorado's health plans. Prior to FY 2018-2019, HSAG reviewed 19 health plans. With Colorado's implementation of ACC Phase II in FY 2018-19, HSAG is contracted to provide on-site compliance monitoring reviews for 16 managed care entities (MCEs), including two Medicaid MCOs, five CHIP MCOs, seven PCCM entities, one CHIP dental prepaid ambulatory health plan (PAHP), and one administrative service organization responsible for CHIP members before enrollment in one of the CHIP MCOs, and for the statewide prenatal/postpartum population. Compliance monitoring activities are designed to determine the MCEs' compliance with Medicaid managed care regulation standards for access to care, structure and operations, enrollee rights and protections, and quality assessment and performance improvement. HSAG formulates the findings for the compliance monitoring through a review of the submitted documents; a review of administrative records related to grievances, denials, appeals, provider credentialing, and care coordination; and through interviews with key health plan staff members. During on-site compliance reviews of the PCCM entities, HSAG includes a qualitative assessment of the PCCM entities to determine progress in

implementing specific goals related to Colorado's ACC program. HSAG prepares individual MCE reports of findings, strengths, and opportunities for improvement and an annual PCCM entity aggregate report; and provides follow-up reviews to ensure completion of corrective action plans.

Validation of Performance Measures

HSAG conducted an on-site validation of performance measures audit and produced individual reports for each of the five BHOs through FY 2018-19. Beginning in FY 2019-20, HSAG will conduct performance measure validation for the behavioral health PIHP population within the PCCM entities. HSAG produces individual reports in accordance with CMS protocols, incorporating results into the annual EQR technical report for each performance measure validation it conducts. Additionally, HSAG prepares annual HEDIS aggregate reports for Medicaid and CHIP that include rates for Medicaid and CHIP MCOs. HSAG obtains HEDIS audit reports from the MCOs to calculate a total Colorado performance average. For each HEDIS measure, HSAG compares each MCO's level of achievement with State standards, Colorado's performance average, and national benchmarks to determine whether the results are statistically above, below, or equal to the average or applicable benchmark. The reports include an explanation of each measure and the HEDIS rates over the past three years, with an analysis of the trends and any limitations for each measure.

Validation of Performance Improvement Projects (PIPs)

Before FY 2018-19, HSAG validated one PIP for each of the 19 Colorado health plans (two Medicaid MCOs, five BHOs, five CHIP MCOs, and seven RCCOs). With Colorado's implementation of the ACC Phase II in July 2018, HSAG is contracted to provide validation of one PIP for each of two Medicaid MCOs, five CHIP MCOs, and one dental PAHP; and two PIPs (one behavioral health and one physical health) for each of the seven PCCM entities. HSAG provides technical assistance as requested, assesses the health plans' methodology for conducting the PIPs, and evaluates overall validity and reliability of PIP results. HSAG reports the findings of the validation activity in individual health plan reports and establishes a timeline detailing key steps and dates for submission, evaluation, resubmission, and report preparation in the PIP process. In each fiscal year, HSAG delivers all final PIP reports on or before the established due date.

Validation of Network Adequacy

Beginning in FY 2018-19, HSAG is collaborating with DHCPF to validate provider network adequacy and ensure that each of the 16 managed care entities serving the Medicaid and CHIP populations —two Medicaid MCOs; five CHIP MCOs; seven PCCM Entities; one PAHP; and the State Managed Care Network (SMCN), the state's administrative service organization (ASO) for fee-for-service (FFS) CHIP—have adequate provider networks in their respective service coverage areas to deliver healthcare services to their managed care members. HSAG uses a multiyear approach that allows Colorado to develop a strong foundation for ongoing Medicaid and CHIP provider network validation and to establish procedures that facilitate collection and analysis of high-quality provider data. Year 1 validation activities included developing provider crosswalks to ensure standardized categorization of providers. Year 2 activities included development of standards and a standardized template for MCEs to use for reporting network adequacy.

Annual EQR Technical Report

HSAG prepares two detailed annual EQR technical reports: a Medicaid physical health/behavioral health combined report and a CHIP report, both of which describe how data from all EQR activities were aggregated and analyzed and how conclusions regarding quality, timeliness, and access to care were made. The reports include an assessment of each health plan's strengths and weaknesses with respect to the quality, timeliness, and access to healthcare services; recommendations for improvement; and an assessment of the health plans' follow-up to prior-year recommendations.

Colorado External Quality Review Services Profile - HSAG Prime Contractor
CMS OPTIONAL EQR ACTIVITIES PERFORMED DURING THE REQUESTED EXPERIENCE PERIOD:

Validation of Encounter Data

Through FY 2017-18, HSAG conducted independent evaluations of all Behavioral Health Organization (BHO) encounter data quality audits, assessing the validity of findings presented in the BHOs' encounter data quality reports based on the BHOs' internal encounter data audits. This activity consisted of conducting a medical record review of 30 cases randomly selected from each of the BHO's sample of 411 cases and is known as the BHO 411 audit. Results were presented in a written report. In addition, HSAG delivered MS Excel worksheets specific to each claim type for each BHO. The worksheets contained the record number, client first name, client last name, client date of birth, and a listing of the data element(s) in which HSAG auditors disagreed with the BHO's audit finding for each case, with at least one data element in disagreement. In FY 2018-19, HSAG performed an information systems review for the state and for each RAE to determine each entity's ability to report accurate behavioral health encounter data. In FY 2019-20, HSAG will resume conducting independent evaluations of the RAEs' behavioral health 411 audits.

HSAG also conducts an independent evaluation of the two MCOs' encounter data quality audits. HSAG over-reads a sample of 30 Medicaid encounters that Colorado's MCOs audit during the annual audit of 412 encounters, with a goal of assessing a health plan's ability to audit its own encounter data. Results are presented in a written report. In addition, an MS Excel worksheet specific to each claim type is delivered, containing the record number, client first name, client last name, client date of birth, and a listing of the data element(s) in which HSAG's auditor disagreed with the MCO's auditor for each case with at least one data element in disagreement.

In addition, through FY 2017-18, HSAG sampled, abstracted, and directly audited medical records to determine the extent to which medical record documentation supported DHCPF's encounter data. For each of five BHOs, HSAG audited 137 medical records (95 percent confidence and ±6.7 percent margin of error) in either one service category or all service categories not covered by the annual BHO 411 audit. HSAG annually audited 685 total encounters across all BHOs. Results were presented in one report with aggregate and BHO-specific findings.

Administration/Validation of Member and Provider Surveys

HSAG performs CAHPS surveys(CAHPS 5.0 Adult Child Medicaid Health Plan Surveys, CG-CAHPS 3.0, and ECHO), for adults and children enrolled in the RAEs, unassigned FFS populations, and the CHIP program. HSAG conducts the annual surveys in English and Spanish for the adult and child populations, administering them in accordance with NCQA protocols. HSAG produces annual plan-specific reports for each population and produces an aggregate CAHPS report.

Calculation of Performance Measures

HSAG conducted an annual HEDIS calculation for the Medicaid FFS population (RCCO and non-RCCO members) through FY 2016-17. HSAG calculated 20 measures for the Medicaid FFS population using the administrative and hybrid methodologies and continues to calculate the Prenatal and Postpartum HEDIS measures for the Child Health Plan Plus (CHP+) SMCN population using the administrative methodology.

Technical Assistance and Training

HSAG provides DHCPF and its health plans with technical assistance when conducting each EQR mandatory and optional activity. This includes developing tools, training, and technical assistance in collaboration with DHCFP and the health plans. HSAG also has consulted with the state to assist it in developing the state-produced member handbook for use with each MCE type. In addition, HSAG consulted with DHCPF to assist in achieving its goal to restructure and streamline the technical reports while continuing to meet all CMS requirements.

In FY 2018-19, HSAG reviewed Colorado's quality strategy to ensure that it addressed 2016 revisions to the Medicaid managed care rules.

Colorado External Quality Review Services Profile - HSAG Prime Contractor
In FY 2019-20 HSAG will work with DHCPF to provide an audit of utilization review decisions to assess quality and accuracy of the determinations. Also, in FY 2019-20, HSAG will provide DHCPF with technical assistance to design its Mental Health Parity reporting. Annually, HSAG collaborates with DHPF to provide an annual PIP Summit and a Quality Improvement workshop for all Colorado health plans.
OTHER ACTIVITIES PERFORMED DURING THE REQUESTED EXPERIENCE PERIOD:
Conducts Quality-of-Care Reviews HSAG conducts quality reviews of cases referred by the State to investigate quality of care concerns. In addition, during the EQR review activities, potential quality-of-care concerns that HSAG or DHCPF identifies may be referred to an HSAG physician or another appropriate reviewer. *Conducts Claims Processing Audits* HSAG conducts claims processing audits of DHCPF's ASO, which is responsible for administering benefits for CHIP members enrolled in the SMCN. HSAG assesses the quality of the ASO's ability to process and pay claims for the SMCN providers by conducting a desk audit of policies, procedures, and system specifications (e.g., system flow charts, system edits) for processing and capturing SMCN claims. Each year the audit includes an assessment of the health plan's ability to process claims and member enrollment data, provider data, and internal audit and decision support processes. HSAG reviews select cases in the monthly anomaly reports to evaluate the extent to which medical record documentation is accurately reflected in the claims systems. Every other year the audit is performed on-site. In alternate years, the audit is performed telephonically and via webinar. *BHO 411 Quality Improvement Plan (QIP)* Beginning in FY 2017-18, HSAG determined issues to be addressed in the BHO's QIP each year and beginning in FY 2020 for the MCOs based on a benchmark of 90 percent accuracy for encounter data submitted, and it populated the QIP template for each BHO/MCO delineating items requiring action and recommendations, if appropriate (based on each health plan's Service Coding Accuracy Report). HSAG reviewed each health plan's process mapping, failure modes analysis, and initial submission of planned interventions to improve encounter data submission accuracy. HSAG also produced one final 508-compliant report for the BHOs and one for the MCOs consisting of an executive summary, aggregate results of the QIP reviews, and separate sections with results for each health plan. HSAG is contracted to perform the QIP activity for the behavioral health population of the RAEs beginning in FY 2020-21. *Utilization Management Review Overread* Beginning in FY 2019-2020 HSAG uses InterQual UR guidelines and parameters set forth by Colorado's FFS Medicaid benefit package and requirements stated in the CO Vendor's contract with DHHS. In FY 2020 HSAG will review 400 requests for services previously reviewed by the Vendor. The purpose of these reviews is to determine the quality, accuracy, and timeliness of the previous determination. HSAG developed a data collection tool and delivers the completed tool (in Excel table format) to DHHS of Health Care Policy and Financing. HSAG employs formal interrater reliability processes to ensure the consistent application of the review criteria among HSAG's reviewers. *Readiness Reviews* In FY 2012-2013 HSAG performed readiness reviews for the seven chosen Regional Collaborative Care Organizations (RCCOs) On July 1, 2018, Colorado's seven Regional Accountable Entities (RAEs) began operations, marking Colorado's transition of its accountable care collaborative (ACC) program to Phase II bringing coordination of behavioral health and physical health services under one roof for each region. HSAG performed readiness reviews of the seven chosen entities and remains contracted to provide compliance site reviews and qualitative evaluations of the entities' progress implementing the goals of Colorado's ACC program. In addition, in FY 2018-19 HSAG performed readiness reviews for one newly contracted dental PAHP.

Florida External Quality Review Services Profile - HSAG Prime Contractor	
Name of Agency/ Address:	Florida Agency for Health Care Administration (AHCA) 2727 Mahan Drive Tallahassee, Florida, 32308
Contact(s):	Cathy Cross, Senior Management Analyst, Supervisor - Bureau of Medicaid Quality (850) 412-4690 Fax: Not available cathy.cross@ahca.myflorida.com
	Jemirah Holland, MSW, FCCM, Government Analyst II - Quality Improvement & Evaluation Contracts Unit (850) 412-4143 Fax: Not available jemirah.holland@ahca.myflorida.com
Duration of the Contract:	Current: 7/1/2013-6/30/2021 Prior: 5/1/2006-6/30/2013
Active/Closed:	Active
Scheduled Date for Completion:	6/30/2021
Actual Completion Date:	Contract still ongoing
Total Value:	$8,294,875
Description of EQR Services Performed for Medicaid Managed Care	
HSAG has held the EQRO contract continuously since 2006 and performs the following EQR services for AHCA:	
CMS MANDATORY EQR ACTIVITIES PERFORMED DURING THE REQUESTED EXPERIENCE PERIOD:	

Compliance Reviews

HSAG has provided technical assistance to AHCA in preparing for and aggregating results from AHCA-led compliance reviews. HSAG has also developed and provided input to the compliance review tools AHCA uses to conduct the reviews. In 2018, HSAG designed and developed a Web-based tool for the AHCA staff and AHCA's contracted MCOs to perform the annual compliance reviews, including file reviews. The managed care survey tool (MCST) capabilities include document storage, survey scheduling, management of detailed findings and scores, and reporting features that allow for creating a corrective actions report. HSAG performs enhancements to improve the MCST, as needed.

Validation of Performance Measures

HSAG validates managed care organization (MCO) performance measures in accordance with current CMS protocols. In addition, HSAG prepares an annual aggregate report based on analysis and comparisons of the MCO HEDIS and agency-required performance measures. The aggregate report guides program evaluation, implementation, and quality improvement efforts.

Validation of Performance Improvement Projects (PIPs)

HSAG validates multiple PIPs for each MCO using the current CMS protocols. HSAG produces MCO-specific reports for each MCO that evaluate the soundness and results of the PIPs, including findings and recommendations, and produces an annual aggregate report of the MCOs' PIP validations.

Florida External Quality Review Services Profile - HSAG Prime Contractor
Validation of Network Adequacy In 2016, HSAG conducted a targeted network adequacy review of hospitals in the Statewide Medicaid Managed Care (SMMC) program. AHCA requested that HSAG perform the review in two stages. First, HSAG compared network data from each SMMC plan to the hospital licensure source data and identified discrepancies in each plan's network data. Second, HSAG compared the Medicare Advantage Health Services Delivery Reference file to the AHCA urban/rural network standards using the SMMC program enrollment for each of the 67 counties in Florida. HSAG identified the differences in the two sets of standards and provided AHCA with a report describing the results. *Annual EQR Technical Report* In accordance with 42 CFR §438.358, HSAG prepares a detailed annual EQR technical report that describes how data from all oversight activities were aggregated and analyzed. The report contains conclusions as to the quality, timeliness, and access to care that AHCA-contracted MCOs provide. The report includes objectives, technical methods of data collection and analysis, a description of data obtained, and conclusions drawn from the data. The technical report also includes an assessment of each MCO's strengths and weaknesses with respect to the quality, timeliness, and access to healthcare services for Medicaid recipients; recommendations for improving the quality of healthcare services that each provides; and an assessment of the degree to which each MCO has effectively addressed the recommendations for quality improvement that HSAG made during the previous year's review processes.
CMS OPTIONAL EQR ACTIVITIES PERFORMED DURING THE REQUESTED EXPERIENCE PERIOD:
Validation of Encounter Data HSAG conducts encounter data validation (EDV) on the AHCA and MCOs' encounter data for several service types, including dental, pharmacy, inpatient/outpatient, long-term care, and physician visits. The EDV activity evaluates the accuracy, completeness, and integrity of the AHCA and MCOs' encounter data. HSAG also performs a medical record review that validates provider-reported encounter data against medical records and provides technical assistance to the MCOs and AHCA on data procurement and study findings. HSAG produces an annual aggregate report of the analysis and findings of the study and it provides recommendations on the encounter data validation process. *Administration/Validation of Member and Provider Surveys* HSAG developed the survey instrument that the state will require the health plans to use when administering provider surveys. Developing the instrument includes field testing. *Technical Assistance and Training* HSAG provides MCOs with technical assistance to address EQRO mandatory and optional activities. This includes tool development, training, and technical assistance in collaboration with AHCA and the MCOs.
OTHER ACTIVITIES PERFORMED DURING THE REQUESTED EXPERIENCE PERIOD:
Stakeholder Meetings *Quarterly Meetings* HSAG plans and facilitates quarterly meetings, including two on-site meetings and two webinars, and prepares agendas, meeting scripts, venues, and presentations, if appropriate. HSAG also assists in the program content and expert speaker research and, when directed, presents EQR activities at the meetings. After each quarterly meeting HSAG posts all presentations to the Florida EQRO website and prepares a meeting summary, which is linked to goals and objectives outlined in AHCA's quality strategy.

Georgia External Quality Review Services Profile - HSAG Prime Contractor	
Name of Agency/ Address:	Georgia Department of Community Health (DCH) 2 Peachtree Street, NW 36th Floor Atlanta, Georgia, 30303-3159
Contact(s):	Kelvin Holloway, MD - Deputy Executive Director/Senior Medical Director, Medical Assistance Plans (404) 463-2832 Fax: Not available kelvin.holloway@dch.ga.gov
Duration of the Contract:	Current: 2/1/2019-6/30/2023 Prior: 7/1/2008-1/31/2019
Active/Closed:	Active
Scheduled Date for Completion:	6/30/2023
Actual Completion Date:	Contract still ongoing
Total Value:	$3,040,620
Description of EQR Services Performed for Medicaid Managed Care	
Since 2008, HSAG has performed EQR services for DCH.	
CMS MANDATORY EQR ACTIVITIES PERFORMED DURING THE REQUESTED EXPERIENCE PERIOD:	

Compliance Reviews

HSAG reviews each care management organizations (CMOs) for compliance with specified standards for quality assessment and performance improvement program operations. Using a combination of document reviews and interviews with CMO personnel, HSAG assesses the CMOs' compliance with the DCH contract and federal Medicaid managed care requirements/standards for the quality and timeliness of, and access to, care and services that promote safe and effective healthcare. HSAG produces a CMO-specific report for DCH and each CMO that encompasses its findings from the compliance reviews. These reports include a summary of the CMO's strengths and, when applicable, opportunities to improve performance; a presentation of the performance results and scores for each standard (set of related requirements) reviewed; a description of HSAG's methodology to prepare for and conduct the reviews; and, as applicable, a template for the CMO to prepare its corrective action plan or any requirement where performance was scored as less than Met.

Validation of Performance Measures

HSAG validates performance measures; evaluates the accuracy of measures reported by the CMOs, the State's fee-for-service program, and the Georgia Families program; and determines both the extent to which these performance measures followed DCH specifications and the results of associated performance measures that the CMOs implemented. HSAG produces a CMO-specific performance results report for DCH and the CMOs and provides DCH with an annual statewide summary performance report across the CMOs that contains recommendations for performance improvement.

Validation of Performance Improvement Projects (PIPs)

HSAG validates PIPs, evaluates the soundness and results of the rapid-cycle PIPs that each of the five CMOs implemented, and produces individual CMO reports for DCH and the CMOs. The reports encompass HSAG's findings resulting from PIP validation activities, recommendations to improve the validity of the CMOs' rapid-cycle PIP processes and, as applicable, performance on the measures.

Annual EQR Technical Report

In accordance with 42 CFR §438.358, HSAG prepares a detailed annual technical report that describes how the data from all activities HSAG conducted were aggregated and analyzed. The report contains conclusions as to the

Georgia External Quality Review Services Profile - HSAG Prime Contractor
quality, timeliness, and access to care the CMOs provide. The report also includes objectives, technical methods of data collection and analysis, a description of data obtained, and conclusions drawn from the data; an assessment of each CMO's strengths and weaknesses with respect to the quality, timeliness, and access to healthcare services provided to its members; recommendations to improve performance and member health outcomes; and a summary and recommendation section that aggregates best practices and opportunities for improvement across the program. After the first contract year, the technical report has included an assessment of the degree to which each CMO effectively addressed the performance improvement recommendations that HSAG made during the previous year's review processes.
CMS OPTIONAL EQR ACTIVITIES PERFORMED DURING THE REQUESTED EXPERIENCE PERIOD:
Implementation of PIPs In 2017, HSAG provided CMOs with technical assistance to support improvement projects they conducted in collaboration with the Centers for Disease Control and Prevention 6/18 Initiative and DCH. At DCH's request, HSAG reviewed the CMOs' final documents for their projects to summarize the interventions tested, the outcomes, and to provide recommendations. *Technical Assistance and Training* *CMO QAPI Plan Assessment* HSAG provided DCH with technical assistance to develop CMO requirements for developing the quality assessment and performance improvement (QAPI) plan and an evaluation that included Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements. In addition, HSAG worked with DCH to develop a checklist that allowed DCH to quickly identify the CMOs' compliance with requirements for the QAPI plan and evaluation. *Auto-Assignment Algorithm* DCH contracted with HSAG to continue the auto-assignment project by deriving the auto-assignment weights/scores by region for each CMO based on the prior year's validated HEDIS and AHRQ performance measures, and by providing the scores to DCH. *Stakeholder Meetings* At the request of DCH, after issuing the EQR reports for each activity, HSAG conducts an annual conference for DCH, the CMOs, and other constituents that DCH identifies, presenting the results of the mandatory EQR activities and/or providing DCH and the CMOs with information related to strategies and best practices for improving performance in one or more DCH-selected high-priority area. HSAG works collaboratively with DCH to identify the focus, content, and audience for each annual conference.

Hawaii External Quality Review Services Profile - HSAG Prime Contractor	
Name of Agency/ Address:	Hawaii Department of Human Services (DHS), Med–QUEST Division (MQD) Kakuhihewa State Office Bldg. 601 Kamokila Blvd., Suite 506A Kapolei, Hawaii, 96707
Contact(s):	Jon Fujii - Health Care Services Branch Administrator (808) 692-8083 Fax: Not available jfujii@dhs.hawaii.gov
	Priscilla Thode - Interim Contract Monitoring/Compliance Section Administrator (808) 692-1865 Fax: Not available pthode@dhs.hawaii.gov
	Kathy Ishihara - Nurse Consultant, Contract Monitoring and Compliance Section (808) 692-8159 Fax: Not available kishihara@dhs.hawaii.gov
Duration of the Contract:	Current: 1/1/2016-12/31/2021 Prior: 7/1/2001-12/31/2015
Active/Closed:	Active
Scheduled Date for Completion:	12/31/2021
Actual Completion Date:	Contract still ongoing
Total Value:	$9,483,372
Description of EQR Services Performed for Medicaid Managed Care	
HSAG has served as the EQRO for Hawaii DHS, MQD, since 2001. MQD contracts with HSAG to perform EQR services for the QUEST Integration program health plans and Community Care Services (CCS) program health plan. HSAG conducts the following activities:	
CMS MANDATORY EQR ACTIVITIES PERFORMED DURING THE REQUESTED EXPERIENCE PERIOD:	
Compliance Reviews In alignment with federal requirements and CMS protocols, HSAG conducts compliance monitoring reviews for the QUEST Integration health plans and CCS program to assess plan compliance with federal and state standards for organizational structure and operations. In 2014, HSAG began conducting compliance reviews for the CCS program (a prepaid inpatient health plan). HSAG conducts a review of half the standards in year one and year two of a three-year period to comply with federal regulations. The reviews are designed to determine managed care organization (MCO) compliance with program requirements, including those set forth in federal regulations, state law, and in health plan contracts with MQD. After each compliance monitoring review, HSAG reviews the QUEST Integration and CCS health plans' corrective action plans (CAPs) for any standards found not fully compliant. HSAG provides the health plans with a CAP template identifying areas requiring improvement. After each plan submits its CAP, HSAG performs an initial review and provides MQD with a recommendation to either approve or revise the CAP. HSAG then conducts an evaluation of the health plans' CAP implementation to review their progress in bringing into compliance those standards found to be noncompliant. Monitoring and reevaluation continue until the health plan achieves full compliance in the deficient area. HSAG produces final follow-up review reports for each plan.	

Hawaii External Quality Review Services Profile - HSAG Prime Contractor
HSAG conducts annual on-site compliance monitoring activities. In the first year of the contract, HSAG conducted a complete compliance review of all federal and state requirements, and in subsequent years, HSAG conducted a review of one-third of the federal and state requirements. *Validation of Performance Measures* HSAG conducts validation of Medicaid performance measures and performs NCQA HEDIS Compliance Audits ™ of QUEST Integration health plans in accordance with CMS protocols and NCQA requirements. The validation of performance measures provides findings related to collecting, calculating, and reporting HEDIS and non-HEDIS performance measures. The HEDIS compliance audits include an on-site review of the plans' information systems and a review of the processes the plans use to collect and calculate the performance measures. HSAG also provides technical assistance for revising and modifying the technical specifications that MQD and QUEST Integration health plans use to collect and report performance measures. In 2014, HSAG began validating performance measures for the CCS program (a prepaid inpatient health plan). *Validation of Performance Improvement Projects (PIPs)* In collaboration with MQD, HSAG validates PIPs in accordance with the CMS protocols and the Institute for Healthcare Improvement's Quality Improvement (QI) Model for Improvement. HSAG's rapid-cycle framework allows the QI plans broad flexibility and a systematic technique to approach an improvement activity for validating PIPs. In 2014, HSAG began validating PIPs for the CCS program (a prepaid inpatient health plan). Each year, MQD works with QUEST Integration, CCS program, and HSAG to define two rapid-cycle PIP topics. HSAG provides technical assistance on the design and execution of quality improvement projects and monitors PIP progress. *Annual EQR Technical Report* The technical report describes how the data from all oversight activities, in accordance with 42 CFR §438.358, are aggregated and analyzed and how the report draws conclusions on the quality, timeliness, and access to care that QUEST Integration and CCS health plans provide. In 2014, HSAG began providing EQR services for the CCS program (a prepaid inpatient health plan) and including information in the EQR technical report. The technical report includes objectives, technical methods of data collection and analysis, a description of data obtained, and conclusions drawn from the data. The technical report also includes an assessment of each MCO's strengths and weaknesses with respect to the quality, timeliness, and access to healthcare services provided to Medicaid recipients; recommendations for improving the quality of healthcare services that each MCO provides; and an assessment of the degree to which each MCO has effectively addressed the recommendations for quality improvement the EQRO made during the previous year's review processes.
CMS OPTIONAL EQR ACTIVITIES PERFORMED DURING THE REQUESTED EXPERIENCE PERIOD:
Validation of Encounter Data Starting in 2020, HSAG is responsible for developing the methodology and conducting a comprehensive assessment of the MQD's encounter data, factors affecting completeness and accuracy, and quality of its encounter data for reporting purposes. Activities include (1) a targeted encounter data information systems assessment, (2) a gap analysis and best practice recommendation on creating a comprehensive encounter data quality program, and (3) an administrative data profile assessing encounter data accuracy, completeness, and timeliness. HSAG is responsible for preparing a report that summarizes the results to the State and the MCO's. *Administration/Validation of Member and Provider Surveys* HSAG coordinates and conducts CAHPS surveys for adults and children enrolled in the Medicaid managed care health plans. HSAG conducts a survey annually for each QUEST Integration plan and alternates between the adult and child CAHPS surveys. In addition, HSAG conducts a statewide CHIP population child survey annually.

Hawaii External Quality Review Services Profile - HSAG Prime Contractor

HSAG administers these surveys in accordance with NCQA protocols and produces annual plan-specific and aggregate reports.

Every other year, HSAG conducts a provider satisfaction survey of the primary care providers and specialty practitioners for each plan. HSAG is responsible for the survey methods and design, survey production, administration, and data analysis. HSAG prepares a written report of survey results with statewide and plan-specific findings.

Technical Assistance and Training

HSAG provides technical assistance to MQD and the health plans to address questions and specific expectations for participating in the EQR activities and MQD's administration of the Med-QUEST program. HSAG assists MQD with a variety of special projects, such as preparing a consumer guide, review and feedback on survey instruments under development, and review and feedback on the quality strategy, among others. HSAG also provides education to MQD's contract compliance staff on managed care principles and the federal managed care regulations and techniques and tools to oversee and monitor the health plans.

At MQD's request, HSAG developed a report of nonduplication strategy recommendations for compliance when a health plan attains national accreditation and for HEDIS Consumer Guide development, and with technical assistance to and training of MQD on EQR-related and quality improvement topics.

OTHER ACTIVITIES PERFORMED DURING THE REQUESTED EXPERIENCE PERIOD:

Conducts Pre-Admission Screening and Resident Review (PASRR) compliance reviews

Quarterly, HSAG's clinical review nurses assess nursing facility compliance with PASRR policies and procedures using information from the medical record, including a resident's history and physical examination, physician's order sheets, consultations, minimum data sets, medication administration records, and care plans. These reviews determine the degree to which Hawaii's Medicaid-certified nursing facilities comply with the federal regulations for screening admissions to nursing facilities. Hawaii provides a sample of cases for review and registered nurses perform the reviews, HSAG reports all findings of noncompliance to the state each month for follow-up, and HSAG provides an annual summary report of findings.

Conducts Long-Term Care (LTC) Level of Care (LOC) Determinations

HSAG's clinical staff conducts assessments of Medicaid recipients who may require long-term care services in nursing facilities or from home and community-based services (HCBS) providers. Each LOC request is evaluated by a Hawaii-licensed registered nurse using a combination of clinical information and functional scores to arrive at a determination. On average, 1,400 LOC determinations are processed every month.

Maintains the LTC LOC determinations database

HSAG developed a secure Web-based application, HILOC, to manage and collect information on LTC LOC determinations. Accessible to registered users from the state, Medicaid health plans, and LTC service providers, HILOC provides an electronic mode of submission and review/approval of LTC LOC requests. HILOC interfaces with the state's prepaid medical management information system and can provide the necessary information to produce monthly, quarterly, annual, and ad hoc reports. Electronic submission of LOC documentation currently exceeds 95 percent. HSAG works closely with DHS to assure the Web-based application and database continue to perform and meet DHS needs.

Conducts Quality of Care (QOC) Reviews

At the request of MQD, HSAG's clinical staff reviews the medical records of Medicaid recipients with an identified quality of care issue. Investigations include collection, review, and determination on the disposition of a given case.

Hawaii External Quality Review Services Profile - HSAG Prime Contractor
Maintains the PASRR submission database HSAG developed, implemented, and continues to maintain a Web-based application, called ePASRR to manage Hawaii's PASRR process. The ePASRR application allows hospitals, nursing facilities, and community-based providers to prepare and submit Level 1 and Level 2 PASRR documentation electronically, request and obtain Level 2 determinations, and coordinate patient placement. Additionally, the ePASRR application allows nursing facilities to submit monthly census reports of admissions. Each quarter, HSAG's clinical staff evaluates nursing facility compliance with the PASRR process. Through the ePASRR application, the staff selects a targeted random sample of nursing facility admissions to assess nursing facility compliance with federal requirements by evaluating the completeness and accuracy of PASRR documentation. The clinical staff prepares and submits a report of findings to the state after each review and provides technical assistance to facilities where noncompliant cases were identified.

Illinois External Quality Review Services Profile - HSAG Prime Contractor	
Name of Agency/ Address:	Illinois Department of Healthcare and Family Services (HFS) 201 S. Grand Ave. East Prescott E. Bloom Building Springfield, Illinois, 62763
Contact(s):	Laura Ray - Program Manager, Bureau of Managed Care (217) 524-7478 Fax: Not available Laura.Ray@Illinois.gov
	Dawn Wells, RN, BSN - Bureau Chief (217) 782-2314 Fax: Not available Dawn.R.Wells@Illinois.gov
Duration of the Contract:	Current: 3/13/2019-3/12/2029 Prior: 8/29/2002-12/27/2018
Active/Closed:	Active
Scheduled Date for Completion:	3/12/2029
Actual Completion Date:	Contract still ongoing
Total Value:	$23,997,836

Description of EQR Services Performed for Medicaid Managed Care

HSAG has performed external quality review (EQR) services for HFS since 2002. HFS contracts with HSAG to conduct an independent EQR of the quality improvement activities by the state's managed care organizations (MCOs), including the Family Health Plan/Affordable Care Act (FHP/ACA) program, the Integrated Care Program (ICP), the Medicare-Medicaid Alignment Initiative (MMAI) program, and the Medicaid Managed Long-Term Care Services and Supports (MLTSS) program. On Jan. 1, 2018, HFS rebooted the Illinois Medicaid managed care program, which serves approximately 2.5 million residents. Under the managed care program reboot, HFS contracted with seven health plans to provide care for 80 percent of all Medicaid enrollees statewide. The key objectives of the reboot were to reduce Medicaid program costs, more efficiently manage utilization of healthcare services, and improve healthcare quality and outcomes. The managed care program before Jan. 1, 2018, was designed to operate in 30 counties; as of April 1, 2018, expansion included all 102 counties statewide. Five of the seven HealthChoice Illinois managed care health plans serve enrollees statewide and two plans serve enrollees in Cook County only. The Statewide Medicaid Managed care program is referred to as the Illinois HealthChoice (HCI) program. HSAG conducts the following activities for this contract:

CMS MANDATORY EQR ACTIVITIES PERFORMED DURING THE REQUESTED EXPERIENCE PERIOD:

Compliance Reviews

HSAG conducts administrative compliance audits for the FHP/ACA, ICP, MLTSS, and MMAI programs to monitor MCO adherence to standards for organizational structure and operations that directly relate to quality of care. To comply with federal regulations, HSAG conducts an audit every year to review all standards within a three-year period. The annual audits determine MCO compliance with program requirements, including those set forth in federal regulations, state laws, and in MCO contracts with HFS.

Validation of Performance Measures

HSAG validates MCO performance measures, including pay-for-performance (P4P) and withhold measures, and performs NCQA HEDIS Compliance Audits™ of MCOs in accordance with CMS protocols and NCQA requirements. The validation of performance measures provides both the findings related to the measures and the general steps to calculate and report the measures appropriately. This audit includes an on-site review of the MCOs' information systems and a review of the processes they use to collect and calculate the performance

measures. In addition, HSAG provides technical assistance for the revision of technical specifications that HFS uses to collect and report the performance measures.

HSAG also conducts performance measure validation (PMV) for each plan's self-reported data on MCO, MLTSS, and MMAI performance measures to ensure there is an accurate and complete reporting of actual enrollee events as they occurred and are documented in the enrollee record. Self-reported measures such as grievances and appeals, health risk screening, health risk assessment, individualized plan of care, prior authorizations, movement between nursing facility and community, and provider disputes are included in the PMV.

HSAG conducts PMV for the Children's Health Insurance Program (CHIP), as required under the Children's Health Insurance Program Reauthorization Act (CHIPRA) in accordance with the CMS protocols. The PMV for CHIP provides findings related to the CHIPRA measures and includes the general steps to calculate and report the performance measures appropriately. This includes a review of the state's information system and a review of the processes used to collect and calculate the CHIPRA measures. In addition, HSAG provides technical assistance for revising technical specifications that HFS uses.

Validation of Performance Improvement Projects (PIPs)

HSAG conducts annual review and report on oversight and validation of MCO PIPs in accordance with the Centers for Medicare & Medicaid Services (CMS) protocols. HFS, in conjunction with the MCOs and HSAG, determines the focus of the PIP. This assistance includes consultation and ongoing monitoring of the collaborative PIP progress. MCOs conduct two PIPs using the rapid cycle approach.

Follow-Up After Behavioral Health Hospitalization

HFS required each MCO to participate in a mandatory PIP focused on behavioral health. The goals of the PIP are to improve the rates of members receiving follow-up appointments within seven to 30 days of discharge from an inpatient stay for mental health treatment.

Patient Engagement After Inpatient Discharge

HFS required each MCO to participate in a mandatory PIP focused on improving both care coordination and patient engagement in care following an inpatient admission with the goal of reducing readmissions.

Validation of Network Adequacy

HSAG evaluates, validates, and monitors network capacity to ensure capacity is sufficient. At the request of HFS, HSAG established a process for MCOs to submit provider network data for each service area. HSAG evaluates and monitors the progress of contracting and credentialing providers and uses the provider network submissions to identify potential network gaps and to monitor progress toward establishing an adequate provider network for members. The network analysis allows HFS to evaluate the provider network capacity across the MCOs using a multifaceted, iterative, and standardized approach. These data are used to support ongoing monitoring, assessment, and reporting activities to evaluate provider network adequacy. HSAG also produces ad hoc network capacity reports that include a range of topics, such as samples of home and community-based services and specialty providers for specific enrollee populations, specific ZIP code analysis, and county-specific analyses for individual provider types. HSAG provides HFS with analyses that focus on areas of concern. HSAG developed a Provider Network Instruction Manual and a provider data dictionary to standardize MCO reporting and in 2018, it expanded the network validation activities to include a time and distance study to validate MCO compliance with provider network time and distance standards.

Conducts Surveys for Access and Availability

To evaluate enrollee access to providers and providers' availability to enrollees. HSAG evaluates members' access to providers and the providers' availability to members through surveys of primary care providers and selected specialties, dentists, and other designated providers. Surveys involve phone calls to sample provider

Illinois External Quality Review Services Profile - HSAG Prime Contractor

offices to determine access and availability for specific appointments. HSAG monitors the health plans corrective action plans if a provider network does not achieve an 80 percent success rate in satisfying the standards.

Conducts Time and Distance Study and Analysis
HSAG utilizes QUEST data analytic software to evaluate and report on the degree to which health plans are complying with time and distance network access standards.

Provides Ad Hoc Network Reporting
At the request of the State, HSAG conducts analyses and reporting for ad hoc provider network reporting, including impact analysis of provider contract termination, comparison of contracted Long-Term Care facilities across MCOs, comparison of OB/GYN provider networks by MCO statewide, contracted specialty providers, analysis of DCFS high utilization/high spend providers and comparison of MCO network contracted providers prior to program implementation, and responding to State FOIA requests pertaining to network providers.

Annual EQR Technical Report
In accordance with 42 CFR §438.358, HSAG produces an annual technical report that describes how the data from all oversight activities were aggregated and analyzed, and how conclusions were drawn, as to the quality, timeliness, and access to the care provided by HFS-contracted MCOs. The report includes objectives, technical methods of data collection and analysis, a description of data obtained, and conclusions drawn from the data. The technical report also includes an assessment of each MCO's strengths and weaknesses with respect to the quality, timeliness, and access to healthcare services provided to Medicaid members; recommendations for improving the quality of healthcare services that each MCO provides; and an assessment of the degree to which each MCO has effectively addressed the recommendations for quality improvement the EQRO made during the previous year's review processes.

CMS OPTIONAL EQR ACTIVITIES PERFORMED DURING THE REQUESTED EXPERIENCE PERIOD:

Validation of Encounter Data
HSAG validates encounter data to determine whether MCOs are reporting the appropriate encounters and whether a reported encounter is an accurate assessment of the services performed. HSAG analyzes data completeness and provides technical assistance regarding use of data collection, evaluates MCO information systems capabilities, and assists MCOs with developing plans for improvement. HSAG validates MCO encounter data through medical record reviews conducted by clinical reviewers and other healthcare experts.

Administration/Validation of Member and Provider Surveys
HSAG conducts a statewide *adult quality of life survey* for the MLTSS population to evaluate members health-related quality of life (QOL). HSAG utilizes the Veterans RAND 12 Item Health Survey (VR-12) for the survey administration.

HSAG conducts a statewide child quality of life survey to evaluate child members health-related QOL. HSAG utilized the Pediatric Quality of Life Inventory (PedsQL) 4.0 Parent Report for Children (ages 8-12) survey.

HSAG conducts a statewide adult and child CAHPS survey that includes child members in the All Kids and Illinois Medicaid programs as well as adult and child managed care beneficiaries in the FHP/ACA and ICP programs. HSAG provides deliverables such as disposition reports and data aggregation reports to inform HFS of decisions regarding opportunities for improvement related to member experience.

Focused Studies
HSAG conducts a focused study to provide quantitative information about prenatal care and associated birth outcomes among Medicaid Managed Care female enrollees.

Illinois External Quality Review Services Profile - HSAG Prime Contractor
Quality Rating System/Consumer Report Card By analyzing MCO HEDIS and CAHPS data, HSAG developed a consumer report card that compares and displays plan performance. The report card displays MCO performance for specific measures in key performance areas identified by the state. The report card is posted on the HFS website and is available to members during open enrollment. *Technical Assistance and Training* HSAG makes recommendations to HFS on the need for MCO-specific technical assistance to implement quality assurance activities. HSAG provides HFS with a report detailing the technical assistance it provided to the MCO and the actual outcome or benefits of this assistance. *Develops the MCO Pay-for-Performance Program (P4P)* HSAG works with HFS to provide technical assistance in developing the P4P program, including selecting the measures and developing minimum and high-performance targets based on national HEDIS benchmarks. The P4P measure selection included alignment with the Integrated Health Home outcome-based payment measures and HFS priority measures, and were representative of the HealthChoice Illinois managed care populations.
OTHER ACTIVITIES PERFORMED DURING THE REQUESTED EXPERIENCE PERIOD:
QIP Validation HSAG conducts a validation of QIPs for MCOs in the MMAI program to ensure the collection and evaluation of intervention data verifies the success of the interventions to improve the quality of care, delivery of services, and outcomes for MMAI members. *Post Implementation Reviews* HSAG conducts post-implementation readiness reviews for MCO/PIHP and MMAI plans. The post-implementation review assesses compliance with successful implementation of applicable state and federal requirements. *Conducts Home and Community-Based Services (HCBS) Waiver Record Reviews* These reviews measure the quality of services provided to LTSS members the MCOs manage. HSAG developed the sampling methodology, record review abstraction tools, and reporting templates. HSAG's clinical review team uses a Web-based database to conduct quarterly on-site reviews of MCO documentation, resulting in data and reports that provide HFS with information about service provision and the ability to report required waiver performance measure data to CMS. HSAG also completes remediation validation to determine if remediation actions were completed appropriately by the MCOs. *Prepares Health, Safety, and Welfare Reports* HSAG developed and customized procedures and reporting templates to ensure the capture of information and timely reporting of health, safety, and welfare concerns to HFS, as identified during EQR activities. HSAG's processes to identify and report potential health, safety, and welfare concerns include timely notification to ensure the member's safety. The reporting notification includes recommendations for corrective action. Upon approval of the report by HFS, HSAG monitors and evaluates remediation responses until the concern has been mitigated. HSAG prepares quarterly and annual HSW data summaries for HFS. *Conducts Care Management/Care Coordination (CM/CC) Staffing and Training Reviews* These reviews evaluate the educational qualifications, related experience, full time equivalency allocation, caseloads, and annual training of CM/CC staff serving the Medicaid managed care population against the HealthChoice, MLTSS, Special Needs Children (SNC), and MMAI contracts, as well as CMS HCBS waiver requirements.

Illinois External Quality Review Services Profile - HSAG Prime Contractor

Conducts Focused Quality Review

HSAG conducts performance monitoring of service delivery and utilization to identify service utilization patterns and trends, quality of care concerns, program needs, and potential program enhancements.

Health, Safety, and Welfare Monitoring Reviews

HSAG conducts quarterly review of HSW/Critical Incident (CI) records to provide feedback and analysis on MCO compliance with HSW and CI requirements. The results of these reviews are used to highlight strengths and identify areas that require immediate and/or additional attention.

MLTSS 1915 (b) Waiver Independent Evaluation and Report

HSAG conducted an independent quality evaluation of the Illinois MLTSS Waiver, utilizing the guidelines set forth in the HCFA publication, Section 1915 (b) Waiver Program Independent Assessments: Guidance to States. HSAG's assessment included an evaluation of access and quality of care. The goals for the MLTSS program are to improve care delivery and improve utilization of community-based services.

MLTSS 1915 (b) Waiver Independent Evaluation Quarterly Monitoring

HSAG completes a quarterly monitoring report that includes all requirements outlined in the MLTSS Waiver's CMS Special Terms and Conditions notice to ensure the state monitors beneficiaries transition from Fee-For-Service to Managed Care. The report also includes recommendations for remediation actions to address potential non-compliance with waiver requirements.

Oversight and Monitoring Quality Assurance Programs (QAPs)

Annually, HSAG assessed and monitored the QAPs of 12 MCOs contracted with HFS. HSAG prepared a report of findings, including recommendations for improvement to achieve continuous quality improvement. HSAG provided the MCOs and HFS with technical assistance at the direction and approval of HFS.

Completed Statewide Managed Care Readiness Review and Post-implementation Compliance Activities

HSAG has worked with Illinois health plans to improve HEDIS rates, resulting in the following achievements:

In SFY 2018, 17 of 34 HEDIS priority measures achieved the national 50th percentile or greater;

In SFY 2019 there was statistically significant improvement in the number and percentage of HCBS waiver participants who received services in the type, scope, amount, and frequency specified in the service plan for two health plans.

Monitors the Corrective Action Plans (CAPs)

HSAG monitors CAPs for compliance review and performance measures. HSAG prepares CAP templates, evaluates MCO CAP submissions, and provides feedback to MCOs. HSAG conducts CAP reviews to assess the sufficiency of the MCOs' proposed interventions/activities and timelines to determine the status of the CAP implementation and if the MCOs can reasonably bring performance into full compliance with the requirements.

Readiness Reviews

HSAG conducts readiness reviews for new plans or programs within 30 days of the HFS request. Such reviews may include a review of proper licensure, operational protocols, MCO processes and standards, network capacity, care management staffing, and systems. HSAG determines whether each MCO's internal processes are sufficient for ongoing contract compliance, quality oversight, and monitoring of the quality assurance plan before the MCO's effective date of enrollment. The review consists of a desk review, an on-site review, and interviews with pertinent personnel so HFS can make an informed assessment of the MCO's ability and readiness to render services.

HSAG develops program-specific assessment documents to validate readiness reviews and responds to any corrective action plans resulting from the review. Most recently, HSAG conducted readiness reviews for the statewide Medicaid expansion of seven MCOs, MLTSS program statewide expansion for 6 MCOs, DCFS Youth

Illinois External Quality Review Services Profile - HSAG Prime Contractor
program implementation for one specialty plan, and Special Needs Children (SNC) statewide program implementation for 6 MCOs. HSAG also conducts information systems readiness reviews. HSAG reviews MCO data management processes and reviews and assesses the procedures the MCO has in place to collect and integrate medical, financial, member, and provider information encompassing clinical and service-related data from internal and external sources. *Quality Strategy Development/Revision/Evaluation* Each year HSAG evaluates HFS' compliance with the requirements related to evaluating the quality strategy outlined in 42 CFR §438.204 in order to provide HFS with recommendations on the effectiveness of the quality strategy in addition to revisions that should be made. This activity includes HSAG's participation in an annual quality assurance meeting that HFS convenes to review the quality strategy with stakeholders, providers, and MCOs.

Michigan (Behavioral Health) External Quality Review Services Profile - HSAG Prime Contractor	
Name of Agency/ Address:	Michigan Department of Health and Human Services (MDHHS) Behavioral Health and Developmental Disabilities Administration (BHDDA) Division of Quality Management and Planning 320 S. Walnut Street Lansing, Michigan, 48913
Contact(s):	Kathleen Haines - MDHHS Manager 517.335.0179 Fax: Not available hainesk@michigan.gov
Duration of the Contract:	Current: 10/1/2019-9/30/2027 Prior: 7/1/2004-9/30/2019
Active/Closed:	Active
Scheduled Date for Completion:	9/30/2027
Actual Completion Date:	Contract still ongoing
Total Value:	$15,629,964.05
Description of EQR Services Performed for Medicaid Managed Care	
Since 2004, HSAG has performed EQR activities for MDHHS, BHDDA, including the following mandatory and optional activities:	
CMS MANDATORY EQR ACTIVITIES PERFORMED DURING THE REQUESTED EXPERIENCE PERIOD:	

Compliance Reviews

In accordance with 42 CFR §438.358, HSAG conducts reviews to determine each Medicaid prepaid inpatient health plans' (PIHPs') compliance with the standards set forth in 42 CFR §438—Managed Care Subpart D and the quality assessment and performance improvement requirements described in 42 CFR §438.330. HSAG also incorporates associated MDHHS contract requirements into the compliance monitoring review of each of the 10 MDHHS PIHPs. HSAG prepares individual reports of findings, which include performance strengths, actions required to comply with regulations, and recommendations for further program improvement.

MDHHS and the individual PIHPs use the information and findings from the compliance monitoring reviews to: Evaluate the quality and timeliness of and access to behavioral healthcare services the PIHPs provide; Identify, implement, and monitor system interventions to improve quality; Evaluate current performance processes; Plan and initiate activities to sustain and enhance current performance processes; Incorporate the review findings into the annual technical report.

Validation of Performance Measures

HSAG validates performance measures in accordance with CMS protocols and a set of performance indicators that MDHHS developed. Working with MDHHS and PIHPs, HSAG customizes the Information Systems Capabilities Assessment Tool to collect the necessary data consistent with Michigan's mental health service delivery model. The performance measure validation includes pre-on-site and on-site activities, including a comprehensive on-site review of each PIHP's information systems, claim and encounter processing, member and provider data, and the processes the PIHP uses to collect, store, validate, and report the performance measure data. After completing the validation activities, HSAG produces individual reports of the findings and incorporates the results in the annual technical report.

Validation of Performance Improvement Projects (PIPs)

HSAG validates PIPs, including an assessment of the PIHPs' methodology to conduct a PIP and an evaluation of overall validity and reliability of study results. For each PIHP, HSAG validates one PIP on a PIHP-selected topic

Michigan (Behavioral Health) External Quality Review Services Profile - HSAG Prime Contractor
and provides the PIHP with technical assistance upon request. After completing the validation activities, HSAG produces individual reports of the findings, which are incorporated into the annual EQR technical report. *Annual EQR Technical Report* In accordance with 42 CFR §438.364, HSAG produces an annual EQR technical report summarizing each mandatory activity described in 42 CFR §438.358, including compliance monitoring, validation of performance measures, and validation of PIPs. In the technical report, and using findings from these activities, HSAG provides an assessment of each PIHP's strengths and weaknesses and makes recommendations for improving the quality, timeliness, and access to care.
CMS OPTIONAL EQR ACTIVITIES PERFORMED DURING THE REQUESTED EXPERIENCE PERIOD:
Administration/Validation of Member and Provider Surveys Annually, HSAG and its subcontractor administer more than 660 face-to-face National Core Indicator (NCI) consumer surveys to assess the satisfaction with services and supports of individuals with intellectual and/or developmental disabilities. In alignment with NCI protocol, HSAG and its subcontractor provide NCI training to all interviewers and ensure that each interviewer has experience with persons with specific communications needs due to intellectual and/or developmental disability. Upon completing the face-to-face surveys, HSAG and its subcontractor enter all responses into the NCI Online Data Entry Survey Application System for inclusion in the national NCI analysis and reporting. HSAG and its subcontractor also prepare additional analyses and present NCI consumer survey information to stakeholders upon MDHHS request. *Technical Assistance and Training* HSAG provides project-specific training and technical assistance to MDHHS and the PIHPs, as necessary, to ensure successful completion of each EQR activity included as part of the Michigan EQRO contract. HSAG offers expert recommendations, ideas, and proposals during every stage of the contract and for all aspects of EQR activities. HSAG also provides ad hoc technical assistance and training for MDHHS and the PIHPs, as requested by MDHHS.

Michigan (Physical Health) External Quality Review Services Profile - HSAG Prime Contractor	
Name of Agency/ Address:	Michigan Department of Health and Human Services (MDHHS) Managed Care Plan Division PO Box 30479 / 400 S. Pine Lansing, Michigan, 48909-7979
Contact(s):	Tom Curtis - Quality Manager 517.284.1152 Fax: Not available curtist2@michigan.gov
Duration of the Contract:	Current: 10/1/2019-9/30/2027 Prior: 9/18/2004-9/30/2019
Active/Closed:	Active
Scheduled Date for Completion:	9/30/2027
Actual Completion Date:	Contract still ongoing
Total Value:	$15,629,964.05

Description of EQR Services Performed for Medicaid Managed Care

Since 2004, HSAG has performed EQR activities for MDHHS. For the most current contract, HSAG conducts various mandatory and optional EQR activities with 11 Medicaid Health Plans, seven integrated care organizations (Financial Alignment Initiative), and two dental plans (Healthy Kids Dental Program). These activities include the following:

CMS MANDATORY EQR ACTIVITIES PERFORMED DURING THE REQUESTED EXPERIENCE PERIOD:

Compliance Reviews

MDHHS contracts with seven integrated care organizations (ICOs) to deliver care to members eligible for both Medicaid and Medicare services under the CMS Financial Alignment Initiative called MI Health Link in Michigan. MDHHS contracted with HSAG to conduct a review determining each ICO's compliance with the standards set forth in 42 CFR §438—Managed Care Subpart D and the quality assessment and performance improvement requirements described in 42 CFR §438.330, as well as requirements outlined in the MDHHS contract with each ICO and the three-way agreement among CMS, MDHHS, and individual ICOs. MDHHS also contracted with HSAG to perform corrective action plan evaluations and to confirm all noted plans of actions are implemented to mitigate any non-compliance with state or federal requirements.

Validation of Performance Measures

HSAG reviews and analyzes Medicaid NCQA HEDIS Compliance Audit™ reports, reviews Medicaid HEDIS interactive data submission system results, and develops a comprehensive statewide written report presenting an analysis of NCQA HEDIS reports with recommendations for improvement. MDHHS requires each Medicaid Health Plan (MHP) and Dental Health Plan (DHP) to collect and report a set of Medicaid HEDIS measures.

HSAG performs an independent evaluation of the audit results and findings to evaluate the accuracy of the performance measure data that the MHP and DHP collects, and to determine the extent to which the specific performance measures calculated by or on behalf of the MHP and DHP followed the specifications established for each measure. To meet the two primary objectives of the validation activity, HSAG performs a measure-specific review of all reported measures as well as a thorough information system evaluation to assess each MHP's and DHP's support system available to report accurate HEDIS measures. Deliverables include the Michigan Quality Trend Report, statewide weighted averages, MACPro results, and the Statewide Aggregate HEDIS Analytical Report.

Michigan (Physical Health) External Quality Review Services Profile - HSAG Prime Contractor

HSAG also conducts performance measure validation on MDHHS-specified performance measures to assess the accuracy of the performance measure data reported by the Integrated Care Organizations (ICOs) and to determine the extent to which performance measures reported by the ICOs follow State and federal specifications and reporting requirements. For new reporting measures, HSAG also conducts a readiness review of the information systems and processes used for data collection and reporting that will be used to calculate future performance measure rates. Based on all validation activities, HSAG determines the results of each performance measure and each measure receives a designation of "Report" or "Not Reported". The validation designation for each measure is included in an ICO-specific report.

MDHHS monitored the performance of the MHPs through key performance measures aimed at improving the quality and efficiency of healthcare services provided to Michigan residents enrolled in a Medicaid program. MDHHS presented data for these measures in quarterly performance monitoring reports. HSAG conducted validation of MDHHS' performance monitoring report measure results by validating the rates for each performance monitoring report measure that MDHHS identified for the state fiscal year reporting. As part of the validation process, HSAG reviewed the source code used to generate the performance measure data element values for each performance measure and the MDHHS completed Information Systems Capabilities Assessment Tool, along with other supporting documentation that included policies and procedures, file layouts, system flow diagrams, system log files, and data collection process descriptions. HSAG also conducted an on-site visit with MDHHS, which included subject matter expert interviews, a system demonstration, review of data output files, primary source verification, observation of data processing, and review of data reports. HSAG reported its validation findings and results to MDHHS in a detailed report.

Validation of Performance Improvement Projects (PIPs)

HSAG validates PIPs, including assessing the 11 MHPs', two DHPs', and seven ICOs' methodology to conduct the PIP and evaluate overall validity and reliability of study results. For each MHP, DHP, and ICO, HSAG validates one PIP on a state-selected topic and produces individual reports of the findings. HSAG also conducts technical assistance calls with the MHPs, DHPs, and ICOs, as necessary. HSAG incorporates the results in the annual EQR technical report.

Validation of Network Adequacy

MDHHS contracted with HSAG to conduct network adequacy validation activities, including secret shopper surveys, to collect information on members' access to providers.

Annual EQR Technical Report

HSAG prepares detailed annual EQR technical reports that describe how the data from all activities conducted in accordance with 42 CFR §438.358 were aggregated and analyzed and how conclusions were drawn as to the quality, timeliness, and access to the care the managed care entities provided, including the MHPs, DHPs, and ICOs. For each EQR-related activity, the reports include objectives, technical methods of data collection and analysis, a description of data obtained, and the conclusions drawn from the data. The reports also include an assessment of each MHP's, DHP's, or ICO's strengths and weaknesses responding to the quality, timeliness, and access to healthcare services provided to Medicaid members; methodologically appropriate, comparative information about all MHPs, DHPs, or ICOs; recommendations for improving the quality of healthcare services that each MHP, DHP, or ICO provides; and an assessment of the degree to which each MHP, DHP, or ICO has effectively addressed the recommendations for quality improvement the EQRO made during the previous year's review processes.

Michigan (Physical Health) External Quality Review Services Profile - HSAG Prime Contractor
CMS OPTIONAL EQR ACTIVITIES PERFORMED DURING THE REQUESTED EXPERIENCE PERIOD:
Administration/Validation of Member and Provider Surveys HSAG administers the CAHPS surveys for MDHHS and reports on the findings. HSAG also works with MDHHS to submit data to NCQA, when appropriate. This project includes conducting a CAHPS survey for adults and children enrolled in the state's MHPs, including a customized child CAHPS survey tailored to the state's Children with Special Health Care Services population. HSAG administers the surveys in accordance with NCQA protocols and produces aggregate reports for each population it surveys during the contract year. *Quality Rating System/Consumer Report Card* Since 2007, MDHHS has contracted with HSAG to analyze HEDIS results, including CAHPS data from the Michigan MHPs to present in the Michigan Medicaid Consumer Information Guide. The guide analysis helps support MDHHS' public reporting of health plan performance information. Beginning in 2020, HSAG also contracted with HSAG to develop a Medicaid Consumer Information Guide that includes the performance of the two dental health plans (DHPs) for the Healthy Kids Dental population. *Technical Assistance and Training* HSAG provides project-specific training and technical assistance to MDHHS, MHPs, DHPs, and ICOs, as necessary, to ensure successful completion of each EQR activity included in the Michigan EQRO contract. HSAG offers expert recommendations, ideas, and proposals during every stage of the contract and for all aspects of EQR activities. HSAG also provides ad hoc technical assistance and training for MDHHS, MHPs, DHPs, and ICOs, as requested by MDHHS. Annually, HSAG attends an in-person meeting with MDHHS, MHP, DHP, and ICO staff members and presents information on topics that MDHHS selects, such as HEDIS performance.

Oregon External Quality Review Services Profile - HSAG Prime Contractor	
Name of Agency/ Address:	Oregon Health Authority (OHA), Health Systems Division 500 Summer Street, NE Salem, Oregon, 97301
Contact(s):	Tawnya Elmore - Quality Assurance Lead (503) 947-5254 Fax: Not available Tawnya.Elmore@state.or.us
	Veronica Guerra - Interim Quality Assurance and Contract Oversight Manager (503) 437-5614 Fax: Not available Veronica.Guerra@state.or.us
Duration of the Contract:	Current: 7/1/2018-6/30/2025 Prior: N/A
Active/Closed:	Active
Scheduled Date for Completion:	6/30/2025
Actual Completion Date:	Contract still ongoing
Total Value:	$5,285,700
Description of EQR Services Performed for Medicaid Managed Care	
HSAG performs the following EQRO services for OHA:	
CMS MANDATORY EQR ACTIVITIES PERFORMED DURING THE REQUESTED EXPERIENCE PERIOD:	

Compliance Reviews

In alignment with federal requirements and CMS protocol, HSAG conducts compliance monitoring reviews for the CCOs and DCOs to assess compliance with program requirements, including those set forth in federal regulations, state laws, and in their contracts with OHA. HSAG conducts reviews of half the standards in years one and two of a three-year period to comply with federal regulations. Based on review findings, the CCOs and DCOs prepare corrective action plans (CAPs) for any standards found not fully compliant. HSAG provides ongoing technical assistance to OHA during implementation and execution of the CAPs.

Validation of Performance Measures

In accordance with 42 CFR §438.330(b)(2), HSAG conducts an annual validation of OHA's calculation of a subset of administrative-based incentive measures. Specifically, HSAG assesses OHA's information systems' data processing and reporting procedures to determine the extent to which its systems can produce valid and reliable performance measures. In 2019, HSAG validated the following five measures: Adolescent Well-Care Visits; Ambulatory Care: Emergency Department Utilization; Dental Sealants on Permanent Molars for Children; Developmental Screening (0-36 months); and Effective Contraceptive Use. Using CMS protocol, HSAG coordinated with OHA to obtain the information necessary to validate whether the measure calculations that OHA performed and OHA's validation process for them adhered to CMS specifications.

Additionally, in conjunction with the CCOs' annual compliance review, HSAG performs an Information Systems Capabilities Assessment of each CCO and the MHO to determine the extent to which systems they operated supported the final production of valid and reliable performance measures calculated by the state.

Validation of Performance Improvement Projects (PIPs)

HSAG validates PIPs that the CCOs and DCOs prepare and implement as required by OHA to comply with requirements set forth in 42 CFR §438.358(b)(1)(i) and that were begun or were under way during the preceding

Oregon External Quality Review Services Profile - HSAG Prime Contractor
12 months. This activity includes the facilitation, validation, and scoring of one statewide PIP required by OHA (i.e., Improving Safety of Opioid Management). HSAG also reviews two additional PIPs and one focused project the CCOs conduct each quarter and provides summative feedback to OHA on the CCOs' progress. HSAG provides ongoing technical assistance and support to the CCOs, DCOs, and OHA upon request. *Validation of Network Adequacy* HSAG conducts a network adequacy validation of each CCO during the preceding 12 months to comply with requirements set forth in 42 CFR §438.68. This annual validation includes a review of CCOs' submitted documentation to assess compliance with provider network adequacy requirements in their contracts with OHA, Oregon Administrative Rules (OARs), and CFRs. Additionally, HSAG conducts up to five ad hoc assessments of individual CCO network adequacy in response to a significant or material change to provider networks, providing analysis to OHA. *Annual EQR Technical Report* In accordance with 42 CFR §438.358, HSAG prepares EQR annual technical reports that describe how HSAG aggregated and analyzed the data from all EQR activities and how it drew conclusions as to the quality, timeliness, and access to healthcare services provided to Medicaid members. The reports include objectives, technical methods of data collection and analysis, a description of data obtained, and conclusions drawn from the data. Additionally, the technical reports include assessments of CCO and DCO strengths and weaknesses, recommendations for improving performance, and an assessment of the degree to which OHA has effectively addressed the recommendations for quality improvement that the EQRO made during the previous year's review processes.
CMS OPTIONAL EQR ACTIVITIES PERFORMED DURING THE REQUESTED EXPERIENCE PERIOD:
Validation of Encounter Data HSAG works with OHA to conduct encounter data validation (EDV) activities with the states 15 CCOs providing physical, dental, and behavioral health to Medicaid members. For 2020, HSAG is conducting an EDV-focused questionnaire and analysis to determine the extent to which the CCOs and OHA have appropriate system documentation and the infrastructure to produce, process, and monitor encounter data. *Technical Assistance and Training* HSAG provides education and technical assistance to OHA, CCOs, and DCOs, and to other key partners as defined by OHA. This education and technical assistance includes: General technical assistance and educational opportunities to CCOs, DCOs, and OHA in accordance with 42 CFR §438.358(d); Training, communication, and technical assistance to CCOs and DCOs before conducting each EQR activity; Annual training, technical assistance, and education on EQR processes established by HSAG, in collaboration with OHA, to ensure effective implementation of EQR activities; Execution of additional analyses of CCO and DCO compliance with provider network adequacy requirements set forth in OHA contracts, CFRs, and OARs; Information dissemination and training related to changes in OHA and MCE requirements based on state and federal policy changes.
OTHER ACTIVITIES PERFORMED DURING THE REQUESTED EXPERIENCE PERIOD:
Mental Health Parity Consistent with 42 CFR §438 Subpart K and CMS guidance, HSAG evaluates Oregon's FFS and each CCOs' non-quantitative treatment limitations (NQTL) related to medical/surgical (M/S) and mental health/substance use disorder (MH/SUD) benefit structure and utilization management processes to determine MH parity. The analysis includes acute care, long-term care, and home and community-based services. Because there is overlap of mental health benefits across CCOs and with FFS, each CCOs' M/S and MH/SUD NQTLs are additionally compared to any NQTLs that apply to FFS benefits. HSAG provides a protocol to guide the

Oregon External Quality Review Services Profile - HSAG Prime Contractor
analyses and follow ups up on parity issues through monitoring corrective action plans. Technical assistance to OHA and the CCOs is also provided through the duration of the analyses and corrective action plan process. *Readiness Reviews* In coordination with OHA, as required by 42 CFR §438.66(d), HSAG is responsible for developing a readiness review protocol with evaluation criteria to support the state's selection of CCOs for its 2020-2024 Medicaid managed care program. HSAG assesses the resources, capacity, and systems of each CCO to ensure they meet contractual requirements. HSAG conducts the reviews and prepares a final report of readiness for each CCO.

Utah External Quality Review Services Profile - HSAG Prime Contractor	
Name of Agency/ Address:	Utah, Department of Health (UDOH) 288 North 1460 West Salt Lake City, Utah, 84114-3108
Contact(s):	Cameron Gunderson - Quality Manager, Bureau of Managed Care, Utah Department of Health (801) 538-6943 Fax: Not available crgunderson@utah.gov
Duration of the Contract:	Current: 1/1/2018-12/31/2020 Prior: 9/1/2014-6/30/2018 1/1/2005-12/31/2007
Active/Closed:	Active
Scheduled Date for Completion:	12/31/2020
Actual Completion Date:	Contract still ongoing
Total Value:	$2,491,114
Description of EQR Services Performed for Medicaid Managed Care	
HSAG performs the following EQRO services for UDOH:	
CMS MANDATORY EQR ACTIVITIES PERFORMED DURING THE REQUESTED EXPERIENCE PERIOD:	

Compliance Reviews

HSAG performs full compliance reviews for the managed care organizations (MCOs), prepaid inpatient health plans/prepaid mental health plans (PIHPs/PMHPs), the Children's Health Insurance Program (CHIP) MCOs, and prepaid ambulatory health plans (PAHPs). HSAG prepares individual plan reports of the compliance review results for each health plan and conducts follow-up reviews of corrective action plan implementation to assess the plans' progress in bringing into compliance those standards not in full compliance. HSAG produces the follow-up review reports for each health plan and submits them to the plans and UDOH.

Validation of Performance Measures

HSAG conducts PMV audits that include an on-site review for one measure, and it produces individual reports for each of 12 (will be 13 in CY 2021) PIHP/PMHPs and the one MCO that provides both physical and mental health services to individuals with developmental disabilities and mental illness. HSAG evaluates the performance measures data the plans calculate and determines the extent to which the specific performance measure calculation followed the specifications that UDOH established for each performance measure.

Validation of Performance Improvement Projects (PIPs)

HSAG validates one PIP for each Medicaid MCO, CHIP MCO, PIHP/PMHP, and PAHP. HSAG provides technical assistance as requested, assesses the plans' methodology for conducting the PIPs, and evaluates overall validity and reliability of PIP results. HSAG reports the findings to the health plans and UDOH in individual health plan reports.

Validation of Network Adequacy

In calendar year 2019, HSAG assessed the State's network analysis needs, reviewed existing standards, and obtained provider network information from the health plans and the state. HSAG performed a baseline network adequacy analysis of the State's and the health plans' provider data, including provider-to-member ratios and time-distance analyses. HSAG also provided recommendations to enhance the State's oversight of the health plans' routine network reporting. In calendar year 2020, HSAG will continue to use the standardized provider

Utah External Quality Review Services Profile - HSAG Prime Contractor
categories developed in calendar year 2019 to assess members' access to care using health plan-specific geospatial analyses and assess the health plans' performance on network standards. *Annual EQR Technical Report* HSAG prepares an annual technical report that describes how the data from all oversight activities, in accordance with 42 CFR §438.358, were aggregated and analyzed and how conclusions were drawn as to the quality, timeliness, and access to care the UDOH-contracted health plans provided. The report includes objectives; technical methods of data collection and analysis; a description of data obtained; an evaluation of the health plans; a statewide comparison of the results; and conclusions related to the quality, timeliness, and access to care, as drawn from the data. The technical report also includes recommendations to improve the quality of care and services each health plan provides and an assessment of the degree to which each health plan has effectively addressed the quality improvement recommendations the EQRO made during the previous year's EQR activities.
CMS OPTIONAL EQR ACTIVITIES PERFORMED DURING THE REQUESTED EXPERIENCE PERIOD:
Technical Assistance and Training HSAG provides UDOH and its contracted health plans with technical assistance to address Medicaid managed care and EQRO mandatory and optional activities. This includes tool development, training, and technical assistance in collaboration with UDOH and the health plans.

Vermont External Quality Review Services Profile - HSAG Prime Contractor	
Name of Agency/ Address:	Vermont Agency of Human Services (AHS) 280 State Drive Center Building, 3rd Floor - E310-1 Waterbury, Vermont, 05671-1000
Contact(s):	Shawn Skaflestad, PhD - Quality Improvement Manager (802) 241-0961 Fax: Not available shawn.skaflestad@ahs.state.vt.us
Duration of the Contract:	Current: 2/15/2016-12/31/2021 Prior: 11/15/2007-2/14/2016
Active/Closed:	Active
Scheduled Date for Completion:	12/31/2021
Actual Completion Date:	Contract still ongoing
Total Value:	$790,388
Description of EQR Services Performed for Medicaid Managed Care	
HSAG's EQR activities focus on the programs operated by the statewide managed care entity (MCE) and DHHS of Vermont Health Access (DVHA) through its intergovernmental agreements with AHS departments/divisions and a network of community-based providers. Since 2007, HSAG has performed EQR services for AHS, including:	
CMS MANDATORY EQR ACTIVITIES PERFORMED DURING THE REQUESTED EXPERIENCE PERIOD:	
Compliance Reviews Annually, HSAG reviews compliance with standards and evaluates DVHA's performance with its compliance with the federal Medicaid managed care regulations and AHS-specified intergovernmental agreement requirements and standards. HSAG conducts a desk review of DVHA's documentation and an on-site review of additional documents and interviews with key DVHA management and program staff members. HSAG then prepares a narrative summary report of review findings that includes a presentation and analysis of the findings and performance data/scores, a summary of DVHA's strengths and opportunities for improvement, and recommendations to improve performance related to the quality and timeliness of, and access to, care and services the MCE provides. *Validation of Performance Measures* HSAG validates performance measures that AHS designate. The validation of DVHA's performance measures includes: Evaluating the accuracy of performance measures reported by, or on behalf of, the MCE, and Determining the extent to which the performance measures calculated by DVHA (or the entity acting on behalf of the MCE) followed specifications the state established. HSAG validates data that DVHA reports and assists AHS by preparing measure specifications and the data submission tool the MCE uses to meet annual data collection requirements. Upon completing this activity, HSAG prepares a Validation of Performance Measures Report. *Validation of Performance Improvement Projects (PIPs)* HSAG validates DVHA's PIPs annually. HSAG prepares and submits to AHS and DVHA an annual PIP validation report of its validation activities and DVHA's PIP performance results. *Annual EQR Technical Report* HSAG prepares the EQR technical report in accordance with 42 CFR §438.358. It describes how HSAG aggregated and analyzed the data from all EQR activities and the conclusions drawn as to the quality, timeliness, and access to the care the MCE provides. The report includes objectives, technical methods of data collection and analysis, a description of data obtained, and conclusions drawn from the data. Additionally, the technical report includes an assessment of the MCE's strengths and weaknesses with respect to the quality, timeliness, and access to healthcare services; recommendations for improving performance related to these same aspects of healthcare services; and an assessment of the degree to which DVHA has effectively addressed the recommendations for quality improvement the EQRO made during the previous year's review processes.	

Virginia External Quality Review Services Profile - HSAG Prime Contractor	
Name of Agency/ Address:	Virginia Department of Medical Assistance Services (DMAS) 600 East Broad Street Richmond, Virginia, 23219
Contact(s):	Laura Boutwell, DM, MPH – Director, Office of Quality and Population Health (804) 371-4070 Fax: Not available laura.boutwell@dmas.virginia.gov
Duration of the Contract:	Current: 2/1/2015-1/31/2021 Prior: N/A
Active/Closed:	Active
Scheduled Date for Completion:	1/31/2021
Actual Completion Date:	Contract still ongoing
Total Value:	$6,334,613

Description of EQR Services Performed for Medicaid Managed Care

DMAS awarded HSAG the EQR services contract in October 2014 and implemented the contract on Feb. 1, 2015. The following activities were conducted for six Medicaid managed care organizations (MCOs); for the Title XXI Virginia Children's Health Insurance Program, referred to as Family Access to Medical Insurance Security (FAMIS); and for three participating Medicare-Medicaid plans (MMPs) that provide services for the dual-eligible enrollees in the Financial Alignment Initiative Demonstration, which began in March 2014.

DMAS integrated the tasks for the Medicaid and FAMIS EQR functions under one set of EQR activities (Medallion 3.0) and the Financial Alignment Initiative Demonstration MMPs under a separate EQR set of activities (Commonwealth Coordinated Care [CCC]).

In July 2017, DMAS transitioned from CCC to CCC Plus. CCC Plus-eligible populations include dual-eligibles; non-dual-eligibles who receive long-term services and supports (LTSS); CCC program enrollees; aged, blind, and disabled individuals who do not receive LTSS; and waiver-eligible enrollees who receive nonwaiver services. In 2018, DMAS transitioned Medallion 3.0 to the Medallion 4.0 program, which includes low-income families and children, community mental health services, addiction and recovery treatment services, and value-based purchasing and innovation. On Jan. 1, 2019, DMAS implemented Medicaid expansion for individuals with incomes below 138 percent of the federal poverty level and between the ages of 19 and 64 for both the Medallion 4.0 and CCC Plus programs.

CMS MANDATORY EQR ACTIVITIES PERFORMED DURING THE REQUESTED EXPERIENCE PERIOD:

Compliance Reviews

HSAG conducts comprehensive operational systems reviews for all six MCOs, each with two lines of business (Medallion 4.0 and CCC Plus), and it reviews MCO compliance with specified standards. Using a combination of document review and onsite interviews with MCO personnel, HSAG assesses the MCOs' compliance with the federal managed care requirements/standards and the DMAS MCO contract for the quality and timeliness of, and access to care and services that promote safe and effective healthcare. HSAG produces an MCO-specific report for DMAS and each of the MCOs that encompasses HSAG findings from the review of compliance. The individual reports include a summary of the MCO's strengths and, when applicable, opportunities to improve performance; presentation of the performance results and scores for each standard (set of related requirements) reviewed; a description of HSAG's methodology to prepare for and conduct the reviews; and, as applicable, a template for the MCO to use in preparing its corrective action plan for any requirement where performance was scored as less than Met.

Virginia External Quality Review Services Profile - HSAG Prime Contractor
For the three MMPs in CCC, HSAG conducted a comprehensive on-site operational system review to monitor MMP compliance with the state's contract requirements and the three-way contract among CMS, DMAS, and the MMPs after the first year of operation. The review included a desk review, a WebEx review, and production of the plan-specific reports on the compliance reviews findings. HSAG developed the review tools, methodology, and report template in collaboration with DMAS and CMS. *Validation of Performance Measures* HSAG validates performance measures (PMs), evaluates the accuracy of PMs that Medallion 4.0 and CCC Plus MCOs reported, and determines the extent to which PMs that the MCOs calculated followed DMAS specifications. HSAG produces an MCO-specific report of performance results for DMAS and the MCOs. HSAG also provides DMAS with an annual statewide summary report of performance across the MCOs that includes recommendations to improve performance. HSAG validates MCO-reported administrative measures for performance incentive awards and performance withhold programs along with measures for healthcare needs assessment of members ages 18 and under in foster care or in adoption assistance. For the CCC Plus program, HSAG validates the performance measures the MCOs reported including timely assessments, timely development of the plan of care, documentation of the plan of care goals, and timely submission of adjudicated claim. In 2019, DMAS contracted with HSAG to validate behavioral health performance measures for the Addition, Recovery, and Treatment Services (ARTS) program. *Validation of Performance Improvement Projects (PIPs)* HSAG evaluates the soundness and results of the PIPs that each of the six Medallion 4.0 and the six CCC Plus MCOs implement and produces individual MCO reports for DMAS and the MCOs. The reports encompass HSAG's findings from the PIP validation activities, recommendations to improve the validity of the MCOs PIP processes and, as applicable, performance on the measures. During 2018, DMAS initiated the process of transitioning to rapid-cycle PIPs. *Validation of Network Adequacy* HSAG conducted a network adequacy review to ensure an adequate network was available to provide the spectrum of services for the expansion members in order to determine the MCO's network capacity to provide services to the Medicaid expansion population. HSAG conducted the readiness reviews through a combination of desk reviews and WebEx reviews, and it produced MCO-specific reports of the findings. *Annual EQR Technical Report* HSAG produces separate annual technical reports each year for the Medallion 4.0 and the CCC Plus programs. The reports include an assessment of the MCOs' progress toward the goals outlined in the Virginia Medicaid Managed Care Quality Strategy. The technical reports also assess an MCO's compliance with quality, access, and timeliness of care and services. HSAG enhanced these reports to incorporate the requirements of the updated Medicaid managed care regulations and to align with the program integration components of the third edition of the DMAS quality strategy. The reports discuss best practices and opportunities in which the MCOs could improve performance related to federal and state requirements.
CMS OPTIONAL EQR ACTIVITIES PERFORMED DURING THE REQUESTED EXPERIENCE PERIOD:
Validation of Encounter Data For the 2015-16 contract year, DMAS contracted with HSAG to conduct an EDV study to assist DMAS in developing an encounter data program that effectively monitored the accuracy and completeness of encounter data the MCOs submitted. HSAG submitted the Medallion aggregate report to DMAS on Jan. 29, 2016. Additionally, DMAS contracted with HSAG to provide technical assistance in 2015 to assist the DMAS staff in developing a CCC encounter data program capable of governing the encounter data submission and processing activities, and for monitoring the overall quality of the data.

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Administration/Validation of Member and Provider Surveys

HSAG conducts the annual administration of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey to Family Access to Medicaid Insurance Security (FAMIS) members receiving health care services through Fee-for-Service (FFS) or managed care. HSAG conducts the CAHPS survey for the Medallion 4.0 and the CCC Plus program populations. The CAHPS survey is administered to a statewide sample of FAMIS members, representative of the entire population of children covered by Virginia's Title XXI program (i.e., Children's Health Insurance Program [CHIP] members in FFS or managed care), per the Centers for Medicare & Medicaid Services' (CMS') Children's Health Insurance Program Reauthorization Act (CHIPRA) CAHPS reporting requirements. HSAG draws the sample, administers the survey, analyzes results and produces a survey report. The statewide aggregate report includes the resulting top-box scores which are compared to NCQA's Quality Compass® Benchmark and Compare Quality Data to derive the overall member experience ratings for each measure. Based on this comparison, ratings of one (★) to five (★★★★★) stars are determined for each CAHPS measure, where one is the lowest possible rating and five is the highest possible rating.

HSAG administers the CAHPS 5.0 Child Medicaid Health Plan Survey with the HEDIS® supplemental item set and the Children with Chronic Conditions measurement set to FAMIS members receiving healthcare services through Medicaid fee-for-service (FFS) or managed care. HSAG administers the survey to a statewide sample of FAMIS members who are representative of the entire population of children who Virginia's Title XXI program covers. HSAG performs an analysis of the results and reports aggregate and comparative information.

Calculation of Performance Measures

HSAG calculates measures' scores for managed care performance incentive awards for three HEDIS measures and three process/administrative measures.

Focused Studies

HSAG conducts an annual focused study that provides quantitative information about prenatal care and associated birth outcomes among women with births paid by Title XIX or Title XXI, which include the Medicaid, Family Access to Medical Insurance Security (FAMIS), and FAMIS MOMS programs. HSAG develops the methodology, conducts the analysis, and reports the results. The Contract Birth Outcomes Focused Study addressed the following questions:

- *To what extent do women with births paid by Medicaid receive early and adequate prenatal care?*
- *What clinical outcomes are associated with Medicaid-paid births?*

HSAG conducts a focused study to assess dental utilization among pregnant women covered by the Virginia Medicaid or the FAMIS MOMS program following the expansion of dental services to this population. The focused study assesses dental utilization in the following categories: adjunctive general services, crowns, diagnostic services, endodontics, periodontics, preventive services, prosthodontics, restorative services (including crowns), and surgery or extraction. HSAG develops the methodology, conducts the analysis, and reports the results.

HSAG conducts an annual foster care study that assesses healthcare utilization among children in foster care compared to utilization among children not in foster care who were enrolled with Virginia Medicaid managed care organizations. HSAG develops the methodology, conducts the analysis, and reports the results. HSAG assesses 14 measures, representing 20 study indicators, across the following domains: primary care; oral health; behavioral health; reproductive health; and respiratory health.

Quality Rating System/Consumer Report Card

In 2015, DMAS contracted with HSAG to develop a prototype Consumer Decision Support Tool using Virginia's Medallion MCOs' performance measure data. The 2015 results were for informational purposes only. The 2016 methodology leveraged the 2015 process using HEDIS 2016 performance measure results and 2016 CAHPS data to assess MCO performance related to Doctors' Communication, Getting Care, Keeping Kids Healthy, Living with

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Illness, and Taking Care of Women. The Consumer Decision Support Tool included the MCO accreditation level and emphasized the standard of quality and integrity expected for the contracted MCOs. The tool was published on the DMAS website in 2017. HSAG continues to work with DMAS to update the tool annually.

Technical Assistance and Training

Develop Performance Measures

In 2019, DMAS contracted with HSAG to develop new performance measure specifications and provide technical assistance for the Addiction, Recovery and Treatment Services (ARTS) program for the following topic areas: preferred Office-based opioid treatment; medication assisted treatment; concurrent counseling and pharmacotherapy; neonatal abstinence syndrome; concurrent prescribing of naloxone and high-dose opioids; naloxone use for those at high-risk of overdose and treatment of Hepatitis C for members diagnosed with Hepatitis C and substance use disorder.

Performance Incentive Program (PIA)

From 2016 through 2018, DMAS implemented a Performance Incentive Award (PIA) program for the Medallion MCOs to assess managed care quality. HSAG conducted analyses to evaluate MCO performance using benchmarks and thresholds for various HEDIS measures and measures developed by Virginia and compared the relative level of performance against the performance of the other MCOs. The PIA program was designed to be budget neutral (i.e., the total MCO awards were equal to the total MCO penalties).

Performance Withhold Program

DMAS contracted with HSAG to develop a performance withhold program in 2019 for the Medallion 4.0 and the CCC Plus programs to reinforce value-based payment principles by connecting financial incentives to the quality of care received by Virginia Medicaid managed care members. The performance withhold program was implemented in 2020.

DMAS transitioned to a Performance Withhold Program (PWP) to evaluate the quality of care received by Medicaid managed care members. For the PWP, MCO performance is evaluated on various process and outcome measures that are compared to performance standards set by DMAS. Performance measures were selected that align with the goals of the respective managed care programs and the characteristics of the populations. The measures are from NCQA's HEDIS, CMS' Adult Core Measure Set and the AHRQ's Pediatric Quality Indicators. DMAS retains a one percent quality withhold from each MCO, and MCOs are eligible to earn back all or a portion of their respective quality withhold based on their performance in meeting or exceeding the performance standards and expectations developed by DMAS.

HSAG provides education and technical assistance to DMAS, MCOs, MMPs, and key partners as requested and defined by DMAS.

OTHER ACTIVITIES PERFORMED DURING THE REQUESTED EXPERIENCE PERIOD:

Readiness Reviews

The expansion of CCC to CCC Plus in 2017 required readiness reviews for the six MCOs selected to participate in CCC Plus. HSAG developed the methodology for the managed LTSS readiness review that included the managed care regulatory standards in 42 CFR §438, the Code of Virginia, Virginia Administrative Code, and the readiness review requirements included in the CCC Plus request for proposal. Additionally, HSAG conducted the desk reviews for four standards (Member Rights and Protections, Provider Participation/Credentialing and Program Integrity, Subcontracts and Delegation, and Confidentiality of Health Information). HSAG reviewed the findings with DMAS in preparation for the on-site reviews.

The expansion of Medallion 3.0 to Medallion 4.0 in 2018 required readiness reviews for the six MCOs selected to participate in Medallion 4.0. HSAG developed the methodology for the reviews that included the managed care regulatory standards in 42 CFR §438, the Code of Virginia, Virginia Administrative Code, and the readiness review

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requirements included in the Medallion 4.0 request for proposal. HSAG conducted the readiness reviews through a combination of desk, on-site, and follow-up WebEx reviews. HSAG received, reviewed, and provided recommendations to DMAS regarding MCO corrective action plans for requirements determined not in full compliance. HSAG produced MCO-specific reports of the readiness review findings. Virginia elected to implement Medicaid expansion on Jan. 1, 2019. The Medicaid expansion required readiness reviews for the 12 MCOs providing services to the Medallion 4.0 and CCC Plus populations. HSAG developed the methodology for the readiness reviews that included the managed care regulatory standards in 42 CFR §438, the CMS Medicaid Expansion Gateway Tool, the Code of Virginia, Virginia Administrative Code, and the readiness review requirements included in the Medallion 4.0 and CCC Plus MCO contracts. HSAG also conducted a network adequacy review to ensure that an adequate network was available to provide the spectrum of services for the expansion members and to determine the MCO's network capacity to provide services to the Medicaid expansion population. HSAG conducted the readiness reviews through a combination of desk and WebEx reviews and produced MCO-specific reports of the findings. *Quality Strategy Development/Revision/Evaluation* HSAG assisted in developing the updated three-year DMAS agency-wide quality strategy covering the Medallion programs, CCC Plus, and the DMAS FFS operations. This third edition of the DMAS quality strategy complies with 42 CFR §438.340. After completion of the public comment period, CMS approved the strategy in the fourth quarter of 2017. In 2019 and 2020, HSAG has worked with DMAS to update and revise the Quality Strategy.

ii. Subcontractor's Experience

HSAG does not intend to subcontract any of the proposed work included under the project requirements of the Nebraska EQRO contract. If HSAG determines it necessary to use subcontractors for any future work requested by DHHS, HSAG will obtain DHHS' review and approval.

iii. Work Performed as a Subcontractor

Table 3 describes HSAG's responsibilities as a subcontractor and highlights the similarities between HSAG's experience and the tasks outlined in this RFP. The description includes the following:

- The duration or time period of the subcontract
- The scheduled and actual completion dates of the subcontract
- A description of HSAG's subcontractor responsibilities for the contract
- The customer name, contact person's name, address, phone number, and email address

Table 3: HSAG's EQR Subcontractor Experience

Tennessee External Quality Review Services Profile - HSAG Subcontractor	
Name of Agency/ Address:	Tennessee Bureau of TennCare Qsource 49 Music Square West, Suite 402 Nashville, Tennessee, 37203
Contact(s):	John Couzins (615) 491-7673 Fax: Not available jcouzins@QSource.org
Duration of the Contract:	Current: 10/1/2020-9/30/2025 Prior: 10/1/2005-9/30/2020
Active/Closed:	Active
Scheduled Date for Completion:	9/30/2025
Actual Completion Date:	Contract still ongoing
Total Value:	$4,975,404
Description of EQR Services Performed for Medicaid Managed Care	
The Bureau of TennCare contracts with Qsource, a federally recognized quality improvement organization (QIO), to provide EQR services for the Medicaid managed care organizations (MCOs). HSAG is a subcontractor to Qsource to perform the following:	
CMS MANDATORY EQR ACTIVITIES PERFORMED DURING THE REQUESTED EXPERIENCE PERIOD:	
Compliance Reviews HSAG conducted annual reviews of the dental prepaid ambulatory health plan's (PAHP's) and each MCO's policies, procedures, and processes concerning credentialing and recredentialing, as well as availability and accessibility of services. The evaluation determined if the program encompassed activities required to meet contract compliance and compliance with current industry, federal, and State requirements for Medicaid managed care programs. Tennessee's LTSS CHOICES population was enrolled in managed care in 2010.	

Tennessee External Quality Review Services Profile - HSAG Subcontractor
Validation of Performance Measures HSAG validates performance measures to evaluate the accuracy of TennCare measures the dental PAHP and the MCOs have reported. As part of this task, HSAG reviews the MCOs' data management processes, evaluates the algorithmic compliance, and verifies that the TennCare-specified performance measures are based on accurate source information. Tennessee's LTSS CHOICES population was enrolled in managed care in 2010. In 2014, Tennessee expanded eligibility with the ACA. *Validation of Network Adequacy* HSAG conducts an annual on-site evaluation of provider network adequacy to ensure the dental PAHP and the MCOs have the capacity to provide covered services accessible to members. HSAG evaluates compliance with contract standards for network composition, geographic location, and access and availability. HSAG also validates the MCOs' credentialing and recredentialing activities. Tennessee's LTSS CHOICES population was enrolled in managed care in 2010.

i. Summary of Contractor's Proposed Personnel/Management Approach

In order to be an EQRO, the Contractor must have the following:

i. Medicaid Beneficiaries, Policies, Data Systems and Processes

i. Staff with demonstrated experience and knowledge of Medicaid beneficiaries, policies, data systems and processes;

Since 1997, HSAG has been evaluating healthcare quality, timeliness, and service accessibility for Medicaid beneficiaries. HSAG currently provides EQR or EQR-related activities in 16 states. Having served as a valued EQRO across the country, HSAG understands the critical factors that impact each state's Medicaid managed care program: demographics, geography, availability and accessibility of appropriate providers, available social service resources to serve Medicaid beneficiaries, and managed care entities or other organizations responsible for ensuring care delivery.

HSAG meets federal competence requirements by employing a sufficient number of qualified staff with demonstrated experience and knowledge about Medicaid beneficiaries, policies, data systems, and processes.

Beneficiaries: HSAG has found that critical factors which contribute to the success of each state's Medicaid program include beneficiary demographics, geography, availability and accessibility of appropriate providers, available resources to serve Medicaid beneficiaries, and health plans or other organizations responsible for ensuring care delivery. HSAG staff members stay current with state program changes (e.g., waivers, Medicaid expansion, integration efforts, and value-based purchasing), changes in health plan contractors, changes in program design and eligibility requirements, population-specific characteristics, state health priorities and challenges, and state or federal regulatory changes that impact Medicaid and the Children's Health Insurance Program (CHIP). HSAG also has extensive experience with inaugural implementation of Medicaid managed care programs in these states: Arizona, California, Colorado, Florida, Hawaii, Iowa, Nevada, New Hampshire, and Vermont. HSAG applies this knowledge to its quality assessment and improvement activities and assisting states achieve success when implementing managed care programs.

Policies: To ensure HSAG's EQR activity evaluations comply with Medicaid policies and processes, staff members remain fully informed of the applicable Medicaid laws, regulations, policies, and trends. They keep contracted states informed of national and state issues and standards for Medicaid managed care populations, §1115 and §1915 waivers, and changes in requirements (such as those required by the BBA and the Health Insurance Portability and Accountability Act [HIPAA]). HSAG staff members also monitor state informational sources, such as related state legislation, statutes, regulations, and consent decrees. Furthermore, HSAG staff members remain apprised of industry standards set by NCQA, The Joint Commission, the National Quality Forum (NQF), and the American Medical Association (AMA). HSAG's senior staff members with significant Medicaid policy experience continue to serve on national and local committees, advisory boards, and panels related to Medicaid. The lessons learned and Medicaid policy information gained from HSAG's involvement in these panels and workgroups are shared with HSAG's Medicaid leadership team to benefit EQRO customers.

Data Systems: HSAG's technical competence is evidenced by its work with a variety of Medicaid data systems and data processing procedures. HSAG analysts possess knowledge and extensive experience in managing and analyzing large data sets including claims, encounters, and provider directory data for several state Medicaid agencies, including Colorado, New Hampshire, and Tennessee.

Processes: HSAG has gained in-depth understanding of the varying Medicaid processes employed by states' health plans of all models and types, including managed care and FFS delivery systems as well as accountable care organizations (ACOs), through its EQR work in several states with varying requirements and specifications. HSAG reviews MCOs, prepaid inpatient health plans (PIHPs), PAHPs, and primary care case management (PCCM) programs for compliance with federal requirements and state contract standards in the context of each state's unique requirements and with the overarching knowledge and understanding of the Medicaid managed care principles related to each operational process (e.g., credentialing, service authorization, and provider network development). HSAG's EQRO project team members stay current with the unique program design and health plan contract requirements for each state's program and apply this knowledge to all EQRO activities. HSAG follows the most recent CMS EQR protocols published in October 2019, and will work closely with the State to ensure it completes each EQR activity included in the scope of work consistent with the most current CMS EQR protocols, federal regulations, any applicable toolkits, and in alignment with the State's program goals.

ii. Managed Care Delivery Systems, Organizations and Financing

ii. Staff with demonstrated experience and knowledge of managed care delivery systems, organizations, and financing;

HSAG meets federal competence requirements by employing staff knowledgeable and experienced in managed care delivery systems, organizations, and financing.

Managed Care Delivery Systems and Organizations: As the largest EQRO, HSAG has demonstrated experience working with a variety of delivery systems and health plan models. For example, HSAG has demonstrated experience working with numerous MCOs and behavioral health organizations (BHOs) in multiple states; regional care coordination organizations (RCCOs) and regional accountable entities (RAEs) in Colorado; and Medicaid FFS programs in Arizona, Colorado, Hawaii, and Nevada. HSAG has performed EQR activities and services for numerous unique Medicaid programs that contract with MCOs, PIHPs, PAHPs (usually DBMs), PCCMs, primary care physician programs, care coordination organizations, and ACOs. HSAG's experience includes working with specialty organizations, such as dental health plans; behavioral health plans; health plans providing long-term services and supports; and health plans serving sub-specialty populations, such as persons with intellectual/developmental disabilities, children/youth in foster care, and persons with HIV/AIDS. HSAG staff members possess a breadth of experience to assess, design, and implement EQR activities for a multitude of managed care delivery systems and organization designs, including staff model managed care plans, local or regional initiative models, and county-organized health systems. In addition, many HSAG team members bring direct managed care experience to HSAG when they join the company. This working knowledge of Medicaid managed care processes at the federal, state Medicaid agency, and/or the MCO, PIHP, PAHP, and PCCM levels provides HSAG's customers with a deep understanding of delivery systems and health plan processes, challenges, attributes, and incentives.

Managed Care Financing: Understanding the financing intricacies of Medicaid managed care is an important component of understanding a state's EQR needs. HSAG staff members' knowledge of the capitated and FFS environments, and of incentive payment structures, allows HSAG to make realistic, reasonable recommendations for improvement. Staff members have assisted states in developing quality improvement (QI) strategies consistent with a state's financing mechanism, as well as developing financial incentive programs (e.g., pay-for- performance) based on provider or health plan performance metrics.

iii. Quality Assessment and Improvement Methods

iii. Staff with demonstrated experience and knowledge of quality assessment and improvement methods;

HSAG staff members' competence includes extensive experience with quality assessment and performance improvement methods as well as research design, methodology, and statistical analysis. HSAG has facilitated numerous QI projects to improve the quality, accessibility, and timeliness of care for beneficiaries enrolled in Medicaid or CHIP programs. The HSAG performance improvement project (PIP) team members are subject matter experts with extensive experience implementing QI techniques. The PIP team supports the facilitation of QI projects and PIPs in its EQRO-contracted states, providing training and education to the health plans and state Medicaid agencies on topics such as:

- Performing drill-down analysis of health plan data to identify opportunities for improvement.

- Process mapping.
- Conducting failure modes and effects analysis.
- Small-scale intervention testing using Plan-Do-Study-Act (PDSA) cycles.
- Developing methods for making fundamental change, such as benchmarking and learning from others; using technology; thinking critically, logically, and creatively about the current system; and using change concepts.
- Overcoming QI obstacles.

Collaborative Quality Improvement Experience

HSAG has planned, conducted, and facilitated several statewide collaborative QI projects. These collaborative projects bring together key stakeholders such as health systems, community leaders, emergency departments, healthcare providers, health plans, and beneficiary and family advocates. Steering committees develop and implement community-specific initiatives across the state that involve key care continuum providers and Medicaid beneficiaries.

Working with clients to identify high-quality data sources and calculate benchmarks tailored to their needs and priorities, HSAG has assisted states and their health plans with quality improvement activities and projects for clinical and nonclinical areas. Using quality science tools to guide actions, HSAG has made actionable recommendations for improvement in the care of Medicaid and CHIP beneficiaries in managed care plans. HSAG also has provided guidance and recommendations for future program development to achieve continuous QI in areas such as:

- Reducing avoidable emergency department visits.
- Improving coordination and communication of care between physical and behavioral health plans.
- Improving care for beneficiaries with diabetes.
- Ensuring timely initiation of long-term services and supports (LTSS).
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services and improving childhood immunization rates.
- Improving birth outcomes.

In each of these areas, HSAG assisted with the development, evaluation, and revision of community-based interventions by providing research and recommendations; drafting, reviewing, and revising materials; and providing guidance to finalize implementation. These efforts have included facilitation and participation in stakeholder meetings, and development of workplans to ensure timely implementation. With the guidance of local and national experts, HSAG has developed web-based clinical toolkits to increase standardization of guidelines, enhance provider knowledge, and advance best practices. HSAG also developed accessible, consumer-friendly toolkits to provide a community resource that consumers can use for education and advocacy. These toolkits contain interactive online learning modules on clinical algorithms for prescribers that can be completed for Maintenance of Certification (MOC) or Continuing Medical Education (CME) credits, as well as facts sheets, guides, and resources for parents, consumers, schools, and agencies. HSAG also assists in the ongoing evaluation and

revision of collaborative interventions by using information and outcomes of the QI initiatives.

State Quality Strategy Experience

HSAG has also been instrumental in assisting states with State Quality Strategy development, review, implementation, and evaluation. HSAG stays abreast of CMS requirements for quality strategies and is able to advise states on the development of their quality strategies in accordance with federal guidelines. In addition, HSAG prepares presentations to update states on new regulations affecting the quality strategy.

HSAG assisted Colorado, Hawaii, Illinois, Michigan, Nevada, Tennessee, and Virginia in the initial development of each state's quality assessment and improvement strategy. Specifically, HSAG has made recommendations for improvement in the care of Medicaid and CHIP beneficiaries in managed care health plans. HSAG also has provided guidance and recommendations for future program development to achieve continuous QI. For several states, HSAG has conducted comprehensive evaluations of state quality strategies to determine compliance with the federal Medicaid managed care requirements and to make recommendations on the effectiveness of the quality strategy. HSAG also assists several states in the ongoing evaluation and revision of their quality strategies, using information and outcomes of various quality initiatives as well as the results of the EQR-related activities that HSAG performed.

HEDIS and Other Performance Measure Experience

HSAG has conducted HEDIS Compliance Audits and performance measure validation since 1999, impacting healthcare quality for millions of Medicaid beneficiaries. One of the core principles of HSAG's quality assessment efforts for Medicaid managed care programs is assuring that health plans deliver the highest quality of care based on established standards and requirements. Much of HSAG's monitoring involves compliance with established performance standards such as HEDIS or other performance measures, allowing a cross comparison of the health plans' performance as well as a comparison against national benchmarks. HSAG provides the health plans with information on how to improve performance pertaining to data collection techniques, data completeness, encounter/claims processing, and QI workgroups.

Medical Record Review Experience

Under several EQRO contracts, HSAG conducts focused quality of care and encounter data validation studies using medical record review. HSAG has conducted more than 1 million medical record reviews since it began this activity in 1998. In each of the completed quality of care studies, HSAG used information from enrollee medical records to develop actionable recommendations designed to improve the quality of care that Medicaid/CHIP beneficiaries received. Through its years of experience, HSAG has gained the knowledge to use medical record review to translate healthcare information into activities that improve health outcomes for Medicaid/CHIP populations.

Enrollee and Provider Survey Experience

In developing and administering member and provider surveys of quality and satisfaction, HSAG is an industry leader in measuring the effectiveness of healthcare and has extensive experience in survey management, instrument design, and report development. In 1995, HSAG began to develop health outcomes expertise with surveys that included patient-reported health status, quality of life, and satisfaction. HSAG quickly became a leader in the field by designing and conducting scientifically sound quality-of-life and outcomes studies, as well as in collecting, analyzing, and reporting data for federal and state agencies, managed care plans, hospitals and academic medical centers, and private sector healthcare companies. HSAG's extensive expertise with surveys enables it to efficiently and effectively integrate CAHPS and other survey results with findings from related QI activities to achieve performance improvement. HSAG possesses a wealth of knowledge gleaned from performing CAHPS and related survey work for 16 states both as an EQRO and through other contracts. HSAG has administered more than four million surveys to adult and child Medicaid beneficiaries in an array of programs (including individuals with disabilities, Temporary Assistance for Needy Families [TANF], and CHIP beneficiaries), as well as surveys to evaluate special needs populations, such as the CAHPS Children with Chronic Conditions (CCC) module and Experience of Care and Health Outcomes (ECHO®) 8 Survey.

Encounter Data Validation Experience

HSAG has conducted encounter data evaluations since 2003, including work in physical health, behavioral health, and dental healthcare. HSAG understands that validation of encounter data is critical to ensuring that data submitted are complete, accurate reflections of the care provided to Medicaid/CHIP beneficiaries and that the validation assists states and health plans in developing improvement initiatives so that data are reliable and comparable across all health plans.

iv. Research Design and Methodology

iv. Staff with demonstrated experience and knowledge of research design and methodology, including statistical analysis;

HSAG's Data Science & Advanced Analytics department has extensive experience conducting analytical projects ranging from case review record sampling and statistical analyses to comprehensive clinical and nonclinical research projects. Since 1993, HSAG has been providing services in healthcare informatics, research design, and reporting, including sampling, data management, and statistical analysis. Throughout its long history of administrating quality of care studies, HSAG has gained experience in a variety of study designs, clinical conditions, nonclinical areas of service, process and outcome measures, population characteristics, data collection and processing methodologies, statistical analyses, and provider/payer arrangements. From conducting simple random samples to complex multistage, cluster sampling, and from straightforward performance rates to risk-adjusted, weighted averages, HSAG has experienced analysts who have the knowledge to apply appropriate analytic methods that ensure the highest-quality studies. More importantly, HSAG's analytic team can

translate complex statistical concepts and quantitative and qualitative research into operational goals and standards and improvement activities. One key to HSAG's success has been its knowledge of research principles and analytic methods coupled with the ability to apply them to real-world opportunities for improvement.

v. Physical, Technological, and Financial Resources

v. Physical, technological, and financial resources to conduct EQR or EQR-related activities;

HSAG meets the requirements for maintaining sufficient physical, technological, and financial resources to conduct EQR or EQR-related activities.

Physical and Technological Resources: HSAG has the facilities, support services, and office equipment to conduct all required EQR and EQR-related activities. HSAG's headquarters are in Phoenix, Arizona, and it has satellite offices throughout the country.

Staff members in all locations stay connected through a secure shared network that houses the information system platforms necessary to support HSAG staff in conducting EQR and related activities. Each office location is equipped with sufficient furniture, supplies, information technology software, computers and related equipment, phones, teleconferencing equipment, copiers, fax machines, and report production equipment.

HSAG has a dedicated IT Department staffed with experienced software development and IT professionals that provide phone, network, data, application, and website capabilities and support for HSAG's business operations 24 hours a day, seven days a week. HSAG's high performance IT systems are based on state-of-the-art technology and processes; due to the critical nature of HSAG's business, security and continuous availability, which are foundational tenets in the design and operation of these systems.

Financial Resources: HSAG is a financially sound, woman-owned, employee-owned, well-managed organization. Established in 1979, the company has maintained steady growth and a strong financial position. For fiscal year 2019, HSAG's combined revenues were $114.6 million, giving it the financial strength to maintain the activities and obligations of a contract resulting from an award from the State of Nebraska. HSAG's financial statements are prepared by a certified public accountant, and the organization follows Generally Accepted Accounting Principles. HSAG's financial strength is a result of its ability to balance growth and working capital. The company's sound financial status has provided the solid base upon which it has expanded the number and size of awarded contracts. HSAG has access to a line of credit with a maximum borrowing base of $7.0 million, and its working capital ratio has been well above industry norms for the last several years.

vi. Clinical and Nonclinical Skills

vi. Other clinical and nonclinical skills necessary to carry out EQR or EQR-related activities and to oversee the work of any subcontractors.

HSAG employs both highly skilled clinical and nonclinical personnel to conduct EQR and EQR-related activities and highly qualified management professionals to lead the organization. Mary Ellen Dalton, PhD, MBA, RN, CHCA, president and chief executive officer, has more than 30 years of direct, hands-on and executive-level experience

managing healthcare projects, and employing quality management and improvement methods for Medicaid health plans. Executive Vice President Rick Potter, MBA, CPA, CHCA, brings more than 25 years of leadership experience in, and knowledge of, healthcare quality systems and managed care programs as they relate to performance-based contracting and Medicaid reimbursement systems. Gretchen Thompson, MBA, CPHQ, chief operating officer, state and corporate services, has more than 22 years of experience in healthcare administration and managed care, with specialized expertise in Medicaid and other publicly funded healthcare systems. Ms. Thompson has worked with both public and private entities in 27 states to develop innovative solutions that demonstrate improved quality of care for the population, reduced costs for the program, and improved federal regulatory compliance. Additionally, HSAG's executive team brings extensive administrative, financial, and clinical leadership experience managing multiple contracts simultaneously for state and federal agencies.

All HSAG staff responsible for conducting EQR activities are educated on and competent in the CMS EQR protocol requirements and HSAG's EQR procedures, receive training on any state-specific requirements, and are supervised and supported by senior subject matter experts. Numerous staff members hold advanced degrees, including clinical and nonclinical degrees and/or licenses and certifications. They include registered nurses, social workers, medical doctors, certified coders, certified professionals in healthcare quality (CPHQs), certified HEDIS Compliance Auditors (CHCAs), and PhDs.

Proposed Approach to the Management of the Project

The contractor should present a detailed description of its proposed approach to the management of the project.

HSAG understands that an organized, on-schedule implementation of the operations supporting all EQR activities is critical to DHHS. To support an on-schedule implementation and ongoing effective management of the project, HSAG's approach to manage the project includes creating a Detailed Work Plan that sets the timeline to complete all EQR activities and deliverables on time. In addition, HSAG's EQR management and oversight plan details the structure of the Nebraska EQR project team, the approach to managing tasks and timelines, and details the communication with DHHS as outlined in the draft Communications Plan, shown in Appendix 5: Communications Plan.

Detailed Work Plan

HSAG developed the draft Detailed Work Plan shown in Appendix 6: Work Plan, which includes all EQR activities in the scope of work and details the schedule of activities and tasks, key personnel responsible for completing each activity, and the persons responsible for providing technical assistance to the MCOs and DBM, and DHHS when requested. HSAG's management approach to execute the Detailed Work Plan involves a robust staffing structure that supports project oversight, management of activities and timelines, and regular communication with DHHS.

HSAG EQR Management Plan and Oversight

HSAG has found that ensuring a smooth transition and ongoing success of annual EQR activities starts with a robust staffing structure. Each project team is composed of highly skilled professionals who have a successful history of managing large-scale projects with multiple priorities. Each project activity team is directed by an activity project manager, who is responsible for ensuring that all required tasks are completed in a timely and high-quality manner. The professional skills of HSAG's staff ensure that the overall project director, assistant project director, and designated activity project managers can function at the senior level to manage the overall project and expertly provide technical assistance to the MCOs and DBM. Each EQR project manager supports the project director to effectively:

- Plan upcoming projects and communicate with DHHS.
- Oversee the development and maintenance of the EQR methodology and data collection tools.
- Communicate with MCOs and the DBM and distribute guidance and data collection tools to them.
- Collect MCO and DBM information and data to complete each EQR activity.
- Oversee the completion of each EQR activity, to include analyzing and compiling findings.
- Submit draft EQR reports to DHHS for review and input.
- Finalize EQR reports to submit to DHHS and distribute to MCOs and the DBM.
- Respond to MCO and DBM questions and conduct technical assistance and training with the MCOs and DBM, as requested.
- Annually evaluate and summarize the EQR activities of the previous year and recommend improvements for future years based on industry best practices.

As project director, Kim Elliott, PhD, CPHQ, CHCA, will be responsible and accountable for the project's success and DHHS's satisfaction. Under her direction, task teams and the assistant project director, Kari Vanderslice, MBA, will function to fulfill the requirements of the Nebraska EQR contract, including all EQR activities, weekly meetings, reporting, and communications with DHHS and the MCOs and DBM. Each activity project manager will serve as a subject matter expert and will work jointly with Dr. Elliott to provide DHHS with EQR support, as requested.

Each activity project manager will be accountable for the work of each functional area's team and will report the status of each task to the project director. HSAG's activity project managers will provide DHHS expert advice on Medicaid managed care issues, policies, and national best practices related to the protocol activities they perform. Jointly, the project director and the activity project managers will present DHHS with proactive ideas and suggestions for enhancements, as needed, for problem-solving.

Management of Activities and Timelines

HSAG will prepare and submit the Detailed Work Plan within two weeks of the EQR contract start date. The Detailed Work Plan will include each activity, the schedule and timing of the activity and its defined subtasks, the proposed submission dates for the

deliverables (draft and final), milestones, and the individuals and teams responsible for the activity. Once DHHS' input is received, HSAG will finalize the documents by incorporating the input from DHHS' staff members. The Detailed Work Plan will be a primary tool to manage the Nebraska EQR contract. The project director will monitor the plan and update it as needed. After the first contract year, HSAG will submit a Detailed Work Plan annually within the time frame required by DHHS. The Detailed Work Plan will function as a "roadmap" that delineates each task, inclusive of milestones, deliverables, responsible personnel, and task completion dates for both HSAG and DHHS to follow throughout the EQR contract.

Communication with DHHS

HSAG anticipates there will be numerous forums and mechanisms to communicate with DHHS about activities underway. Most forums will be teleconferences, webinars, or face-to-face meetings and will provide the mechanism for HSAG to communicate the status of EQR activities with DHHS staff members. In addition to working directly with the project director, DHHS' staff members also will have direct access to each EQR activity project manager and are encouraged to maintain direct, regular communication with activity project managers for the duration of the EQR activity. Similarly, HSAG's activity project managers may contact DHHS' staff members to discuss the status of data transfer or other information that might be necessary to complete the activity. HSAG anticipates that, at a minimum, the following types of meetings will occur:

- **Kick-off meeting**—At a time agreed to by DHHS, HSAG will hold a kick-off meeting with DHHS' staff members. This meeting will allow HSAG to introduce its project director, assistant project director, and EQR activity project managers to DHHS' staff members, and to discuss the project objectives, Detailed Work Plan, timelines, and the EQR strategy for each of the tasks scheduled for the first year of the contract. The kick-off meeting also will enable HSAG staff members to clarify DHHS' expectations for each deliverable, gain knowledge regarding the initiatives in progress, obtain DHHS' input for initial and ongoing EQR project timelines and deliverables for the first EQR contract year, and finalize the Detailed Work Plan.
- **Monthly progress meeting**—HSAG's project director will facilitate monthly progress meetings, at a minimum, between DHHS staff members and the EQR activity project managers. DHHS will determine the dates and times for the meetings. The progress meetings will review the status of each EQR activity detailed in DHHS-approved Detailed Work Plan, discuss milestones associated with each activity, and discuss any outstanding issues that have the potential to impact the timeline.
- **Monthly Progress Report**—HSAG will prepare and submit to DHHS, at a minimum, a monthly progress report that will include the status of major activities and tasks in relation to the DHHS-approved EQR Detailed Work Plan. The progress report will provide a status for each activity since the prior period, a status update and target completion dates for remaining and upcoming tasks and activities, and challenges and accomplishments since the prior period. If the need arises to revise the overall

work schedule, the HSAG project director will discuss the need with DHHS and seek approval for a revision.

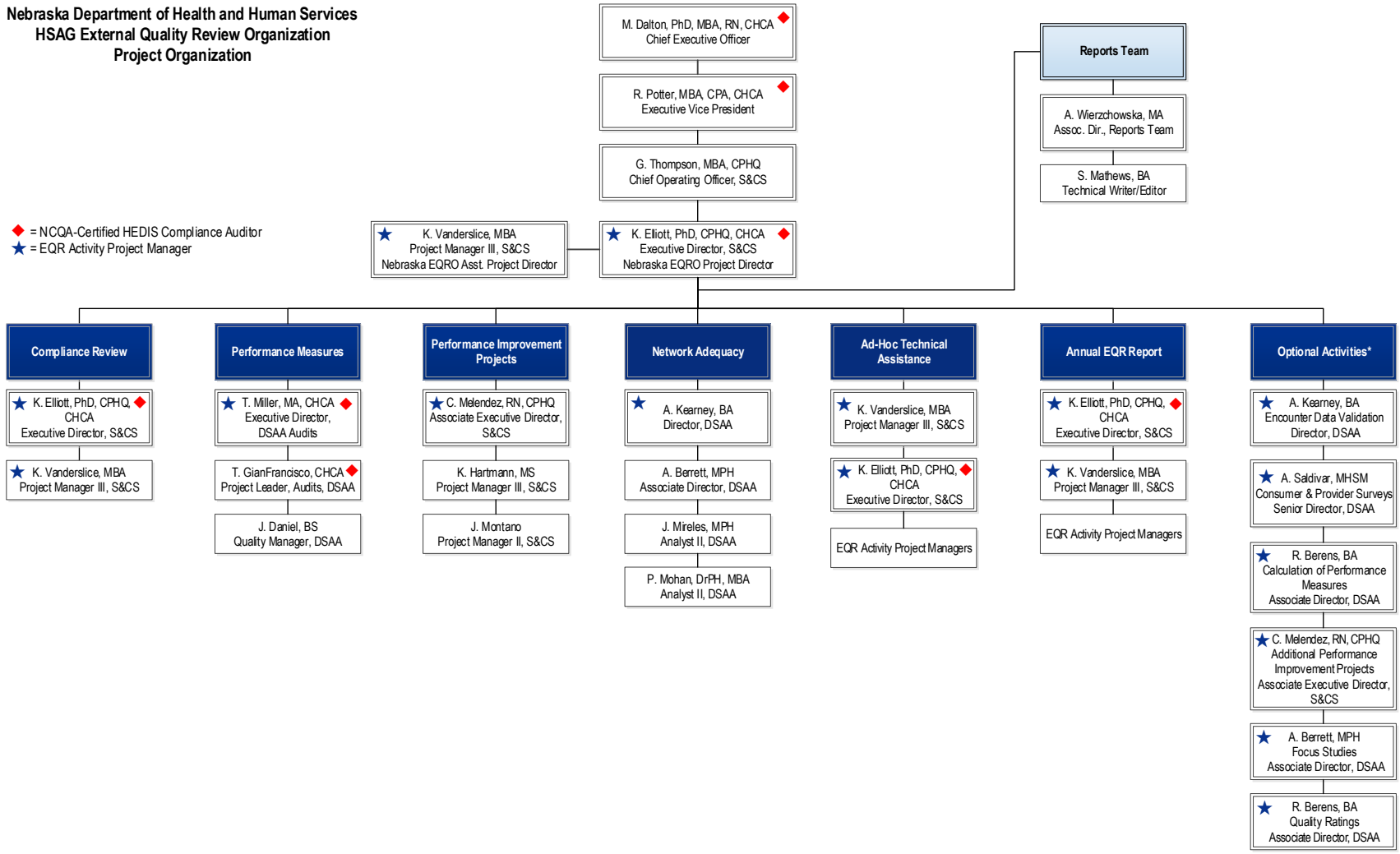
- **Quarterly operational meetings**—HSAG will participate in the quarterly operational meetings with the MCOs and DBM in conjunction with DHHS. HSAG staff members will be prepared to discuss or present agenda topics at the request of DHHS, which may include but not be limited to, providing technical assistance, presenting information and findings from EQR reports and activities, updates to Medicaid managed care regulations or protocols, and facilitating discussions related to improving performance in EQR activities according to best practices.
- **Ad hoc meetings and technical assistance**—To clarify the objectives of any activity requested by DHHS, such as technical assistance for DHHS or MCO or DBM staff members, HSAG will facilitate ad hoc meetings with DHHS' staff. For technical assistance requests related to a specific EQR activity, the project director will forward the information to the EQR activity project manager, who will meet with DHHS staff members to clarify expectations and develop appropriate training materials as required. If HSAG discovers that MCO and/or DBM staff members are struggling with EQR concepts or with meeting data submission requirements, it will notify DHHS and recommend a specific technical assistance or training strategy specific for the MCO/DBM to guide them through the EQR activity. Additionally, the MCOs and DBM can request technical assistance from HSAG at any time during the duration of each EQR activity. For example, the MCOs and DBM may consult with HSAG when developing performance improvement projects, obtain guidance on the interpretation of State and/or federal regulations as part of the compliance review activity, and/or discuss development of appropriate corrective action plans in response to any noted deficiencies identified through the annual EQR or EQR-related activities.

Team Leadership and Staffing Plan

The contractor should identify the specific professionals who will work on the State's project if their company is awarded the contract resulting from this solicitation. The names and titles of the team proposed for assignment to the State project should be identified in full, with a description of the team leadership, interface and support functions, and reporting relationships. The primary work assigned to each person should also be identified.

HSAG has selected its Nebraska EQR project team based on specific qualifications and expertise in providing each EQR activity. All key personnel and staff members chosen to conduct the Nebraska EQRO activities are currently employed by HSAG. Figure 1: HSAG Nebraska EQRO Organization Chart depicts how HSAG staff members are organized to oversee the activities required by the Nebraska EQRO contract. The figure displays the names and titles of the team members assigned to each EQR activity as well as the interface and reporting relationships amongst the teams. EQR activity project managers are designated with a blue star. Staff members with the CHCA designation are designated with a red diamond.

Figure 1: HSAG Nebraska EQRO Organization Chart



* HSAG will provide additional activities and associated resumes upon DHHS' request for optional activities.

Team Leadership

HSAG bases its approach to project management on a matrix style, wherein **Kim Elliott, PhD, CPHQ, CHCA**, will serve as the EQRO project director for the Nebraska EQRO contract and will maintain contract oversight. Dr. Elliott is an executive-level contract manager with 20 years of experience performing Medicaid quality review activities and is authorized to represent HSAG in all matters pertaining to the EQRO contract with DHHS. Working collaboratively with the activity project managers and other key personnel, she ultimately will be responsible and accountable for ensuring that all EQR activities, invoicing, data submission, and reporting meet the requirements the State establishes. Dr. Elliott will be available to communicate with DHHS by telephone and e-mail as requested by DHHS. Dr. Elliott will provide oversight for developing all contract deliverables and will be responsible for the quality of work that project staff members perform. Additionally, Dr. Elliott will lead the annual Compliance Review and Annual EQR Report activities.

Kari Vanderslice, MBA, will serve as the assistant project director on the contract, assisting Dr. Elliott with operational tasks such as meeting agendas and minutes, scheduling, and tracking timelines and deliverables. In conjunction with Dr. Elliott, Ms. Vanderslice will also serve as the lead over the Compliance Review and Annual EQR Report activities. Ms. Vanderslice has over 20 years of experience managing quality improvement and health innovation activities, and her extensive project management experience will help ensure the successful completion of all EQR activities.

The Nebraska EQRO project leadership team will consist of Dr. Elliott, Ms. Vanderslice, and each activity project manager. HSAG activity project managers have the management experience necessary to manage the daily activities for their assigned area and will work closely with the project director and the assistant project director to ensure deliverables are delivered on time and of high quality.

Other key staff members who will serve as Nebraska's EQR Activity Project Managers include:

Thomas Miller, MA, CHCA, will serve as the performance measure project manager responsible for overseeing all performance measure activities. Mr. Miller has more than 20 years' experience in the healthcare industry, with nearly 17 years at HSAG in operations, data analysis, information technology, and auditing across a variety of healthcare delivery systems and payers. His expertise includes management of EQR activities including performance measure validation audits and calculation of Adult and Child Medicaid Core Measures. He will oversee the operations for all performance measure activities and ensure all related goals and objectives, including deliverables and task schedules, are met on time and of high quality.

Christi Melendez, RN, CPHQ, will serve as the PIP project manager responsible for overseeing all PIP related activities. Ms. Melendez has more than 30 years of experience in health care quality improvement, performance improvement projects, technical assistance, on-site training, policies and processes and working directly with Medicaid and Medicare populations. She will oversee the operations for all PIP activities

and ensure all related goals and objectives, including deliverables and task schedules, are met on time and of high quality.

Amy Kearney, BA, will serve as the network adequacy project manager responsible for overseeing all network adequacy validation activities. Ms. Kearney has nearly 30 years of experience in the health care industry, with expertise in Medicaid programs and data. She will oversee the development and completion of all encounter data validation studies, network adequacy activities, and focused studies, as needed, in support of the Nebraska EQRO contract. Ms. Kearny will ensure the completion of assigned analytics tasks according to contract specifications and in accordance with the DHHS budget and requirements.

Amber Saldivar, MHSM, will serve as the project manager for consumer and provider surveys, should this optional activity be requested. Ms. Saldivar has over 15 years of experience in the health care industry, with expertise in research, analysis, and reporting. She will provide oversight in all survey analytic activities including CAHPS, quality of life, and provider surveys, performance measure development and calculations, and summarizing performance variation and trends in metrics.

Ray Berens, BA, will serve as the project manager for calculation of performance measures as well as quality ratings, should either of these optional activities be requested. Mr. Berens has over seven years of experience performing, designing, and overseeing analyses of healthcare performance measure data and calculating performance measures utilizing administrative and CAHPS survey data tools. He will provide oversight in all analytic activities in the areas of performance measure calculations, performance measure reporting, and analysis, if selected for the Nebraska EQRO contract.

Alana Barrett, MPH, will serve as the project manager for focus studies, should this optional activity be requested. Ms. Barrett has more than 14 years of experience in the healthcare and public health industries providing research leadership, analytic expertise and mentoring of staff, and acting as an internal and external liaison for analytic activities by planning, executing, and monitoring studies of healthcare quality among Medicaid beneficiaries. She will over oversee the operations of all focus study activities, if selected, and ensure all related goals and objectives, including deliverables and task schedules, are met on time and of high quality.

Alicja Wierzchowska, MA, will serve as the project manager for the reports team. Ms. Wierzchowska has 20 years of experience in the healthcare industry with expertise in developing, writing, and editing a variety of technical manuals, marketing/advertising literature, journals, and research support data. She has been a member of the HSAG Reports Team since its inception in 2002 and has experience in formatting, editing, and 508 compliance services as well as template development. Ms. Wierzchowska will ensure that all reports and deliverables meet professional standards and are submitted on time and of high quality.

HSAG's Nebraska EQR project team also includes the staff members identified in Figure 1: HSAG Nebraska EQRO Organization Chart, who will support the Activity

Project Managers for each required EQR activity. The project team will communicate and collaborate closely to provide customized EQR services for each state customer while drawing upon the skills, knowledge, and experience conducting similar activities in other states. The ability to coordinate like resources ensures staff members' ongoing learning and exposure to state-of-the-art Medicaid program information as well as to emerging and successful practices in quality assessment and performance improvement across all 16 states for which HSAG provides EQR services.

Knowledge Transfer

By assigning a large, diverse, and experienced team to this project, HSAG will enable knowledge transfer among staff members and teams within its organizational structure to mitigate risks associated with vacancies that could occur. If there is a key staff member vacancy due to termination or resignation, replacement personnel will have, at a minimum, the comparable skills and experience of the predecessor. HSAG will notify the DHHS staff within one (1) business day after initial knowledge of staffing changes. In addition, because of HSAG's "deep bench" of talent, Dr. Elliot will have the authority to allocate and coordinate resources and engage additional resources when positions are vacated for a brief period (e.g., vacations), or when additional resources are needed to meet all of DHHS' requirements.

If it becomes necessary to replace the project director, HSAG will ensure that the replacement is comparably qualified and sufficiently prepared to assume the leadership duties of the contract. To ensure knowledge transfer has occurred and the transition is smooth, a similarly qualified project director will be assisted by the activity project managers and the assistant project director until the new project director is fully prepared to assume the role.

Resumes

The contractor should provide resumes for all personnel proposed by the contractor to work on the project. The State will consider the resumes as a key indicator of the contractor's understanding of the skill mixes required to carry out the requirements of the solicitation in addition to assessing the experience of specific individuals.

Resumes should not be longer than three (3) pages. Resumes should include, at a minimum, academic background and degrees, professional certifications, understanding of the process, and at least three (3) references (name, address, and telephone number) who can attest to the competence and skill level of the individual. Any changes in proposed personnel shall only be implemented after written approval from the State.

Appendix 7: HSAG Staff Resumes includes the resumes for all staff members proposed for the Nebraska EQR contract. For each staff member, resumes include the staff member's academic background and degrees, professional certifications, understanding of the process, and at least three (3) references who can attest to the competence and skill level of the individual.

j. Subcontractors

If the contractor intends to Subcontract any part of its performance hereunder, the contractor should provide:
i. name, address, and telephone number of the Subcontractor(s);
ii. specific tasks for each Subcontractor(s);
iii. percentage of performance hours intended for each Subcontract; and
iv. total percentage of Subcontractor(s) performance hours.

HSAG does not intend to subcontract any of the proposed work included under the project requirements of the Nebraska EQRO contract. If HSAG determines it necessary to use subcontractors for any future work requested by DHHS, HSAG will provide DHHS with the required information and will not move forward with any subcontractor without DHHS' approval.

Completed Sections II.–IV.— Terms and Conditions, Contractor Duties, Payment

II. TERMS AND CONDITIONS

Contractors should complete Sections II through VI as part of their proposal. Contractor is expected to read the Terms and Conditions and should initial either accept, reject, or reject and provide alternative language for each clause. The contractor should also provide an explanation of why the contractor rejected the clause or rejected the clause and provided alternate language. By signing the solicitation, contractor is agreeing to be legally bound by all the accepted terms and conditions, and any proposed alternative terms and conditions submitted with the proposal. The State reserves the right to negotiate rejected or proposed alternative language. If the State and contractor fail to agree on the final Terms and Conditions, the State reserves the right to reject the proposal. The State of Nebraska is soliciting proposals in response to this solicitation. The State of Nebraska reserves the right to reject proposals that attempt to substitute the contractor's commercial contracts and/or documents for this solicitation.

The contractors should submit with their proposal any license, user agreement, service level agreement, or similar documents thatthe contractor wants incorporated in the Contract. The State will not consider incorporation of any document not submitted with the contractor's proposal as the document will not have been included in the evaluation process. These documents shall be subject to negotiation and will be incorporated as addendums if agreed to by the Parties.

If a conflict or ambiguity arises after the Addendum to Contract Award have been negotiated and agreed to, the Addendum to Contract Award shall be interpreted as follows:

1. If only one Party has a particular clause then that clause shall control;
2. If both Parties have a similar clause, but the clauses do not conflict, the clauses shall be read together;
3. If both Parties have a similar clause, but the clauses conflict, the State's clause shall control.

A. GENERAL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
MED			

The contract resulting from this solicitation shall incorporate the following documents:

1. Request for Proposal and Addenda;
2. Amendments to the solicitation;
3. Questions and Answers;
4. Contractor's proposal (Solicitation and properly submitted documents);
5. The executed Contract and Addendum One to Contract, if applicable; and,
6. Amendments/Addendums to the Contract.

These documents constitute the entirety of the contract.

Unless otherwise specifically stated in a future contract amendment, in case of any conflict between the incorporated documents, the documents shall govern in the following order of preference with number one (1) receiving preference over all other documents and with each lower numbered document having preference over any higher numbered document: 1) Amendment to the executed Contract with the most recent dated amendment having the highest priority, 2) executed Contract and any attached Addenda, 3) Amendments to solicitation and any Questions and Answers, 4) the original solicitation document and any Addenda, and 5) the Contractor's submitted Proposal.

Any ambiguity or conflict in the contract discovered after its execution, not otherwise addressed herein, shall be resolved in accordance with the rules of contract interpretation as established in the State of Nebraska.

B. **NOTIFICATION**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
MED			

Contractor and State shall identify the contract manager who shall serve as the point of contact for the executed contract.

Communications regarding the executed contract shall be in writing and shall be deemed to have been given if delivered personally or mailed, by U.S. Mail, postage prepaid, return receipt requested, to the parties at their respective addresses set forth below, or at such other addresses as may be specified in writing by either of the parties. All notices, requests, or communications shall be deemed effective upon personal delivery or five (5) calendar days following deposit in the mail.

Either party may change its address for notification purposes by giving notice of the change, and setting forth the new address and an effective date.

C. **NOTICE (POC)**

The State reserves the right to appoint a Buyer's Representative to manage [or assist the Buyer in managing] the contract on behalf of the State. The Buyer's Representative will be appointed in writing, and the appointment document will specify the extent of the Buyer's Representative authority and responsibilities. If a Buyer's Representative is appointed, the Contractor will be provided a copy of the appointment document, and is expected to cooperate accordingly with the Buyer's Representative. The Buyer's Representative has no authority to bind the State to a contract, amendment, addendum, or other change or addition to the contract.

D. **GOVERNING LAW (Statutory)**

Notwithstanding any other provision of this contract, or any amendment or addendum(s) entered into contemporaneously or at a later time, the parties understand and agree that, (1) the State of Nebraska is a sovereign state and its authority to contract is therefore subject to limitation by the State's Constitution, statutes, common law, and regulation; (2) this contract will be interpreted and enforced under the laws of the State of Nebraska; (3) any action to enforce the provisions of this agreement must be brought in the State of Nebraska per state law; (4) the person signing this contract on behalf of the State of Nebraska does not have the authority to waive the State's sovereign immunity, statutes, common law, or regulations; (5) the indemnity, limitation of liability, remedy, and other similar provisions of the final contract, if any, are entered into subject to the State's Constitution, statutes, common law, regulations, and sovereign immunity; and, (6) all terms and conditions of the final contract, including but not limited to the clauses concerning third party use, licenses, warranties, limitations of liability, governing law and venue, usage verification, indemnity, liability, remedy or other similar provisions of the final contract are entered into specifically subject to the State's Constitution, statutes, common law, regulations, and sovereign immunity.

The Parties must comply with all applicable local, state and federal laws, ordinances, rules, orders, and regulations.

E. **BEGINNING OF WORK**

The contractor shall not commence any billable work until a valid contract has been fully executed by the State and the successful Contractor. The Contractor will be notified in writing when work may begin.

F. **AMENDMENT**

This Contract may be amended in writing, within scope, upon the agreement of both parties.

G. **CHANGE ORDERS OR SUBSTITUTIONS**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
MED			

The State and the Contractor, upon the written agreement, may make changes to the contract within the general scope of the solicitation. Changes may involve specifications, the quantity of work, or such other items as the State may find necessary or desirable. Corrections of any deliverable, service, or work required pursuant to the contract shall not be deemed a change. The Contractor may not claim forfeiture of the contract by reasons of such changes.

The Contractor shall prepare a written description of the work required due to the change and an itemized cost sheet for the change. Changes in work and the amount of compensation to be paid to the Contractor shall be determined in accordance with applicable unit prices if any, a pro-rated value, or through negotiations. The State shall not incur a price increase for changes that should have been included in the Contractor's proposal, were foreseeable, or result from difficulties with or failure of the Contractor's proposal or performance.

No change shall be implemented by the Contractor until approved by the State, and the Contract is amended to reflect the change and associated costs, if any. If there is a dispute regarding the cost, but both parties agree that immediate implementation is necessary, the change may be implemented, and cost negotiations may continue with both Parties retaining all remedies under the contract and law.

In the event any product is discontinued or replaced upon mutual consent during the contract period or prior to delivery, the State reserves the right to amend the contract or purchase order to include the alternate product at the same price.

*****Contractor will not substitute any item that has been awarded without prior written approval of SPB*****

H. **VENDOR PERFORMANCE REPORT(S)**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
MSD			

The State may document any instance(s) of products or services delivered or performed which exceed or fail to meet the terms of the purchase order, contract, and/or solicitation specifications. The State Purchasing Bureau may contact the Vendor regarding any such report. Vendor performance report(s) will become a part of the permanent record of the Vendor.

I. **NOTICE OF POTENTIAL CONTRACTOR BREACH**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
MSD			

If Contractor breaches the contract or anticipates breaching the contract, the Contractor shall immediately give written notice to the State. The notice shall explain the breach or potential breach, a proposed cure, and may include a request for a waiver of the breach if so desired. The State may, in its discretion, temporarily or permanently waive the breach. By granting a waiver, the State does not forfeit any rights or remedies to which the State is entitled by law or equity, or pursuant to the provisions of the contract. Failure to give immediate notice, however, may be grounds for denial of any request for a waiver of a breach.

J. **BREACH**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
MD			

Either Party may terminate the contract, in whole or in part, if the other Party breaches its duty to perform its obligations under the contract in a timely and proper manner. Termination requires written notice of default and a thirty (30) calendar day (or longer at the non-breaching Party's discretion considering the gravity and nature of the default) cure period. Said notice shall be delivered by Certified Mail, Return Receipt Requested, or in person with proof of delivery. Allowing time to cure a failure or breach of contract does not waive the right to immediately terminate the contract for the same or different contract breach which may occur at a different time. In case of default of the Contractor, the State may contract the service from other sources and hold the Contractor responsible for any excess cost occasioned thereby. OR In case of breach by the Contractor, the State may, without unreasonable delay, make a good faith effort to make a reasonable purchase or contract to purchased goods in substitution of those due from the contractor. The State may recover from the Contractor as damages the difference between the costs of covering the breach. Notwithstanding any clause to the contrary, the State may also recover the contract price together with any incidental or consequential damages defined in UCC Section 2-715, but less expenses saved in consequence of Contractor's breach.

The State's failure to make payment shall not be a breach, and the Contractor shall retain all available statutory remedies and protections.

K. **NON-WAIVER OF BREACH**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
MD			

The acceptance of late performance with or without objection or reservation by a Party shall not waive any rights of the Party nor constitute a waiver of the requirement of timely performance of any obligations remaining to be performed.

L. **SEVERABILITY**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
MD			

If any term or condition of the contract is declared by a court of competent jurisdiction to be illegal or in conflict with any law, the validity of the remaining terms and conditions shall not be affected, and the rights and obligations of the parties shall be construed and enforced as if the contract did not contain the provision held to be invalid or illegal.

M. **INDEMNIFICATION**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
MG			

1. GENERAL
The Contractor agrees to defend, indemnify, and hold harmless the State and its employees, volunteers, agents, and its elected and appointed officials ("the indemnified parties") from and against any and all third party claims, liens, demands, damages, liability, actions, causes of action, losses, judgments, costs, and expenses of every nature, including investigation costs and expenses, settlement costs, and attorney fees and expenses ("the claims"), sustained or asserted against the State for personal injury, death, or property loss or damage, arising out of, resulting from, or attributable to the willful misconduct, negligence, error, or omission of the Contractor, its employees, Subcontractors, consultants, representatives, and agents, resulting from this contract, except to the extent such Contractor liability is attenuated by any action of the State which directly and proximately contributed to the claims.

2. INTELLECTUAL PROPERTY
The Contractor agrees it will, at its sole cost and expense, defend, indemnify, and hold harmless the indemnified parties from and against any and all claims, to the extent such claims arise out of, result from, or are attributable to, the actual or alleged infringement or misappropriation of any patent, copyright, trade secret, trademark, or confidential information of any third party by the Contractor or its employees, Subcontractors, consultants, representatives, and agents; provided, however, the State gives the Contractor prompt notice in writing of the claim. The Contractor may not settle any infringement claim that will affect the State's use of the Licensed Software without the State's prior written consent, which consent may be withheld for any reason.

If a judgment or settlement is obtained or reasonably anticipated against the State's use of any intellectual property for which the Contractor has indemnified the State, the Contractor shall, at the Contractor's sole cost and expense, promptly modify the item or items which were determined to be infringing, acquire a license or licenses on the State's behalf to provide the necessary rights to the State to eliminate the infringement, or provide the State with a non-infringing substitute that provides the State the same functionality. At the State's election, the actual or anticipated judgment may be treated as a breach of warranty by the Contractor, and the State may receive the remedies provided under this solicitation.

3. PERSONNEL
The Contractor shall, at its expense, indemnify and hold harmless the indemnified parties from and against any claim with respect to withholding taxes, worker's compensation, employee benefits, or any other claim, demand, liability, damage, or loss of any nature relating to any of the personnel, including subcontractor's and their employees, provided by the Contractor.

4. SELF-INSURANCE
The State of Nebraska is self-insured for any loss and purchases excess insurance coverage pursuant to Neb. Rev. Stat. § 81-8,239.01 (Reissue 2008). If there is a presumed loss under the provisions of this agreement, Contractor may file a claim with the Office of Risk Management pursuant to Neb. Rev. Stat. §§ 81-8,829 – 81-8,306 for review by the State Claims Board. The State retains all rights and immunities under the State Miscellaneous (Section 81-8,294), Tort (Section 81-8,209), and Contract Claim Acts (Section 81-8,302), as outlined in Neb. Rev. Stat. § 81-8,209 et seq. and under any other provisions of law and accepts liability under this agreement to the extent provided by law.

5. ALL REMEDIES AT LAW
Nothing in this agreement shall be construed as an indemnification by one Party of the other for liabilities of a Party or third parties for property loss or damage or death or personal injury arising out of and during the performance of this contract. Any liabilities or claims for property loss or damages or for death or personal injury by a Party or its agents, employees, contractors or assigns or by third persons, shall be determined according to applicable law.

6. The Parties acknowledge that Attorney General for the State of Nebraska is required by statute to represent the legal interests of the State, and that any provision of this indemnity clause is subject to the statutory authority of the Attorney General.

N. **ATTORNEY'S FEES**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
MED			

In the event of any litigation, appeal, or other legal action to enforce any provision of the contract, the Parties agree to pay all expenses of such action, as permitted by law and if ordered by the court, including attorney's fees and costs, if the other Party prevails.

O. **ASSIGNMENT, SALE, OR MERGER**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
MED			

Either Party may assign the contract upon mutual written agreement of the other Party. Such agreement shall not be unreasonably withheld.

The Contractor retains the right to enter into a sale, merger, acquisition, internal reorganization, or similar transaction involving Contractor's business. Contractor agrees to cooperate with the State in executing amendments to the contract to allow for the transaction. If a third party or entity is involved in the transaction, the Contractor will remain responsible for performance of the contract until such time as the person or entity involved in the transaction agrees in writing to be contractually bound by this contract and perform all obligations of the contract.

P. **CONTRACTING WITH OTHER NEBRASKA POLITICAL SUB-DIVISIONS OF THE STATE OR ANOTHER STATE**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
MED			

The Contractor may, but shall not be required to, allow agencies, as defined in Neb. Rev. Stat. §81-145, to use this contract. The terms and conditions, including price, of the contract may not be amended. The State shall not be contractually obligated or liable for any contract entered into pursuant to this clause. A listing of Nebraska political subdivisions may be found at the website of the Nebraska Auditor of Public Accounts.

The Contractor may, but shall not be required to, allow other states, agencies or divisions of other states, or political subdivisions of other states to use this contract. The terms and conditions, including price, of this contract shall apply to any such contract, but may be amended upon mutual consent of the Parties. The State of Nebraska shall not be contractually or otherwise obligated or liable under any contract entered into pursuant to this clause. The State shall be notified if a contract is executed based upon this contract.

Q. **FORCE MAJEURE**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
MED			

Neither Party shall be liable for any costs or damages, or for default resulting from its inability to perform any of its obligations under the contract due to a natural or manmade event outside the control and not the fault of the affected Party ("Force Majeure Event"). The Party so affected shall immediately make a written request for relief to the other Party, and shall have the burden of proof to justify the request. The other Party may grant the relief requested; relief may not be unreasonably withheld. Labor disputes with the impacted Party's own employees will not be considered a Force Majeure Event.

R. **CONFIDENTIALITY**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
MED			

All materials and information provided by the Parties or acquired by a Party on behalf of the other Party shall be regarded as confidential information. All materials and information provided or acquired shall be handled in accordance with federal and state law, and ethical standards. Should said confidentiality be breached by a Party, the Party shall notify the other Party immediately of said breach and take immediate corrective action.

It is incumbent upon the Parties to inform their officers and employees of the penalties for improper disclosure imposed by the Privacy Act of 1974, 5 U.S.C. 552a. Specifically, 5 U.S.C. 552a (i)(1), which is made applicable by 5 U.S.C. 552a (m)(1), provides that any officer or employee, who by virtue of his/her employment or official position has possession of or access to agency records which contain individually identifiable information, the disclosure of which is prohibited by the Privacy Act or regulations established thereunder, and who knowing that disclosure of the specific material is prohibited, willfully discloses the material in any manner to any person or agency not entitled to receive it, shall be guilty of a misdemeanor and fined not more than $5,000.

S. **OFFICE OF PUBLIC COUNSEL (Statutory)**
If it provides, under the terms of this contract and on behalf of the State of Nebraska, health and human services to individuals; service delivery; service coordination; or case management, Contractor shall submit to the jurisdiction of the Office of Public Counsel, pursuant to Neb. Rev. Stat. §§ 81-8,240 et seq. This section shall survive the termination of this contract.

T. **LONG-TERM CARE OMBUDSMAN (Statutory)**
Contractor must comply with the Long-Term Care Ombudsman Act, per Neb. Rev. Stat. §§ 81-2237 et seq. This section shall survive the termination of this contract.

U. **EARLY TERMINATION**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
MED			

The contract may be terminated as follows:

1. The State and the Contractor, by mutual written agreement, may terminate the contract at any time.

2. The State, in its sole discretion, may terminate the contract for any reason upon thirty (30) calendar days written notice to the Contractor. Such termination shall not relieve the Contractor of warranty or other service obligations incurred under the terms of the contract. In the event of termination the Contractor shall be entitled to payment, determined on a pro rata basis, for products or services satisfactorily performed or provided.

3. The State may terminate the contract immediately for the following reasons:

   a. if directed to do so by statute;
   b. Contractor has made an assignment for the benefit of creditors, has admitted in writing its inability to pay debts as they mature, or has ceased operating in the normal course of business;
   c. a trustee or receiver of the Contractor or of any substantial part of the Contractor's assets has been appointed by a court;
   d. fraud, misappropriation, embezzlement, malfeasance, misfeasance, or illegal conduct pertaining to performance under the contract by its Contractor, its employees, officers, directors, or shareholders;
   e. an involuntary proceeding has been commenced by any Party against the Contractor under any one of the chapters of Title 11 of the United States Code and (i) the proceeding has been pending for at least sixty (60) calendar days; or (ii) either the Contractor has consented, either expressly or by operation of law, to the entry of an order for relief; or (iii) the Contractor has been decreed or adjudged a debtor;
   f. a voluntary petition has been filed by the Contractor under any of the chapters of Title 11 of the United States Code;
   g. Contractor intentionally discloses confidential information;
   h. Contractor has or announces it will discontinue support of the deliverable; and,
   i. In the event funding is no longer available.

V. CONTRACT CLOSEOUT

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
MKD			

Upon contract closeout for any reason the Contractor shall within 30 days, unless stated otherwise herein:

1. Transfer all completed or partially completed deliverables to the State;
2. Transfer ownership and title to all completed or partially completed deliverables to the State;
3. Return to the State all information and data, unless the Contractor is permitted to keep the information or data by contract or rule of law. Contractor may retain one copy of any information or data as required to comply with applicable work product documentation standards or as are automatically retained in the course of Contractor's routine back up procedures;
4. Cooperate with any successor Contactor, person or entity in the assumption of any or all of the obligations of this contract;
5. Cooperate with any successor Contactor, person or entity with the transfer of information or data related to this contract;
6. Return or vacate any state owned real or personal property; and,
7. Return all data in a mutually acceptable format and manner.

Nothing in this Section should be construed to require the Contractor to surrender intellectual property, real or personal property, or information or data owned by the Contractor for which the State has no legal claim.

III. CONTRACTOR DUTIES

A. INDEPENDENT CONTRACTOR / OBLIGATIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
MED			

It is agreed that the Contractor is an independent contractor and that nothing contained herein is intended or should be construed as creating or establishing a relationship of employment, agency, or a partnership.

The Contractor is solely responsible for fulfilling the contract. The Contractor or the Contractor's representative shall be the sole point of contact regarding all contractual matters.

The Contractor shall secure, at its own expense, all personnel required to perform the services under the contract. The personnel the Contractor uses to fulfill the contract shall have no contractual or other legal relationship with the State; they shall not be considered employees of the State and shall not be entitled to any compensation, rights or benefits from the State, including but not limited to, tenure rights, medical and hospital care, sick and vacation leave, severance pay, or retirement benefits.

By-name personnel commitments made in the Contractor's proposal shall not be changed without the prior written approval of the State. Replacement of these personnel, if approved by the State, shall be with personnel of equal or greater ability and qualifications.

All personnel assigned by the Contractor to the contract shall be employees of the Contractor or a subcontractor, and shall be fully qualified to perform the work required herein. Personnel employed by the Contractor or a subcontractor to fulfill the terms of the contract shall remain under the sole direction and control of the Contractor or the subcontractor respectively.

With respect to its employees, the Contractor agrees to be solely responsible for the following:

1. Any and all pay, benefits, and employment taxes and/or other payroll withholding;
2. Any and all vehicles used by the Contractor's employees, including all insurance required by state law;
3. Damages incurred by Contractor's employees within the scope of their duties under the contract;
4. Maintaining Workers' Compensation and health insurance that complies with state and federal law and submitting any reports on such insurance to the extent required by governing law;
5. Determining the hours to be worked and the duties to be performed by the Contractor's employees; and,
6. All claims on behalf of any person arising out of employment or alleged employment (including without limit claims of discrimination alleged against the Contractor, its officers, agents, or subcontractors or subcontractor's employees)

If the Contractor intends to utilize any subcontractor, the subcontractor's level of effort, tasks, and time allocation should be clearly defined in the contractor's proposal. The Contractor shall agree that it will not utilize any subcontractors not specifically included in its proposal in the performance of the contract without the prior written authorization of the State.

The State reserves the right to require the Contractor to reassign or remove from the project any Contractor or subcontractor employee.

Contractor shall insure that the terms and conditions contained in any contract with a subcontractor does not conflict with the terms and conditions of this contract.

The Contractor shall include a similar provision, for the protection of the State, in the contract with any Subcontractor engaged to perform work on this contract.

B. **EMPLOYEE WORK ELIGIBILITY STATUS**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
MED			

The Contractor is required and hereby agrees to use a federal immigration verification system to determine the work eligibility status of employees physically performing services within the State of Nebraska. A federal immigration verification system means the electronic verification of the work authorization program authorized by the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, 8 U.S.C. 1324a, known as the E-Verify Program, or an equivalent federal program designated by the United States Department of Homeland Security or other federal agency authorized to verify the work eligibility status of an employee.

If the Contractor is an individual or sole proprietorship, the following applies:

1. The Contractor must complete the United States Citizenship Attestation Form, available on the Department of Administrative Services website at http://das.nebraska.gov/materiel/purchasing.html
2. The completed United States Attestation Form should be submitted with the solicitation response.
3. If the Contractor indicates on such attestation form that he or she is a qualified alien, the Contractor agrees to provide the US Citizenship and Immigration Services documentation required to verify the Contractor's lawful presence in the United States using the Systematic Alien Verification for Entitlements (SAVE) Program.
4. The Contractor understands and agrees that lawful presence in the United States is required and the Contractor may be disqualified or the contract terminated if such lawful presence cannot be verified as required by Neb. Rev. Stat. §4-108.

C. **COMPLIANCE WITH CIVIL RIGHTS LAWS AND EQUAL OPPORTUNITY EMPLOYMENT / NONDISCRIMINATION (Statutory)**

The Contractor shall comply with all applicable local, state, and federal statutes and regulations regarding civil rights laws and equal opportunity employment. The Nebraska Fair Employment Practice Act prohibits Contractors of the State of Nebraska, and their Subcontractors, from discriminating against any employee or applicant for employment, with respect to hire, tenure, terms, conditions, compensation, or privileges of employment because of race, color, religion, sex, disability, marital status, or national origin (Neb. Rev. Stat. §48-1101 to 48-1125). The Contractor guarantees compliance with the Nebraska Fair Employment Practice Act, and breach of this provision shall be regarded as a material breach of contract. The Contractor shall insert a similar provision in all Subcontracts for goods and services to be covered by any contract resulting from this solicitation.

D. **COOPERATION WITH OTHER CONTRACTORS**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
MED			

Contractor may be required to work with or in close proximity to other contractors or individuals that may be working on same or different projects. The Contractor shall agree to cooperate with such other contractors or individuals, and shall not commit or permit any act which may interfere with the performance of work by any other contractor or individual. Contractor is not required to compromise Contractor's intellectual property or proprietary information unless expressly required to do so by this contract.

E. **DISCOUNTS**

Prices quoted shall be inclusive of ALL trade discounts. Cash discount terms of less than thirty (30) days will not be considered as part of the proposal. Cash discount periods will be computed from the date of receipt of a properly executed claim voucher or the date of completion of delivery of all items in a satisfactory condition, whichever is later.

F. **PRICES**

Prices quoted shall be net, including transportation and delivery charges fully prepaid by the contractor, F.O.B. destination named in the solicitation. No additional charges will be allowed for packing, packages, or partial delivery costs. When an arithmetic error has been made in the extended total, the unit price will govern.

All prices, costs, and terms and conditions submitted in the proposal shall remain fixed and valid commencing on the opening date of the proposal until the contract terminates or expires.

The State reserves the right to deny any requested price increase. No price increases are to be billed to any State Agencies prior to written amendment of the contract by the parties.

The State will be given full proportionate benefit of any decreases for the term of the contract.

G. **COST CLARIFICATION**

The State reserves the right to review all aspects of cost for reasonableness and to request clarification of any proposal where the cost component shows significant and unsupported deviation from industry standards or in areas where detailed pricing is required.

H. **PERMITS, REGULATIONS, LAWS**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
MED			

The contract price shall include the cost of all royalties, licenses, permits, and approvals, whether arising from patents, trademarks, copyrights or otherwise, that are in any way involved in the contract. The Contractor shall obtain and pay for all royalties, licenses, and permits, and approvals necessary for the execution of the contract. The Contractor must guarantee that it has the full legal right to the materials, supplies, equipment, software, and other items used to execute this contract.

I. **OWNERSHIP OF INFORMATION AND DATA / DELIVERABLES**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
MED			

The State shall have the unlimited right to publish, duplicate, use, and disclose all information and data developed or obtained by the Contractor on behalf of the State pursuant to this contract.

The State shall own and hold exclusive title to any deliverable developed as a result of this contract. Contractor shall have no ownership interest or title, and shall not patent, license, or copyright, duplicate, transfer, sell, or exchange, the design, specifications, concept, or deliverable.

J. **INSURANCE REQUIREMENTS**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
MED			

The Contractor shall throughout the term of the contract maintain insurance as specified herein and provide the State a current Certificate of Insurance/Acord Form (COI) verifying the coverage. The Contractor shall not commence work on the contract until the insurance is in place. If Contractor subcontracts any portion of the Contract the Contractor must, throughout the term of the contract, either:

1. Provide equivalent insurance for each subcontractor and provide a COI verifying the coverage for the subcontractor;
2. Require each subcontractor to have equivalent insurance and provide written notice to the State that the Contractor has verified that each subcontractor has the required coverage; or,
3. Provide the State with copies of each subcontractor's Certificate of Insurance evidencing the required coverage.

The Contractor shall not allow any Subcontractor to commence work until the Subcontractor has equivalent insurance. The failure of the State to require a COI, or the failure of the Contractor to provide a COI or require subcontractor insurance shall not limit, relieve, or decrease the liability of the Contractor hereunder.

In the event that any policy written on a claims-made basis terminates or is canceled during the term of the contract or within two (2) years of termination or expiration of the contract, the contractor shall obtain an extended discovery or reporting period, or a new insurance policy, providing coverage required by this contract for the term of the contract and two (2) years following termination or expiration of the contract.

If by the terms of any insurance a mandatory deductible is required, or if the Contractor elects to increase the mandatory deductible amount, the Contractor shall be responsible for payment of the amount of the deductible in the event of a paid claim.

Notwithstanding any other clause in this Contract, the State may recover up to the liability limits of the insurance policies required herein.

1. **WORKERS' COMPENSATION INSURANCE**
   The Contractor shall take out and maintain during the life of this contract the statutory Workers' Compensation and Employer's Liability Insurance for all of the contactors' employees to be engaged in work on the project under this contract and, in case any such work is sublet, the Contractor shall require the Subcontractor similarly to provide Worker's Compensation and Employer's Liability Insurance for all of the Subcontractor's employees to be engaged in such work. This policy shall be written to meet the statutory requirements for the state in which the work is to be performed, including Occupational Disease. **The policy shall include a waiver of subrogation in favor of the State. The COI shall contain the mandatory COI subrogation waiver language found hereinafter**. The amounts of such insurance shall not be less than the limits stated hereinafter. For employees working in the State of Nebraska, the policy must be written by an entity authorized by the State of Nebraska Department of Insurance to write Workers' Compensation and Employer's Liability Insurance for Nebraska employees.

2. **COMMERCIAL GENERAL LIABILITY INSURANCE AND COMMERCIAL AUTOMOBILE LIABILITY INSURANCE**
   The Contractor shall take out and maintain during the life of this contract such Commercial General Liability Insurance and Commercial Automobile Liability Insurance as shall protect Contractor and any Subcontractor performing work covered by this contract from claims for damages for bodily injury, including death, as well as from claims for property damage, which may arise from operations under this contract, whether such operation be by the Contractor or by any Subcontractor or by anyone directly or indirectly employed by either of them, and the amounts of such insurance shall not be less than limits stated hereinafter.

   The Commercial General Liability Insurance shall be written on an **occurrence basis**, and provide Premises/Operations, Products/Completed Operations, Independent Contractors, Personal Injury, and Contractual Liability coverage. **The policy shall include the State, and others as required by the contract documents, as Additional Insured(s). This policy shall be primary, and any insurance or self-insurance carried by the State shall be considered secondary and non-contributory. The COI shall contain the mandatory COI liability waiver language found hereinafter.** The Commercial Automobile Liability Insurance shall be written to cover all Owned, Non-owned, and Hired vehicles.

REQUIRED INSURANCE COVERAGE	
COMMERCIAL GENERAL LIABILITY	
General Aggregate	$2,000,000
Products/Completed Operations Aggregate	$2,000,000
Personal/Advertising Injury	$1,000,000 per occurrence
Bodily Injury/Property Damage	$1,000,000 per occurrence
Medical Payments	$10,000 any one person
Damage to Rented Premises (Fire)	$50,000 each occurrence
Contractual	Included
Independent Contractors	Included
Abuse & Molestation	Included
If higher limits are required, the Umbrella/Excess Liability limits are allowed to satisfy the higher limit.	
WORKER'S COMPENSATION	
Employers Liability Limits	$500K/$500K/$500K
Statutory Limits- All States	Statutory - State of Nebraska
Voluntary Compensation	Statutory
COMMERCIAL AUTOMOBILE LIABILITY	
Bodily Injury/Property Damage	$1,000,000 combined single limit
Include All Owned, Hired & Non-Owned Automobile liability	Included
Motor Carrier Act Endorsement	Where Applicable
UMBRELLA/EXCESS LIABILITY	
Over Primary Insurance	$1,000,000 per occurrence
CYBER LIABILITY	
Breach of Privacy, Security Breach, Denial of Service, Remediation, Fines and Penalties	$1,000,000
Includes Non-Owned Disposal Sites	
MANDATORY COI SUBROGATION WAIVER LANGUAGE	
"Workers' Compensation policy shall include a waiver of subrogation in favor of the State of Nebraska."	
MANDATORY COI LIABILITY WAIVER LANGUAGE	
"Commercial General Liability & Commercial Automobile Liability policies shall name the State of Nebraska as an Additional Insured and the policies shall be primary and any insurance or self-insurance carried by the State shall be considered secondary and non-contributory as additionally insured."	

4. EVIDENCE OF COVERAGE

The Contractor shall furnish the Contract Manager, with a certificate of insurance coverage complying with the above requirements prior to beginning work at:

Department of Health and Human Services
Division of Medicaid and Long-Term Care
Attn: EQRO Contract Manager
301 Centennial Mall S., 5th floor
Lincoln, NE 68509

These certificates or the cover sheet shall reference the RFP number, and the certificates shall include the name of the company, policy numbers, effective dates, dates of expiration, and amounts and types of coverage afforded. If the State is damaged by the failure of the Contractor to maintain such insurance, then the Contractor shall be responsible for all reasonable costs properly attributable thereto.

Reasonable notice of cancellation of any required insurance policy must be submitted to the contract manager as listed above when issued and a new coverage binder shall be submitted immediately to ensure no break in coverage.

5. DEVIATIONS

The insurance requirements are subject to limited negotiation. Negotiation typically includes, but is not necessarily limited to, the correct type of coverage, necessity for Workers' Compensation, and the type of automobile coverage carried by the Contractor.

K. **ANTITRUST**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
MED			

The Contractor hereby assigns to the State any and all claims for overcharges as to goods and/or services provided in connection with this contract resulting from antitrust violations which arise under antitrust laws of the United States and the antitrust laws of the State.

L. **CONFLICT OF INTEREST**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
MED			

By submitting a proposal, bidder certifies that no relationship exists between the bidder and any person or entity which either is, or gives the appearance of, a conflict of interest related to this Request for Proposal or project.

Bidder further certifies that bidder will not employ any individual known by bidder to have a conflict of interest nor shall bidder take any action or acquire any interest, either directly or indirectly, which will conflict in any manner or degree with the performance of its contractual obligations hereunder or which creates an actual or appearance of conflict of interest.

If there is an actual or perceived conflict of interest, bidder shall provide with its proposal a full disclosure of the facts describing such actual or perceived conflict of interest and a proposed mitigation plan for consideration. The State will then consider such disclosure and proposed mitigation plan and either approve or reject as part of the overall bid evaluation.

M. **STATE PROPERTY**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
MED			

The Contractor shall be responsible for the proper care and custody of any State-owned property which is furnished for the Contractor's use during the performance of the contract. The Contractor shall reimburse the State for any loss or damage of such property; normal wear and tear is expected.

N. **SITE RULES AND REGULATIONS**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
MKD			

The Contractor shall use its best efforts to ensure that its employees, agents, and Subcontractors comply with site rules and regulations while on State premises. If the Contractor must perform on-site work outside of the daily operational hours set forth by the State, it must make arrangements with the State to ensure access to the facility and the equipment has been arranged. No additional payment will be made by the State on the basis of lack of access, unless the State fails to provide access as agreed to in writing between the State and the Contractor.

O. **ADVERTISING**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
MKD			

The Contractor agrees not to refer to the contract award in advertising in such a manner as to state or imply that the company or its goods or services are endorsed or preferred by the State. Any publicity releases pertaining to the project shall not be issued without prior written approval from the State.

P. **NEBRASKA TECHNOLOGY ACCESS STANDARDS (Statutory)**
Contractor shall review the Nebraska Technology Access Standards, found at https://nitc.nebraska.gov/standards and ensure that products and/or services provided under the contract are in compliance or will comply with the applicable standards to the greatest degree possible. In the event such standards change during the Contractor's performance, the State may create an amendment to the contract to request the contract comply with the changed standard at a cost mutually acceptable to the parties.

Q. **DISASTER RECOVERY/BACK UP PLAN**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
MKD			

The Contractor shall have a disaster recovery and back-up plan, of which a copy should be provided upon request to the State, which includes, but is not limited to equipment, personnel, facilities, and transportation, in order to continue delivery of goods and services as specified under the specifications in the contract in the event of a disaster.

R. **DRUG POLICY**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
MKD			

Contractor certifies it maintains a drug free work place environment to ensure worker safety and workplace integrity. Contractor agrees to provide a copy of its drug free workplace policy at any time upon request by the State.

S. **WARRANTY**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
MeD			

Despite any clause to the contrary, the Contractor represents and warrants that its services hereunder shall be performed by competent personnel and shall be of professional quality consistent with generally accepted industry standards for the performance of such services and shall comply in all respects with the requirements of this Agreement. For any breach of this warranty, the Contractor shall, for a period of ninety (90) days from performance of the service, perform the services again, at no cost to Customer, or if Contractor is unable to perform the services as warranted, Contractor shall reimburse Customer the fees paid to Contractor for the unsatisfactory services. The rights and remedies of the parties under this warranty are in addition to any other rights and remedies of the parties provided by law or equity, including, without limitation actual damages, and, as applicable and awarded under the law, to a prevailing party, reasonable attorneys' fees and costs.

IV. PAYMENT

A. **PROHIBITION AGAINST ADVANCE PAYMENT (Statutory)**
Neb. Rev. Stat. §§81-2403 states, "[n]o goods or services shall be deemed to be received by an agency until all such goods or services are completely delivered and finally accepted by the agency."

B. **TAXES (Statutory)**
The State is not required to pay taxes and assumes no such liability as a result of this solicitation. The Contractor may request a copy of the Nebraska Department of Revenue, Nebraska Resale or Exempt Sale Certificate for Sales Tax Exemption, Form 13 for their records. Any property tax payable on the Contractor's equipment which may be installed in a state-owned facility is the responsibility of the Contractor

C. **INVOICES**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
MED			

Invoices for payments must be submitted by the Contractor to the agency requesting the services with sufficient detail to support payment. **Contractor shall submit invoices to the DHHS Contract Manager for payment at the fixed rate for services provided in accordance with the Contractor's statement of work upon completion of deliverables. Contractor shall submit invoices within thirty (30) calendar days following the date of deliverable completion and no later than thirty (30) calendar days following the end of each contract term.** The terms and conditions included in the Contractor's invoice shall be deemed to be solely for the convenience of the parties. No terms or conditions of any such invoice shall be binding upon the State, and no action by the State, including without limitation the payment of any such invoice in whole or in part, shall be construed as binding or estopping the State with respect to any such term or condition, unless the invoice term or condition has been previously agreed to by the State as an amendment to the contract.

D. **INSPECTION AND APPROVAL**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
MED			

Final inspection and approval of all work required under the contract shall be performed by the designated State officials.

The State and/or its authorized representatives shall have the right to enter any premises where the Contractor or Subcontractor duties under the contract are being performed, and to inspect, monitor or otherwise evaluate the work being performed. All inspections and evaluations shall be at reasonable times and in a manner that will not unreasonably delay work.

E. **PAYMENT (Statutory)**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
MED			

Payment will be made by the responsible agency in compliance with the State of Nebraska Prompt Payment Act (See Neb. Rev. Stat. §81-2403). The State may require the Contractor to accept payment by electronic means such as ACH deposit. In no event shall the State be responsible or liable to pay for any goods and services provided by the Contractor prior to the Effective Date of the contract, and the Contractor hereby waives any claim or cause of action for any such services.

F. **LATE PAYMENT (Statutory)**
The Contractor may charge the responsible agency interest for late payment in compliance with the State of Nebraska Prompt Payment Act (See Neb. Rev. Stat. §81-2401 through 81-2408).

G. **SUBJECT TO FUNDING / FUNDING OUT CLAUSE FOR LOSS OF APPROPRIATIONS (Statutory)**
The State's obligation to pay amounts due on the Contract for a fiscal years following the current fiscal year is contingent upon legislative appropriation of funds. Should said funds not be appropriated, the State may terminate the contract with respect to those payments for the fiscal year(s) for which such funds are not appropriated. The State will give the Contractor written notice thirty (30) calendar days prior to the effective date of termination. All obligations of the State to make payments after the termination date will cease. The Contractor shall be entitled to receive just and equitable compensation for any authorized work which has been satisfactorily completed as of the termination date. In no event shall the Contractor be paid for a loss of anticipated profit.

H. **RIGHT TO AUDIT (First Paragraph is Statutory)**
The State shall have the right to audit the Contractor's performance of this contract upon a thirty (30) days' written notice. Contractor shall utilize generally accepted accounting principles, and shall maintain the accounting records, and other records and information relevant to the contract (Information) to enable the State to audit the contract. (Neb. Rev. Stat. §84-304 et seq.) The State may audit and the Contractor shall maintain, the Information during the term of the contract and for a period of five (5) years after the completion of this contract or until all issues or litigation are resolved, whichever is later. The Contractor shall make the Information available to the State at Contractor's place of business or a location acceptable to both Parties during normal business hours. If this is not practical or the Contractor so elects, the Contractor may provide electronic or paper copies of the Information. The State reserves the right to examine, make copies of, and take notes on any Information relevant to this contract, regardless of the form or the Information, how it is stored, or who possesses the Information. Under no circumstance will the Contractor be required to create or maintain documents not kept in the ordinary course of contractor's business operations, nor will contractor be required to disclose any information, including but not limited to product cost data, which is confidential or proprietary to contractor.

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:
MLD			

The Parties shall pay their own costs of the audit unless the audit finds a previously undisclosed overpayment by the State. If a previously undisclosed overpayment exceeds one-half of one percent (0.5%) of the total contract billings, or if fraud, material misrepresentations, or non-performance is discovered on the part of the Contractor, the Contractor shall reimburse the State for the total costs of the audit. Overpayments and audit costs owed to the State shall be paid within ninety (90) days of written notice of the claim. The Contractor agrees to correct any material weaknesses or condition found as a result of the audit.

Completed Attachment 1— Technical Approach Narrative

ATTACHMENT 1

TECHNICAL APPROACH NARRATIVE

Instructions: *Please complete all sections titled "Bidder Response" in the Technical Approach Narrative below. File should retain a minimum of 12 point Arial-type font with 1" margins. This form does not replace the Corporate Overview Narrative, which must be submitted as a separate narrative.*

V.C. Business Requirements	
Section	Description
V.C.1.	Describe how Bidder meets or exceeds the independence requirements of this section.

Bidder Response:

HSAG Exceeds Independence Requirements

Health Services Advisory Group, Inc. (HSAG) is independent from the State of Nebraska, Department of Health and Human Services (DHHS), and the three Managed Care Organizations (MCOs) and the Dental Benefits Manager (DBM) that will be reviewed. HSAG fully meets the competence qualifications and independence requirements for an external quality review organization (EQRO) set forth in 42 CFR §438.354, as required by the Social Security Act [42 USC 1932(c)(2)] for external independent review of all managed care entities (MCEs), which include MCOs and the DBM. Specifically, HSAG is not a State agency, department, university, or other State entity and does not have Medicaid purchasing or managed care licensing authority. None of the members of the HSAG board of directors is a government employee. In addition, HSAG does not:

1. Exert control over, or has control exerted over it, by the MCOs and DBM that will operate in Nebraska through stock ownership; stock options and convertible debentures; voting trusts; common management, including interlocking management; or contractual relationships (as used here, "control" has the meaning given in 48 CFR §19.101 as referenced in 42 CFR §438.354[c][2][i]);
2. Deliver any health care services to Medicaid enrollees;

3. Conduct, on the State's behalf, ongoing Medicaid managed care program operations related to oversight of the quality of each MCO and DBM services, except for the related activities specified in 42 CFR §438.358;
4. Conduct accreditation reviews for MCOs and the DBM (described in §438.310[c][2]); or
5. Have a present or known future direct or indirect financial relationship with the MCOs or DBM that it will review as an EQRO.

Additionally, HSAG meets the standards for the current federal Centers for Medicare & Medicaid Services (CMS) protocols used for external quality review (EQR) activities to determine each MCO's and DBM's compliance with federal regulations and the DHHS contract provisions relative to the quality, appropriateness, timeliness of, and access to health care services provided to all Nebraska Medicaid enrollees under MCO or DBM contracts. Moreover, CMS recognizes HSAG as an EQRO as confirmed in *CMS' Table 1. External Quality Review Organizations with State Medicaid Contracts in 2018-2019,* available under EQR Annual Reporting at *Quality of Care External Quality Review Medicaid.gov.*

In addition to ensuring it meets the independence requirements, HSAG takes special care to prevent actual, potential, and/or apparent personal conflicts of interest. HSAG executives, board of directors, directors, managers, key personnel, and subcontractors must disclose any potential or perceived personal conflict of interest annually and report any changes to HSAG's compliance officer within 30 days. There are no business relationships or financial interests for HSAG, or relationships of the company's officers, directors, managers, or key personnel, that would cause any actual, apparent, or potential conflicts of interest with the Nebraska EQRO contract scope of work.

V.C.2.	Describe how Bidder meets or exceeds the non-duplication requirements of this section and ensures mandatory activities with Medicare or accreditation review are not duplicated.

Bidder Response:

HSAG Exceeds the Non-Duplication Requirements and Ensures Mandatory Activities within Medicare or Accreditation are Not Duplicated

HSAG has worked with multiple state Medicaid agencies applying nonduplication to the compliance review activity for more than a decade and, in alignment with the 2016 Medicaid Managed Care Final Rule, has expanded nonduplication efforts to include the validation of Performance Improvement Measures (PIPs) and performance measures.

In accordance with the guidance CMS has issued in the CMS EQR Protocols, and as set forth in 42 CFR §438.360, DHHS has the option to use information from a Medicare or private accreditation review of an MCO or DBM in place of generating that information through one or more of the three mandatory EQR-related activities (Validation of

Performance Improvement Projects, Validation of Performance Measures, and Review of Compliance with Medicaid Managed Care Regulations), when all of the following conditions are met:

- The MCO and/or DBM is in compliance with the applicable Medicare Advantage or private accreditation standards;
- The Medicare or private accreditation review standards are comparable to those established through the EQR protocols for the three mandatory EQR-related activities; and
- The MCO and/or DBM provides DHHS with all applicable reports, findings, and other results of the Medicare or private accreditation review applicable to the specified EQR-related activities.

This option to states is referred to as nonduplication. Because DHHS has elected to exercise the nonduplication option, it must document in its managed care quality strategy the EQR-related activities for which it will use nonduplication along with the rationale for its determination that the Medicare or private accreditation review standards are comparable to those in the EQR protocols.

In efforts to reduce the administrative burden on the MCOs and the DBM, while still ensuring it has relevant information available for the annual EQR, HSAG will work with DHHS to obtain the reports, findings, and other results from the Medicare or private accreditation review for each MCO and DBM. HSAG will then assess the information to determine the extent of nonduplication across each allowable EQR activity, as well as for each MCO and DBM.

To determine the extent of nonduplication, HSAG will leverage its extensive experience working with numerous state Medicaid agencies to tailor a methodology for Nebraska that will assess comparability between current federal Medicaid managed care regulations and Medicare and private accreditation program standards, such as the accreditation requirements imposed by the National Committee for Quality Assurance (NCQA). For example, since the MCOs and DBM are NCQA-accredited, HSAG will use, for the compliance with standards activity, the most current NCQA Medicaid Managed Care Crosswalk to assess whether each NCQA accreditation standard has met the relevant regulation in the Code of Federal Regulations (CFR) under the following standards:

- 42 CFR Subpart D: §438.206, Availability of Services; §438.207, Assurances of Adequate Capacity and Services; §438.208, Coordination and Continuity of Care; §438.210, Coverage and Authorization of Services; §438.214, Provider Selection; §438.224, Confidentiality; §438.228, Grievance and Appeal Systems; §438.230, Subcontractual Relationships and Delegation; §438.236, Practice Guidelines; and §438.242, Health Information Systems.
- 42 CFR Subpart E: §438.330, Quality Assessment and Performance Improvement Program.

HSAG will create a crosswalk table that identifies the relevant NCQA standards and the regulatory requirements set forth in 42 CFR Subpart D and the Quality Assessment and Performance Improvement Program requirement under 42 CFR §438.330, as listed above. HSAG will then complete a comprehensive review of the NCQA Medicaid Managed Care Crosswalk; the Medicaid managed care regulations related to access, structure and operations, and measurement

and improvement standards; and the prior EQR nonduplication reports, as available. HSAG will then create crosswalk tables using the relevant NCQA standards and the Medicaid managed care regulations that align with the availability of services, assurances of adequate capacity and services, coordination and continuity of care, coverage and authorization of services, provider selection, confidentiality, grievance and appeal systems, subcontractual relationships and delegation, practice guidelines, health information systems, and quality assessment and performance improvement program standards. HSAG will use the crosswalk information to determine the percentage of comparability of NCQA standards to the Medicaid managed care regulations and identify those regulations that CMS considers eligible for nonduplication.

As a result of this comprehensive nonduplication review, HSAG will make recommendations on the accreditation and standards found to be comparable with the Medicaid managed care regulations and eligible for nonduplication. HSAG will complete and/or update, as appropriate, a crosswalk of federal and State program requirements with NCQA accreditation and will submit this crosswalk and a summary report detailing HSAG's findings and recommendations to DHHS. Table V.C.2.a provides an excerpt from a crosswalk, while table V.C.2.b provides an example of an excerpt from a nonduplication crosswalk summary report.

Table V.C.2.a— Nonduplication Crosswalk

CFR Regulation	NCQA Standard	NCQA Description	HSAG's Evaluation of the Percentage of Elements Met by NCQA Standards	Comments
§438.207 (a) *Basic rule.* The State must ensure, through its contracts, that each MCO gives assurances to the State and provides supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area, in accordance with the State's standards for access to care under this subpart.	None	None	0%	NCQA: State Function—not reviewed as part of accreditation standards.

CFR Regulation	NCQA Standard	NCQA Description	HSAG's Evaluation of the Percentage of Elements Met by NCQA Standards	Comments
§438.207 (b) *Nature of supporting documentation.* Each MCO must submit documentation to the State, in a format specified by the State, to demonstrate that it complies with the following requirements: (1) Offers an appropriate range of preventive, primary care, and specialty services that is adequate for the anticipated number of enrollees for the service area.	NET 1: Availability of Practitioners	The organization maintains sufficient numbers and types of primary care, behavioral health, and specialty care practitioners in its network.	100%	NCQA: Met

Table V.C.2.b.— Crosswalk Summary Report

CFR Area	Number of CFR Requirements Eligible for Nonduplication	Number of NCQA Standards 100% Comparable with CFRs
Availability of Services	11	7
Assurances of Adequate Capacity and Services	5	1
Coordination and Continuity of Care	10	0
Coverage and Authorization of Services	7	3

HSAG will review its overall findings and recommendations with DHHS, and at DHHS' direction, will determine the final standards and elements accepted under EQR so duplication does not occur. HSAG will then evaluate each MCO's and the DBM's accreditation findings and results to determine if the individual MCO or DBM meets the criteria for the specific standard and element to be excluded from review during the EQR activity. Before excluding any element from review, HSAG will work with DHHS to determine if the exclusion is appropriate. For example, if an MCO received a noncompliance action in a particular program area, DHHS may determine that the standard or a related element should not be excluded from review even though the MCO passed the NCQA requirements, since the MCO exhibited poor performance in that area.

Similar to the compliance review activity, HSAG will assess the validation of performance improvement projects and validation of performance measure activities to determine components within these EQR activities where DHHS can exercise the nonduplication option, ultimately reducing the administrative burden to the MCOs and DBM and DHHS.

Before implementing any nonduplication efforts, HSAG will review Nebraska's quality strategy for the Heritage Health and Dental Benefit Program and will work with DHHS to ensure the quality strategy is updated to reflect the specific EQR-related activities for which it will use nonduplication along with DHHS' rationale for its determination that the Medicare or private accreditation standards are comparable to standards specified in the relevant EQR protocol(s).

V.D. Project Requirements	
V.D.1.	Describe the Bidder's use of the required protocols of this section and Bidder's approach to ensure current protocols are utilized in performance of duties under this contract.

Bidder Response:

Use of the Required Protocols

Since the inception of the first set of protocols issued in 2002, HSAG has complied with the guidance CMS has published to conduct both mandatory and optional activities described in 42 CFR §438.358. Serving as a long-standing partner to CMS, HSAG staff members have provided input to CMS in its quest to revise protocols in 2012 and again in 2019. Recently, HSAG staff members were invited to participate with CMS and its subcontractor, Mathematica, to discuss content related to validation of network adequacy so CMS may draft a protocol related to the mandatory activity, validation of MCO, prepaid inpatient health plans (PIHP), or DBM network adequacy. In each of the states where HSAG serves as an EQRO, HSAG conducts each EQR activity in accordance with the most current set of protocols issued by CMS. As the EQRO for DHHS, HSAG will conduct all mandatory and requested optional EQR-related activities and the

annual EQR consistent with the October 2019 published EQR protocols, or the most current version if CMS publishes a newer version during any contract year.

Approach to Ensure Current Protocols Utilized

On an ongoing basis, and with any revisions to the protocols, HSAG project directors and EQR project managers evaluate existing EQR activity processes, procedures, and tools to ensure consistency with the protocols and to implement any efficiencies and best practices noted through HSAG's experience working with its 16 state Medicaid agencies in conducting EQR activities. All HSAG staff members who conduct EQR activities are educated on and are competent in the most current CMS EQR protocol requirements and HSAG-developed EQR processes, procedures, and tools. Often HSAG is made aware of changes to protocols, or new protocols, prior to the protocols being issued since CMS staff members outreach to HSAG to be involved in the process for ongoing review, revision, or new protocol development. HSAG's highly qualified and experienced staff members provide input to CMS during this process and thus are able to stay informed prior to the protocols being made public.

Before conducting any mandatory or optional EQR-related activity, HSAG will schedule a meeting with DHHS staff members to discuss the overall scope of the EQR activity and HSAG's proposed approach to completing the activity and addressing both DHHS' specific needs and the distinctive aspects of Nebraska's managed care environment, as well as complying with the most current activity-specific EQR protocol. Based on DHHS feedback during this meeting, HSAG will develop a comprehensive methodology document that will describe the data collection methods and tools it will use to ensure information is collected with both reliability and validity. The methodology document will be sent to DHHS for approval before HSAG implements the EQR activity.

V.D.2.a.	Describe the Bidder's approach to conducting an annual external quality review of the MCOs and PAHP in Nebraska, and how the approach meets or exceeds the requirements of this RFP.

Bidder Response:

Approach to Conducting an Annual External Quality Review of MCOs and PAHP

Within two weeks of contract initiation, and subsequently at the beginning of each contract year, HSAG will provide DHHS with a Detailed Work Plan that will ensure mandatory EQR activities set forth in 42 CFR §438.358(b) and any optional activities under 42 CFR §438.358(c), as well as any activities requested by DHHS, are completed within the appropriate time frames so the activity-specific data and results can be included in the annual EQR. HSAG will use the Detailed Work Plan to ensure it delivers the annual EQR and the resulting EQR technical report to DHHS no later than October 15 of each year.

HSAG will use the results of the mandatory EQR activities, as described in 42 CFR §438.358(b) and as conducted in accordance with methodologies consistent with the CMS EQR protocols, to assess the performance related to the quality and timeliness of, and access to, care and services that the three Nebraska MCOs and the prepaid ambulatory health plan (PAHP) referred to as the DBM provide to Medicaid enrollees. The purpose of these activities is to provide valid and reliable data and information about each MCO's and the DBM's performance. HSAG will use the findings from the following EQR activities to derive conclusions and make recommendations about the quality and timeliness of, and access to, care and services provided by each MCO and the DBM:

- **Validation of Performance Improvement Projects (PIPs):** HSAG's validation of each MCO's and the DBM's PIPs to ensure that the projects were designed, conducted, and reported in a methodologically sound manner, allowing real improvements in care and giving confidence in the reported improvements. HSAG also will include results from each MCO's and the DBM's Medicare and/or private accreditation review standards in the assessment, when appropriate.
- **Validation of Performance Measures:** HSAG's validation and/or the analysis of the data collection and reporting processes the MCOs and the DBM use to report data for DHHS-required performance measures. The EQR shall include HSAG's review and analysis on MCO- and DBM-specific and statewide aggregated Healthcare Effectiveness Data and Information Set (HEDIS®)[1] data. HSAG also will include in the assessment, when appropriate, results from each MCO's and the DBM's Medicare and/or private accreditation review standards in the assessment.
- **Compliance Review:** HSAG's comprehensive review of each MCO's and the DBM's compliance with all federally mandated Medicaid managed care standards and their associated state-specific requirements, when applicable. HSAG also will include results from each MCO's and the DBM's Medicare and/or private accreditation review standards in the assessment, when appropriate.
- **Validation of Network Adequacy:** HSAG will include the Validation of Network Adequacy activity results in the annual EQR no later than one year from the issuance of Protocol 4, or sooner at the direction of DHHS. HSAG will evaluate the results describing each MCO's and the DBM's provider network capacity to determine whether there is a sufficient network of providers to provide enrollees with adequate access to all covered services.

To provide DHHS and CMS with a more robust assessment of the Medicaid managed care program, and to identify all potential opportunities for quality improvement, HSAG will include in the annual EQR, upon DHHS' request, any optional EQR activity results conducted by DHHS, HSAG, or another entity over the preceding 12 months.

[1] HEDIS® is a registered trademark of NCQA.

To summarize the information gleaned from the annual EQR, HSAG will produce an annual EQR technical report. In the report, HSAG will compare and analyze the overall findings and conclusions of EQR activities for all MCOs and the DBM to develop overarching conclusions and recommendations for the Heritage Health program in the annual detailed EQR technical report. HSAG will provide technical assistance to DHHS, as well as the MCOs and the DBM, to ensure understanding of the findings and conclusions and to help implement the recommendations, as applicable. Throughout the year, HSAG will meet regularly with DHHS staff members, MCOs, and the DBM to ensure EQR activities remain on track according to the approved Detailed Work Plan.

How Approach Exceeds Requirements of the RFP

HSAG has adopted and adapted its EQR methods not only to be consistent with CMS protocols but to be responsive to the developmental level and changing needs of each state's Medicaid program and its participating MCOs and the DBM. HSAG has found that in some of its contracted states, the level of sophistication related to certain EQR activities, such as compliance reviews, has exceeded state expectations for federal and state contractual compliance; however, performance measure results did not yield significant improvement. While the components of EQR activities are designed to work together to inform states, Medicaid members, and relevant stakeholders about the quality, timeliness, and access to services furnished to Medicaid members, high performance in one component does not necessarily indicate high performance in another. In response to this, HSAG facilitates a more progressive level of involvement by the MCO, DBM, and state staff members to improve MCO and DBM performance, as well as managed care program performance overall. These activities may include, but not be limited to:

- Inviting MCOs and the DBM to present corrective action plans that demonstrate an MCO's or DBM's systematic changes to address deficiencies and the success of these changes to prevent further deficiencies.
- Facilitating focus groups and workshops with MCOs and the DBM to discuss barriers common to all MCOs and the DBM that impede improvement in a given performance measure or domain of care and to discuss collaborative efforts to overcome those barriers.
- Using MCOs' and the DBM's case presentations to demonstrate how the MCOs and DBM meets certain compliance review standards, such as ensuring care coordination, providing culturally and linguistically responsive services, or investigating and resolving a grievance or appeal.
- Inviting MCOs and the DBM to showcase (1) successful interventions used to positively impact performance measures, as evidenced by significant improvement in a performance measure; (2) barrier analyses performed to identify the potential causes that impacted performance measures, which then resulted in a significant decline in performance, and (3) lessons learned from unsuccessful interventions that proven to have little or no benefit on the population for a given performance measure.

- Requesting that MCOs and the DBM present their use of information from EQR activities to make programmatic changes that can improve services furnished to Medicaid members.

HSAG has found that ongoing involvement by MCOs and the DBM in the aim to improve the program overall brings about more buy-in and ownership of actions by MCOs and the DBM. MCOs and the DBM are more inclined to implement sweeping interventions to improve health outcomes and the Medicaid managed care program overall if MCO and DBM staff members were part of the decision-making process to implement changes. Furthermore, MCOs and the DBM are more likely to try an intervention to improve performance if another contractor in the program shows evidence of success with a similar intervention.

Since the HSAG EQR team is well-positioned to analyze the EQR activity findings and to draw conclusions about each MCO's and the DBM's access, quality, and timeliness of services to enrollees, HSAG is well-positioned to provide meaningful and actionable recommendations for improving the overall Medicaid managed care program based on the aggregated results of the EQR activities and garner MCO and DBM participation in the process.

V.D.2.b.	Describe the Bidder's approach to performing validation of PIPs, and how the approach meets or exceeds the requirements of this RFP.

Bidder Response:

Approach to Performing Validation of PIPs

Nebraska's MCOs and the DBM are required under 42 CFR §438.330 to conduct PIPs that focus on clinical and nonclinical services as a part of their annual quality assessment and performance improvement (QAPI) program. HSAG will validate one clinical, nonclinical, or joint PIP for each MCO and the DBM annually, as mandated by DHHS. HSAG will evaluate and assess each MCO's and the DBM's methodology for conducting PIPs and the overall PIP validity and reliability. HSAG bases its PIP validation methodology on CMS *EQR Protocol 1, Validation of Performance Improvement Projects (PIPs): A Mandatory EQR-Related Activity, October 2019* (EQR Protocol 1), available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf.

HSAG's purpose for PIP validation, as CMS intended, is to ensure the MCOs and the DBM conduct their PIPs in a manner consistent with EQR protocols, industry best practices, and the requirements set forth in federal regulations. HSAG's goal for its PIP validation process is to ensure that DHHS and key stakeholders have confidence that any reported improvement can be clearly linked to the quality improvement strategies and processes the MCOs and the DBM conduct.

HSAG's validation approach will include two key components of the quality improvement process:

Evaluation of the PIP's technical structure—HSAG will evaluate the technical structure of the PIP to ensure the MCOs and the DBM designed, conducted, and reported it in a methodologically sound manner, meeting all DHHS and federal requirements. HSAG's review will determine whether the PIP design (e.g., PIP aim statement, population, PIP variables, measure[s], sampling method, and data collection methodology/process) is based on sound methodological principles and can measure outcomes reliably. MCEs' successful development of the PIP design ensures PIP results are accurate and capable of measuring improvement.

Evaluation of the PIP implementation—HSAG will evaluate each MCO's and the DBM's PIP implementation. Once a PIP is designed, each MCO's and the DBM's effectiveness in improving outcomes depends on the data collection process, data analysis, barrier identification, and the subsequent development relevant to targeted interventions. Through this component, HSAG will evaluate how well each MCO and the DBM improves outcomes, quality, access, and timeliness of care provided to its enrollees by implementing effective quality improvement processes.

To monitor, assess, and validate PIPs, HSAG will use its outcome-focused approach to evaluate each MCO's and the DBM's compliance with each of the nine steps listed in the EQR Protocol 1, cited above. HSAG will evaluate each step and each MCO's and the DBM's adherence to the nine following steps using a series of evaluation elements.

- Step 1—Review the Selected PIP Topic
- Step 2—Review the PIP Aim Statement
- Step 3—Review the Identified PIP Population
- Step 4—Review the Sampling Method
- Step 5—Review the Selected PIP Variables and Performance Measures
- Step 6—Review the Data Collection Procedures
- Step 7—Review the Data Analysis and Interpretation of PIP Results
- Step 8—Assess the Improvement Strategies
- Step 9—Assess the Likelihood that Significant and Sustained Improvement Occurred

During the validation, HSAG will evaluate how well each MCO and the DBM improved its outcomes, quality, access, and timeliness of care it provides its enrollees by implementing effective quality improvement processes (i.e., barrier analyses, intervention, and evaluation of results). HSAG will conduct a critical evaluation of each MCO's and the DBM's causal/barrier analyses and methods to evaluate the interventions' effectiveness. This critical review will determine if each MCO's and the DBM's barrier analysis was rigorous enough and sufficient to identify appropriate interventions with the potential to bring about real improvement. To reduce administrative burden on the MCOs and DBM and avoid duplication, HSAG will advise them to use audited HEDIS data and processes in their PIPs when possible. CMS allows

this under the nonduplication option. It will also help each MCO and the DBM eliminate redundant documentation of data collection processes in the PIP submission form.

After the annual validation, HSAG will provide DHHS with an MCO-specific and DBM-specific PIP validation report that adheres to the DHHS-approved Detailed Work Plan. The report will include:

Background information for each PIP submitted by each MCO and the DBM and validated by HSAG.

1. A discussion of the types of data gathered and the data collection sources.
2. A discussion of all validation steps and the methods used to conduct the validation.
3. Specific validation findings for each evaluation element.
4. PIP outcomes and the statistical significance of any changes in performance.
5. A critical evaluation of MCO and DBM causal/barrier analysis processes, identified barriers, and implemented interventions.
6. A discussion of conclusions drawn, identified strengths, opportunities for improvement, and recommendations to improve performance. This will include any requirements for corrective actions and a review of any outstanding required corrective action(s) from the previous year.

HSAG's PIP team has extensive experience providing technical guidance and assistance. HSAG will provide technical guidance and assistance to both the DHHS staff and the MCOs and the DBM together at the initiation of the PIP activity to identify potential topics specific to DHHS' strategic goals and objectives and to introduce HSAG's PIP process and templates. HSAG also will provide MCO-specific and DBM-specific technical guidance and assistance as needed for the duration of each PIP to ensure PIPs are methodologically sound and meet CMS requirements for implementing a PIP. Other components and benefits for technical guidance and assistance include but are not limited to:

- Providing information on industry standard practices for conducting PIPs.
- Identifying industry best practices, common issues, and performance trends, and conveying this information to the MCOs and the DBM.
- Educating MCOs and the DBM on quality improvement science techniques that include setting aims, establishing measures, determining interventions through process mapping and failure modes effects analysis, testing interventions using Plan-Do-Study-Act (PDSA) cycles, and spreading successful changes.
- Educating MCOs and the DBM on how to conduct statistical testing and accurately interpret and report study indicator outcomes.
- Providing MCOs and the DBM with timely feedback so midcourse corrections can be made.

How Approach Exceeds Requirements of the RFP

Technical Assistance Provided by Quality Improvement Experts

HSAG's PIP team comprises health care professionals, including registered nurses, licensed medical social workers, a health care measures specialist, a health care analyst, and a biostatistician. Both the registered nurses and social workers hold and maintain their Certified Professional in Health Care Quality certification and Six Sigma black belt certification. The health care analyst and biostatistician bring a wealth of expertise to the validation process, including experience in PIP design and methodology, sampling, epidemiology, and statistical testing. Team members are subject-matter experts in quality improvement science and adept at using rapid-cycle techniques to drive improvement. In addition to validating PIPs and providing technical guidance and assistance, this team supports the facilitation of quality and performance improvement projects in contracted states and will leverage lessons learned and best practices to provide training and education to MCOs, DBMs, and state Medicaid agency staff members on the following:

- Performing drill-down analysis of the MCE's data to identify opportunities for improvement
- Process mapping
- Conducting failure modes and effects analysis
- Small-scale intervention testing using PDSA cycles
- Developing methods for making fundamental change, such as benchmarking and learning from others; using technology; thinking critically, logically, and creatively about the current system; and using change concepts
- Overcoming quality improvement obstacles
- Developing improvement measures/metrics
- Developing study designs/methodologies

Additionally, HSAG has developed a PIP submission form and accompanying instructions for the MCOs and the DBM to use as they complete their PIPs. The instructions will aid them in documenting each step of the PIP process and in addressing all requirements for conducting PIPs, as set forth in the CMS PIP protocol. The PIP submission form is modeled after the CMS PIP protocol and will guide the MCOs and the DBM to structure their PIPs in a methodologically sound manner and accurately and appropriately document the PIP related to each of the nine required protocol steps. The accompanying instructions describe the requirements in detail for each step in the process and explain step-by-step how to document and complete the PIP submission form.

CMS has commended HSAG for its PIP templates, as evidenced by the following comment: "The PIP submission form and validation tool developed by HSAG were outstanding."

Alternative Rapid-Cycle Approach

In addition to the approach described above, HSAG has developed a PIP approach that integrates concepts of quality improvement science by using rapid-cycle techniques and small tests of change. The rapid-cycle PIP framework is based on a modified version of the Model for Improvement that Associates in Process Improvement developed and that the Institute for Health Care Improvement modified. This rapid-cycle approach is intended to improve processes and outcomes of health care through continuous improvement focused on small tests of change in order to determine what truly works. Because PIPs must meet CMS requirements, HSAG completed a crosswalk of this new framework against the most current EQR protocols, then presented the crosswalk and new framework components to CMS to demonstrate how the framework aligned with the CMS validation protocols. CMS agreed that with the pace of quality improvement science development and the prolific use of PDSA cycles in modern PIPs within health care settings, a new approach was needed. CMS gave HSAG its approval to implement this new approach for states that desired a different approach to quality improvement.

The key concepts of this framework include the formation of a PIP team, setting aims, establishing measures, determining interventions, testing interventions, and spreading successful changes. The core component of the new approach involves testing changes on a small scale—using a series of PDSA cycles and applying rapid-cycle learning principles over the course of the improvement project to adjust intervention strategies—so that improvement can occur more efficiently and lead to long-term sustainability.

Using the rapid-cycle PIP approach is now an option for states that prefer this type of approach in their quality improvement efforts and strategies. HSAG is the first EQRO to use this approach and has successfully transitioned eight of its contracted states to using rapid-cycle learning principles in their intervention strategies. In 2017, CMS asked the executive director of HSAG's PIPs team to speak at the national quality conference about this new rapid cycle methodology for conducting PIPs, and EQR Protocol 1 was recently updated to include information about the rapid cycle evaluation approach. For future contract years, if this is an approach DHHS would like to initiate, HSAG will work with DHHS to implement a transition method for conducting rapid-cycle PIPs.

V.D.2.c.	Describe the Bidder's approach to providing validation of MCO and PAHP performance measures, and how the approach meets or exceeds the requirements of this RFP.

Bidder Response:

Approach to Providing Validation of MCO and DBM Performance Measures

The HSAG performance measure validation (PMV) team excels in using established methods to validate performance measures following CMS *EQR Protocol 2: Validation of Performance Measures: A Mandatory EQR-Related Activity, October 2019* (EQR Protocol 2) and NCQA HEDIS Compliance Audit™[2] methodology. HSAG staff members keep current with the CMS EQR protocols, toolkits, and other resources related to performing the EQR activities to ensure the most appropriate methods are applied to the validation of MCO and DBM performance measures. More importantly, HSAG will work with DHHS to ensure this activity is conducted effectively to deliver quality results in a timely and effective way.

To eliminate redundancy and duplication in effort, HSAG proposes to review independently audited Medicaid quality performance program measures including, but not limited to, NCQA HEDIS Compliance Audit and URAC accreditation audit findings and results. HSAG's PMV team will review final audit reports, performance measure results, and information system surveys in alignment with the goals and objectives of EQR Protocol 2:

1. To evaluate the accuracy of Medicaid-specific performance measures reported by each MCO and the DBM.
2. To determine the extent to which measures calculated by each MCO and the DBM adhered to the measure specifications and reporting requirements.

If particular measures are not part of independently audited results, HSAG will collect and evaluate the same type of information to support the validation of the non-audited performance measures. Based on the results of its review, HSAG will compile the findings to produce an annual report summarizing plan-specific performance measure validation activities and findings. Where applicable, HSAG will assess performance relative to Heritage Health's quality strategy and payment incentive program standards to develop action-oriented recommendations that will support ongoing improvement activities. HSAG also will identify areas of concern associated with each MCO and the DBM and highlight ways to improve performance measures.

[2] HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA).

HSAG has outlined its PMV methodology to conduct the validation of performance measure to reflect HEDIS Compliance Audits for NCQA HEDIS measures and EQR Protocol 2 for non-HEDIS measures (i.e., Adult Core Set and Child Core Set measures, State-specific measures, or modified HEDIS measures). While most plans use HEDIS technical specifications to calculate the Medicaid quality performance program measures required by the State, HSAG recognizes that some plan types may report and follow other quality indicator data.

Proposed Performance Measure Validation Methodology

HSAG understands that DHHS requires all MCOs and the DBM to report performance measures results (i.e., Adult Core Measures, Child Core Measures, and HEDIS measures) annually by June 30 of the reporting year. Although CMS based its Validation of Performance Measure Protocol in part on the NCQA HEDIS Compliance Audit methodology, there are some differences between the two. The performance measure process may be used to validate any performance measure, not strictly HEDIS measures. It also allows the EQRO the flexibility to use findings from other parties, which NCQA prohibits. For each MCO and the DBM that currently undergo an independent review of performance measures, HSAG proposes to use the findings from the independent audits, augmented by additional validation activities identified in the EQR protocol.

As such, where each MCO's and the DBM's submission of measure data has been audited and certified independently by an external entity (e.g., NCQA Certified HEDIS Compliance Auditor, URAC accreditation audit), HSAG will collect and review these results to ensure compliance with the mandatory validation of performance measures activity described in 42 CFR §438.358, while avoiding duplicative processes. HSAG understands that some health plans (depending on plan type) report a variety of HEDIS and non-HEDIS quality indicator measures. To ensure nonduplication, HSAG will request confirmation that the MCOs and the DBM are in compliance with the applicable audit standards and/or accreditation; that they are comparable to those established through the EQR protocols for the three mandatory EQR-related activities; and that all applicable reports, findings, and other results of the independent review are available.

The following steps indicate HSAG's proposed approach to the validation of performance measures activity:

Step One—PMV Initiation and Planning: Establishing clear objectives, expectations, and responsibilities is the foundation for a successful performance measure validation. HSAG has found it invaluable to emphasize the validation planning process so all key players clearly identify and agree on deadlines and expectations for deliverables. Early in the PMV process, HSAG will work with DHHS to identify the performance measure(s) selected for validation and to clarify measure specifications (e.g., sampling guidelines, eligible population criteria, and numerator and denominator identification).

Step Two—Request Documentation from the MCOs and DBM: Once it defines the scope of validation activities, HSAG will prepare and provide DHHS with a draft document request packet for review and approval. The request packet will detail all required audit activities, required documentation, and submission guidelines, along with the associated timelines for completion. In addition to document request packet elements outlined previously for HEDIS measures, PMV audits that include non-HEDIS measures require two additional components (in bold face below).

- Overview of the PMV audit process
- PMV timeline
- List of PMV performance measures
- Request for final audit information, including:
  - For HEDIS measures—NCQA's completed Record of Administration, Data Management, and Processes (Roadmap), and associated supplemental documentation.
  - ***For non-HEDIS measures—Information Systems Capabilities Assessment Tool (ISCAT) and associated supplemental documentation.***
  - Final audit report.
  - Audited and locked Interactive Data Submission System (IDSS) submission, for HEDIS measures.
  - ***Final audited rates via HSAG's rate reporting template (non-HEDIS measures only)***
- Where to submit requested documentation.
- Contact information and next steps.

While most of the information systems capabilities information is captured as part of the NCQA Roadmap and its associated attachments, this sometimes lacks information crucial to evaluate potential bias in non-HEDIS measures. To capture these components, HSAG will develop a customized ISCAT to identify and collect information specific to the non-HEDIS performance measures. Each MCO and the DBM will be required to complete this supplemental tool and provide any applicable attachments. Additionally, since non-HEDIS measures cannot be reported on NCQA's IDSS, HSAG will work with DHHS to implement HSAG's RRT (rate reporting template) to capture all critical measurement data. Similar to the data elements captured in the IDSS, the RRT allows the MCOs and the DBM not only to submit final rate information (i.e., numerator, denominator, and rate), but information critical to assessing bias (e.g., eligible population, excluded cases). The RRT also allows the automated processing of the MCOs' and the DBM's rates to support aggregation and reporting of performance measure results.

Once approved, each participating MCO and the DBM will receive the document request packet. HSAG also will provide each MCO and the DBM with technical assistance to ensure all required performance measures are reported in a

manner suitable for validation. During the initial PMV kick-off call, HSAG will introduce the validation team to the MCOs and the DBM, clearly define the roles and responsibilities, and address any questions regarding the activity.

Step Three—Review MCO's and DBM's Information and Final Audit Reports: Upon receipt of all requested documentation, a team of reviewers, including Certified HEDIS Compliance Auditors, will review all submitted documentation, including the Roadmap and attachments, responses to the supplemental ISCAT questions developed by HSAG, and the Final Audit Report. Using standardized data collection tools, HSAG reviewers will gather information systematically on each MCO's and the DBM's information system and its capabilities to produce valid rates. Core components captured will include information systems used to collect, store, manage, and publish performance measure data; quality of data sources used to calculate performance measures; data integration and programming for numerator and denominator identification; and the calculation and reporting of performance measure rates. Any issue that may impact a performance measure will be flagged for further investigation. In addition, an evaluation of each MCO's and the DBM's information system capability will be completed.

Step Four—Site Visit: Annually, HSAG staff members will conduct an on-site review of participating MCOs and the DBM. During the site visit, HSAG will collect additional information related to each MCO's and the DBM's calculation of performance measures using several methods, including interviews, system demonstration, review of data output files, primary source verification, observation of data processing, and review of data reports. To reduce the burden on the MCOs and the DBM, HSAG's PMV team will coordinate site visit activities to correspond with on-site compliance reviews to eliminate unnecessary duplication in activities. The site visit activities will include the following evaluation components:

- Review of key information systems and data processes
- Enrollment, eligibility, provider, and claims/encounter systems and processes
- Overview of data integration and control procedures
- System demonstrations
- Primary source verification

Step Five—Perform Independent Review of Reported Rates: HSAG's review teams will perform an independent review of the reported rates via locked IDSS files and custom rate reporting templates and compare them to national benchmarks, previous MCO or DBM historical data, and other applicable benchmarks or reports. The teams also will complete an evaluation of the measures to determine reasonability and expected outcome, and both the custom rate template and IDSS contain data fields that assist in estimating potential bias. These fields include the eligible population size, denominator, numerator, and number of exclusions. The review teams will evaluate these additional fields and

results of denominator benchmarking, as well as the final reported rates in context with the review findings from the information systems evaluation and measure-specific concerns identified in Step Three.

Step Six—Aggregate and Categorize Validation Findings: The review team will aggregate and categorize MCO-specific and DBM-specific findings into two types: information systems findings and measure-specific findings. This will allow the team to identify common information system issues that affect multiple MCOs and the DBM and whether these lead to a significant bias for a reported measure. In addition, the team will identify common measure-specific issues that influence multiple MCOs and the DBM, as well as statewide trends and including both strengths and areas for improvement.

IDSS and custom rate data also will be aggregated to provide plan-specific metrics for all evaluated measures. Individual MCO and DBM rates will be compared to State standards, national benchmarks, and trended where applicable. Additionally, performance will be summarized across key domains designed to align with Heritage Health's quality strategy and program objectives. HSAG will work closely with DHHS while developing the report template to incorporate design elements that ensure the report is accessible to a diverse audience (e.g., consumer-friendly graphics).

Upon completion of all validation activities, the results will be synthesized to develop an overall validation finding for each MCO and the DBM, and for each measure. These validation findings are based on the impact that identified errors have on the ability to report complete, accurate, and reliable results. There will be four designations to summarize the results of the audit:

- Reportable (R)—The MCO or DBM rate was compliant with State specifications.
- Do Not Report (DNR)—The MCO or DBM rate was materially biased and should not be reported.
- Not Applicable (NA)—The MCO or DBM was not required to report the measures.
- Not Reported (NR)—The MCO or DBM did not offer the required benefit.

Step Seven—Publication of Preliminary and Final Reports: HSAG will incorporate the findings and results from the validation of the performance measures into a plan-specific PMV report. Drawing on the results generated from Step 6, the report will present two sets of findings: validation results and performance measure results. The validation results will highlight HSAG's assessment of each MCO's and the DBM's information systems review along with identification of the validation results (i.e., Reportable, Not Reported) for the reported measures. When applicable, performance measure results will compare validated rates to the previous year's performance, established national benchmarks, and DHHS-defined performance targets. HSAG also will draw MCO-specific as well as DBM-specific conclusions and recommendations on ways to improve data processes and performance in the measures. In addition, the report will include a summary of performance on systems capabilities and overall data reporting. This section will address

strengths and weaknesses in data collection and reporting that impact the reported rates. HSAG will provide each MCO and the DBM with a draft report for review and comment and produce a final report that will include any requested changes and feedback.

How Approach Meets or Exceeds Requirements of the RFP

HSAG's approach meets both guidelines established in EQR Protocol 2 and streamlines the assessment and reporting process, effectively reducing the burden on participating MCOs and the DBM. With more than 1,100 HEDIS and PMV audits performed since its inception, HSAG will be able to provide a level of expertise and perspective to meet the requirements of Heritage Health and the populations it serves. In addition, HSAG has developed a customized ISCAT to help identify and collect information from MCOs and the DBM related to performance measures along with customized rate reporting templates for critical assessment. Both tools will help ensure that DHHS and its health plans are being evaluated for crucial metrics and will expose any errors or biases that might have been overlooked in previous evaluations.

The HSAG PMV team excels in using established methods to validate performance measures following EQR Protocol 2 and NCQA HEDIS Compliance Audit methodology. As previously mentioned, HSAG keeps current with the EQR protocols, toolkits, and other resources related to performing the EQR activities. Additionally, HSAG is a nationally recognized expert in performance measurement and one of the few EQROs that is also a CMS Measure and Instrument Development and Support (MIDS) contractor. Its staff members have participated in several CMS technical expert panels (TEPs) focused on measures, including the recent CMS TEP that guided the development of the Medicaid Quality Rating System requirements. In addition to extensive performance measure audit experience, HSAG has developed and calculated performance measures for more than a dozen Medicaid agencies. This uniquely positions HSAG to provide DHHS with technical assistance to create measures and/or recommend appropriate measures specific to the Nebraska population.

V.D.2.d.	Describe the Bidder's approach to performing a review to determine the MCOs and PAHPs compliance with the standards set forth in 42 CFR 438, subpart D and the quality assessment and performance improvement requirements described in 42 CFR § 438.330, and how the approach meets or exceeds the requirements of this RFP.

Bidder Response:

Approach to Performing Compliance Reviews of MCOs and PAHPs

To meet federal requirements outlined in 42 CFR §438.358(b)(iii), HSAG will conduct a full comprehensive compliance review at least once every three years to determine each MCO's and the PAHP's compliance with the standards set forth in 42 CFR §438 Subparts D and E (the PAHP hereby will be referred to as the DBM). HSAG's comprehensive compliance reviews are conducted in accordance with CMS *EQR Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity, October 2019* (EQR Protocol 3). In alignment with federal managed care regulations and EQR Protocol 3, HSAG will review, at a minimum, the following standards over a three-year cycle:

- Availability of services §438.206
- Assurances of adequate capacity and services §438.207
- Coordination and continuity of care §438.208
- Coverage and authorization of services §438.210
- Provider selection §438.214
- Confidentiality §438.224
- Grievance and appeal systems §438.228
- Subcontractual relationships and delegation §438.230
- Practice guidelines §438.236
- Health information systems §438.242
- Quality assessment and performance improvement program §438.330

HSAG also will collaborate with DHHS to determine if other State statutory, regulatory, or contractual requirements should be included as part of the review. Additionally, to eliminate redundancy and avoid duplication, HSAG will use the most current reports, findings, and other results of each MCO's and the DBM's accreditation surveys (e.g., NCQA, URAC) to determine compliance with applicable standards and requirements under review.

HSAG understands that the most recent comprehensive compliance review occurred in April 2018 and included a review of all federally required standards. Upon contract initiation, HSAG will consult with DHHS to identify any compliance review tasks that the incumbent EQRO already has completed for the 2021 review. In contract Year One,

as applicable, HSAG will follow the methodology, tools, document requests, review schedules, and other tasks the incumbent EQRO already has finalized and will plan to go on-site to each MCO and the DBM in Quarter Two of 2021 (April–June, 2021). If DHHS and the incumbent EQRO have not yet initiated the planning activities for the 2021 compliance review, HSAG will collaborate with DHHS to understand its expectations. HSAG will then work quickly to develop the necessary document requests, tools, agendas, and other MCO and DBM materials so DHHS can review and approve the documents and they can be shared subsequently with the MCOs and the DBM in preparation for the Quarter Two on-site reviews.

For the compliance review activities in contract Year Two, HSAG proposes to conduct a thorough review of the corrective action plans the MCOs and the DBM developed to mitigate the deficiencies identified in the Year One comprehensive compliance review. This process will include a review of supporting documentation to confirm the MCOs and the DBM have implemented the actions proposed in their plans and have successfully mitigated the deficiencies, thereby ensuring all federal and State-reviewed standards and requirements are compliant within the three-year compliance review cycle. For contract Year Three, HSAG proposes a targeted review of any program area(s) that may still be problematic for the MCOs and the DBM, as well as any program areas that DHHS has identified as requiring a targeted review. HSAG will collaborate with DHHS to determine those target areas of focus that will help DHHS and the MCOs and the DBM improve the quality, timeliness, and access to care and services provided to Medicaid enrollees. Examples of targeted reviews could include areas such as utilization management, care management, the grievance system, nonemergency medical transportation, and/or quality assessment and performance improvement programs.

Regardless of the compliance review approaches employed over the three-year cycle, HSAG will use EQR Protocol 3 as a guide to assess MCO and DBM compliance. To ensure each compliance review is organized, streamlined, and successful, HSAG has developed and, with DHHS' approval, will employ an eight-step process in its compliance review activities.

Step 1: Planning for Compliance Review Activities

Each year, HSAG will begin the planning process by gathering and assessing any previous findings of compliance, which may include results from State monitoring activities or accreditation surveys. HSAG will work with DHHS to determine the dates for the on-site reviews and overall compliance review schedule, ensuring the reviews are conducted in Quarter Two of each year. HSAG also will provide ongoing communication and technical assistance to the MCOs and the DBM regarding the process, timelines, and expectations to ensure the compliance review process is methodical, well-organized, efficient, and effective.

Step 2: Creating Compliance Review Tools and Establishing Compliance Thresholds

HSAG will create and submit to DHHS for approval complete and accurate compliance review tools that align with the federal standards, the requirements found in 42 CFR §438, and the associated DHHS-specific requirements found in the MCO and DBM contracts. Each tool will include the specific requirement under review, federal and State citations, and examples of suggested evidence of compliance. An excerpt from an HSAG-developed compliance review tool is provided below in Figure V.D.2.d.1. to showcase HSAG's ability to develop comprehensive and effective tools for assessing MCO and DBM compliance.

Figure V.D.2.d.1.— Compliance Review Tool

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the ICO**	**Score**
Delivery Network		
1. The MCO maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract for all enrollees, including those with limited English proficiency or physical or mental disabilities. 42 CFR §438.206(b)(1) 42 CFR §422.112(a)(1)(i) Contract 2.7.1.1.	**HSAG suggested evidence:** Example(s) of provider contract/provider contract template Example(s) of network analyses Provider directory (link is acceptable)	☐ Met ☐ Not Met ☐ NA
MCO Description of Process:		
HSAG Findings: **Program Recommendations:**		
Required Actions:		

Every compliance review comprises a review of documents that include policies, procedures, reports, meeting minutes, and process information. The compliance review also includes file reviews to verify the MCO and DBM puts into practice what is written in its policies, and that its procedures comply with federal and State standards. HSAG conducts file reviews of enrollee grievances, enrollee appeals, denials of services, credentialing, recredentialing, care management, and delegation oversight. These file review tools are designed to comply with federal requirements, but also take into consideration any State-specified review areas. An excerpt from a care management tool is provided in

Figure V.D.2.d.2. to showcase HSAG's ability to develop comprehensive and effective file review tools that will meet DHHS' specific needs.

Figure V.D.2.d.2.— Care Management Tool

Care Management File Review Tool		
Requirement	**Review Elements**	**Score**
Section I: Enrollee Information		
Enrollee Information	Enrollee Initials: _____ Enrollee Identification Number: _____ Date of Enrollment in MCE: _____ Risk Stratification Level: _____ Date of Care Plan: _____ ☐ Initial ☐ Annual Review ☐ Revised	
Comments:		
Section II: Individual Integrated Care and Supports Plan—Person-Centered Planning Process		
1. The enrollee will lead the person-centered planning process where possible. The enrollee's representative should have a participatory role, as needed and as defined by the enrollee, unless State law confers decision-making authority to the legal representative. All references to members include the role of the member's representative. • *The integrated care team (ICT) will honor the enrollee's choice about his or her level of participation. This choice will be revisited periodically by the MCO Care Coordinator as it may change.* 42 CFR §441.301(c)(1) Contract 2.5.2.7.	Documentation supports that the enrollee led the person-centered planning process: ☐ Yes ☐ No If *No*, documentation supports that the MCO Care Coordinator discussed with the member his or her preference about the level of participation in the ICT: ☐ Yes ☐ No If *No*, explanation: _____	☐ Met ☐ Not Met ☐ NA

HSAG also uses checklists to verify each MCO's and the DBM's contractual compliance for certain documents, such as the member handbook, provider manual, provider directory, and members' rights.

Levels of Compliance

HSAG will collaborate with DHHS to define the levels of compliance that will be used to assign a numerical value to indicate the degree of compliance with a given regulatory provision. EQR Protocol 3 provides examples of several compliance rating scales that can be used by EQROs, including the five-point scoring methodology currently in use by DHHS. Based on HSAG's experience conducting compliance reviews across the nation, HSAG recommends DHHS consider compliance ratings of *Met* and *Not Met*, as these ratings more clearly depict a MCO's and DBM's compliance with the standards and elements under review.

HSAG's recommended two-point scoring methodology indicates the degree to which each MCO's and the DBM's performance complies with the requirements under review.

***Met* (1 point)** indicates full compliance defined as *both* of the following:

- All reviewed documentation and data sources, including MCO and DBM data and documentation, case file reviews, and systems demonstrations for a regulatory provision, or component thereof, are present and provide supportive evidence of congruence.
- Staff members are able to provide reviewers with responses that are consistent with each other, with the data and documentation reviewed, and with the regulatory provision.

***Not Met* (0 points)** indicates noncompliance defined as *any* of the following:

- Documentation and data sources are not present and/or do not provide supportive evidence of congruence with the regulatory provision.
- Staff members have little or no knowledge of processes or issues addressed by the regulatory provisions.
- For those provisions with multiple components, key components of the provision could not be identified and/or do not provide sufficient evidence of congruence with the regulatory provision. Any findings of *Not Met* for these components would result in an overall provision finding of noncompliance, regardless of the findings noted for the remaining components.

HSAG will use the results from the file review tools, policies and procedures, systems demonstrations, staff member interviews, accreditation surveys, and other MCO and DBM-provided documentation when assessing each element for compliance. HSAG also will assess for congruence among all data sources as well as patterns of compliance or noncompliance when all data sources are taken into consideration. The overall assessment of all data sources will determine a *Met* or *Not Met* finding. Any *Not Met* designation indicates an area of deficiency that the MCO and DBM will need to address during the corrective action process.

Step 3: Training the HSAG Compliance Review Team

The compliance review team, which will be led by Nebraska EQRO project director Dr. Kim Elliott, includes staff members with extensive knowledge of Medicaid managed care programs and related regulations and experience conducting compliance activities. The project director and Nebraska EQRO Assistance Project Director Kari Vanderslice, will conduct training sessions to ensure each HSAG team member has a thorough understanding of:

- CMS Medicaid managed care requirements included in the compliance review.
- DHHS-specific requirements included in the compliance review.
- Requirements for any checklists or file reviews included in the compliance review.
- Structure and operation of Nebraska's Heritage Health program.
- Instructions concerning the completion of the compliance review tools and reports.
- Timelines associated with the compliance review.
- Published guidance from nationally recognized organizations as they relate to topics included in the compliance review.

Step 4: Establishing Contact with and Collecting Compliance Review Data from the MCOs and the DBM

HSAG, or DHHS based on DHHS' preference, will establish early communication with the MCOs and the DBM through written notice of the upcoming reviews, providing the MCOs and the DBM with an opportunity to identify any concerns about the proposed date span for on-site reviews. HSAG will establish on-site dates with DHHS, taking into consideration each MCO's and the DBM's feedback. Six to eight weeks before the first scheduled on-site review, HSAG will send the MCOs and the DBM a document request packet that will include the DHHS-approved compliance review tools and instructions for completing and submitting the documents to HSAG prior to the desk review, which will occur before the on-site review. HSAG also will provide information about accessing HSAG's secure access file exchange (SAFE) site to upload completed review tools and related source documents that HSAG will assess during the desk review (pre-on-site review) process. As applicable, HSAG also will conduct file reviews during the desk review process. This will allow for more meaningful discussion during the on-site review.

HSAG will continue communication with the MCOs and the DBM through a 60- to 90-minute group informational webinar session during which it will introduce the various documents it sent previously to the MCOs and the DBM, and will reiterate the process for completing and uploading the requested documents to the HSAG SAFE site. It is during this webinar that MCO and DBM staff members may ask questions and seek clarification about the compliance review tools, process, timelines, and logistics associated with the on-site review. Regular updates via email also will be

provided, as needed, to keep the MCOs and the DBM well-informed of processes and information associated with the compliance review.

Step 5: Completing Desk Review (Pre-On-Site) and Posting the Agenda

Desk Review

Approximately four weeks prior to the first scheduled on-site review, the HSAG compliance review team will begin the desk review of documents the MCOs and the DBM submitted. Based on the desk review, HSAG compliance review team members will draft interview questions to guide the discussions during the on-site review.

Posting the Agenda

Before the on-site review, HSAG will post the agenda for the one- to two-day review within the MCO and DBM-specific folder on HSAG's SAFE site. The length of time needed for the on-site review depends on the number of standards and related requirements reviewed that year, and the number and complexity of the file reviews.

The agenda lists the proposed time for interviews with the MCO's and DBM's staff members. HSAG will allow the MCO and DBM the opportunity to rearrange the agenda to accommodate the needs of its staff members, in addition to allowing changes to the schedule while on-site to ensure all key staff members are available for the interview sessions.

Step 6: Completing On-Site Review Activities

Opening Conference and Staff Interviews

HSAG staff members will introduce themselves during the opening conference and explain their roles in the on-site compliance review activities. The MCO and DBM staff members will share information about their organization's operations and provide any recent challenges and/or successes that may influence the compliance review findings. HSAG also welcomes DHHS staff members to attend the on-site reviews, either in person or through Webex, to observe HSAG's review processes. After the opening conference, HSAG reviewers will ask questions to clarify the information submitted with the pre-on-site documents, and will conduct interviews with the MCO and DBM staff members to:

- Gain a clear and concise understanding of each MCO's and the DBM's compliance with the regulatory requirements and receive clarification concerning pending questions.
- Answer questions from each MCO's and the DBM's staff members about the review standards.
- Compare the information gained from a review of the pre-on-site documents and case files to information gained during the interviews.
- Provide HSAG reviewers the opportunity to request additional relevant documents.

- Provide HSAG reviewers the opportunity to share industry best practices and program recommendations specific to each standard under review.
- Encourage each MCO's and the DBM's staff members to share any innovative projects to improve processes or enhance reporting capabilities.

Closing Conference and Exit Interviews

At the end of the on-site visit, HSAG will conduct a closing summation with each MCO's and the DBM's staff members to discuss HSAG reviewers' comprehension of information obtained during the compliance review, and to provide preliminary compliance review findings. HSAG also will indicate the specific elements that will require additional evidence to support compliance, and it will provide the MCO and DBM with a limited time period to submit the additional documents. Finally, HSAG will share the timeline to submit the draft report of findings to DHHS, as well as the process for the MCO and DBM to submit a corrective action plan, if one is required.

Step 7: Analyzing and Compiling Findings

To determine compliance with each element in each standard listed in the compliance review tools, HSAG will analyze the information the MCO and DBM submits for the desk review, the findings from the file reviews, the responses it receives during the on-site interviews, and the results of reviewing additional documentation presented during and after the on-site review. HSAG reviewers will assign scores and conduct peer reviews of the findings to ensure consistency in documenting and evaluating policies and processes, and to determine the scores across all standards.

Step 8: Reporting Results to the MCO, DBM, and DHHS

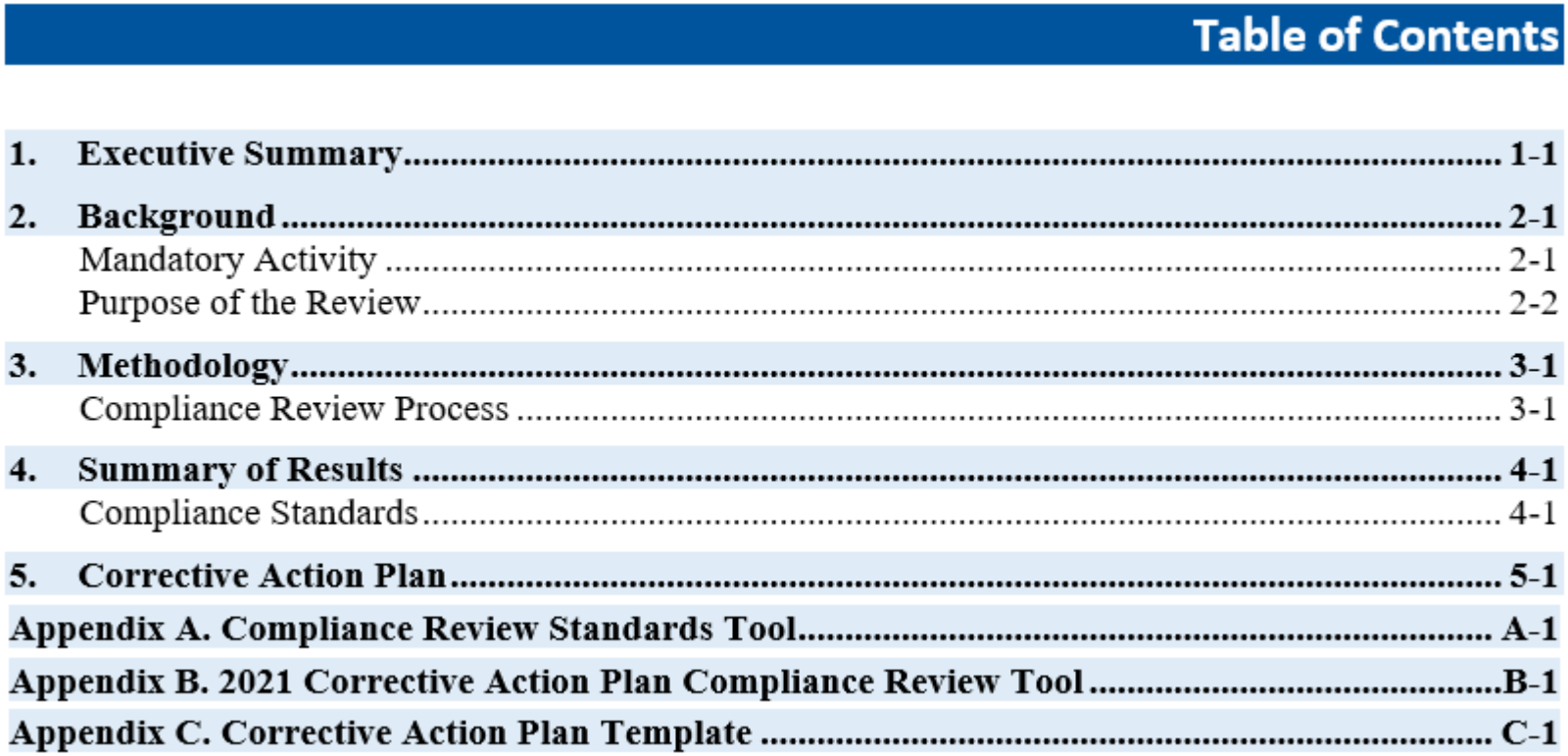
After compiling the results from the on-site review and determining the level of compliance with each element, HSAG will create a comprehensive compliance report that includes the completed compliance tools used for the review. HSAG will propose a report template that ensures the peer-reviewed, final annual written compliance review report meets DHHS' expectations for the format, structure, organization, and content. The report template will include the information needed to describe each MCO's and the DBM's compliance with the standards, and an explanation of the technical methods of data collection and analysis. At a minimum, HSAG will include the following information in each MCO's and the DBM's report:

- Summary of results, which will include a table with the scores for each compliance standard reviewed.
- Specific findings and required actions with respect to each MCO's and the DBM's compliance with federal requirements and the DHHS contract standards.
- A listing of areas requiring corrective action to bring the MCO and DBM into full compliance with the requirement for each standard that HSAG reviewed.

- A template the MCO and DBM will use to document its corrective action plan (CAP) for each element that did not receive a *Met* rating.

HSAG will request that the MCO and DBM submit a CAP response for each area that did not receive a *Met* rating within 30 days of receiving the report, or within another time frame as approved by DHHS. HSAG also will facilitate the process for receiving and reviewing the CAP's sufficiency and, in collaboration with and at DHHS' request, will approve each MCO's and the DBM's CAP response. Figure V.D.2.d.3. Compliance Review Table of Contents is an excerpt from the table of contents of a compliance review report, showcasing HSAG's ability to develop comprehensive and valuable report of findings.

Figure V.D.2.d.3. — Compliance Review Table of Contents



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HSAG will ensure that DHHS receives each draft MCO-specific and DBM-specific report within 90 days of the on-site review, in electronic format, and will provide a final report inclusive of DHHS feedback within 30 days of the draft report delivery. HSAG also will include the results of each MCO's and the DBM's compliance review in the annual detailed technical report that will be finalized and submitted to DHHS no later than October 15 each year.

How Approach Meets or Exceeds Requirements of the RFP

HSAG's compliance review approach aligns with the guidelines established in EQR Protocol 3 and reduces the burden on participating MCOs and the DBM through implementation of CMS' non-duplication option described in 42 CFR §438.360. Additionally, from the initiation phase through the completion phase, HSAG will provide technical assistance to the MCOs and the DBM and DHHS, as necessary, to ensure all parties have a comprehensive understanding and accurate interpretation of the federal requirements under review. HSAG has significant experience using historical and current Federal Registers, published by CMS, to fully comprehend the intent of each Medicaid managed care regulation stipulated under 42 CFR 438, and HSAG staff members share their knowledge with state Medicaid agencies and MCOs and DBMs freely during the compliance review process.

Because of its multistate EQR work, HSAG also has an in-depth understanding of the varying Medicaid managed care program and waiver types, delivery systems, and benefit designs that states and their MCOs and DBMs employ. HSAG reviews managed care organizations, prepaid inpatient health plans, prepaid ambulatory health plans, and primary care case management programs for compliance with federal and state contract standards in both the context of a state's own contract requirements and with the overarching knowledge and understanding of the Medicaid managed care regulations and principles related to each operational process (e.g., quality assessment and performance improvement programs and initiative development, credentialing and recredentialing of providers, appeal and grievance processes, delegation oversight and vendor management, care management programs, and care plan development). HSAG stays fully informed of applicable Medicaid and Children's Health Insurance Program (CHIP) rules, regulations, and CMS publications. Staff members regularly monitor informational sources from states (including related state legislation, rules, and regulations), federal Medicaid regulatory sources (including websites publishing CMS EQR protocols, toolkits, and state Medicaid director letters), and industry standards sources such as the National Committee for Quality Assurance (NCQA). In addition, HSAG actively engages in review and comment opportunities for stakeholders; for example, on NCQA's proposed changes to performance measure specifications, CMS' publication of proposed rules related to Medicaid and CHIP, and CMS' requests for input on new or revised EQR protocols. This keeps HSAG current with potential revisions and it provides a deeper understanding of the direction and rationale for any proposed

regulatory changes. HSAG consistently applies this knowledge in its compliance review activities and shares this information with the state and managed care entities, as applicable, through the compliance review process.

Finally, through its nonpunitive, consultative, and collaborative approach to the compliance review process, HSAG has created a culture that lends to open information-sharing and transparency by the MCOs and the DBM, resulting in engaging discussions and sharing of best practices that further promote high performance in the managed care program. HSAG's intention is to conduct the compliance reviews with the Nebraska MCOs and the DBM in this same manner, with the goal to improve performance in all areas of the Heritage Health program, which in turn should result in improved enrollee health outcomes and enrollee satisfaction.

V.D.2.e.	Describe the Bidder's approach to performing validation of MCO and PAHP network adequacy, and how the approach meets or exceeds the requirements of this RFP.

Bidder Response:

Approach to Performing Validation of MCO and PAHP Network Adequacy

HSAG will collaborate with DHHS to review and define network adequacy validation (NAV) activities for each contract year. HSAG has a cross-functional team capable of supporting all NAV components of the contract. As a result of HSAG's current NAV and reporting activities, HSAG has a deep understanding of the services and solutions required to conduct the NAV activity in alignment with federal and Nebraska State laws. HSAG will support the validation and analysis of the MCO and PAHP (hereby referred to as the DBM) provider networks. HSAG's validation will consider each MCO's and the DBM's compliance with DHHS-established time and distance standards for the respective provider networks.

HSAG is aware that it will be required to validate network adequacy for all Heritage Health MCOs and the DBM, in accordance with 42 CFR §438.68. According to managed care federal regulations released in May 2016, the activity related to 42 CFR 438.358(b)(1)(iv), validation of network adequacy, will begin no later than one year from the issuance of the associated EQR protocol. Since CMS' validation of network adequacy EQR protocol has not been published at the time of this response, HSAG understands that it will collaborate with DHHS to modify and finalize the validation methodology upon release of the protocol.

The sections below describe HSAG's anticipated methodology and approach to accomplish the NAV activity.

Project Initiation and Management: Upon contract initiation and each subsequent contract year, HSAG will conduct a project kick-off meeting with DHHS to establish and promote a transparent process that will continue over the life of the project and will outline the tasks needed to complete the activity's scope of work. To ensure a successful execution, HSAG will work with DHHS to confirm key project contacts, establish regular status meetings, and determine

appropriate lines of communication. The kick-off meeting also will include a requirements-gathering session with the DHHS staff. Based on this meeting, HSAG will develop a NAV study methodology for DHHS' review and approval. Once finalized, the methodology will be used to generate a detailed reporting template. These documents will be the foundation from which HSAG develops and executes all study protocols.

HSAG will coordinate and conduct regular written status updates with DHHS to detail tasks completed for each project phase, including an overall summary of the activity's progress and discussion of upcoming efforts. As required by DHHS, HSAG will facilitate monthly status meetings to discuss recommended resolutions to any issues encountered. This process will allow DHHS to shape decision-making on critical issues, provide guidance on ongoing efforts, and help resolve problems and challenges throughout the activity. Most importantly, the status updates will focus on specific action items and timelines outlined within the DHHS-approved project work plans to promote the most efficient use of time and resources for all parties.

In Year One, starting in April 2021, HSAG proposes to collaborate with DHHS to transition any ongoing NAV activities to HSAG and define the project activities for the remainder of the project period. HSAG proposes to use Year One of the project period to set the foundation for the subsequent NAV project tasks and will conduct a desk review of available network adequacy standards, requirements, data collection templates, and contract language for provider network requirements. Additionally, HSAG will review the quarterly network adequacy submissions for each MCO and the DBM to assess the consistency of the data collection, the completeness of the information, and the format of the data submissions. If HSAG determines there is a lack of consistency with the classification of providers across plans (e.g., all plans define primary care providers [PCPs] differently), HSAG can collaborate with DHHS to develop a provider crosswalk to outline consistent definitions of provider specialties across MCOs and the DBM.

In Year One, HSAG will also submit a provider data structure questionnaire to the MCOs and the DBM to collect information about how they collect and maintain provider data, including what fields are available (e.g., provider type, provider specialty, provider taxonomy), how the data are maintained and updated, and if the provider data include information listed in the provider online directory (e.g., physical accessibility, availability of telemedicine).

Starting in Year Two and each subsequent year, HSAG proposes to conduct a multilevel NAV analysis that includes the following objectives:

1. Calculate the time/distance and provider ratio results for each MCO and the DBM to validate the results submitted to DHHS annually in the Network Development Plan & Network Development Plan Template report.
2. For MCOs not in compliance with the time/distance standards, supply DHHS with a list of providers contracted with other MCOs in the same or adjacent counties.

NAV activities will begin with data collection, during which HSAG will collaborate with DHHS and the MCOs and the DBM to identify provider and enrollee data required for validation analyses. HSAG understands that its customers use state-specific approaches to maintain and oversee the MCOs' and the DBM's data. As such, HSAG anticipates working with DHHS to determine the degree to which provider and/or enrollee data will be requested directly from DHHS and the MCOs and the DBM or accessed directly from data available to HSAG for other EQR activities. HSAG will determine overall data quality by reviewing the data files received to ensure submitted data contain the requested information in the intended format. HSAG will review with DHHS any discrepancies in the submitted data and will request that the data provider(s) supply corrected files, if necessary. Because multiple resubmissions will impact the timely completion of the study, HSAG will work with DHHS to assess limitations inherent to available data and determine the extent to which it will accept resubmissions. HSAG uses Quest Analytics Suite software to review enrollee and provider addresses and ensure they can be geocoded to exact geographic locations (i.e., latitude and longitude). Geocoded enrollee and provider addresses are assembled into datasets used to calculate the percentage of applicable enrollees within the DHHS-defined time and distance requirements. Quest calculates the duration of travel time or physical (driving) distance between enrollee addresses in the enrollee demographic files and the addresses of their nearest providers.

To support geo-access (i.e., time and distance) analyses, HSAG maintains licenses for both Quest software and a service to standardize address data to align with the United States Postal Service (USPS) Coding Accuracy Support System (CASS). Additionally, HSAG uses SAS® for data manipulation, analysis, and reporting.[3]

To assess each MCO and the DBM 's compliance with the time/distance standards, HSAG will compare the MCO-specific and DBM-specific time/distance results the MCOs and the DBM submit to DHHS during the geo-access reporting and score each standard as "*met*," "*not met*," "*not applicable (NA)*," or "*not reported (NR)*." Based on existing NAV activities, HSAG proposes to continue using the following scoring definitions:

- A score of "*met*" will indicate that HSAG's time/distance results show a percentage of enrollees or anticipated enrollees at or above the time/distance standard.
- A score of "*not met*" will indicate that HSAG's time/distance results show a percentage of enrollees or anticipated enrollees below the time/distance standard.
- The value "*NA*" will identify standards not applicable to the MCO or DBM, provider type, and/or urbanicity (i.e., urban and rural).

[3] SAS and all other SAS Institute Inc. product of service names are registered trademarks of SAS Institute Inc. in the United States and other countries.

- The value "*NR*" will identify standards for which no enrollees or anticipated enrollees met the network requirement denominator for the MCO or DBM and urbanicity; therefore, HSAG calculated no corresponding time/distance result.

Table V.D.2.e.1 shows a potential option for presenting the time/distance validation results.

Table V.D.2.e.1: Sample Table for NAV Results, by Provider Type

Minimum Network Requirement	MCO-Reported Result	HSAG-Reported Results		Validation Score
		Count of Enrollees	% of Enrollees Meeting Standard	
PCP, Adult	100.0%	1,177	100.0%	Met
PCP, Pediatric	99.9%	854	100.0%	Met
Obstetrics/Gynecology (OB/GYN)	100.0%	393	100.0%	Met
Cardiologist	100.0%	1,177	81.1%	Not Met
Neurology	97.0%	854	97.0%	Met
Hospital	100.0%	2,031	100.0%	Met
Pharmacy	93.1%	2,031	82.4%	Not Met

Cells highlighted in yellow represent MCO-reported results that differ from HSAG's results and meet the compliance standard based on HSAG's results.
Cells highlighted in red represent MCO-reported results that do not meet the compliance standard based on HSAG's results.

When HSAG determines an MCO or DBM is out of compliance with DHHS' network requirements based on HSAG's time/distance calculations, HSAG will conduct a saturation analysis. Saturation analyses consider the degree to which each MCO and the DBM's provider network reflects available DHHS-registered providers. Following the annual NAV, HSAG will generate lists containing saturation analysis results for any provider type that HSAG determines not to have met the time/distance requirements. Each MCO-specific or DBM-specific list will contain the DHHS-registered providers

in the same county or adjacent counties that were not already associated with the respective MCO or DBM's provider file. These lists will allow DHHS to determine the extent to which deficiencies in the MCO's or the DBM's provider network resulted from its failure to contract with available DHHS-registered providers, versus a lack of providers because of provider type availability or geography.

Reporting: Before drafting the annual NAV report, HSAG will provide a formatted report template for DHHS' review and approval according to the DHHS-approved timeline. HSAG will produce MCO-specific and DBM-specific reports describing each respective MCO's and the DBM's network sufficiency with respect to the time/distance and provider ratio standards validated from the Annual Network Certification Report. The annual NAV reports will contain, at a minimum, a focused summary of the validation methodologies and the subsequent analytic results, presented using charts and written descriptions of the validation findings.

HSAG will submit the draft report to DHHS for review and approval based on a mutually agreed-upon project timeline so DHHS will have sufficient time for review. HSAG will then incorporate DHHS' feedback and deliver the final reports to DHHS in a 508-compliant format, as needed.

How Approach Meets or Exceeds Requirements of the RFP

Since 2001, HSAG has conducted more than 60 managed care provider network adequacy assessments across 12 states. HSAG works with each state Medicaid agency to design study topics and methods that ensure each health plan has an adequate provider network to deliver health care services to its covered managed care enrollees. Table V.D.2.e.2 highlights HSAG's current and previous experience across varying aspects of network adequacy assessment and provider network validation.

Table V.D.2.e.2—HSAG's Experience Conducting Network Adequacy Assessments in 14 States

NAV Element	AZ	CA	CO	FL	IL	IA	MI	NV	NH	OH	OR	TN	UT	VA
Years Conducting Network Adequacy Validation	2	3	3	2	3	4	1	2	3	11	2	18	2	1
Provider Crosswalk		X	X			X		X					X	
Network Capacity Analysis (Provider to Enrollee Ratios)		X		X		X		X	X			X	X	
Geographic Distribution Analysis (Time/Distance Analysis)		X	X	X	X	X	X	X	X			X	X	
Secret Shopper Telephone Survey			X		X	X	X	X	X	X				X
Direct Call Telephone Survey		X							X	X				
Provider Directory Audit					X	X				X	X	X		
Development and Calculation of Provider Network Metrics		X								X				
Validation of Health Plan Network Adequacy Metrics	X										X			

HSAG collaborates with each state Medicaid agency to define and customize the network adequacy assessments best suited for the state's Medicaid population, MCOs, DBMs, and current provider network status and reporting. For states with limited current reporting and provider network validation assessments, HSAG will assist DHHS in developing a provider crosswalk to ensure that all MCOs are identifying provider categories (e.g., PCPs, cardiologists, pediatric hospitals for MCOs and pedodontist, endodontists for DBM) in a consistent manner. For states with robust provider

classification definitions and regular network adequacy assessments, HSAG will validate the findings of the MCOs' and the DBM's network adequacy assessments.

Additionally, HSAG has more than 10 years of experience conducting appointment availability surveys to confirm that enrollees have timely access to health services and provider directory validations to ensure the information available to enrollees on the MCOs' and the DBM's online provider directories is complete and accurate. HSAG will collaborate with DHHS to identify innovative and meaningful network adequacy validation approaches that are appropriate to the Heritage Health program's provider and enrollee networks once the EQR NAV protocol is published.

HSAG staffs a multidisciplinary NAV team with statisticians, epidemiologists, public health professionals, mathematicians, and clinicians working to ensure meaningful and actionable results for its customers. The NAV team will work closely with DHHS' project team to identify the goals for the network analyses. HSAG's NAV team and DHHS' project team will work together to shape decision-making on critical issues, provide guidance on ongoing efforts, and help resolve problems and challenges throughout the project.

V.D.3.	Describe the Bidder's approach to providing technical assistance as identified in this section, and how the approach meets or exceeds the requirements of this RFP.

Bidder Response:

Approach to Providing Technical Assistance

HSAG's approach to providing technical assistance (TA) to states and their contracted MCOs and the DBM is flexible and responsive to the specific needs, environment, and EQRO contract requirements of each state it serves as the EQRO. Drawing from its extensive pool of subject matter experts, HSAG plans and executes TA projects in a professional and expert manner. These projects create a successful environment for learning and provide the best opportunity for improving performance and outcomes. The following comment highlights one state Medicaid agency's appreciation for the TA HSAG provided:

> ***"Nevada is in a period of rapid change and we have relied on HSAG to provide us with analysis on the impact of certain areas of health care reform. They have also helped us develop requests for information and requests for proposal to procure a managed FFS vendor. They have also assisted the State in drafting health care related grant applications worth millions of dollars to the State. Their knowledge of federal regulations has been invaluable to us in many areas." –Nevada Division of Healthcare Financing and Policy***

HSAG will focus its TA on helping to improve individual MCO and DBM performance and overall statewide performance in Nebraska. HSAG understands the DHHS mission, vision, and quality strategy priorities. Specifically, HSAG will tailor its TA to support DHHS in meeting its mission and quality strategy goals in line with the DHHS Quadruple Aim to improve enrollee experience of care and provider experience, the health of populations, and the reduction of per-capita cost of health care.

Pursuant to 42 CFR §438.358(d), HSAG will provide TA to DHHS, the MCOs, and the DBM while conducting activities related to the EQR activities. HSAG will use a team approach for TA, where HSAG's Nebraska EQRO project director will identify and collaborate with HSAG's subject matter experts to ensure the most efficient TA that will result in an enhanced understanding of quality improvement (QI) and, ultimately, in improved performance. HSAG accounts for TA that is specific to the mandatory and optional EQR services it provides and is included in the work plans and budgets for each activity. Additionally, HSAG understands that TA of up to 120 hours beyond the typical assistance related to EQR activities may be required and stands ready to provide customized TA at DHHS' request.

a. Provide Technical Guidance in Conducting Activities that Provide Information for the EQR

The Contractor will, at the State's direction, provide technical guidance to groups of MCOs or the DBM to assist them in conducting activities related to the mandatory and additional activities that provide information for the EQR.

Upon DHHS' direction and authorization to provide technical guidance to the MCOs and the DBM, HSAG will support the MCOs and the DBM on activities that provide information for the EQR. This TA will enhance the MCOs' and the DBM's understanding of EQR activities and the importance of each in assessing and improving MCO, DBM and statewide performance. As described in more detail below, HSAG will work with DHHS to:

- Establish TA topics
- Plan for the TA
- Conduct TA
- Submit deliverables

Establish TA Topics

Upon DHHS' request for TA, HSAG will work with DHHS to determine the TA topics needed to provide guidance to the MCOs and the DBM. HSAG's EQR project team will contribute extensive knowledge and expertise in all areas related to EQR activities, such as development of performance improvement projects; validation of performance improvement projects; performance measure development; validation, calculation, and reporting; biostatistics and complex analytics; network analyses and validation; survey development and administration; and encounter data validation as well as

Medicaid-related technical assistance such as managed care rules and regulation interpretation and Medicaid managed care expansion.

Following are examples of areas in which HSAG has provided TA to state Medicaid agencies and their contracted MCOs, PAHPs, and PIHPs and which have led to improved quality outcomes:

- Performance improvement projects
- Grievance and appeals process
- Care management/care coordination programs
- Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[4] sampling and development of CAHPS supplemental questions
- Pay-for-performance program methodology and performance measures
- Health plan compliance and readiness reviews
- Identifying and selecting program-specific performance measures
- Developing and implementing new Medicaid programs
- Home and community-based services waiver program requirements

HSAG will tailor its technical guidance to the specific needs of DHHS and its MCOs and the DBM. As the largest and most experienced EQRO in the nation, HSAG is well positioned to anticipate and provide guidance to DHHS for areas in which the MCOs and the DBM may require TA.

Plan for the TA

At DHHS' direction, HSAG will facilitate all TA projects through HSAG's assigned project director of the Nebraska EQRO contract, collaborating with the EQR activity project manager who is the subject matter expert for the TA topic.

HSAG will initiate a planning process with DHHS to implement EQR-related TA and will schedule a planning meeting with the appropriate DHHS staff members to learn about DHHS' vision and intended goals for the TA. HSAG also will gather background information from DHHS for HSAG's approach on providing the TA. When it receives DHHS' background information and goals, HSAG will identify internal subject matter experts to conduct the TA. HSAG's staff will conduct extensive research on the best approach for the TA, exploring options for customized TA content and structure.

[4] CAHPS®is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Once HSAG identifies the subject matter expert(s) and receives DHHS approval on the approach, it will coordinate with DHHS to establish the date and time for the TA session. HSAG will develop a save-the-date message and work with DHHS to determine the best mechanism to communicate the information to DHHS, MCO, and DBM participants.

HSAG will submit to DHHS the draft agenda and training materials ahead of the TA session and incorporate DHHS' input to ensure HSAG meets the training objectives. Once DHHS approves the training materials and prior to the training, HSAG will send participants the final agenda and training materials by email.

Conduct TA

To reduce costs and promote more flexible and timely TA delivery, HSAG will provide TA primarily by teleconference, webinar, and email, but can provide any TA activities on-site, as requested by DHHS. For webinars, HSAG will organize a Webex meeting for each TA session. Hosting the training on Webex will allow for a large number of DHHS, MCO, and DBM staff members to participate because it does not require travel expenditures. At the beginning of the TA session, HSAG will document the attendance of participating DHHS, MCO, and DBM staff members. HSAG also will announce conference line logistics and introduce the TA trainer. HSAG's trainer will conduct an educational training on the specified EQR category TA topic and facilitate a question-and-answer and discussion session to encourage DHHS, MCO, and DBM participation and ensure all questions and concerns are addressed. HSAG recognizes that the information generated from its EQR activities and findings must provide DHHS, MCOs, and the DBM with meaningful and actionable results, including recommendations to improve performance.

Submit Deliverables

After each TA session, HSAG will submit to DHHS a written summary of the technical assistance provided. The summary will include the names of HSAG, DHHS, MCO, and DBM participants; training presentations; training notes; and a summary of the question-and-answer session. Once approved, HSAG will distribute the written summary to DHHS, MCO, and DBM participants. Additionally, HSAG will include in the annual EQR technical report results and recommendations related to the EQR-related TA sessions.

b. Report Problems and Propose a Corrective Action Plan

The Contractor will report in writing any problems with the administration of the MCO or the DBM Contracts and will propose a corrective action plan for any problems directly related to the performance of this Contract.

In its tenure conducting EQR activities in 16 states, HSAG has identified needs for technical assistance by conducting EQR activities and performing root cause analyses of deficiencies identified in the process. Sometimes, HSAG finds opportunities to improve administration of managed care contracts as well as to clarify language in the managed care

contract itself. If in its EQR of the program HSAG finds issues with the administration of the MCO or the DBM contract, HSAG will provide a written summary of issues identified and will provide consultation, expertise, and specific recommendations, in the form of a CAP to DHHS. HSAG will use its comprehensive knowledge of DHHS, each MCO and DBM, information from statewide and comparative results of EQR activities, and performance outcomes and trends to make recommendations for areas identified as opportunities for improvement.

HSAG's CAP-specific TA is successful because of the close interaction and cooperation HSAG's staff establishes with its contracted state Medicaid agencies and MCOs or DBMs. HSAG staff members have the experience to identify statewide or overall program opportunities for improvement and make recommendations to overcome systemwide areas of weak performance.

Supporting MCO and DBM CAPs

When findings of deficiency in MCO or DBM operations or performance occur, HSAG will work with the MCOs and the DBM to address and remediate the deficiencies through CAPs. HSAG will support this process by providing DHHS with guidance and TA, as needed, as the MCOs and/or DBM develop and implement CAPs. HSAG will provide CAP templates to facilitate the process. HSAG will provide ongoing communication to DHHS, the MCOs, and the DBM regarding the CAP process, timelines, and expectations to ensure this communication is methodical, well-organized, efficient, and effective. HSAG's TA will be tailored to the specific needs of DHHS and its contracted MCOs and the DBM. Once the MCO and DBM documents its plans of action to mitigate the identified deficiencies, HSAG will provide needed TA to ensure the CAP sufficiently addresses the recommendations for improvement and can reach compliance for the standard successfully when the CAP is implemented. HSAG has an expert clinical and analytical staff with extensive experience in providing TA to states on an array of topics tailored to support the success of the managed care program.

c. Provide Technical Guidance in the Development of Performance Improvement Projects

The Contractor will provide technical guidance in the development of performance improvement projects.

HSAG will provide ongoing technical guidance in the development of PIPs. For each PIP, HSAG will collaborate with DHHS to select a specific QI topic that aligns with the priority areas that DHHS identifies. HSAG will draw on its EQRO expertise as well as extensive knowledge of best practices and lessons learned in other states to provide DHHS with specific recommendations for PIP topics and indicators.

Technical guidance for developing PIPs will include but is not limited to:

- Providing information on industry standards for conducting PIPs.

- Identifying industry best practices, common issues, and performance trends, and conveying this information to DHHS, the MCOs, and the DBM.
- Educating the MCOs and the DBM on QI science techniques that include setting aims, establishing measures, determining interventions through process mapping and failure modes and effects analysis, and testing interventions using PDSA cycles, along with widespread implementation.
- Educating the MCOs and the DBM on how to conduct statistical testing and accurately interpret and report study indicator outcomes data.
- Using data to conduct drill-down analysis.
- Providing the MCOs and the DBM with timely feedback to make midcourse correction and correct identified deficiencies.

HSAG will organize a kick-off meeting with DHHS to discuss potential PIP topics and goals, and to develop and verify the overall project plan.

Study Design

HSAG's approach will begin with developing the study design for the PIP(s). The study design will establish the methodological framework for the PIP, with steps that will include:

- **Select the study topic—**The topic(s) will address the overarching goal of a PIP, which is to improve processes and outcomes of health care the MCOs and the DBM provides. Study topics must reflect MCO and DBM enrollee characteristics, including demographics, prevalence of disease, and the potential consequences of disease.
- **Develop the PIP aim statement—**The aim statement will identify the focus of the PIP and establish the framework for data collection and analysis. The aim statement will define the improvement strategy, population, and time period. It should be clear, concise, and answerable.
- **Identify the PIP population—**The PIP population step will clearly identify the target population in relation to the PIP aim statement (such as age, length of enrollment, diagnoses, procedures, and other characteristics). Depending on the nature of the PIP aim statement, PIP population, and available data, the PIP may include the entire population or a sample of the population.
- **Use sound sampling methods—**HSAG will work with DHHS, the MCOs, and the DBM to select appropriate sampling methods to ensure the collection of information can produce valid, reliable results.
- **Select the PIP Variables—**The number and types of study indicators will be selected based on what is needed to answer the aim statement. The PIP variable(s) also will be based on whether appropriate, reliable data are available to measure performance and track improvement over time. HSAG also will consider the availability of data when selecting the PIP variable(s), since more frequent access to data supports continuous QI and PDSA efforts.

- **Collect valid and reliable data—**HSAG will ensure that the data collection methodology is valid and reliable. Validity means that the data are measuring what is intended. Reliability means that the data are producing consistent results.

Analyze and Interpret Results

HSAG will facilitate discussions with DHHS, the MCOs, and the DBM regarding QI processes as well as analysis and interpretation of the results generated from the baseline rate. The MCOs and the DBM will be required to submit data to HSAG in the manner HSAG requests for analysis. HSAG will assign the MCOs and the DBM with the tasks of completing a causal/barrier analysis to determine barriers to performance, prioritize the identified barriers, and develop actionable interventions targeted to improve outcomes.

Review Improvement Strategies

HSAG will provide TA and guidance throughout the PIP process, as well as education and training on the use of QI science tools to review data and develop improvement strategies reasonably thought to impact the PIP variables identified in the design stage. HSAG will facilitate discussions between DHHS, the MCOs, and the DBM on using tools such as process mapping, failure modes and effects analysis, and failure mode priority ranking to determine interventions to test through a series of thoughtful, incremental PDSA cycles.

How Approach Meets or Exceeds Requirements of the RFP

HSAG is well-positioned to ensure it works with and provides DHHS with the precise level of technical guidance to meet DHHS needs, and to support DHHS' and the MCOs' and DBM's performance improvement. Following are ways HSAG exceeds the requirements of the RFP in conducting technical guidance that provides the results DHHS is seeking. HSAG:

- Uses its experience and lessons learned across the 16 states in which it conducts EQR activities to inform its approach.
- Conducts ongoing research to stay informed on the most current issues affecting the health care industry and, specifically, the Medicaid population and managed care programs and health plans.
- Uses a technical approach that aligns with the pace of QI science and includes a focus on health care outcomes, rapid-cycle improvement, setting achievable goals, skill-building, and recommending actions that positively impact health care delivery and improve health care outcomes.
- Has subject matter experts on staff who are immediately available to DHHS and its contracted MCOs and DBM and who have extensive experience in QI and all EQR activities.

Additionally, HSAG works closely with CMS to ensure HSAG's PIP designs, tools, and forms are of the highest quality and promote quality improvement. To that end, CMS has praised HSAG's PIP forms and validation tools, and has updated the protocols to include mention of HSAG's rapid-cycle PIP process.

V.D.4.a.	Describe the Bidder's approach to providing an annual detailed technical report for each MCO and PAHP, and how the approach meets or exceeds the requirements of this RFP.

Bidder Response:

Approach to Providing an Annual Detailed Technical Report for each MCO and PAHP

HSAG has extensive experience developing, writing, assembling, and submitting annual detailed technical reports. HSAG currently prepares annual technical reports for Arizona, California, Colorado, Florida, Georgia, Hawaii, Illinois, Iowa, Michigan, Nevada, New Hampshire, Oregon, Utah, Vermont, and Virginia. HSAG's technical reports provide quality performance information on more than 170 managed care entities (MCEs) within these states. In addition to ensuring the report meets the federal reporting requirements, HSAG will collaborate with DHHS to customize technical reports to meet the State's needs, ensuring that DHHS can use the reports to improve its ability to oversee and manage each MCO and the PAHP (hereby referred to as the DBM), while helping the MCOs and the DBM improve their performance with respect to quality, timeliness, and access to care. Using its well-established comprehensive approach, HSAG will produce annual detailed technical reports for each MCO and the DBM and, in alignment with the technical report guidance in the CMS EQR Protocols, October 2019[5] (EQR protocols), an aggregate report that summarizes results across all MCOs and the DBM and provides statewide recommendations for performance improvement. HSAG's approach for developing the reports will involve the following four key steps, which are further described in the sections that follow:

Step 1: Establish report content and timeline

Step 2: Develop report templates

Step 3: Obtain information from the MCOs and the DBM

Step 4: Produce content-rich reports

[5] The CMS EQR Protocols may be found at https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/quality-of-care-external-quality-review/index.html. Accessed on: September 8, 2020.

Establish Report Content and Timeline

Annually and in accordance with 42 CFR §438.364, HSAG will produce one independent EQR technical report for each MCO and DBM, and one overall aggregate report that summarizes performance across all MCOs and the DBM. In producing the reports, HSAG will use data from all mandatory and optional EQR activities conducted in a manner consistent with the EQR protocols, and will include for each activity the procedures used to analyze the data collected and how HSAG reached its conclusions regarding the quality, timeliness, and access to care that each MCO and the DBM provided. HSAG will include the following components as outlined in the technical report guidance in the EQR protocols:

- The objectives
- Methodology for data collection and analysis
- Description of data obtained
- Conclusions based on the data analysis

HSAG also will ensure that the reports contain the following information for each MCO and the DBM:

- An assessment of the individual strengths and weaknesses associated with the quality, timeliness, and access to health care services provided to Medicaid enrollees.
- Recommendations to improve the quality of health care services provided to enrollees.
- Assessment of the degree to which the MCO or DBM has effectively addressed the EQRO recommendations from the previous EQR.

HSAG also will prepare an annual EQR technical report that provides aggregate results and findings across all MCOs and the DBM for all EQR activities and the Heritage Health program. As part of this process, HSAG will provide the following:

- Methodologically appropriate comparative information about the MCOs and the DBM, when applicable.
- An assessment of the Heritage Health program based on aggregated results of all EQR activities.
- Recommendations for how DHHS can target goals and objectives in the quality strategy to support improvement in the quality, timeliness, and access to health care services provided to Medicaid enrollees.

To ensure timely delivery of all draft and final reports, HSAG will collaborate with DHHS to develop a detailed timeline that includes HSAG's submission of the draft reports to DHHS, DHHS' review of and feedback on each draft report, and the submission of final reports to DHHS. HSAG will ensure the reports are finalized well in advance. This will allow time for HSAG to compile and include the aggregate information in the respective annual EQR technical reports before submitting them to DHHS no later than October 15 each year.

Develop Report Templates

In collaboration with DHHS, HSAG will develop report templates that align with the guidance CMS provides in its most current EQR protocols and will take into consideration any DHHS feedback and lessons learned from the previous year's report deliverables. The report template development process provides HSAG and DHHS the opportunity to collaborate on the format and content of the reports before HSAG's report production process begins. To ensure consistency across all MCO and DBM reports, the template will include boilerplate language that will be duplicated in all reports and will be modified, as appropriate, for each MCO and the DBM. The aggregate report will be a compilation of MCO and DBM-specific data and statewide aggregated information. HSAG will submit, for DHHS' review, a draft template for each report and will incorporate DHHS' feedback. After receiving DHHS approval, HSAG will produce final templates for each report.

Obtain Needed Information from the MCOs and the DBM

Most of the information for the annual EQR will be available to HSAG through the activity-specific deliverables. However, before producing the annual EQR technical reports, HSAG will work with DHHS, the MCOs and the DBM, as applicable, to confirm or obtain necessary information. HSAG will request the following information from DHHS:

- **Overview of MCOs and the DBM:** HSAG will confirm MCO and DBM-specific enrollment information.
- **Quality Strategy:** HSAG will confirm that the quality strategy available on DHHS' website is the most current version for use in the technical report.
- **Quality Initiatives:** HSAG will consult with DHHS to determine which quality initiatives, if any, it should include as part of the technical report.
- **Focus Areas:** HSAG will collaborate with DHHS to determine whether there are any DHHS-specific focus areas to emphasize in the report.
- **EQR Activities:** HSAG will consult with DHHS to determine if there are optional activities that DHHS or another entity conducted or validated and that should be included as part of the technical report (e.g., CAHPS, provider surveys, encounter data validation results).
  - As applicable, HSAG will request that DHHS provide the activity reports and results to HSAG for inclusion in the EQR technical reports.

HSAG also will request the following information from the MCOs and the DBM:

- **Follow-Up on Prior EQR Recommendations:** HSAG will develop, and subsequently email to the MCOs and the DBM, plan-specific templates with instructions for use in documenting the activities and/or interventions that were implemented in response to the recommendations from the prior year's technical report.
  - HSAG will use the MCOs' and the DBM's responses to assess the degree to which each MCO and the DBM addressed the recommendations to support improvement in the quality, timeliness, and access to health care services provided to its members.

Produce Reports

HSAG is dedicated to producing highly professional, accurate, timely, and useful technical reports. HSAG will develop detailed annual EQR technical reports that align with DHHS' expectations and adhere to both the requirements in federal rule and the tips presented in the EQR protocols. HSAG develops reports that are actionable, clear, and concise, and that will provide DHHS, CMS, the MCOs, the DBM, and stakeholders with a comprehensive understanding of each MCO's and the DBM's performance, as well as overall statewide performance in providing high quality, timely, and accessible services to the enrollees in the Heritage Health program. Within the report, HSAG will include meaningful and relevant recommendations for improving areas of low performance. Before finalizing the technical reports, HSAG will validate all data and conduct extensive quality checks to ensure accuracy.

Following are descriptions of HSAG's steps for the report production process.

Compile Data, Conduct Analyses, and Draw Conclusions

HSAG's EQR technical report will include a description of the way data from all EQR activities, conducted in accordance with 42 CFR §438.358, were aggregated and analyzed and how conclusions were drawn with regard to the quality, timeliness, and access to health care services. HSAG's annual technical report format includes a section containing the description of the objectives related to each mandatory and optional activity; the technical methods for collecting data and performing analyses of the data for each activity; and a description of the data obtained through completion of each activity. These data will include performance data validated by highly skilled staff members working in HSAG's Data Science & Advanced Analytics (DSAA) division. The conclusions drawn from the data for each activity also will be included throughout the report.

To support impactful quality improvement, HSAG will comprehensively assess MCO and the DBM's performance in providing quality, timely, and accessible health care services to enrollees by analyzing and evaluating findings from EQR mandatory and optional activities, and from DHHS-required activities, as applicable. HSAG's methodology for

developing actionable recommendations based on these results is multifaceted. This methodology includes formulating objectives, employing technical methods for collecting data, analyzing findings, identifying strengths and opportunities for improvement, and integrating data from multiple sources to assess and make recommendations.

For each EQR-related activity, HSAG uses quantitative and qualitative methods for data collection and analysis, such as document and file reviews; medical record reviews; encounter data validation; surveys; audits; and interviews. HSAG uses unique proprietary evaluation tools and statistically sound data validation practices to review MCO and DBM activities objectively. HSAG will document the conclusions drawn, ensuring that appropriate statistical and methodological guidelines are used to reach the conclusions. HSAG will present the findings from the data in graphs, tables, and charts, with accompanying detailed narrative explanations, as necessary, to describe the impact on MCO, DBM, or statewide performance. Within the findings and conclusions section of the technical report, HSAG will summarize the results for each EQR activity, as appropriate. HSAG will describe any cautions to consider if limited data are received, if there is less than complete confidence in the completeness and accuracy of the data, if there are differences in the collection methodology, or if there are differences in the measurement periods. HSAG will provide meaningful and credible conclusions by comparing performance to available established benchmarks as approved by DHHS, using regularly updated national databases as the source.

Performance Measure Results

Conclusions will be drawn from each MCO's and the DBM's validated performance measure results and considered for inclusion in the EQR technical report. HSAG has been an NCQA-certified HEDIS/CAHPS survey vendor and NCQA-licensed HEDIS Compliance Audit Organization since the inception of the NCQA program, and it maintains impeccable standards for performance measure validation activities. The validation activity will use NCQA data collection and analytical methods to validate each MCO's and the DBM's source code, supplemental data, and primary source data, and to draw conclusions from the data. Additionally, HSAG has flexibility to adapt performance measure analyses to draw conclusions and ensure alignment across EQR activities. For example, HSAG can provide specific consideration for presenting data and associated conclusions to align with DHHS-specific initiatives.

Performance Improvement Projects (PIPs)

HSAG also will include conclusions drawn from the PIP activity in the technical report. HSAG's PIP methodology aligns with CMS' EQR Protocol 1: Validation of PIPs. This activity verifies whether an MCO or DBM's PIP used sound methodology in its design, implementation, analysis, and reporting. HSAG's validated results of the performance improvement project activity will be a component in developing conclusions about each MCO's and the DBM's overall performance.

Compliance Review

The applicable compliance review results also will be considered when drawing conclusions in the technical report. The compliance process methodology includes an analysis of whether the MCOs and the DBM complied with federal and State requirements. In alignment with EQR Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations, HSAG will analyze the MCOs' and the DBM's submitted information, the responses during the on-site interviews, and the results of additional documentation and records that HSAG reviews while on-site (when applicable). Reviewers will analyze each standard area to determine strengths and opportunities for improvement that relate to all mandatory and optional activities conducted within the previous 12 months. Since DHHS follows a three-year cycle for its comprehensive compliance reviews, HSAG will use other compliance review activities, such as CAP follow-up and reviews of targeted program areas, to meet the EQR technical report requirement.

Network Adequacy

Upon CMS development of the network adequacy validation protocol, or DHHS' initiation of the network adequacy activity, HSAG will include the conclusions drawn from the network adequacy activity. HSAG has significant experience using the results of network adequacy results to determine the extent to which MCOs and the DBM have adequate provider networks in coverage areas to deliver health care services to its managed care enrollees.

EQR Activity Results

HSAG will evaluate the mandatory and optional activity results, for individual MCOs and the DBM and for the MCOs and the DBM collectively, using industry-appropriate methods to collect, analyze, and validate the data and information. The report will describe the methods used to develop overall conclusions about the contracted MCOs' and the DBM's performance.

Draw Conclusions

HSAG will base its conclusions related to all activities on data that subject matter experts have reviewed and analyzed. HSAG's analyses will reflect performance assessment, including the effect performance may have on the quality, accessibility, and timeliness of services provided to Medicaid enrollees. As applicable, HSAG will include comparisons to previous performance, trend information, comparisons to the DHHS-established minimum and high-performance levels, analysis related to the Medicaid quality strategy focus areas, and comparisons to national benchmarks (e.g., Quality Compass®, Healthy People 2030 goals). As applicable and based on its review and assessment of all activities, HSAG will identify MCO and DBM-specific strengths and opportunities for improvement and provide MCO and DBM-specific recommendations for steps to improve performance. HSAG will make meaningful conclusions and

methodologically appropriate and actionable recommendations for each MCO and the DBM, as appropriate, to target performance improvement activities within and across the domains of care related to quality, timeliness, and access to care. When making recommendations, HSAG will consider its thorough knowledge of federal and State requirements as well as MCO and DBM-level promising practices and will ensure that recommendations inform progress on DHHS' quality strategy priorities as well as other priority areas.

Produce Draft and Final Reports

HSAG will produce and submit draft reports for DHHS' review and feedback. Upon receiving feedback, HSAG will incorporate DHHS' edits and produce final versions of the reports. All final versions will be in a Portable Document Format (PDF) format and will meet DHHS' accessibility standards for public posting.

How Approach Meets or Exceeds Requirements of the RFP

HSAG has the skills and experience to report the results of the EQR-related activities in the technical report in a way that exceeds the requirements of this RFP. The HSAG staff members who produce annual technical reports have extensive knowledge of current best practices in the health care industry and national standards and guidelines in all areas of Medicaid managed care. In addition, the professional backgrounds of staff members responsible for the EQR activities and subsequent development of the annual technical reports include expertise related to physical health care, behavioral health care, dental care, and long-term services and supports, as well as data aggregation and analysis. With its extensive experience producing annual technical reports in multiple states with more than 170 MCEs combined, the HSAG EQR project team is well-positioned to analyze the activity findings and to draw conclusions about each MCO's and the DBM's access, quality, and timeliness of services to enrollees.

With the release of the EQR protocols in October 2019, HSAG redesigned its technical report templates to align with CMS' expectations for providing information of the greatest use to states and other stakeholders. To that end, HSAG is committed to providing DHHS with high-quality reports that are actionable, clear, and concise; highlight substantive findings for each MCO, the DBM, and the Heritage Health program; and contain actionable and relevant recommendations. When it identifies weaknesses within the MCO, DBM, or the Heritage Health program, HSAG will include its understanding of why the weaknesses exist, along with recommendations for mitigating the issues. Through its aggregated findings across all MCOs and the DBM, HSAG will be able to determine if issues are localized to one MCO or the DBM or whether there is a systemic issue within the Heritage Health program that need to be addressed. Finally, HSAG has taken significant steps to reduce the nonessential narratives within its reports by showcasing key findings through visual displays of information (e.g., tables, charts, graphs) and using appendices to document technical information, such as activity-specific methodologies.

Multiple states have used HSAG's technical reports, and specifically the conclusions and recommendations sections, to make significant changes to their programs that address low performing areas. For example, one state used the program recommendations that HSAG presented in the annual EQR technical report to modify the goals and objectives within its quality strategy, and it subsequently conducted work groups with its MCOs and the DBM to develop initiatives that addressed the recommendations that HSAG provided. The results are already showing considerable improvement in the care management services that the state provides to its enrollees, as determined through enrollee care management surveys. Similarly, another state improved its enrollment and disenrollment processes based on feedback and recommendations that HSAG provided in that state's annual technical report. This state has significantly reduced the burden to its enrollees through changes in its processes.

These examples provide evidence that HSAG's approach to producing the annual technical reports meets or exceeds the requirements of this RFP

V.D.4.b.	Describe the Bidder's approach to providing an annual assessment of each MCO's or PAHP's strengths and weaknesses for the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries, and how the approach meets or exceeds the requirements of this RFP.

Bidder Response:

Approach to Providing an Annual Assessment of Each MCO's or PAHP's Strengths and Weaknesses

From the collected data during the composition of the annual technical report, HSAG will summarize the MCOs' and the DBM's strengths and weaknesses and provide an overall assessment and evaluation of the quality, timeliness of, and access to, care and services the MCOs and the DBM provide to enrollees. HSAG will identify areas of strong performance by individual MCOs and the DBM and across both the MCOs and the DBM collectively. This will include highlighting the MCOs' and the DBM's performance in meeting or exceeding DHHS' performance targets as well as noting promising practices that may have contributed to the high performance. Identifying MCO and DBM strengths also will assist in spreading successful interventions across all MCOs and the DBM and/or throughout DHHS' statewide Medicaid program.

By assessing performance strengths and weaknesses in the domains of quality, access, and timeliness, DHHS can identify where each MCO and the DBM performs well and where further quality improvement is needed.

Assessments will be based on the following definitions of quality, access, and timeliness:

- **Quality:** CMS defines "quality" in the final rule at 42 CFR §438.320 as follows: "Quality, as it pertains to external quality review, means the degree to which an MCO and the DBM increases the likelihood of desired health outcomes of its enrollees through its (1) structural and operational characteristics, (2) the provision of services that

are consistent with current professional, evidence-based-knowledge, and (3) interventions for performance improvement."

- **Timeliness:** NCQA defines "timeliness" relative to utilization decisions as follows: "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation." It further discusses the intent of this standard to minimize any disruption in the provision of health care. HSAG extends this definition of timeliness to include other managed care provisions that impact services to enrollees and that require a timely response from the MCO or the DBM (e.g., processing expedited enrollee appeals and providing timely follow-up care).
- **Access:** CMS defines "access" in the final rule at 42 CFR §438.320 as follows: "Access, as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by MCEs successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under §438.68 (Network adequacy standards) and §438.206 (Availability of services)."

In assessing strengths and weaknesses, HSAG will consider the MCO's and the DBM's structure and operations, regional demographics, and any national benchmarks available for comparison, as well as DHHS' contract with the MCOs and the DBM and the federal managed care standards. HSAG will draw from its detailed knowledge of health plans' performance across the nation to derive its assessment of the MCOs and the DBM. Additionally, over time and in successive years, strengths and weaknesses will identify performance trends.

HSAG will assess and, within the report, describe the linkage of results across the activities, looking for themes and similarities or, conversely, differences in results within the same domain of care. For example, if network adequacy results show a lack of available appointments for primary care, the result has the potential of a negative impact on access-related measures. If it appears that access-related measures are being affected, HSAG will highlight this finding in the report and recommend that the MCO and/or DBM identify the gaps in its provider network and develop strategies to make appointments more available. HSAG has found that by providing more robust analyses in its technical reports, both MCE and state staff members are better informed as to what may be driving and impacting MCE performance within each EQR activity and across multiple EQR activities. Moreover, MCEs are better equipped to implement measurable, impactful, and meaningful quality improvement interventions based on the analyses, conclusions, and recommendations presented in the technical report.

How Approach Meets or Exceeds Requirements of the RFP

HSAG has extensive experience conducting hundreds of EQRs across the nation. Additionally, the HSAG staff members who will lead the Nebraska EQR activities have significant and varying experience in the health care industry, including experience working both at state Medicaid agencies and at Medicaid managed care health plans in clinical

and nonclinical roles. Although clinical and nonclinical roles are very different types of positions, they both bring critical aspects to understanding the overall Medicaid managed care program. This all-encompassing experience positions HSAG staff members well to assess the strengths and weaknesses of the MCOs, the DBM, and the Heritage Health program in comparison to both State performance metrics and national standards, and overall health care outcomes. To highlight its experience and its ability to exceed the requirements of the RFP, HSAG provides the following real-life assessment of a health plan's opportunities for improvement, identified through the annual EQR process.

Example: An MCO's rates for follow-up care for children receiving attention-deficit hyperactivity disorder (ADHD) medication presented opportunities for improvement. Both measure indicators demonstrated a decline in performance from HEDIS 2017 to HEDIS 2018, and the continuation and maintenance phase indicator fell below the 50th national Medicaid percentile. Through the compliance review activity, HSAG noted that the MCO's 2017 quality improvement program evaluation did not include an analysis of the measure results for Follow-Up Care for Children Prescribed ADHD Medication, as it did for other Medicaid performance measures. Further, the MCO's 2018 quality improvement work plan did not include any goals for this performance measure. HSAG recommended that, to identify interventions that could improve these rates, the MCO should monitor performance related to care for children on ADHD medication in the manner performed for other Medicaid performance measures.

HSAG's process for reviewing MCO and DBM performance across the continuum of program areas demonstrates HSAG's ability to assess for strengths and weaknesses effectively, and subsequently to provide relevant, innovative, and action-oriented recommendations, therefore meeting or exceeding the requirements of this RFP.

V.D.4.c.	Describe the Bidder's approach to providing recommendations for improving the quality of health care services furnished by each MCO or PAHP, and how the approach meets or exceeds the requirements of this RFP.

Bidder Response:

Approach to Providing Recommendations for Improving the Quality of Health Care Services Furnished by Each MCOs or PAHP

When HSAG identifies deficiencies or areas of suboptimal performance, it will offer the MCOs, the DBM and, as applicable, DHHS, its recommendations for improvement. To make actionable and relevant recommendations, HSAG will draw upon its knowledge of emerging and best practices as well as its experience with MCEs and the Medicaid programs in the for which it provides EQR services. HSAG will identify overall performance successes and challenges and provide recommendations for effective improvement interventions, when indicated. In addition to providing recommendations to the MCOs and the DBM, HSAG will identify how DHHS can refine its quality strategy goals and objectives to support MCO and DBM improvements in the quality and timeliness of, and access to, health care, and

include the findings in the technical report, as the Medicaid and Children's Health Insurance Plan (CHIP) Managed Care Final Rule requires. HSAG will review DHHS' Quality Strategy for Heritage Health and the Dental Benefit Program in comparison to the findings across all EQR activities, and will use this information to identify and recommend enhancements to the strategy so goals and objectives are in alignment and support the MCOs' and the DBM's quality improvement work. HSAG staff members have the experience to identify program opportunities for improvement and make recommendations to overcome areas of weak performance, and they will offer measurable and actionable recommendations. HSAG's recommendations have served as topic areas for targeted technical assistance to health plans and states, and as topics for quarterly quality meetings or conferences. HSAG's EQR technical report recommendations also have been used to develop, revise, or add health plan contract requirements, as well as to align state quality strategy initiatives with areas of greatest need for improvement.

How Approach Meets or Exceeds Requirements of the RFP

States and MCEs have used HSAG's recommendations to improve the performance within their Medicaid managed care programs. HSAG's findings of performance trends and the resulting quality improvement recommendations are often the catalyst for state-level policy changes, contract revisions, statewide improvement initiatives, and technical assistance forums. To demonstrate the high-quality and detailed recommendations that it will provide to DHHS, the MCOs', and the DBM, HSAG is providing the following actual examples of recommendations that HSAG presented to an MCE and a state Medicaid agency within the annual technical report:

MCO/DBM-Specific Recommendation Example

Performance Measures

As a result of the findings related to the quality of, timeliness of, and access to care and services provided by *[Name of MCO/DBM]* to members, HSAG recommends that *[Name of MCO/DBM]* incorporate efforts for improvement for performance measures that fell below the statewide average. To prioritize its efforts, *[Name of MCO/DBM]* should identify a specific subset of the measures below and develop initiatives to improve the performance of those selected measures. The selected measures, and any subsequent initiatives and interventions, should be included as part of *[Name of MCO/DBM]* quality improvement strategy within its Quality Assessment and Performance Improvement Program (QAPIP):

[Name of MCO/DBM] should include within its next annual QAPIP review of the results of analyses for the performance measures selected from those listed above and that answer the following questions:

1. What were the root causes associated with low-performing areas?
2. What unexpected outcomes were found within the data?

3. What disparities were identified in the analyses?
4. What are the most significant areas of focus (or populations) for which improvement initiatives are planned? What is the highest impact area(s) to make an improvement(s) (low effort/high yield)?
5. What intervention(s) is *[Name of MCO/DBM]* considering or has already implemented to improve rates and performance for each identified performance measure?

Based on the information presented above, *[Name of MCO/DBM]* should include the following within its quality improvement work plan:

- Measurable goals and benchmarks for each performance measure.
- Mechanisms to measure performance.
- Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates.
- Identified opportunities for improvement.
- Ongoing analysis to identify factors that impact adequacy of rates.
- Quality improvement interventions that address the root cause of the deficiency.
- A plan to monitor the quality improvement interventions to detect whether they effect improvement.

State-specific Recommendation Example

Access to Care—Children's Preventive Services

Complete and accurate provider directories and provider information are imperative to provide enrollees with adequate information that helps them choose a provider, allows for timely access to providers when needed, and increases satisfaction with their provider and the *[State]* Medicaid managed care program. Inaccuracies in provider information maintained and published by the MCOs could potentially contribute to access issues being experienced by members. Resolving these inaccuracies could improve enrollee satisfaction and address some of the factors impeding children's access to primary care providers (PCPs) for preventive care visits, which in turn should result in improved HEDIS rates and reduce the number of avoidable emergency department visits. To improve the accuracy of provider data, HSAG recommends *[State Medicaid agency]* expand the scope of existing provider data validation activities within the state's monitoring review by conducting an evaluation of each MCO's provider data systems and published provider directories. This review could include:

- A focused review and assessment of each MCO's collection, maintenance, and publication of provider data.
- An evaluation of provider data accuracy on a statistically significant sample of in-network providers enrolled with each MCO through a provider survey or other method deemed appropriate by *[State Medicaid agency]*. This evaluation should include high-volume specialists, in addition to PCPs.

- An evaluation of provider data accuracy on a sample of in-network providers enrolled with multiple MCOs to allow controlled comparisons of key data elements (e.g., Is the provider accepting new patients from only one MCO or all contracted MCOs? Is the provider listed with the same specialty in multiple networks or listed differently?).
- Implementation of a time-limited work group consisting of *[State Medicaid agency]* and the MCOs to:
  - Identify best practices for collecting, maintaining, and producing accurate provider data.
  - Evaluate MCO procedures for capturing provider network changes and determine how to limit gaps or deficiencies in data submitted to *[State Medicaid agency]* or published for enrollees.
  - Address the refinement or development of guidelines defining expectations for providers and MCOs regarding the collection and maintenance of up-to-date provider information, including updating the time frame allowed for making directory changes (e.g., revise from 30 days to seven days upon receipt of provider updates).

HSAG is confident it will exceed DHHS' expectations and the requirements of this RFP by providing recommendations that not only will improve the quality of health care services being provided to enrollees, but also will drive improvement in health outcomes.

V.D.4.d.	Describe the Bidder's approach to providing methodologically appropriate, comparative information about all MCOs and PAHPs, upon request, and how the approach meets or exceeds the requirements of this RFP.

Bidder Response:

Approach to Providing Methodologically Appropriate, Comparative Information about all MCOs and PAHPs Upon Request

Consistent with guidance issued in the EQR protocols, HSAG will provide meaningful and methodologically appropriate comparative information about all MCOs and the DBM, as applicable. HSAG will present the findings from the data in graphs, tables, and charts, with an accompanying detailed narrative, as necessary, to describe the impact on health plan or statewide performance. The visual displays of information will include performance measure scores and ratings from each EQR activity and for each contracted MCO and the DBM, as appropriate, for comparison. In addition to using national benchmarks for assessment and comparisons of performance, HSAG will calculate and apply statewide averages in its analysis and comparison of individual MCO and the DBM's performance results. If available, HSAG also will compare the MCO and DBM rates to local or regional benchmarks or specific DHHS quality strategy targets. The comparative information will be trended over time to reveal if the MCOs and the DBM are declining, remaining constant, or improving performance as measured by each EQR activity. HSAG will describe any cautions to consider if limited

data are received, if there is less than complete confidence in the completeness and accuracy of the data, if there are differences in the collection methodology, or if there are differences in the measurement periods.

Within the statewide conclusions and recommendations section of the aggregated technical report, HSAG will summarize the results for each mandatory and optional EQR activity it conducted, as appropriate, and discuss overall strengths and weaknesses of the Heritage Health program based on aggregated performance of the MCOs and the DBM.

HSAG will evaluate the comparative results from the mandatory and optional activities and develop overall conclusions about the Heritage Health program and its contracted MCOs and the DBM.

How Approach Meets or Exceeds Requirements of the RFP

HSAG's DSAA division has significant experience using analytical tools to collect, report, and compare sets of data and to present in easy-to-read and visually pleasing formats. Additionally, the HSAG Nebraska EQRO project director and project managers bring a breadth of knowledge and experience to each of the EQR activities, and collectively they will assess and compare the performance of the MCOs and the DBM to identify the substantial strengths and weaknesses of each MCO and the DBM when compared to each other, and also compared holistically across the Heritage Health program. HSAG's approach to assessing the contracted MCOs, the DBM, and the Medicaid managed care program exceeds the requirements of the RFP. The approach will ensure that DHHS has a sound understanding of the overall strengths and weaknesses of the program's performance related to quality, timeliness, and access to care, and will help provide DHHS the information it requires to facilitate performance improvement efforts that will lead to higher performing health care delivery systems for Nebraska Medicaid enrollees.

V.D.4.e.	Describe the Bidder's approach to providing an annual assessment of the degree to which each MCO or PAHP has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR, and how the approach meets or exceeds the requirements of this RFP.

Bidder Response:

Approach to Providing an Annual Assessment of the Degree Each MCO and PAHP Effectively Addressed Recommendations for Quality Improvement made by the EQRO in the Previous Year

As required by 42 CFR §438.364, HSAG will include in each annual technical report an assessment of the degree to which each MCO and the DBM effectively addressed the recommendations from the prior year's EQR. This assessment will include each MCO's and the DBM's responsiveness to, and success in, addressing any CAPs that resulted from the

EQR activities. To gather the information for this assessment, HSAG will provide each MCO and the DBM with a template form that will include the prior year's recommendations, instructions for completing the form, and examples of the level of detail that HSAG will be expecting to receive to effectively evaluate the MCO's and the DBM's level of success in each area with identified opportunities for improvement. HSAG will send the template form to each MCO and the DBM electronically and request that the form be returned within a designated amount of time, typically 30 days. An excerpt from HSAG's Follow-Up Response to Prior Year EQR Recommendations template is included in Figure V.D.4.e.1. which demonstrates how HSAG ensures that the MCOs' and the DBM's responses are complete and contain enough detail for HSAG to assess each MCO's and the DBM's progress in mitigating any identified deficiencies.

Figure V.D.4.e.1. — Prior Year Recommendations from EQR Technical Report

(EXAMPLE 1) Prior Year Recommendation from the EQR Technical Report for HEDIS/Performance Measures:
HSAG recommends that ABC Health Plan incorporate efforts for improvement for performance measures that fell below the 25th percentile and decreased by more than 5 percentage points from the following year's rates. To prioritize its efforts, ABC Health Plan should identify a specific subset of these measures and develop initiatives to improve the performance of selected measures. The selected measures, and any subsequent initiatives and interventions, should be included as part of ABC Health Plan's Quality Assurance and Performance Improvement (QAPI) program.
MCE's Response:
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • ABC Health Plan selected two measures [Measure #1 and Measure #2] in the 25th percentile to focus on in 2020. For each measure, two goals were added to the quality improvement work plan with targeted interventions directed toward improved performance. These goals are being monitored quarterly by the Quality Committee.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Measure #1: Demonstrated [XX] percent increase in performance for the past two quarters. Interventions [member gift card, reminder texts, etc.] were successful and have been incorporated into normal practice.
c. Identify any barriers to implementing initiatives: • Measure #2: Improved performance has yet to be demonstrated. ABC Health Plan has identified a large provider with low performance. Interventions are being targeted to this provider and performance will be monitored over the next quarter.

Upon receiving the completed form, HSAG will evaluate the MCOs' and the DBM's responses and compare the information to the MCOs' and the DBM's current performance in the area being evaluated. Based on the assessment, HSAG will document the effectiveness of each MCO's and the DBM's initiatives and interventions. Even well-planned, targeted plans of action that an MCO or the DBM implements will not always result in improvement. To that end, HSAG understands that the MCO and DBM may need to re-evaluate and analyze the root causes of its deficiencies to better target interventions that achieve improved results. In the current year's technical report, HSAG will provide additional follow-up recommendations to assist the MCOs and DBM, as necessary, through its analysis and corrective action planning process. HSAG also will provide DHHS with additional recommendations, as needed, to help ensure each MCO and the DBM has a successful process in place to support improvement.

How Approach Meets or Exceeds Requirements of the RFP

Since the inception of this requirement, HSAG has ensured that each technical report it produces includes an assessment of each MCE's responses to previous EQR recommendations. As demonstrated by the sample template form on the previous page, HSAG's approach to including this assessment in its technical reports is well-planned, meets the intent of the federal requirement, and ensures an effective process is in place to gather information about each MCO's and the DBM's level of success in implementing interventions and initiatives that address the recommendations HSAG made in the prior year's EQR. This documented process assures DHHS that HSAG's approach exceeds the requirements of the RFP.

V.D.4.f.	Describe the Bidder's approach to providing ad hoc studies and reports, how the proposed hourly rate is competitive, and how the approach meets or exceeds the requirements of this RFP.

Bidder Response:

Approach to Providing Ad Hoc Studies and Reports

HSAG is committed to providing DHHS with the data and reports that it needs to understand the strengths and weaknesses of the contracted MCOs and the DBM, and to successfully manage the Heritage Health program. HSAG has significant experience conducting the optional activities described in 42 CFR §438.358, as demonstrated in the HSAG EQR Experience Matrix tables in the Corporate Overview section of this RFP response. When completing these activities, HSAG follows the guidance that CMS provides in the activity-specific EQR protocols (Protocols 6-10). HSAG also has experience conducting activities for states that are not included as part of the EQR mandatory and optional activities. The following are several examples of work that HSAG has conducted for state Medicaid agencies but not required under 42 CFR §438.358:

- Development of state quality strategies
- Readiness reviews
- Independent assessments of Section 1915(b) waivers
- Independent assessments of Medicaid Section 1115 waivers
- Focus groups with Medicaid enrollees (resulting from a state legislative mandate)
- Provider interviews (to assist with the state's program readiness)
- State monitoring technical assistance and toolkit development
- Targeted reviews/focused studies of specific program areas (e.g., care management, grievance system, credentialing)
- Information system reviews (outside of the EQR required reviews)
- LTSS claims reimbursement study

Upon DHHS' request for additional work not described in the RFP, the Nebraska EQRO project director, Dr. Kim Elliott, will schedule a meeting with DHHS to gain a comprehensive understanding of the expectations of the request. Based on the expectations and the requirements of the new work, Dr. Elliott will determine the HSAG staff members with the most appropriate level of experience and expertise to complete the ad hoc study and will provide DHHS with the required deliverables (e.g. reports, dashboards, data spreadsheet). In consultation with DHHS, HSAG will then develop a Detailed Project Work Plan that outlines the tasks, responsible parties, due dates, and deliverables, and will submit the work plan for DHHS' approval. HSAG also will provide the name of each staff member assigned to the activity, along with resumes and the number of hours each staff member will need to complete the work. Once it has obtained DHHS' approval to begin work, HSAG will develop a methodology describing the components of the activity (e.g., study questions, case selection, data collection, data aggregation and analysis, reporting) and submit the methodology to DHHS for review. This will ensure HSAG's approach will provide DHHS with the expected outcomes of the activity.

Although HSAG's approach may vary depending on DHHS' specific request, the ad hoc study will be guided by HSAG's experience conducting ad hoc studies and activities in many of the 16 states for which HSAG provides EQR-related services. HSAG's approach will ensure that the ad hoc study is conducted to effectively address topics of concern and/or focus areas of DHHS with appropriate scientific rigor, and will include the major steps detailed below, as necessary and as applicable.

Develop Study Design—Once notified by DHHS of the decision to implement an ad hoc study, HSAG will work with DHHS to define the study topic as well as the scope of work and expected objectives. HSAG will then conduct an in-depth literature review to identify best practices for the populations under study and develop a study proposal encompassing the study question, study population, measurement period(s), data sources, study indicators, data

collection process, and analytic plan. Because focused studies may require adapting standard health care quality measures for applicability to special populations, HSAG's analytic plan will detail the technical specifications for these measures to ensure they are methodologically sound and can be reliably calculated for the populations under study.

Collect Data—HSAG will use administrative data supplied by DHHS to determine the prevalence rate and any patterns by enrollee's sociodemographic or clinical subgroups for the study topic that DHHS identifies. After finalizing the methodology for each ad hoc study, HSAG will work with DHHS to determine the appropriate data source(s) for the study and develop study-specific data to ensure the most appropriate data are extracted for each study and minimize the burden on DHHS' data personnel.

Conduct Analyses—HSAG will conduct statistical analyses according to the approved analytic plan and methodology. Primary analysis will address the study question and provide the results for the study indicators. HSAG also will perform a secondary analysis to examine variations among subgroups (e.g., male and female), patterns of care and outcomes, impact of explanatory variables on the indicators, and the correlation between variables. All analysis and reporting will incorporate comparison between the MCOs' and the DBM's populations, as applicable. All results will be validated independently by another member of the analytic staff.

Produce a Final Report—At the end of each ad hoc study, HSAG will produce a report for DHHS that includes an executive summary; study methodology, including the data collection and analysis process; the study results; and conclusions and recommendations. In addition to presenting the findings associated with the study questions, the report will discuss implications of the results in light of the policy environment within Nebraska and will produce actionable recommendations for the MCOs, the DBM, and DHHS to improve the delivery of health care to enrollees. These recommendations may include proposed performance measure development strategies specific to a target population for the topic of interest.

HSAG is committed to delivering timely and actionable ad hoc study reports to DHHS. Because study timelines may vary based on study topic and data sources, HSAG will work with DHHS at the study's initiation to develop a timeline that reflects study milestones and deliverables, including different phases of review for the final report. Upon completing the study analyses and prior to assembly of the final study report, HSAG will supply the MCOs and the DBM with preliminary study results for their consideration, as appropriate. Based on DHHS' direction, HSAG may give the MCOs and the DBM an opportunity to provide feedback on the study findings, and this feedback will be incorporated into the final report if indicated. HSAG also will ensure that DHHS has the opportunity to review and provide feedback on the draft report within the established time frame and separate from the MCOs' and the DBM's reviews. HSAG will incorporate DHHS' feedback into the final, comprehensive, aggregated summary report and submit it to DHHS within the designated time frame.

The HSAG project manager will arrange ad hoc meetings to discuss other ancillary DHHS requests and will monitor all activities to ensure they are completed in time.

How the Proposed Hourly Rate is Competitive

To ensure HSAG's hourly rates are competitive for the type of work conducted, the geographic service area, and the degree and skill set of the staff, a salary survey is conducted by an outside vendor and updated annually. Since HSAG is a government contractor, the salary survey vendor compares HSAG's prospective rates with others in similar positions and adjusts our salary grades and steps to accommodate real-time data. As a result, HSAG will offer a competitive hourly rate for its staff and services.

How Approach Meets or Exceeds Requirements of the RFP

HSAG has a solid reputation for client satisfaction. As stated in the Corporate Overview response, HSAG has never had a contract terminated for default and has been highly successful in having contracts re-awarded despite very competitive bidding processes. Additionally, as demonstrated by the HSAG EQR Experience Matrix table in the Corporate Overview section of this RFP response, HSAG has been the designated EQRO in 10 of 15 states for at least 15 years. In many of these and under newer contracts, HSAG has been asked to complete additional work not originally included in the initial scope of work, which demonstrates that these states have a high level of confidence in HSAG's approach to completing ad hoc studies and activities, as well as the resulting deliverables. Upon contract award, HSAG is committed to ensuring that DHHS trusts in and sees the value and expertise that HSAG staff members bring to each activity included as part of this RFP, as well as any additional activities and ad hoc studies and reports requested in the future. HSAG's overarching goal is for DHHS to have the same high level of confidence in the work HSAG produces in the states HSAG currently serves as the EQRO. HSAG knows that this high level of confidence can only be gained through dedication and hard work, which will be demonstrated through HSAG's efficient and effective approaches to completing the requirements of this RFP.

V.D.5	Describe the Bidder's approach to distributing the EQR reports, assessments, and recommendations of section V.D.5., and how the approach meets or exceeds the requirements of this section.

Bidder Response:

Approach to Distributing EQR Reports, Assessments, and Recommendations of Section V.D.5

HSAG's approach to distributing EQR reports, assessments, and recommendations is iterative and will involve ongoing collaboration with DHHS. By working interactively with DHHS staff members, HSAG will obtain and incorporate DHHS'

preferences to ensure EQR reports, assessments, and recommendations include all required information and are distributed on time to all DHHS intended stakeholders and approved interested parties in accordance with the DHHS-approved detailed communications plan.

HSAG is also available to plan, conduct, and facilitate presentations of its EQR findings and final deliverables to DHHS, MCOs, the DBM, and/or other stakeholders, as appropriate. In doing so, HSAG will ensure that the information it presents is valuable and easy for the audience to understand.

HSAG also will provide DHHS with technical support and assistance in responding to inquiries that CMS and local, state, and national stakeholders may pose based on the EQR reports, assessments, and recommendations. HSAG works collaboratively with state Medicaid agencies to provide clear, succinct, and accurate responses to questions regarding a variety of EQR-related projects, including EQR technical reports, performance measure reporting, clinical focused studies, and development and review of quality strategies.

a. Provide Copies of the Information in Section V.D.4. to Interested Parties

The Contractor must provide copies of the information specified in Section V.D.4. above, upon request, through print or electronic media, to interested parties such as participating health care providers, enrollees, and potential enrollees of the MCO or DBM, beneficiary advocacy groups and members of the general public.
i. This information must be made available in alternative formats for persons with disabilities, when requested.
ii. The information released must not disclose the identity of any patient or any other information protected by law.
iii. The Contractor will not share or deliver to any other individual or entity without prior written approval of DHHS, reports and any data utilized for reporting purposes. The schedule, number of copies, and media for reports shall be specified by DHHS.

As described in the draft communications plan protocols, HSAG will provide copies of information from each reporting requirement in Section V.D.4 of the RFP, upon request and DHHS' approval, to interested parties such as health care providers, enrollees and potential enrollees, advocacy groups, and the general public. HSAG can provide the copies in print or electronic formats.

a.i. Information in Alternative Formats

Once HSAG produces final versions of the reports, they will all be in PDF and will meet accessibility standards for public posting. HSAG ensures that all EQR reports meet the highest professional standards for quality, organization, accuracy of content, and adherence to federal and state requirements, including accessibility standards, as described in the response to Section V.H. Project Planning and Management and in the draft communications plan protocols. HSAG provides information in a user-friendly format and in accordance with health literacy practices. In support of federal and state contract reporting requirements, HSAG has a dedicated team of report preparation experts for all annual EQR

technical reports and other publicly posted reports. This team monitors impending changes to the federal requirements of Section 508 and is fully prepared to incorporate any new guidance into its operational practices for making information accessible to individuals with disabilities. The HSAG Section 508-compliance review process adheres to requirements set forth in the U.S. DHHS Section 508 Accessibility guidelines. HSAG also complies with the United States Access Board Section 508 Standards for all technical products it produces and meets functional performance criteria for these products.

a.ii. Protected Information

HSAG will provide aggregate results in EQR reports, with a summary of performance across the state and individual MCOs and the DBM, and it will not disclose the identity of any Medicaid enrollees. HSAG understands the sensitivity of this information and takes necessary steps to ensure all applications and reports secure all protected health information and personally identifiable information. HSAG employs stringent quality assurance processes and extensive quality control measures to ensure all data have undergone proven security and data protection. HSAG has implemented organizational policies and procedures to protect against unauthorized disclosure of confidential information and to ensure compliance with the Health Insurance Portability and Accountability Act's (HIPAA's) administrative, physical, and technical safeguards.

Additionally, to further protect enrollee information, all HSAG staff members must complete and pass security, confidentiality, and HIPAA training upon employment and annually thereafter. HSAG takes confidentiality, protection of sensitive patient health records, and protected health information of Medicaid enrollees very seriously. HSAG has extensive knowledge and experience in analyzing and complying with all federal and state laws related to the use and disclosure of information, including protecting health information as defined by HIPAA and as contained in the Health Information Technology for Economic and Clinical Health (HITECH) Act. HSAG has implemented a thorough HIPAA compliance and protection program that meets or exceeds federal regulations and includes recurring training as well as policies and procedures that address physical security, electronic security, and day-to-day operations.

a.iii. Prior Written DHHS Approval

HSAG will seek and obtain DHHS' written approval before distributing EQR reports, assessments, and recommendations, including any data used for reporting purposes, to an individual or entity other than DHHS. As part of obtaining this approval, HSAG will work with DHHS to obtain a specified schedule, the number of copies, and media for reports that will be distributed.

b. Develop, Update, and Maintain a Report Distribution List

The Contractor will be required to develop, update, and maintain a report distribution list during the contract period to incorporate changes required by DHHS.

HSAG will develop, update, and maintain a report distribution list and incorporate any changes that DHHS requires throughout the contract period. The report distribution list will be established based on DHHS input and will include the name, title, organization, email, mailing address, and phone number of each individual who will receive EQR-related reports, assessments, and recommendations. HSAG understands that staff organizational charts are ever-changing and will consult with DHHS on whether there have been any changes to the report distribution list before distributing information, and it will update the report distribution list accordingly.

How Approach Meets or Exceeds Requirements of the RFP

HSAG has extensive experience collaborating and communicating with federal, state, and county governments; external stakeholders who include enrollees and their family members and caretakers; advocates; legislative staffs; MCO and DBM leadership and staffs; medical associations; clinical staffs; and health care providers. HSAG's approach to distributing EQR reports, assessments, and recommendations and working with stakeholders is based on a long history of having a comprehensive, efficient process that results in well-written, concise, and accurate reports distributed to state Medicaid agencies and their stakeholders. In addition to providing written reports, HSAG has provided presentations to MCOs, DBMs, state staff members, Medicaid administrators, industry stakeholders, providers, as well as members of the state's legislature that inform the audience about the performance of the managed care program overall and what opportunities for improvement exist within the program. The presentations are consistent with the content detailed in EQR reports and the live presentation enables the audience to ask questions about the performance of the program and the action steps available to make improvements.

Because of its EQR involvement in numerous states and with the federal government, HSAG is in an exceptional position to share lessons learned with DHHS and its stakeholders, as well as benchmarks and trends from extensive activities and data from health care quality improvement work across the country.

V.D.6.	Describe the Bidder's approach to meetings, and how the approach meets or exceeds the requirements of this section.

Bidder Response:

Approach to Meetings

HSAG's proven success and effectiveness in meeting performance expectations is due, in part, to maintaining ongoing communication with state Medicaid agencies and their contracted MCOs and the DBM. In order to maintain continuous and timely communication, HSAG will conduct ongoing and ad-hoc meetings with DHHS staff members via phone, video conference, Webex, or on-site, as required, to discuss each activity's progress, barriers, and any issues related to implementing requirements under the contract. HSAG will coordinate, schedule, and facilitate meetings with DHHS as described in the draft communications plan protocol and summarized below.

HSAG anticipates there will be numerous forums and mechanisms to communicate with DHHS about activities under way. Most forums will be teleconferences and webinars, and will provide the mechanism for HSAG to communicate the status of EQR activities to DHHS staff members. In addition to working directly with the EQRO project director and assistant project director, DHHS staff members will have direct access to each EQR activity project manager and will be encouraged to maintain direct and regular communication with the activity project managers for the duration of the EQR activity. With DHHS approval, HSAG EQR activity project managers may contact DHHS staff members to discuss the status of data transfer or other information necessary to complete an EQR activity. HSAG anticipates that, at a minimum, the following types of meetings will occur:

- **Kick-off meeting**–At an agreed-upon time, HSAG will hold a kick-off meeting with DHHS. At this meeting, HSAG will introduce its staff to DHHS, establish the communication plan for the contract, and discuss the contract objectives, the EQR draft work plan for each EQR activity, and the HSAG strategy for each task scheduled for Contract Year One. HSAG also will clarify DHHS' expectations for each deliverable, provide information regarding the EQR process, gain knowledge regarding the recent developments in the Heritage Health program, and obtain DHHS' input for the annual EQR work plan for all EQR activities and deliverables in Contract Year One. HSAG will finalize the Detailed Work Plan after the discussion and include DHHS feedback obtained at the kick-off meeting.
- **Monthly progress meetings**–HSAG will schedule and facilitate monthly progress meetings between DHHS and HSAG. During these meetings, HSAG will review the status of each EQR activity detailed in the DHHS-approved Detailed Work Plan, discuss milestones associated with each activity, and bring to light any outstanding issues that may have the potential to impact the timeline. These progress meetings will also be used as forums for DHHS and/or HSAG to make decisions on critical milestones, solicit guidance or make recommendations on ongoing

activities, and resolve any issues that may impact an activity. HSAG also will be available to provide DHHS with technical assistance during these calls, as needed, and will provide minutes to DHHS after each meeting.

- **Ad hoc technical assistance meetings**–HSAG will be prepared to address additional DHHS requests for any ad hoc technical assistance for DHHS and/or MCO and DBM staff members. For training or technical assistance requests related to a specific EQR activity, HSAG will facilitate the meetings and arrange for the EQR project director, the assistant project director, and the activity project manager, depending on the topic, to meet with DHHS or MCO and DBM staff members to clarify expectations and develop appropriate and required training materials for DHHS' review and approval.

For each above-mentioned meeting, HSAG will develop a draft agenda and associated meeting materials for DHHS review and approval, and will distribute minutes from each meeting.

a. Establish Monthly Technical Assistance Meetings or Conference Calls with DHHS

The Contractor will establish monthly technical assistance meetings or conference calls with DHHS staff.

As described in the draft communications plan, HSAG will schedule and host monthly technical assistance and progress meetings with DHHS staff members. HSAG recommends conducting the meetings using Webex to allow for a large number of participants and provide presenters a platform to share presentation visuals effectively. HSAG will work with DHHS to identify dates and times for the monthly meetings. Once set, HSAG will create a Webex session for each meeting and will send invitations to DHHS for the entire contract year, as appropriate. HSAG also will attach each approved final agenda to the meeting invitation and email a copy of the agenda well in advance of each scheduled meeting date.

For each meeting, the HSAG project director and the assistant project director will organize the meetings and include activity project managers, as necessary, to provide DHHS with details concerning the tasks for each EQR activity phase, including an overall summary of the activity's progress and an outline of upcoming efforts. During these monthly meetings, HSAG staff members will discuss recommended resolutions to any issues they encounter during the EQR activities and will provide DHHS with guidance on decision-making about critical issues, updates on ongoing efforts, and assistance in resolving problems and challenges. Most importantly, the meetings will focus on specific action items and timelines outlined within the approved work plan to promote the most efficient use of time and resources. After completing each meeting, HSAG and DHHS will define action items to ensure follow-up for outstanding issues identified during the discussions.

b. Prepare Agendas Ahead of Meetings

The Contractor will prepare agendas ahead of meetings.

HSAG will prepare and submit to DHHS the agenda for each monthly meeting at least two days before its scheduled time. The agenda will include a discussion of each active EQR activity, topics of interest for technical assistance based on issues DHHS and HSAG identify during EQR activities, and other items as necessary to complete each EQR activity successfully and fulfill the obligations under the contract. Once DHHS approves the agenda topics, HSAG will attach the final agenda to the meeting invitation and send a copy with the written progress report to all meeting recipients.

c. Taking and Distributing Minutes at all Meetings

The Contractor is responsible for taking and distributing minutes at all meetings required under this contract. Distribution will be no less than five (5) business days before the meeting.

Within two business days of a meeting, HSAG will record and publish minutes of every meeting with DHHS, the MCOs, and the DBM and will provide DHHS and the MCO and DBM staffs with informational materials, if applicable. HSAG will obtain DHHS approval on all documents before distributing them. HSAG will take and distribute minutes from all meetings conducted under the contract. During each meeting, the HSAG project manager will record key discussion items and follow-up action items. As required by DHHS, HSAG also will update the meeting minutes with DHHS and/or MCO/DBM feedback, as applicable, and distribute a final copy of the meeting minutes at least five business days before the next scheduled meeting.

d. Participate in Conjunction with DHHS, in Quarterly Operational Meetings with the MCOs and DBM

The Contractor will participate, in conjunction with DHHS, in the quarterly operational meetings with the MCOs and DBM.

HSAG will participate with DHHS in quarterly operational meetings with the MCOs and the DBM to ensure EQR and quality-related activities remain on track, and that HSAG is available to provide technical assistance and offer guidance to support the MCOs' and the DBM's obligations under the Heritage Health program. As requested by DHHS and/or the MCOs/DBM, and with DHHS approval, HSAG will be prepared to discuss upcoming or existing EQR activities, any pertinent updates to Medicaid managed care such as changes to existing regulations and/or protocols, and/or any best practices within the Medicaid managed care industry. In its work with other states, HSAG has found these quarterly meetings provide a collaborative environment to promote sharing of information about emerging practices identified by the managed care entities and about continual quality improvements. These quarterly meetings also will enable DHHS to track progress toward meeting the goals and objectives identified in the DHHS quality strategy.

If requested, HSAG also can assist DHHS in ensuring that each MCO and the DBM is responsible for identifying, through routine data analysis and evaluation, quality improvement initiatives that support improvement in quality, access, and timeliness of services delivered to Medicaid enrollees. By testing the efficacy of these initiatives over time, the MCOs and the DBM can determine which of them yields the greatest improvement. It is at these collaborative quarterly operational meetings that DHHS may request the MCOs and the DBM to present the results of data analyses and evaluations that address recommendations HSAG has made. The MCOs and the DBM could also present the interventions and initiatives that have yielded success for their membership and, consequently, performance measure rates. Sharing of these best practices among the MCOs and the DBM can lead to performance improvement and better outcomes across the entire program.

How Approach Meets or Exceeds Requirements of the RFP

As the largest and most experienced EQRO in the nation, HSAG offers DHHS a strong appreciation for the opportunities and challenges with Medicaid managed care programs. HSAG has a long history working with numerous state Medicaid agencies to provide customized EQR-related services. This distinctly positions HSAG to work with DHHS and its MCOs and the DBM to comply with federal requirements and support the DHHS mission of "Helping People Live Better Lives."

HSAG staff members stay current with state and federal program changes as well as changes within each state's managed care entities, program design, eligibility requirements, population-specific characteristics, state health priorities, and challenges that impact the Medicaid program. HSAG will apply this knowledge to immediately identify and communicate with DHHS any contract compliance issues and performance trends, and assist DHHS and its MCOs and the DBM with improving access to appropriate services, better coordination, and integration of care. In addition to communications through meetings, HSAG will provide DHHS with prompt and personal communications throughout the term of the contract. Jointly the project director, assistance project director, and activity project managers will present forward-looking and innovative ideas to DHHS, offering suggestions for enhancements and problem-solving, as needed.

In addition to conducting ongoing meetings, HSAG has the appropriate knowledge and expertise to facilitate other ad-hoc meetings. Many states are looking to implement practical, cost-effective solutions that improve the quality of care for its Medicaid enrollees. HSAG has assisted with developing, evaluating, and revising managed care initiatives and interventions by providing research and recommendations; drafting, reviewing, and revising materials; and providing guidance to finalize implementation. HSAG can also facilitate and convene community forums and steering committees to develop and implement specific initiatives that involve key care continuum providers and Medicaid enrollees across the state. For these collaborative projects, HSAG has:

- Facilitated teleconferences and on-site meetings to gather input and feedback from stakeholders and to identify key barriers and available resources critical to resolving issues.
- Designed, tested, and implemented interventions with pilot populations.
- Selected goals and established measures to track progress.

For example, HSAG planned, conducted, and facilitated a collaborative learning project in one of its states, called IMPROVE (Implement Medicaid Programs for the Reduction of Avoidable Visits to the ED). The statewide collaborative brought together key stakeholders such as health systems, community leaders, emergency departments, health care providers, managed care plans, and consumer and family advocates. During the 18-month project span, IMPROVE successfully developed and implemented community-specific initiatives across the state, involving key care continuum providers and Medicaid enrollees. The IMPROVE collaborative has been recognized as a groundbreaking effort that proactively addresses today's healthcare reform challenges and has been gaining national attention. It became a promising model for building health care coalitions to address Medicaid managed care initiatives for high-need and complex-care consumers. This project received an honorable mention at an annual Care Innovations Summit, and was selected among 25 innovations from across the country to receive recognition by the summit.

HSAG assures DHHS, that regardless of the meeting type, HSAG's project director, assistant project director, activity project managers, and/or subject matter experts will provide DHHS and its contracted MCOs and the DBM with the knowledge, technical expertise, support, and guidance needed to conduct and complete EQR activities successfully while sharing best practices and tools to help improve the overall performance of the Heritage Health program.

V.D.7.	Describe the Bidder's approach to performing quality review, and how the approach meets or exceeds the requirements of this section.

Bidder Response:

Approach to Performing Quality Review

HSAG provides EQR services in 16 states for each of the MCEs in these states, including MCOs, PIHPs, PAHPs, and primary care case management (PCCM) entities, to assess the quality of care provided to Medicaid and CHIP enrollees in managed care programs. As required by 42 CFR §438.350, HSAG uses information from the EQR-related activities and from the results of a Medicare or private accreditation review, as applicable, to conduct the EQR. HSAG is prepared to use information from additional activities set forth in 42 CFR §438.358(c), including information derived during the previous calendar year. At the direction of the state, HSAG will conduct any or all of the following activities:

- **Validation of Encounter Data:** HSAG will assess the completeness and accuracy of the encounter data that the MCOs and the DBM submit to DHHS.

- **Administration or Validation of Quality of Care Surveys:** HSAG will analyze survey results, such as the CAHPS, to assess enrollees' experiences with their health care.
- **Calculation of Performance Measures:** HSAG will calculate performance measures in addition to those included in each MCO's and the DBM's QAPI programs. The results may include an analysis of MCO and DBM performance in relation to specified benchmarks.
- **Implementation of Additional Performance Improvement Projects (PIPs):** HSAG will conduct PIPs that are in addition to those the MCOs and the DBM perform as part of their QAPI programs, and it will assess the results of these PIPs to determine the level of improvement in processes and outcomes of care that the MCOs and the DBM provide.
- **Conducting Focus Studies of Health Care Quality:** HSAG will conduct and analyze the results of the focused study/studies related to areas of clinical care and/or nonclinical services to assess quality of care at a point in time.
- **Quality Rating:** At DHHS' direction, HSAG will include the quality rating of MCOs and the DBM upon issuance of Protocol 10.

For all EQR-related activities, HSAG follows the guidelines established in the most recent CMS EQR Protocols, which currently is October 2019 (EQR protocols). Upon DHHS' request for HSAG to perform one or more of the optional EQR activities, the HSAG Nebraska EQR project director or assistant project director will schedule a meeting confirm DHHS' expectations for the activity. The HSAG project director will then assign the most qualified project manager to lead the activity. The project manager, in consultation with the project director and DHHS, as necessary, will develop and subsequently provide DHHS with a Detailed Work Plan that will include the agreed upon tasks, due dates, and assigned staff; a methodology document; and a report deliverable template for DHHS review and approval. HSAG will include the optional activity information and data in the annual EQR and will present the assessment conclusions in the detailed annual technical report.

HSAG will use the approaches described in the following sections a through g to obtain information for the annual EQR and annual technical report.

a. Provide Validation of Encounter Data

The Contractor will provide, at the State's direction, validation of encounter data reported by the MCOs and the DBM.

HSAG's approach to validating encounter data aligns with the general principles found in the *CMS External Quality Review (EQR) Protocol 5, Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan*[6] (EQR Protocol 5). HSAG understands the validation of encounter data is critical to ensuring that data submitted are complete, accurate, and timely reflections of the care provided to Medicaid enrollees—a necessary requirement so reports, quality measures, and capitation payment rates developed from the data are reliable and comparable across all MCOs and the DBM, when applicable. HSAG's experience in conducting encounter data validation (EDV) spans more than 16 years and includes extensive work in physical health, behavioral health, and dental Medicaid managed care. EQR Protocol 5 and HSAG's EDV process consist of five activities:

Activity 1: Review State Requirements
Activity 2: Review the MCO's and DBM's Capability
Activity 3: Analyze Electronic Encounter Data
Activity 4: Review Medical Records
Activity 5: Submit Findings

EDV is a core HSAG competency. HSAG's significant experience ensures a thorough review and evaluation of encounter data completeness, accuracy, and timeliness through the following four activities: information systems reviews, administrative profiles, comparative analyses, and medical record reviews (MRRs). These activities, as well as the final EDV report, are not only consistent with EQR Protocol 5 but also enable HSAG to customize each encounter data methodology to meet specific customer needs.

Manage EDV Study

If requested to conduct an EDV study, HSAG will initiate a project kick-off meeting to establish and promote a transparent process that will continue over the life of the contract and will outline the tasks needed to complete the scope of work. To ensure a successful execution, HSAG's EDV activity project manager will work with the DHHS activity leadership to confirm key project contacts, establish regular status meetings, and determine appropriate lines of communication. The kick-off meeting also will include a requirements-gathering session with DHHS' staff. Based on this

[6] Department of Health and Human Services, Centers for Medicare & Medicaid Services. EQR Protocol 5 Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan. Protocol 5. October 2019.

meeting, HSAG will develop a study methodology for DHHS' review and approval. Once finalized, the methodology will be used to generate a detailed analysis plan that will provide the foundation to develop and execute all study protocols.

HSAG will coordinate and conduct regular status meetings with DHHS' EDV project team to detail the tasks completed for each EDV phase, summarize the EDV project's overall progress, and discuss upcoming efforts. The status meetings will review any issues identified during the period and discuss recommendations. This process will allow DHHS to shape decision-making on critical issues, provide guidance on ongoing efforts, and help resolve challenges throughout the project. Most importantly, the status updates will focus on specific action items and timelines outlined within the approved project work plan to promote the most efficient use of time and resources for all parties.

Perform Information Systems Reviews

As with any activity, HSAG tailors its EDV approach to address a state's specific needs and aspects of its managed care environment in accordance with EQR Protocol 5. To ensure the collection of critical information, HSAG's information systems review employs a multistep process that includes (1) document review, (2) developing and fielding a customized encounter data assessment, and (3) follow-up interviews with key DHHS, MCO, and DBM staff members. HSAG recommends initiating any EDV activity with a thorough desk review of documents related to encounter data initiatives/validation activities currently required by DHHS. HSAG will then develop a customized questionnaire, in collaboration with DHHS, to gather additional information from DHHS, its vendors, and the MCOs and the DBM for data processing, personnel, and data acquisition capabilities. Where applicable, this assessment also will include a review of supplemental documentation regarding other data systems, including enrollment and providers. After a review of the completed assessments, HSAG will conduct follow-up interviews with key MCO and DBM information technology personnel to clarify any questions the reviews generate. Overall, through the information systems reviews, HSAG will document current processes and develop a thematic process map identifying critical points that impact the submission of quality encounter data. From the reviews, HSAG will be able to provide actionable recommendations for the existing encounter data systems on areas for improvement or enhancement. This activity corresponds to **Activity 1: Review State Requirements** and **Activity 2: Review the MCO's and DBM's Capability** in EQR Protocol 5.

Review Administrative Profile

An administrative profile, or analysis, of a state's encounter data is essential to gauging the general completeness, accuracy, and timeliness of encounter data, as well as whether encounter data are sufficiently robust for additional evaluations (i.e., comparative analyses or MRR). This analysis corresponds to the encounter data micro/macro analyses in **Activity 3: Analyze Electronic Encounter Data** of EQR Protocol 5. In order to examine the completeness, accuracy, and timeliness of DHHS' encounter data, HSAG will evaluate metrics such as (1) monthly encounter data

volume per 1,000 enrollee months and monthly paid amount per 1,000 enrollee months; (2) claims lag triangle evaluation; (3) percentage present and percentage with valid values for key data elements; (4) impact of rejected encounters on completeness and accuracy; (5) cross-sectional or longitudinal comparison of utilization measures; and (6) discrepancy analyses of age- and gender-specific diagnoses and procedures (e.g., male enrollees with an encounter for pregnancy). HSAG will examine all claims/encounter data types (i.e., institutional, professional, pharmacy, and dental). Depending on the needs that DHHS identifies, HSAG can stratify all analyses by service type or subpopulation to provide DHHS with additional comparative information. HSAG may also design additional evaluation metrics based on DHHS' existing concerns on the encounter data.

Based on the administrative review results, HSAG will develop recommendations that DHHS may consider. HSAG will focus its recommendations on three critical areas for monitoring encounter data quality: (1) encounter data submission standards, (2) encounter data completeness and accuracy of performance metrics, and (3) encounter data monitoring report structure and content.

Perform Comparative Analysis

The goal of the comparative analysis between DHHS' encounter data and the data extracted from the MCOs' and the DBM's data systems is to evaluate the extent to which encounters submitted to DHHS by the MCOs and the DBM are complete and accurate, based on corresponding information stored in the MCOs' and the DBM's data systems. This activity demonstrates an approach to conducting **Activity 3: Analyze Electronic Encounter Data** in EQR Protocol 5.

HSAG will use data from both DHHS and the MCOs and DBM to evaluate the accuracy and completeness of the encounter data. To ensure the extracted data from both sources represent the same universe of encounters, HSAG will target data with the same encounter types submitted to DHHS before the same selected date. The encounter types/subtypes will be selected in collaboration with DHHS and will vary based on plan type or benefits covered.

Once HSAG receives data files from both data sources, the analytic team will conduct a preliminary file review to ensure data are sufficient to conduct the evaluation. Based on the results of the preliminary file review, HSAG will generate a report that highlights major findings requiring the MCOs and DBM to resubmit data, as needed. Once HSAG receives and processes the final data, it will conduct a series of analyses. To facilitate the presentation of findings, HSAG will divide the comparative analysis into two analytic sections.

First, HSAG will assess record-level data completeness using the metrics for each encounter data type. Second, based on the number of records present in both data sources, HSAG will further examine completeness and accuracy for select data elements. HSAG's analyses will focus on an element-level comparison for each data element. Element-level accuracy will be limited to those records with values present in both the MCOs' and DBM's submitted files and DHHS'

data warehouse. HSAG will establish the selected fields for the analysis in collaboration with DHHS; however, standard fields in HSAG's analysis will include date of service, enrollee identification, billing and servicing provider identification, primary diagnosis, procedure code(s), payment fields, and data fields specific to the type of encounters (e.g., revenue codes and the diagnosis-related group fields for institutional encounters).

Conduct MRR

As outlined in EQR Protocol 5, **Activity 4: Review Medical Records**, MRR is a complex and resource-intensive process. HSAG has extensive experience and proven processes and procedures for using medical and clinical records to validate encounter data across health care settings. However, based on its experience and due to the resource-intense nature of this type of study, HSAG recommends that an MRR be conducted once a minimal level of quality has been assessed within a state's encounter data system.

In Nebraska, HSAG's MRR activities will begin in collaboration with DHHS to define the specific audit question. HSAG then will request appropriate data files from DHHS to generate a statistically valid sample for MRR. Typically, HSAG uses encounter, eligibility, and enrollment data to develop a sample file that represents the population from which the sample will be drawn. Once it selects the sample, HSAG will match the provider associated with the selected date of service for sampled enrollees against the master provider demographic file and then distribute the sample cases to each MCO and the DBM. The MCOs and the DBM will procure and submit the selected medical record documentation to HSAG for review.

During the MRR activity, HSAG's reviewers and certified coders will collect and document findings in an HSAG-designed electronic data collection tool. The tool is designed with edits to assist in the accuracy and consistency of data collection. The validation of encounter data incorporates a unique two-way approach through which encounters are chosen from both the electronic encounter data and from medical records and are subsequently compared with one another.

Once the abstraction is complete, HSAG analysts will export the abstraction data and conduct analyses for each MCO and the DBM. In general, three primary indicators of data completeness and accuracy will be reported for each key data element (e.g., date of service, procedure code, and diagnosis code): (1) medical record omission, (2) encounter record omission, and (3) accuracy rate.

Submit Final Report

Before drafting the report for the contract year, HSAG will submit a formatted report outline/template to DHHS for review and approval. The report will follow the EQR Protocol 5, **Activity 5: Submit Findings**, to include key findings, conclusions, and recommendations. Based on the findings and on experience working with other customers, HSAG will

provide recommendations that are specific and actionable. HSAG will submit the draft report to DHHS for review and approval based on a mutually agreed-upon project timeline so that DHHS staff members will have sufficient time for review. HSAG will then incorporate DHHS' feedback and deliver the final, approved report before the end of the contract year, or as determined by DHHS.

b. Perform Administration or Validation of Consumer or Provider Surveys of Quality of Care

The Contractor will perform administration or validation of consumer or provider surveys of quality of care.

HSAG will comply with CMS *EQR Protocol 6: Administration or Validation of Quality Care Surveys*, October 2019 (EQR Protocol 6) for all survey administration and/or validation. HSAG is thoroughly familiar with all specified activities that must be undertaken to ensure methodologically sound surveys.

Survey Administration Activities

If requested to administer a survey, HSAG will implement the following activities as outlined in EQR Protocol 6:

Activity 1. Identify the survey purpose, objectives, and audience—HSAG will work with DHHS to determine the scope (e.g., populations to be surveyed, domains that need to be evaluated), the intended use, and the audience (e.g., enrollees, policymakers, plans) of the survey results and will use this information to recommend possible survey instruments, sampling strategies, and data collection processes/procedures. HSAG will conduct the necessary background research and hold calls with DHHS regarding the population(s) being surveyed.

Activity 2. Develop a work plan—HSAG will work with DHHS to develop a work plan that outlines all key tasks and milestones to administer a survey, including survey material preparation, development of methodology documents (e.g., analytic and sampling plans), survey administration, and deliverables (e.g., data files, reports) production. The work plan will be developed in collaboration with DHHS based on the survey purpose, objective, and audience identified in Activity 1.

Activity 3. Select the survey instrument—If available, HSAG recommends using an existing survey instrument (e.g., CAHPS Surveys). If an existing survey instrument that meets the survey objectives is not available, HSAG will work with DHHS to adapt an existing survey or develop a new survey instrument. If requested, HSAG is able to test any newly developed survey instruments for face and content validity.

Activity 4. Develop the sampling plan—HSAG will develop a sampling plan that identifies the study population, the type of sampling (e.g., simple random sample, stratified sample), and sample sizes for each reporting unit. HSAG recommends a sampling strategy that will yield a 5 percent margin of error at a 95 percent confidence interval. HSAG will select the sample from the eligible population in accordance with the approved sampling plan.

Activity 5. Develop a strategy to maximize response—HSAG will work with DHHS to design a survey protocol (e.g., mail, telephone, internet, mixed-mode) that will have the most success in reaching sampled enrollees or providers. In addition, HSAG will ensure that materials are in appropriate languages (e.g., English, Spanish) and all correspondence is produced to maximize response rates (e.g., prepaid postage envelope for returning mail surveys, cover letter emphasizing state sponsorship). HSAG will develop sample frame (e.g., eligible population) instructions that outline who is eligible for the survey and the fields (e.g., name, address, phone number) that will be required for each person in the file. HSAG will review the eligible population file to check for any issues that may impact responses, including invalid address and telephone numbers.

HSAG will calculate response rates using nationally recognized methods (e.g., NCQA specifications, American Association for Public Opinion Research). HSAG can perform a nonrespondent analysis to identify potential nonresponse bias (e.g., identify demographic characteristics that are different between the respondent and nonrespondent populations).

Activity 6. Develop a quality assurance plan—HSAG will monitor all aspects of the survey administration (including ensuring the sample is selected correctly), reviewing proof prints and seed mailings, monitoring live telephone interviews, and reviewing programming online tools. The specific quality assurance activities will be determined based on the survey methodology and design.

Activity 7. Implement the survey according to the work plan—HSAG will implement the survey according to the approved work plan (i.e., Activity 2). This may include mailings, telephone calls, and/or an online protocol. HSAG will communicate to DHHS any deviations from the work plan (e.g., extending the survey field in order to attempt to capture additional completes).

Activity 8. Prepare and analyze survey data and present results in a final report—Upon completing survey administration, HSAG will verify and validate all survey data for completeness, valid values, and appropriate skip patterns. HSAG will analyze the data in accordance with the approved analysis plan. Examples of analyses that HSAG may perform include frequency distributions for each question (i.e., cross-tabulations); sample weighting; nonrespondent analysis; comparisons of results to national benchmarks; comparisons of results across reporting units (e.g., plan comparisons); and trending. In its reporting to DHHS, HSAG will document all survey process activities and analytic methodologies; include results in tabular and graphical format; and identify key findings, strengths and weaknesses, and conclusions. HSAG will provide a draft report to DHHS for review and approval before preparing a final report.

Survey Validation Activities

If requested to validate a survey, HSAG will implement the following activities as outlined in EQR Protocol 6:

Activity 1. Review the survey purpose, objective, and audience—HSAG will review the following: identification of the study population, construction of the sampling frame, and sampling (e.g., sample size, sampling method).

Activity 2. Review the work plan—HSAG will review the work plan to ensure key steps and activities for survey preparation, administration, and analysis were adequately performed.

Activity 3. Review the reliability and validity of the survey instrument—HSAG will review the appropriateness of the survey instrument for the population(s) surveyed. If a nontested survey instrument was used, HSAG will review the instrument for validity and reliability (e.g., question order, skip patterns).

Activity 4. Review the sampling plan—HSAG will review the following items regarding sampling: identification of the study population, construction of the sampling frame (i.e., eligible population), and sampling (e.g., sample size, sampling method, procedures for sample selection).

Activity 5. Review the adequacy of the response rate—HSAG will review the response rate calculation methodology, methods used to maximize the response rate, and the overall response rate compared to benchmarks, where appropriate, to determine potential sources of bias.

Activity 6. Review the quality assurance plan—HSAG will review the quality checks that were put in place to ensure accuracy of the survey activities, including sample selection review, data collection checks (e.g., review mail materials, interview training and monitoring), and data processing controls.

Activity 7. Review the survey implementation—HSAG will review whether the survey protocol was appropriate, and whether procedures aligned with the sampling, work plan, and quality assurance plan.

Activity 8. Review the survey data analysis and final report—HSAG will review how the data were analyzed and if appropriate statistical procedures were used. HSAG also will review the final report of results to ensure that the presentation, conclusions, and limitations were appropriately presented.

c. Calculate Performance Measures in Addition to those Reported by an MCO or DBM and Validated by an EQRO

The Contractor will, at the State's direction, calculate performance measures in addition to those reported by an MCO or DBM and validated by an EQRO in accordance with 42 CFR §438.358(b)(1)(ii).

At DHHS' direction, HSAG will calculate performance measures in accordance with the CMS *EQR Protocol 7: Calculation of Additional Performance Measures*, October 2019 (EQR Protocol 7). HSAG developed and implemented the Performance Measurement Calculation Platform (PMCP) used to calculate CMS Adult and Child Core Set measures, and other performance measures using administrative, registry, vital statistics, and medical record review data. HSAG uses PMCP to perform measure calculations on behalf of several state Medicaid agencies.

HSAG first will work with DHHS to determine the performance measures to be calculated along with the applicable technical specifications for each measure, and if a measure will need to be calculated using the hybrid collection methodology. Upon confirming the performance measures, HSAG will develop a performance measurement worksheet that includes performance measure specifications for each measure, identifies comparative benchmarking sources (e.g., national benchmarks, statewide performance standards), and outlines any other information required to complete the calculation activity (e.g., any deviations from the technical specifications).

HSAG then will create a data request document and will convene a meeting to review the document with DHHS and any other delegated entities. In this document, HSAG will outline the data required for performance measure calculations (e.g., claims/encounter dates of service, provider files) and describe how HSAG will ensure that DHHS and any other data providers transmit data to HSAG with appropriate privacy and security safeguards. HSAG will work with DHHS to receive the data in an agreed-upon format and through a secure file transfer protocol site.

Upon receiving the data from DHHS or delegated entities, HSAG will evaluate the data files and perform preliminary file validation. HSAG will verify that the data are complete and accurate by ensuring correct formatting, confirming reasonable value ranges for critical data fields, assessing monthly enrollment and claim counts, and identifying fields with a high volume of missing values. HSAG will maintain an issue log to document any data issues identified throughout the review process. Upon completing this review, HSAG will discuss with DHHS the extent to which the identified data issues may affect the performance measure results. HSAG will collect data via a secure transfer mechanism and ensure that all data elements required for performance measure calculation, as defined in the performance measurement worksheet, are present. Once HSAG determines all data are usable, it will integrate the data into HSAG's performance measure repository.

Upon receipt of clean and accurate data, HSAG will proceed with calculating performance measures. To achieve the most appropriate and cost-effective analysis of performance measure data, HSAG will use SAS software to perform all analytic activities. HSAG will develop SAS programming code for each performance measure, adhering to the appropriate technical specifications. HSAG will assign a lead programming analyst and a validating analyst to each performance measure. The lead analyst will develop the primary code based on the approved specifications. After the lead analyst completes the analyses, the validating analyst will validate the results independently, which will ensure that the results are accurate and complete. Specifically, the validating analyst will use the approved specifications to develop his or her own program code and compare the results with those generated by the lead programming analyst. This separate program run process will allow for a more comprehensive and thorough validation to identify any issues with the lead programming analyst's results. The validating analyst will maintain a validation log and communicate to the lead analyst any issues or discrepancies. Once the performance measure rates are validated, the lead programming analyst will compare the measure rates to any applicable benchmarks or historical measure results for reasonability.

Upon finalizing the performance measure calculations, HSAG will provide preliminary findings in an agreed-upon format (e.g., Microsoft Excel spreadsheets) that includes numerator and denominator counts, and comparisons to prior years' results and/or statewide or national performance standards, where applicable. HSAG will invite DHHS, the MCOs, and the DBM to offer comments and documentation to support correction of any errors or issues identified. If issues are identified after the review, HSAG will revise the measures and recalculate the rates. Once the measures are recalculated, DHHS will receive finalized rates.

d. Conduct Performance Improvement Projects in Addition to those Conducted by an MCO or DBM and Validated by an EQRO

The Contractor will, at the State's direction, conduct performance improvement projects in addition to those conducted by an MCO or DBM and validated by an EQRO in accordance with 42 CFR §438.358(b)(1)(i) .

HSAG will align its processes with the CMS *EQR Protocol 8: Implementation of Additional Performance Improvement Projects*, October 2019 (EQR Protocol 8) for any PIPs that HSAG conducts to assess and improve processes and outcomes of care that the MCOs and the DBM provide to their members.

The HSAG PIP team has been working with MCOs, PAHPs, and states to determine appropriate and relevant PIP topics for several years. HSAG has assisted in the successful development and implementation of both clinical and nonclinical new PIPs. HSAG's approach to conducting PIPs includes the following activities:

Activity 1: Select the PIP Topic—Upon request from DHHS for HSAG to conduct a PIP, HSAG will schedule a meeting with DHHS to better understand the concerns that prompted the need for a new PIP. HSAG will work collaboratively with DHHS to determine potential PIP topics by reviewing:

- Data, outcomes, and performance for topic ideas.
- Areas of priority in the DHHS' quality strategy.
- CMS projects for Medicaid.
- The Nebraska Legislature, governor, and sister agencies' priorities.
- The concerns of advocates, community organizations, and the provider community.

HSAG also will solicit input from the MCOs and the DBM, as appropriate and approved by DHHS, which may include reviewing MCO and DBM-specific PIP proposals, hosting individual or group MCO and DBM conference calls, facilitating work groups, among others.

The remaining steps within the Conducting Additional PIPs activity align with the steps in EQR Protocol 1. HSAG's approach to conducting PIPs is almost identical to its approach for validating PIPs, and includes the following activities:

Activity 2: Define the PIP Question
Activity 3: Identify the PIP Population
Activity 4: Use Sound Sampling Methods
Activity 5: Select the PIP Variables
Activity 6: Collect Valid and Reliable Data
Activity 7: Analyze Data and Interpret PIP Results
Activity 8: Review Improvement Strategies
Activity 9: Assess Whether Significant and Sustained Improvement Occurred

Please refer to HSAG's response to V.D.2.b for more detailed information on HSAG's process for the validation of PIPs.

e. Conduct Studies on Quality that Focus on a Particular Aspect of Clinical or Nonclinical Services at a Point in Time

The Contractor will, at the State's direction, conduct studies on quality that focus on a particular aspect of clinical or nonclinical services at a point in time.

HSAG will follow the guidance documented in CMS *EQR Protocol 9: Conducting Focused Studies of Health Care Quality*, *An Optional EQR-Related Activity, October 2019* (EQR Protocol 9) when conducting focused studies for quality improvement or for administrative, legislative, or other purposes as identified by DHHS.

Upon a DHHS request for a focused study, HSAG will collaborate with DHHS to design a study that will provide the information DHHS needs to better understand a particular clinical or nonclinical aspect of care that the MCOs and the

DBM provide. HSAG's focused study activities will center on the assurance that services provided to Medicaid enrollees are medically necessary, appropriate, and provided at the most efficient level of care. Examples of studies may include, among others, specific assessments of the interventions or delivery system reforms described within Nebraska's quality strategy for Heritage Health and the Dental Benefit Program (e.g., integration and expansion of populations and services, improvements in substance use disorder treatment and access to care, redesign and improvement in the delivery of long-term care, integration of nonemergency medical transportation into managed care), and HSAG will use information from a point in time as indicated by DHHS.

Depending on the topic and the level of complexity involved in the focused study, the processes and outputs may vary; however, HSAG's approach to completing the focused study activity will contain, at a minimum, the following steps:

Initiation Step: Methodology and Tools to Administer Quality Studies—Once assigned by the HSAG project director, the focused study activity project manager will work with DHHS' project leadership to confirm key project contacts, establish regular status meetings, and determine appropriate lines of communication. HSAG also will coordinate and conduct regular status meetings with the DHHS project team to detail tasks completed for each project phase, including an overall summary of the project's progress, and upcoming efforts. As needed, HSAG's focused study team will request study-specific status meetings beyond the regularly scheduled EQR progress reporting to discuss recommended resolutions to issues encountered during the period.

Activities 1 and 2: Select the Study Topic and Define the Study Question(s)—HSAG will collaborate with DHHS to select a study topic(s) that meets the needs of Nebraska's Heritage Health program. HSAG will draw on its EQRO expertise to provide State-specific recommendations for study topics and indicators. Examples of HSAG's recent Medicaid-focused studies include administrative data studies, medical record reviews, and qualitative studies evaluating perinatal dental service utilization, birth outcomes among Medicaid members, tobacco cessation services, health care utilization among children in foster care transitioned from fee-for-service to managed care service delivery, long-acting reversible contraceptive policies and utilization, and assessment of opioid dependence treatment.

HSAG will organize a kick-off meeting with DHHS to discuss study topics and goals, including the completion of HSAG's focused study planning worksheet. In addition to project management topics, HSAG will work with DHHS during this meeting to identify the study topic, appropriate study population(s), and the overall project plan.

Once the study topic(s) is defined and HSAG has conducted a literature review to assess current work in the topic area, HSAG will translate the topic into clear and concise study questions and materials that include measurable indicators and analytics for a defined population and time period. In addition to a work plan and pertinent data collection tools,

study materials will include a methodology that defines the specific study question(s), study population, measurement period, data sources, study indicators, data collection process, and analytic plan.

Activity 3: Select the Study Variable(s)—Study indicators address quality of care, timeliness, and type(s) of services, with consideration to the data source (e.g., encounter data, medical records, vital records, and/or survey results). HSAG will select study variables that will enable HSAG staff members to measure the MCOs' and the DBM's performance on the elements of care identified in the study question.

At DHHS' discretion, HSAG may develop novel study indicators, use established study indicators (e.g., HEDIS), and/or collaborate with stakeholders to develop study indicators. Study indicator development includes the following considerations:

- Identifying indicators that address quality of care and performance measurement, with consideration for the data source.
- Defining the criteria for case selection/exclusion, and for issues specific to MCOs and the DBM (e.g., contraindications, patient refusal, provider participation).
- Defining the specific criteria to apply to the numerator and denominator for each study indicator.
- Agreeing on the indicator goals, standards of quality, or performance levels that MCOs and the DBM should strive to achieve (i.e., the level at which an indicator result will be considered "good").

Activity 4: Develop a Plan to Study the Population (Sampling Methodology)—To ensure meaningful results, HSAG will work with DHHS to identify study populations to produce reliable and generalizable results, and will make decisions regarding the use of the entire eligible population within a defined measurement period. Based on the study goal(s), measurement period, and study data, HSAG may recommend selecting a representative sample from the eligible population to reduce the burden on participating MCOs and the DBM and/or data sources.

If the study requires medical record review, HSAG will include a description of a sampling methodology, a record review tool, and a record abstraction protocol in DHHS-approved study materials. Additionally, studies using administrative data may employ sampling based on the overall research design. HSAG will estimate sample sizes and consider statistical reliability in conjunction with the final DHHS-approved methodology. Over-sampling may be required for subgroup analyses, and the sample strata will be weighted to achieve population-level prevalence in these instances. When relevant, HSAG will include practice guidelines or standards in its study materials.

Activity 5: Reliably Collect Data—HSAG's priority is complete and accurate data collection, regardless of the information source. As data are collected, HSAG follows established policies and procedures to monitor data validity and accuracy continually. If required, HSAG will provide technical assistance to data submitters (i.e., MCOs, the DBM,

or DHHS' technical staff) to ensure clear expectations and appropriately extracted data. If data are submitted over a period of time, HSAG will use tracking tools to keep DHHS apprised of data collection progress.

For studies using administrative data, HSAG will prepare a DHHS-approved data requirements document detailing the study data specifications, including time frame (dates of service), population, types of files (e.g., claims or demographics), the pertinent project timeline, and specific data elements. HSAG will encourage the data submitters to communicate via telephone or email to clarify data requirements, if necessary. HSAG also has experience in supplementing administrative encounters and claims data with alternate data sources, (e.g., birth registry or case management databases). These supplemental data sources allow for a more detailed examination of targeted health care topics.

For studies requiring data collection using medical or case management records, HSAG is responsible for securely receiving, storing, and abstracting study data from the records. After identifying sampled cases, HSAG will procure medical records using a study-specific record tracking tool to track MCOs' and the DBM's procurement compliance. HSAG will work with DHHS to design informational materials that give the MCOs and the DBM a study overview and stress the importance of cooperation to ensure a successful study outcome. Informational materials, the list of sampled cases, and HSAG-designed procurement instructions will accompany HSAG's record request to each MCO and the DBM.

Regardless of data type, HSAG will run standard edits after data collection as a final validity check. During this process, HSAG will review frequency distributions, conduct valid range checks, and review a series of logical field-to-field comparisons. HSAG's health care analysts use the SAS statistical software package to assess data validity. Data issues might include values outside an expected range, unassigned values, and illogical field-to-field comparisons (e.g., the date of service occurred before a member's date of birth). HSAG will resolve any questions or concerns that result from this validation with the data submitted to DHHS' satisfaction prior to analysis.

Activity 6: Analyze Data and Interpret Study Results—For each focused study, HSAG will develop an analysis plan to supplement the DHHS-approved study methodology. The analysis plan will serve as an intermediate document that translates methodology into analytic programming, including specific descriptions of the data elements used to identify and describe study indicators and applicable statistical analyses.

HSAG will conduct statistical analyses according to DHHS-approved study materials. Primary analyses will address the study question(s) and provide study indicator results. HSAG also may perform secondary analyses to examine variations among subgroups (e.g., by demographic or enrollment characteristics), patterns of care and outcomes, impact of explanatory variables on the indicators, and correlation among variables. HSAG is cognizant of the various

threats to internal and external validity outlined by Cook & Campbell (1979)[7]. HSAG's focused studies are designed to ensure that each threat to validity is addressed and minimized to the extent possible. All results will be validated independently by another analyst to ensure the validity and accuracy of reported findings.

Activity 7: Report Results to the State—In addition to presenting study results in a written report, HSAG is experienced with alternative reporting methods (e.g., oral presentations, data workbooks, and dashboards). Regardless of DHHS' requested reporting format, HSAG will close each focused study by producing a report that describes the study methodology, including the data sampling, collection, and analysis process; the study results; and the conclusions. When applicable, reports will include HSAG's recommendations and a summary of actions that the MCOs, DBM, or DHHS have taken in response to any corrective actions or recommendations from prior pertinent studies or DHHS initiatives.

For each focused study, HSAG will provide DHHS with a draft report template for review and approval. The report template will show how HSAG proposes to organize the study methodology and findings within the report. DHHS will also review and provide feedback for each draft report before HSAG produces a final version of the report. After DHHS' review and approval, HSAG will produce and provide DHHS with an electronic copy of the final report per DHHS-approved study timeline.

f. Assist with the Quality Rating of the MCOs and the DBM

The Contractor will, at the State's direction, assist with the quality rating of the MCOs and DBM consistent with 42 CFR § 438.334.

As described in 42 CFR §438.334, each state contracting with an MCE to provide services to Medicaid members must adopt the Medicaid and CHIP (MAC) managed care quality rating system (QRS) developed by CMS or adopt an alternative QRS that produces substantially comparable results. A QRS enables states to better measure and manage the quality of care that MCEs provide and assist consumers in selecting an MCE based on performance. HSAG works with several state Medicaid agencies, including those in Illinois, Iowa, Michigan, and Virginia, to implement QRSs. HSAG is prepared to assist with developing QRSs for DHHS that highlight the performance of the MCOs and the DBM, align with DHHS' expectations, and meet CMS requirements.

HSAG first will meet with DHHS to discuss its vision and objectives for developing and implementing QRSs for the MCOs and DBM. During this meeting, HSAG will discuss CMS' guidance as related to QRSs to date, as well as HSAG's

[7] Cook, TD & Campbell, DT. Quasi-experimentation: Design & Analysis Issues for Field Settings. Boston, MA: Houghton-Mifflin, 1979.

proposed approach for developing an alternative QRS. HSAG also will work with DHHS to determine whether to adopt CMS' QRS methodology or implement an alternative one for the MCOs and the DBM.

Although CMS has not yet released the technical specifications for the MAC QRS, HSAG will review CMS' technical specifications once available to determine if the mandatory performance measures and methodology align with the Nebraska's Heritage Health program. Based on its expertise developing and implementing QRSs, HSAG will provide DHHS with recommendations regarding the use of the MAC QRS methodology based on the availability of data and DHHS' required services. If DHHS does not collect the mandatory measures outlined in CMS' MAC QRS methodology, HSAG will work with DHHS to require the MCOs and the DBM to report the measures if they are applicable to the population. If DHHS elects to implement CMS' methodology, HSAG will produce the QRSs using the CMS MAC technical specifications for DHHS to publish annually.

If DHHS elects to develop an alternative QRS methodology, HSAG will develop a methodology that yields results substantially comparable to CMS' MAC QRS. HSAG will work with DHHS to ensure its MCOs and the DBM are reporting the required CMS MAC QRS measures and any additional performance measures, as required by DHHS. The MCO alternative methodology will use HEDIS data and CAHPS survey results to calculate summary scores for each MCO for specified quality domains based on comparisons of MCOs' performance with one another. The difference between an MCO's summary score and the statewide summary score (i.e., the average MCO summary score) will determine the MCO ratings for the summary measures (e.g., significantly above average, average, significantly below average). The DBM alternative methodology will rely on any applicable performance measures the DBM is required to report and will compare the performance measure rates to national benchmarks, where applicable. HSAG will work with DHHS to ensure that the alternative QRSs meet its needs and are easily interpreted by the intended audience (e.g., consumers), while truly reflecting the performance of the MCOs and the DBM.

As part of developing the alternative QRS methodology, HSAG will create documents to share with stakeholders, such as the MCOs and the DBM, for comment. This will include, at a minimum, the methodology document, proposed measure list, and a QRS results template that displays the results of the alternative QRS analysis. After receiving DHHS' feedback and final approval on the methodology document, proposed measure list, and QRS results template, HSAG will assist DHHS with posting the stakeholder documents for public comment for at least 30 days. Additionally, at DHHS' request, HSAG will assist with responding to stakeholder feedback and public comments. This will include providing rationale for incorporating or rejecting the feedback on the alternative QRS methodology. Upon DHHS' direction, HSAG will make any necessary modifications to the alternative QRS methodology based on stakeholder feedback.

At DHHS' request, HSAG will implement the agreed-upon QRS methodology, update the QRS template, and calculate QRS results for DHHS annually.

g. Provide Technical Guidance to MCOs or DBMs to Assist in Conducting EQR-Related Activities

The Contractor will, at the State's direction, provide technical guidance to MCOs or DBMs, to assist in conducting activities related to the mandatory and optional activities that provide information for the EQR and the resulting EQR technical report.

As stated and further described in section V.D.3.a., HSAG will provide technical guidance to the MCOs and the DBM to assist them through all mandatory and optional EQR-related activities that provide information for the annual EQR and the resulting EQR technical report. HSAG is proactive through each EQR-related activity, and at the initiation of every activity that includes the MCOs and the DBM, HSAG will schedule a webinar session to explain the purpose of the activity; walk through all materials related to the activity, including the timeline, methodology, data submission requirements, tools, and scoring criteria, among others; discuss the review logistics (when applicable); and provide the contact information for the HSAG project team. HSAG also leaves sufficient time during the webinar session to answer any questions that MCO and DBM staff members or DHHS may have. Further, HSAG staff members are always available to consult with the MCO and DBM staff and welcome any questions that MCO and DBM staff members may have throughout the activity processes. HSAG also takes an active role in the technical guidance process and will reach out to DHHS and/or the MCOs/DBM directly when HSAG notices that a particular MCO, DBM, or a group of MCOs is struggling to complete tasks (either accurately or timely) during the activity completion process.

Although HSAG typically provides technical guidance through teleconferences or webinar sessions, HSAG also will attend MCO/DBM/DHHS operational meetings, work groups, and planning sessions, either virtually or in person as necessary, to ensure the MCOs, DBM, and DHHS have the tools and support they need to conduct an activity successfully.

How Approach Meets or Exceeds Requirements of the RFP

HSAG's ultimate goal when conducting activities with MCOs and DBMs is to ensure they achieve success and demonstrate optimal performance in every activity in which they partake. HSAG's standard approach to conducting all mandatory and optional EQR-related activities is to provide customized analyses and technical guidance to MCOs and DBMs as part of the overall activity process. Identifying issues and problems regarding access, quality, and utilization is the first step in using EQR for quality improvement. The next step is to provide actionable recommendations the MCO or the DBM may use to correct a problem. HSAG's content rich analyses of the EQR activities performed enables MCOs, DBMs, and state staff members identify the starting point for performance improvement. Furthermore, HSAG staff members are equipped to work with MCOs and the DBM to drill-down within the data or systemic processes within

the MCO/DBMs operations to identify root causes that may impact overall performance. HSAG will be collaborative and supportive, and provide technical guidance, through every step of the activity process. HSAG staff members regularly receive positive feedback from MCO, DBM, and state Medicaid agency staff members, expressing their appreciation for the level of support and guidance that HSAG provides through each activity. HSAG assures DHHS that it will exceed the expectations of the RFP, and DHHS' contracted MCOs and the DBM will appreciate the approach that HSAG takes for offering and providing technical guidance.	
V.G. Work Plan	
V.G.	Describe the Bidder's approach to successfully completing all EQR-related services and how the approach meets or exceeds the requirements of this RFP. Bidder must include a Draft Work Plan that includes a timeline of deliverable submission for review.
Bidder Response:	**Approach to Successfully Completing all EQR-Related Services** HSAG' extensive experience working with State Medicaid agencies, MCOs, and DBMs puts it in an excellent position to complete all EQR-related services and produce EQR-related deliverables successfully. HSAG's approach is based on decades of having a comprehensive, efficient process for annual EQR-related services that results in well-written, concise, and accurate deliverables. This includes developing and communicating activity-specific work plans, developing timelines and schedules for key milestones and reporting activities, adhering to lines of authority and accountability, and reporting progress to DHHS at least monthly. These processes ensure that activities and decisions will be planned and executed thoughtfully with appropriate stakeholder involvement, and will result in timely, accurate, and consistent implementation, deliverables, and technical reports. HSAG understands it is critical to have an organized, on-schedule implementation of the operations supporting all EQR activities. The caliber and depth of HSAG's project management staff as well as its analytic and support staff will enable it to leverage personnel resources effectively. Each activity project team is composed of highly skilled professionals with a successful history of managing large-scale projects with multiple priorities. An activity project manager who ensures the timely and high-quality completion of required tasks will direct each activity project team. The professional skills of HSAG's staff ensure that the overall project director, assistant project director, and designated activity project managers function at the senior level to manage the overall project. Additionally, HSAG's streamlined approach to deliverable production ensures concise communication of data, content-rich

	analyses, and actionable recommendations. HSAG's in-house technical writers, editorial staff, and its accessible Section 508-compliance staff ensure HSAG produces well-written, grammatically accurate, accessible deliverables. HSAG ensures the accuracy of all deliverables through a process of quality assurance review by a team of trained reviewers familiar with the spectrum of report types and analyses that HSAG creates, as well as the numerous data sources that HSAG uses. The Quality Assurance Team (QAT) collaborates with subject matter experts and their teams to understand the purpose of each deliverable, the data sources used, and the methodologies applied. Contract deliverables are developed by activity project managers and their teams. Once the development of a draft deliverable is completed, the activity project managers provide the document and its associated source documents to the QAT for validation. The QAT reviews the deliverable document to ensure that multiple components are accurate and correctly interpreted, as follows: • Source documents are internally consistent, and calculations are correct • Contents of figures and data tables agree with source documents and analytic results • Figures and data tables are placed correctly within the deliverable • Text interpretations accurately reflect the figures and data tables The QAT assigns two independent reviewers to examine the draft deliverable and source documentation and identify any issues with data analyses, presentation, or interpretation. After completing their reviews, the independent reviewers meet to reconcile their findings, resolve any discrepancies, and generate a final list of issues requiring revision. After its review, the QAT provides the subject matter experts and their teams the reconciled list of any issues for their revision. The activity project managers and their teams then submit the revised deliverable to HSAG's in-house editorial team to ensure all necessary revisions have been incorporated and the deliverable represents the highest level of quality. HSAG's internal work plans take into consideration the time necessary for the editorial staff and QAT to complete their reviews before the HSAG project manager submits the draft deliverable to DHHS for review and feedback. HSAG's approach and collaborative relationship with DHHS will ensure all EQR-related services are completed successfully and that deliverables include all required information and are submitted to DHHS by the agreed-upon due date. HSAG's draft Work Plan (included as Appendix 6: Work Plan) demonstrates that HSAG has the experience and the ability to create work plans that will ensure timely completion of all activities,

tasks, and deliverables. When developing the draft Work Plans for each contract deliverable, HSAG assumes the following:

- In April 2021, HSAG will begin activity tasks that include transitioning all previously initiated activities from the incumbent EQRO, and it will use results from the activities conducted in 2020 in the October 2021 EQR technical report.
- HSAG's full documented approach to activity tasks, as described within each activity response in Section V.D of this proposal, will begin on January 1, 2022, unless the activity has not already been completed by the incumbent EQRO.
- HSAG will provide all draft deliverables to DHHS at least two months in advance of the deliverable due date to ensure DHHS has adequate time for review and feedback.
- The final performance improvement project validation and performance measure validation deliverables are due annually by December 31.
- HSAG will produce deliverables that account for three MCOs and one DBM.
- The draft Work Plans, once approved by DHHS, will be referred to as the final Detailed Work Plan.

HSAG has noted in the draft Work Plan the data it requires from DHHS and the MCOs/DBM to perform each EQR activity successfully. While HSAG does not anticipate major complications related to producing the deliverables, unforeseen circumstances like the Coronavirus Disease 2019 (COVID-19) has required HSAG to redesign its approach to conducting certain EQR activities. For example, HSAG has been collaborating with state Medicaid agencies to modify timelines for 2020-2021 deliverables to accommodate decisions resulting from the effects of COVID-19. If a major event affects the timeline for the deliverable activities, HSAG will work collaboratively with DHHS to amend the approach and timeline so the activity is completed according to the State's specifications and needs for reporting.

Deliverables

Contractor shall provide all EQR-related services necessary to analyze and evaluate aggregated information on quality, timeliness, and access to the health care services that a managed care plan, or its contractors, furnish to Medicaid beneficiaries in a way that meets or exceeds the minimum requirements of section V.
a. Deliverable 1: Annual EQR Report- MCO.
Fixed cost per report. One (1) annual report for each MCO.

b. Deliverable 2: Annual EQR Report- DBM.
Fixed cost per report. One (1) annual report for each DBM

	c. Deliverable 3: Annual Validation of PIP Report- MCO. Fixed cost per report. One (1) annual report for each MCO. d. Deliverable 4: Annual Validation of PIP Report- DBM. Fixed cost per report. One (1) annual report for each DBM. e. Deliverable 5: Annual Validation of Performance Measures Report- MCO. Fixed cost per report. One (1) annual report for each MCO. f. Deliverable 6: Annual Validation of Performance Measures Report- DBM. Fixed cost per report. One (1) annual report for each DBM. g. Ad-Hoc Deliverable 7: Annual Validation of Network Adequacy Report, at DHHS request- MCO. Fixed cost per report. One (1) annual report for each MCO. h. Ad-Hoc Deliverable 8: Annual Validation of Network Adequacy Report, at DHHS request- DBM. Fixed cost per report. One (1) annual report for each DBM. i. Ad-Hoc Deliverable 9: Ad-hoc technical assistance and consultation, at DHHS request. Services at a fixed hourly rate. All rates shall be prorated for any fraction of an hour spent actually providing services, which shall be rounded to the nearest 15-minute increment for each hour worked pursuant this contract. j. Optional Deliverable 10: Ad-hoc reports, at DHHS request. Fixed cost per project based on hourly rate. Work may be needed that was not originally delineated in this RFP, but considered within the scope of work. This additional work may stem from legislative mandates, emerging technologies, and/or secondary research not otherwise addressed in this RFP or known at the time this RFP was issued. If additional work is needed, the Contractor must submit a Detailed Project Work Plan, Title/Role(s), number of hours, and due dates/deliverables for DHHS review and approval prior to commencing work. HSAG has developed a draft two-year Work Plan for completing and submitting the draft and final reports (deliverables) described in this section. A copy of the draft Work Plan is provided in Appendix 6: Work Plan. The Work Plan includes the sequence and timing of each activity and its defined subtasks, the proposed submission dates for deliverables (draft and final), and those responsible for each task and subtask. Upon contract award, HSAG will work with DHHS during the contract kick-off meeting to obtain feedback, make changes as requested, and provide a final Detailed Work Plan for DHHS' approval. The Detailed Work Plan will function as a "living roadmap" for both HSAG and

DHHS, serve as the basis of monthly progress meetings, and be updated with any changes that reflect actual progress or delays. HSAG will monitor each task and provide monthly progress updates on the written progress report to DHHS.

a. Deliverable 1: Annual EQR Report-MCO

Fixed cost per report. One (1) annual report for each MCO

HSAG has decades of experience implementing EQR contracts and is prepared to execute DHHS' requested scope of service for Deliverable 1: Annual EQR Report-MCO. By employing several internal continuous quality improvement strategies, HSAG will monitor and ensure the annual EQR report for the MCOs is delivered on time and on budget, uses scientifically sound methodologies for data collection and analysis, and meets DHHS' expectations and contract requirements. When developing the Annual EQR Report-MCO, HSAG will use information from the mandatory and, as appropriate, optional EQR activities to analyze and aggregate MCO performance on the quality, timeliness, and access to health care services provided to Medicaid enrollees. The report will include, at a minimum, data from the annual compliance review, performance improvement projects, performance measure validation, and network adequacy. HSAG also will collaborate with DHHS to determine whether to include additional EQR data such as data from surveys or encounter data validation activities.

Kari Vanderslice, MBA, will serve as the activity project manager for the annual EQR reports, with support from the project director, Kim Elliott, PhD, CPHQ, CHCA. Ms. Vanderslice will monitor the Work Plan, timeline, and other activities associated with the reports and will update the activity Work Plan before each scheduled monthly progress meeting with DHHS. During that meeting, HSAG and DHHS will review the Work Plan, focusing on the status of ongoing activities and, if issues arise, recommend viable solutions with DHHS. Ms. Vanderslice will discuss all recommended modifications to the Work Plan with DHHS and seek approval for the modifications, as necessary. Both Ms. Vanderslice and Dr. Elliott will be available to communicate with DHHS by telephone and email, as requested, during production of the Annual EQR Report-MCO.

b. Deliverable 2: Annual EQR Report-DBM

Fixed cost per report. One (1) annual report for each DBM

HSAG will follow the same well-established comprehensive approach, as described for the MCOs, to produce an Annual EQR Report-DBM under this contract.

c. Deliverable 3: Annual Validation of PIP Report- MCO

Fixed cost per report. One (1) annual report for each MCO.

Christi Melendez, RN, CPHQ, will serve as the activity project manager for the Validation of PIP activity and submission of Deliverable 3: Annual Validation of PIP Report-MCO. Ms. Melendez will be supported by Kristine Hartmann, MS, and Jenny Montano. Ms. Melendez, Ms. Hartmann, and Ms. Montano will monitor the Work Plan, timeline, and other activities associated with the report and update the activity Work Plan before each monthly progress meeting with DHHS. During that meeting, HSAG and DHHS will review the Work Plan, focusing on the status of ongoing validation of PIP activities and, if issues arise, recommend viable solutions with DHHS. Ms. Melendez will discuss all recommended modifications to the Work Plan with DHHS and seek approval for modifications, as necessary. Ms. Melendez, Ms. Hartmann, and Ms. Montano will be available to communicate with DHHS by telephone and email as requested during production of the Annual Validation of PIP Report-MCO.

d. Deliverable 4: Annual Validation of PIP Report-DBM

Fixed cost per report. One (1) annual report for each DBM.

HSAG will follow the same well-established comprehensive approach, as described for the MCOs, to produce an annual validation of PIP report for the DBM under this contract.

e. Deliverable 5: Annual Validation of Performance Measures Report-MCO

Fixed cost per report. One (1) annual report for each MCO.

Thomas Miller, MA, CHCA, will serve as the activity project manager for the validation of performance measures activity and submission of Deliverable 5: Annual Validation of Performance Measures Report-MCO. Mr. Miller will be supported by Tammy GianFrancisco, CHCA, and Jacilyn Daniel, BS. Mr. Miller, Ms. GianFrancisco, and Ms. Daniel will monitor the Work Plan, timeline, and other activities associated with the Annual Validation of Performance Measures Report-MCO, and they will update the activity Work Plan before each monthly progress meeting with DHHS. During the meeting, HSAG and DHHS will review the Work Plan, focusing on the status of ongoing activities and, if issues arise, recommend viable solutions with DHHS. Mr. Miller will discuss all recommended modifications to the Work Plan with DHHS and seek approval for the modifications, as necessary. Mr. Miller, Ms. GianFrancisco, and Ms. Daniel will be available to communicate with DHHS by telephone and email, as requested, during production of the Annual Validation of Performance Measures Report-MCO.

f. Deliverable 6: Annual Validation of Performance Measures Report- DBM

Fixed cost per report. One (1) annual report for each DBM.

HSAG will follow the same well-established comprehensive approach, as described for the MCOs, to produce an annual validation of performance measures report for the DBM under this contract.

g. Ad-Hoc Deliverable 7: Annual Validation of Network Adequacy Report - MCO

Fixed cost per report. One (1) annual report for each MCO.

Amy Kearney, BA will serve as the activity project manager for the validation of network adequacy activity and submission of the Deliverable 7: Annual Validation of Network Adequacy Report-MCO. Ms. Kearney will be supported by Alana Berrett, MPH; Joe Mireles, MPH; and Prashanthinie Mohan, DrPH, MBA. Ms. Kearney, Ms. Berrett, Mr. Mireles, and Dr. Mohan will monitor the Work Plan, timeline, and other activities associated with the Annual Validation of Network Adequacy Report-MCO and update the activity Work Plan before each monthly progress meeting with DHHS. During the meeting, HSAG and DHHS will review the Work Plan, focusing on the status of ongoing activities and, if issues arise, recommend viable solutions with DHHS. Ms. Kearney will discuss all recommended modifications to the Work Plan with DHHS and seek approval for the modifications, as necessary. Ms. Kearney, Ms. Berrett, Mr. Mireles, and Dr. Mohan will be available to communicate with DHHS by telephone and email, as requested, during production of the Annual Validation of Network Adequacy Report-MCO.

h. Ad-Hoc Deliverable 8: Annual Validation of Network Adequacy Report - DBM

Fixed cost per report. One (1) annual report for each DBM.

Upon DHHS' request, HSAG will follow the same well-established comprehensive approach, as described for the MCOs, to produce an annual validation of network adequacy report for the DBM under this contract.

i. Ad-Hoc Deliverable 9: Ad-hoc technical assistance and consultation

Services at a fixed hourly rate. All rates shall be prorated for any fraction of an hour spent actually providing services, which shall be rounded to the nearest 15-minute increment for each hour worked pursuant this contract.

Upon DHHS' request for technical assistance, HSAG staff members, led by Kim Elliott, PhD, CPHQ, CHCA, Kari Vanderslice, MBA, and the activity project managers depending on the activity, will provide ad-hoc technical assistance and consultation to the MCOs, DBM, and/or DHHS on topics that DHHS selects. Both Dr. Elliott and Ms. Vanderslice will be available to communicate with the MCOs,

DBM, and DHHS by telephone, email, webinar sessions, and in-person, as requested. Given the complex and multifaceted nature of EQR activities and the administration of Medicaid managed care programs, Dr. Elliott and Ms. Vanderslice are aware of the importance of technical assistance and consultation in facilitating the successful completion of EQR activities and administration of the requirements under the Heritage Health program. HSAG has considerable experience sharing its expertise and Dr. Elliott and Ms. Vanderslice will recommend practical solutions for any issues that arise during the EQR process. Ms. Vanderslice and Dr. Elliott understand that throughout the EQR activities evaluations, situations may arise that require technical assistance beyond what is anticipated, and already included as part of each EQR activity approach. When requested, and as approved by DHHS, HSAG will provide ad hoc technical assistance and consultation services at a fixed hourly rate, prorated for any fraction of an hour and rounded off to the nearest 15-minute increment for each hour worked pursuant to a resulting contract.

j. Optional Deliverable 10: Ad-hoc reports

Fixed cost per project based on hourly rate. Work may be needed that was not originally delineated in this RFP, but considered within the scope of work. This additional work may stem from legislative mandates, emerging technologies, and/or secondary research not otherwise addressed in this RFP or known at the time this RFP was issued. If additional work is needed, the Contractor must submit a Detailed Project Work Plan, Title/Role(s), number of hours, and due dates/deliverables for DHHS review and approval prior to commencing work.

HSAG stands ready to perform work that was not originally delineated in this RFP but considered in the scope of work, which may stem from legislative mandates, emerging technologies, and/or secondary research, or may include one or more of the optional activities described in 42 CFR §438.358(c) should DHHS request additional tasks. If additional work is needed, HSAG will submit a draft project Work Plan with due dates/deliverables, titles and/or roles of staff members involved, estimated number of hours and budget for DHHS' review and approval prior to commencing the work. HSAG will provide DHHS with ad-hoc reports resulting from this additional work.

How Approach Meets or Exceeds Requirements of the RFP

HSAG is an industry leader in measuring and improving health care effectiveness and has more than 40 years of experience collaborating with federal, state, and county governments; external stakeholders; advocates; legislative staffs; MCO/DBM staffs; medical associations; clinical staffs; and health care providers. Because of its EQR involvement in numerous states since the inception of the EQR requirements, HSAG is in an exceptional position to work with DHHS and manage activities and

	decisions that are thoughtfully planned and executed. HSAG will apply its well-established and comprehensive work plan approach to conducting successful and timely EQRs that exceed the requirements of CMS and of DHHS, and will result in timely, accurate, and consistent implementation and deliverables to DHHS. While it includes best practices and lessons learned in its work plan approach to EQR activities, HSAG will customize each work plan to produce an agreed-upon format and structure based on DHHS' needs. HSAG will work closely with DHHS to ensure an effective work plan is in place to conduct the EQR and determine the most meaningful and impactful way to present the results. **Draft Work Plan with Timeline of Deliverable Submission for Review** In Appendix 6: Work Plan of the proposal, HSAG provides a draft Work Plan that includes a timeline of all deliverables, tasks, subtasks, activities, deliverable milestones, and start and end dates described in section V.F of the RFP. HSAG will submit the Detailed Work Plan to DHHS no later than two weeks after the contract's start date. At least monthly, HSAG will submit to DHHS a written progress report on the status of work completed from the Detailed Work Plan.

V.H. Project Planning and Management	
V.H.	Describe the Bidder's approach to communication planning and how the approach meets or exceeds the requirements of this section. Bidder must include a Draft Communications Plan for review.
Bidder Response	**Approach to Communication Planning** No later than two (2) weeks after the contract start date, the contractor must develop and submit a Detailed Communications Plan meeting the requirements of Section V.D. The Detailed Communications Plan must include but is not limited to the following: Based on HSAG's experience working with a widely diverse customer base, a comprehensive communications plan is critical to the successful implementation of a contract. HSAG's history of proven success and effectiveness in meeting and exceeding performance expectations is due, in part, to maintaining regular and meaningful communication with state Medicaid agencies and their contracted managed care entities. HSAG is experienced in project management, communication, collaboration, and efficient EQR activity execution. It uses project management principles to ensure the EQR work plan will serve as a guide to communicate EQR activity progress and status at meetings and trainings and in reports. Additionally, a well-defined communications plan that outlines the expectations and protocols for communicating effectively and directly with the appropriate DHHS, MCO, DBM, and HSAG staff members, along with other stakeholders as required, ensures DHHS' activity and deliverable expectations are met in accordance with contract requirements. No later than two weeks after the contract start date, HSAG will develop and submit a Detailed Communications Plan to DHHS that, at a minimum, meets the requirements of Sections V.D Project Requirements **a. Contract Communication Protocols** a. Contract communication protocols, including formal and informal communications with DHHS staff and communication with other parties other than DHHS staff. i. Protocols must include notification to DHHS in writing of any key staff hiring, resignations and dismissals within one (1) business day after initial knowledge of the change. ii. Protocols must include distribution of the EQR reports, assessments, and recommendations that meet the requirements of Section V.D.5. iii. Protocols must include meeting planning that meet the requirements of Section V.D.6. iv. Protocols must include technical assistance planning that meets the requirements of Section V.D.3 of this RFP

The draft Communications Plan, attached as Appendix 5: Communications Plan, contains contract communication protocols for both formal and informal communications with the DHHS staff and other parties. At the start of the contract and before implementing EQR-related activities, the HSAG project director, Dr. Kim Elliott, will provide DHHS with all pertinent HSAG staff contact information. In addition, HSAG's draft Communications Plan, on page 2-2, specifies that HSAG will maintain a communication protocol document that includes a list of:

- HSAG staff members that indicates the EQR activity for which they are responsible, as described in the scope of work, with telephone numbers and email addresses.
- DHHS staff members who are primarily responsible for each EQR activity, with telephone numbers and email addresses.
- DHHS contracted Medicaid MCO/DBM staff members with telephone numbers, email addresses, and an indication of the EQR activity for which each individual is responsible.

HSAG staff members will respond to all telephonic and email communications from DHHS staff members within 24 hours of receipt. In the event an HSAG staff member is out of the office for more than 24 hours, DHHS staff members will be notified of an alternate contact. This practice will ensure continuity of the contract and any related tasks.

a.i. Communication of Staffing Changes

HSAG will notify the DHHS staff in writing and within one business day after initial knowledge of staffing changes, including hiring, resignations, and dismissals, as detailed on page 2-2 in the draft Communications Plan. By assigning a large, diverse, and experienced team to this contract, HSAG will enable knowledge transfer among staff members and teams within its organizational structure to mitigate risks associated with any vacancies. If there is a key staff member vacancy, replacement personnel will have, at a minimum, the comparable skills and experience of the predecessor. In addition, because of HSAG's "deep bench" of talent, Dr. Elliott will have the authority to allocate and coordinate resources and engage additional resources when positions are vacated for a brief period (e.g., vacations), or when additional resources are needed to meet DHHS' requirements.

If it becomes necessary to replace the project director or any of the activity project managers, HSAG will ensure the replacement is comparably qualified and sufficiently prepared to assume the leadership duties of the contract. To ensure that knowledge transfer and the transition are smooth, a

similarly qualified replacement project director or activity project manager will be assisted by the other activity project managers and the assistant project manager until they are fully prepared to assume the role.

a.ii. Distribution of EQR Reports, Assessments and Recommendations

HSAG will produce detailed technical reports annually that include an assessment of each MCO's and the DBM's performance and recommendations for improvement and that describe the manner in which the data from all EQR-related activities conducted in accordance with 42 CFR §438.358 were aggregated and analyzed, and conclusions drawn, as to the quality, timeliness, and access to care provided to Medicaid managed care enrollees. HSAG will produce and finalize this report by October 15 of each year to ensure DHHS has sufficient time to meet the annual April 30 deadline for posting the final EQR technical report and submitting it to CMS.

HSAG's draft Communications Plan protocols, on pages 2-6 and 2-7, specify that upon completion of the annual EQR technical report, HSAG will provide DHHS with a 508-compliant Portable Document Format (PDF) to upload to DHHS' website in adherence with the requirements under 42 CFR §438.364. HSAG will consult with DHHS to determine the number of hard copies to print for distribution to DHHS staff members, MCOs, the DBM, providers, enrollees, advocacy groups, members of the general public, and/or any other identified stakeholders. In addition, HSAG will:

- Not share or deliver any EQR-related reports, including the annual EQR technical report, or any supporting data to any other individual or entity without prior written approval from DHHS.
- Not disclose in the EQR-related reports the identity of any Medicaid enrollee or any other information protected by law.
- Develop, update, and maintain a report distribution list during the contract period to incorporate changes required by DHHS.

a.iii. Meeting Planning

HSAG's draft Communications Plan protocols on page 2-3 specify HSAG's role in facilitating, at a minimum, monthly technical assistance and quarterly operational meetings or conference calls between DHHS staff members and the EQR activity project managers. DHHS will determine the dates and times for the meetings, and the HSAG project director or manager will:

- Send a recurring meeting invitation to all applicable attendees.
- Provide DHHS with a recommended agenda for approval at least two days ahead of meetings.

	• Take and distribute meeting minutes not later than two business days after conclusion of each meeting. • Facilitate additional meetings, as DHHS' request, to ensure successful completion of all EQR activities. In conjunction with DHHS and, as stated on page 2-4 of HSAG's draft Communications Plan, HSAG will participate in the quarterly operational meetings with the MCOs and DBM. HSAG will be prepared to discuss upcoming or existing EQR activities, as requested by DHHS and/or at the recommendation of the MCOs and DBM, such as any pertinent updates to Medicaid managed care (e.g., changes to existing regulations and/or protocols and/or any best practices within the Medicaid managed care industry). HSAG also will attend and/or participate in any other meetings as requested by DHHS. ***a.iv. Technical Assistance*** HSAG's draft Communications Plan protocols on page 2-4 specify procedures for HSAG to facilitate technical assistance (TA) to DHHS and/or MCO/DBM staff members, as necessary, to ensure successful completion of EQR activities and deliverables. HSAG will identify and provide the necessary technical assistance and training to the MCOs and the DBM—individually or as a group, as needed—to ensure each MCO and the DBM is fully prepared for the role it will play within an activity. HSAG will review for the MCO and DBM the timelines and due dates for the MCO's and DBM's active participation; the staff members, information, and other resources it will need for the activity; and how it will communicate the outcome and results of the activity (usually a report). If HSAG discovers that MCO and/or DBM staff members are struggling with EQR concepts or with meeting data submission requirements, it will notify DHHS and recommend a specific TA or training strategy specific for the MCO/DBM to guide it through the EQR activity. Additionally, with DHHS approval, MCOs and the DBM can request TA from HSAG at any time during each EQR activity. For example, the MCOs and DBM may consult with HSAG when developing performance improvement projects, obtain guidance from HSAG on interpreting State and/or federal regulations as part of the compliance review activity, and/or discuss development of appropriate corrective action plans in response to any noted deficiencies identified through the annual EQR or EQR-related activities. HSAG also can provide DHHS with training, education, and TA to DHHS-designated personnel and staff members.

HSAG will:

- Submit to DHHS the draft agenda and training materials in advance of each TA session for DHHS input and approval.
- Send participants the final agenda and training materials in advance of the TA session by email.
- Provide TA primarily by Webex webinar, conference call and email, or on-site, as requested by DHHS.
- Organize a Webex meeting for each TA session.
- Take roll call of DHHS and MCO/DBM staff members and document the attendance.
- Announce conference line logistics and introduce the TA trainer
- Conduct the TA session following the DHHS-approved agenda.
- Facilitate a question-and-answer and discussion session to encourage DHHS and MCO/DBM participation and ensure all questions and concerns are addressed.

b.i. Deliverable Submission and DHHS Draft Report Review Protocols

i. Protocols must include submission of draft reports to DHHS with a minimum of two (2) months lead time for review and a correction of any noted deficiencies identified by DHHS within two (2) weeks.

HSAG's draft Communications Plan protocols, on page 2-5, specify that HSAG will submit all activity-specific draft reports to DHHS for review and approval, as follows:

- HSAG will provide DHHS with draft reports a minimum of two months before their due dates for DHHS review.
- HSAG will respond to DHHS' feedback and requested corrections of any noted deficiencies or corrections within two weeks of receiving the draft report back from DHHS.
- HSAG will provide the final report deliverable in accordance with the DHHS-approved work plan.
- Upon request from DHHS, HSAG will schedule a meeting with DHHS staff members and conduct a walk-through of each deliverable produced to provide DHHS with an overview of the findings and the potential impact those findings could have on enrollees receiving services through the Heritage Health program.

c.i. Ad-hoc deliverable request and initiation protocols

i. Protocols must include responses to DHHS EQR-related informational requests within one (1) business day, or as agreed upon with DHHS, throughout the Contract.

HSAG's draft Communications Plan protocols, on page 2-1, specify that upon DHHS' request, HSAG will respond to ad hoc informational or deliverable requests within one business day or as agreed upon with DHHS, throughout the contract. HSAG will facilitate ad hoc meetings and provide TA to DHHS and/or MCO/DBM staff members, as requested by DHHS. In addition, HSAG will complete ad hoc studies and associated reports in an agreed-upon time frame. HSAG will include this information in the annual technical report as requested by DHHS.

d.i. Work plan progress review protocols

i. Protocols must include conference calls with DHHS monthly or as directed by DHHS throughout the Contract to review contract deliverables.

HSAG's draft Communications Plan protocols, on page 2-3, include conference calls with DHHS each month or as directed by DHHS throughout the contract to review contract deliverables. The project director and assistant project director will facilitate the monthly progress conference call meetings between DHHS and the HSAG EQR activity project leaders. HSAG will use agendas that incorporate action items, risk logs, visual tools, and dashboards to present project status, risks, and upcoming tasks. During the monthly meetings, HSAG will review the status of each EQR activity detailed in the DHHS-approved EQR work plan, discuss milestones associated with each activity, and bring to light any outstanding issues that may have the potential to impact the timeline. The monthly meetings will give DHHS staff members the opportunity to provide feedback on decisions pertaining to critical milestones, provide guidance on ongoing activities, and help resolve issues that may impact an activity. The HSAG assistant project director, or designee, will take meeting minutes and will distribute the minutes to all meeting participants no later than two business days after conclusion of each meeting.

Detailed Communications Plan Subject to DHHS Approval

DHHS may approve or reject, in writing, the Detailed Communications Plan or any proposed updates to the Detailed Communications Plan.

HSAG understands that DHHS may approve or reject, in writing, the Detailed Communications Plan or any updates to the plan. HSAG will work with DHHS to ensure full satisfaction with the plan.

How Approach Meets or Exceeds Requirements of the RFP

HSAG's draft Communications Plan outlines the actions and processes proposed to facilitate effective communication among DHHS, HSAG, MCOs, the DBM, and other stakeholders. It also includes a framework for the management and timeliness of ongoing progress reporting, provides guidelines for preparing and distributing EQR-related deliverables, and fully meets DHHS' requirements for section V.H.1. Communication Planning. HSAG will make prompt revisions to any processes or deliverables as requested by DHHS. In addition, HSAG completes EQR Process Evaluations to determine if improvements or enhancements are needed to the services offered by HSAG.

Conduct Annual EQR Process Evaluation

HSAG understands the importance of an ongoing evaluation of processes to improve the services HSAG provides to its state customers. HSAG customers are the best gauge to ensure EQR activities are conducted in the manner expected of DHHS staff members and MCOs and the DBM. HSAG typically conducts an after-action review at the close of each activity to examine lessons-learned and improvements it can make to its EQR processes. At the conclusion of in-person or webinar trainings and presentations, HSAG collects evaluations from attendees, analyzes the results, and makes rapid-cycle changes for future events. In addition, HSAG will conduct an annual EQR process evaluation and incorporate feedback from the MCOs and DBM to improve its EQR processes and performance. Once determined what enhancements can be made, HSAG will update the Communications Plan, as appropriate, to ensure any modifications to activities are communicated in accordance with the plan.

Draft Communications Plan for Review

The HSAG draft Communications Plan is attached as Appendix 5: Communications Plan.

HSAG Appendices

Appendix 1: Audited Financial Statements

HEALTH SERVICES HOLDINGS, INC. AND HEALTH SERVICES ADVISORY GROUP, INC.

CONSOLIDATED FINANCIAL STATEMENTS AND ADDITIONAL INFORMATION

Years Ended June 30, 2019, 2018 and 2017

HEALTH SERVICES HOLDINGS, INC. AND HEALTH SERVICES ADVISORY GROUP, INC.

CONSOLIDATED FINANCIAL STATEMENTS AND ADDITIONAL INFORMATION

Years Ended June 30, 2019, 2018, and 2017

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INDEPENDENT AUDITORS' REPORT

To the Board of Directors and Stockholders of

HEALTH SERVICES HOLDINGS, INC. AND
HEALTH SERVICES ADVISORY GROUP, INC.

We have audited the accompanying consolidated financial statements of ***Health Services Holdings, Inc. and Health Services Advisory Group, Inc.***, which comprise the consolidated balance sheets as of June 30, 2019, 2018, and 2017, and the related consolidated statements of income and retained earnings, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditors' judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the consolidated financial position of ***Health Services Holdings, Inc. and Health Services Advisory Group, Inc.*** as of June 30, 2019, 2018, and 2017, and the results of their operations and their cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Report on Consolidating Information

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The consolidating balance sheet as of June 30, 2019 and consolidating statement of income and retained earnings for the year then ended are presented for purposes of additional analysis of the consolidated financial statements rather than to present the financial position, results of operations, and cash flows of the individual companies, and are not a required part of the consolidated financial statements.

Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The consolidating information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the consolidating information is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

Mayer Hoffman McCann P.C.

September 30, 2019

HEALTH SERVICES HOLDINGS, INC. AND HEALTH SERVICES ADVISORY GROUP, INC.

CONSOLIDATED BALANCE SHEETS

June 30, 2019, 2018, and 2017

ASSETS

	2019	2018	2017
CURRENT ASSETS			
Cash and cash equivalents	$ 3,930,854	$ 3,323,879	$ 4,799,329
Receivables	30,093,150	25,551,482	21,748,334
Prepaid expenses and other current assets	1,888,714	2,194,358	1,360,018
Income taxes receivable	-	182,973	-
TOTAL CURRENT ASSETS	35,912,718	31,252,692	27,907,681
PROPERTY AND EQUIPMENT, net	4,180,065	3,409,890	4,461,292
DEFERRED INCOME TAXES	3,181,669	2,102,774	3,246,591
OTHER ASSETS	167,454	167,454	179,354
TOTAL ASSETS	$ 43,441,906	$ 36,932,810	$ 35,794,918

LIABILITIES AND STOCKHOLDERS' EQUITY

CURRENT LIABILITIES			
Accounts payable	$ 2,569,462	$ 2,366,943	$ 1,966,951
Accrued expenses	14,457,139	12,729,059	13,210,756
Income taxes payable	941,591	-	110,131
Deferred revenues	3,298,778	4,351,664	2,299,145
Other current liabilities	1,298,173	1,298,173	2,152,486
Lines of credit	2,500,000	-	-
TOTAL CURRENT LIABILITIES	25,065,143	20,745,839	19,739,469
DEFERRED RENT	2,823,264	1,238,410	1,514,144
NOTES PAYABLE - STOCKHOLDERS	6,292,467	6,018,646	5,756,869
TOTAL LIABILITIES	34,180,874	28,002,895	27,010,482
COMMON STOCK, par value $1, authorized 1,000,000 shares, issued and outstanding 3,232 shares	3,232	3,232	3,232
ADDITIONAL PAID-IN CAPITAL	16,970	16,970	16,970
RETAINED EARNINGS	9,240,830	8,909,713	8,764,234
TOTAL STOCKHOLDERS' EQUITY	9,261,032	8,929,915	8,784,436
TOTAL LIABILITIES AND STOCKHOLDERS' EQUITY	$ 43,441,906	$ 36,932,810	$ 35,794,918

HEALTH SERVICES HOLDINGS, INC. AND HEALTH SERVICES ADVISORY GROUP, INC.

CONSOLIDATED STATEMENTS OF INCOME AND RETAINED EARNINGS

Years Ended June 30, 2019, 2018, and 2017

	2019	2018	2017
SERVICE REVENUES			
Federal contracts	$ 82,043,112	$ 74,779,550	$ 71,064,634
State and corporate contracts	32,532,889	26,228,813	24,282,179
TOTAL SERVICE REVENUES	114,576,001	101,008,363	95,346,813
DIRECT EXPENSES	66,537,412	62,301,774	58,831,488
GROSS MARGIN	48,038,589	38,706,589	36,515,325
ADMINISTRATIVE EXPENSES	47,333,743	36,836,816	35,711,502
INCOME FROM OPERATIONS	704,846	1,869,773	803,823
OTHER EXPENSE	(250,331)	(206,634)	(520,892)
INCOME BEFORE INCOME TAXES	454,515	1,663,139	282,931
INCOME TAXES			
Current provision	1,202,293	373,843	570,459
Deferred provision (benefit)	(1,078,895)	1,143,817	(483,440)
TOTAL INCOME TAXES	123,398	1,517,660	87,019
NET INCOME	331,117	145,479	195,912
RETAINED EARNINGS, BEGINNING OF YEAR	8,909,713	8,764,234	8,568,322
RETAINED EARNINGS, END OF YEAR	$ 9,240,830	$ 8,909,713	$ 8,764,234

HEALTH SERVICES HOLDINGS, INC. AND HEALTH SERVICES ADVISORY GROUP, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS

Years Ended June 30, 2019, 2018, and 2017

	2019	2018	2017
CASH FLOWS FROM OPERATING ACTIVITIES			
Net income	$ 331,117	$ 145,479	$ 195,912
Adjustments to reconcile net income to net cash provided by (used in) operating activities:			
Depreciation and amortization	1,596,387	1,598,445	1,618,846
Change in deferred income taxes	(1,078,895)	1,143,817	(483,440)
Additional cash received on disposition of property and equipment	-	-	10,959
Increase in notes payable - stockholders due to accrued interest	273,821	261,777	250,264
Changes in operating assets and liabilities:			
Decrease (increase) in:			
Receivables	(4,541,668)	(3,803,148)	(2,219,101)
Prepaid expenses and other current assets	305,644	(834,340)	162,065
Income taxes receivable	182,973	(182,973)	27,712
Increase (decrease) in:			
Accounts payable	71,856	422,745	(462,808)
Accrued expenses	1,728,080	(481,697)	2,387,626
Deferred revenues	(1,052,886)	2,052,519	(770,574)
Income taxes payable	941,591	(110,131)	76,131
Other current liabilities	-	(854,313)	380,391
Deferred rent	1,584,854	(275,734)	(181,120)
Net cash provided by (used in) operating activities	342,874	(917,554)	992,863
CASH FLOWS FROM INVESTING ACTIVITIES			
Purchases of property and equipment	(2,235,899)	(569,796)	(1,401,362)
Change in other assets	-	11,900	(15,757)
Net cash used in investing activities	(2,235,899)	(557,896)	(1,417,119)
CASH FLOWS FROM FINANCING ACTIVITIES			
Proceeds from lines of credit	2,500,000	-	-
Payments on notes payable - stockholders	-	-	(214,931)
Change in deferred compensation expense	-	-	461,980
Net cash provided by financing activities	2,500,000	-	247,049
NET CHANGE IN CASH AND CASH EQUIVALENTS	606,975	(1,475,450)	(177,207)
CASH AND CASH EQUIVALENTS, BEGINNING OF YEAR	3,323,879	4,799,329	4,976,536
CASH AND CASH EQUIVALENTS, END OF YEAR	$ 3,930,854	$ 3,323,879	$ 4,799,329
SUPPLEMENTAL DISCLOSURE OF CASH FLOW INFORMATION			
Cash paid for interest	$ 3,628	$ 11,126	$ 12,902
Cash paid for income taxes	$ 77,729	$ 666,947	$ 483,396
SUPPLEMENTAL DISCLOSURE OF NON-CASH INVESTING AND FINANCING ACTIVITIES			
Increase in notes payable - stockholders due to accrued unpaid interest	$ 273,821	$ 261,777	$ 250,264
Purchases of property and equipment included in accounts payable	$ 130,663	$ -	$ 22,753

(1) Company operations and summary of significant accounting policies

Company operations - ***Health Services Holdings, Inc. and Health Services Advisory Group, Inc.*** (collectively, the "Company") is engaged in providing health care information in Arizona, Arkansas, California, Colorado, Florida, Georgia, Hawaii, Illinois, Iowa, Louisiana, Massachusetts, Maryland, Michigan, Minnesota, Nevada, New Hampshire, New Mexico, North Carolina, Ohio, Oklahoma, Oregon, Tennessee, U.S. Virgin Islands, Utah, Vermont, Virginia, and Wyoming. Company efforts are designed to improve the quality of health care through the study of information.

The significant accounting policies followed by the Company are summarized below:

Principles of consolidation - The accompanying consolidated financial statements include the accounts of ***Health Services Holdings, Inc.*** ("HSH") and ***Health Services Advisory Group, Inc.*** ("HSAG"). In February 2004, HSH was established as a holding company of HSAG. The transactions to establish HSH resulted in the stockholders of HSAG becoming the majority stockholders of HSH. This transaction was accounted for under the rules applying to reverse acquisition accounting, under which HSAG's historical financial statement balances are carried forward as the financial reporting parent under the legal parent entity's name (HSH). All significant intercompany transactions and accounts have been eliminated in consolidation.

Management's use of estimates - The preparation of consolidated financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements and reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Revenue recognition - The Company recognizes revenue as services are performed. Cash received for future services is deferred until the service has been performed. The Company's contracts with the Department of Health and Human Services are on a cost-plus-fee basis, fixed price basis, or cost only basis. Therefore, revenues for the contracts are recognized to the extent reimbursable costs are incurred and estimated fees are earned if applicable. Billings in excess of reimbursable costs incurred plus estimated fees are recorded as deferred revenue. Provisions for estimated losses on contracts are recognized in the period in which such losses are determined.

Costs related to certain contracts are subject to adjustment based on negotiations with, and the audits of the Company's records by its customers, including representatives of the federal government. Revenues for such contracts are recorded in amounts that are expected to be realized. It is reasonably possible that some portion of revenues recorded in the current period may be disallowed in future periods as a result of audits performed by the Company's customers. These disallowed revenues may be required to be refunded to the customer upon final settlement of the contract.

Cash and cash equivalents - Cash includes cash and, at times, cash equivalents which consist of highly liquid debt instruments purchased with original maturities of three months or less. Cash deposits are insured up to $250,000 by the Federal Deposit Insurance Corporation ("FDIC").

(1) Company operations and summary of significant accounting policies (continued)

Receivables - Receivables are carried at the outstanding balances less an allowance for doubtful accounts. The Company evaluates the collectability of its receivables based on a combination of factors. In circumstances where it is aware of a specific customer's inability to meet its financial obligations, the Company records a specific reserve to reduce the amounts recorded to what is estimated to be collected. Accounts are charged off against the allowance when they are deemed to be uncollectible. Accounts receivable at June 30, 2019, 2018, and 2017 are considered by management to be collectible in full and, accordingly, an allowance for doubtful accounts is not necessary.

Depreciation and amortization - Depreciation and amortization is computed using straight-line and accelerated methods over the following estimated useful lives:

Furniture and equipment	3 - 10 years
Leasehold improvements	2 - 10 years
Equipment held under capital lease	5 years

Impairment of long-lived assets - The Company accounts for long-lived assets in accordance with the provisions of The Financial Accounting Standards Board ("FASB") ASC 360, *Property, Plant, and Equipment*, which requires that long-lived assets be reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset may not be recoverable. Recoverability of assets to be held and used is measured by a comparison of the carrying amount of an asset to future undiscounted net cash flows expected to be generated by the asset. If such assets are considered to be impaired, the impairment to be recognized is measured by the amount by which the carrying amount of the assets exceeds the fair value of the assets. Assets to be disposed of are reported at the lower of the carrying amount or fair value less costs to sell. No impairment charges were recorded for the years ended June 30, 2019, 2018, and 2017.

Deferred rent - Deferred rent represents the difference between the total rent payments amortized using the straight-line method over the life of the leases and the actual cash expenditures. Tenant incentives received under leasing arrangements are capitalized under leasehold improvements in property and equipment and amortized over the life of the lease as a reduction of rent expense.

Income taxes - The Company follows FASB ASC 740, *Income Taxes*. FASB ASC 740 requires an asset and liability approach for financial accounting and reporting for income tax purposes. This statement recognizes (a) the amount of taxes payable or refundable for the current year, and (b) deferred tax liabilities and assets for future tax consequences of events that have been recognized in the consolidated financial statements or tax returns.

The Company accounts for uncertainty in income taxes through the application of a "more likely than not" threshold to the recognition and derecognition of uncertain tax positions. The provisions require that a change in judgment related to the expected ultimate resolution of uncertain tax positions be recognized in earnings in the year of such change. The Company's policy is to classify income tax penalties and interest as interest expense in its consolidated financial statements. At June 30, 2019, 2018, and 2017, the Company did not have any unrecognized tax benefits.

The Company files income tax returns in the U.S. federal jurisdiction and various state and local jurisdictions. The Company is no longer subject to U.S. federal and state and local income tax examinations by tax authorities for years before 2014.

(1) Company operations and summary of significant accounting policies (continued)

Recently issued accounting pronouncements - The FASB issued Accounting Standards Update ("ASU") No. 2014-09 - *Revenue from Contracts with Customers (Topic 606)* (ASU 2014-09) in May 2014, as amended, which is effective for nonpublic entities for annual reporting periods beginning after December 15, 2018, which would be the fiscal year ending June 30, 2020 for the Company. The FASB is currently undertaking efforts to provide implementation guidance to preparers of financial statements. The Company has not completed the process of evaluating the impact that will result from adopting ASU 2014-09 and is therefore unable to disclose the effects of adoption, if any, on the consolidated financial statements. During 2019, the Company established an implementation team to identify potential differences that could result from applying the requirements of this new standard, together with adoption of ASU No 2014-09. The team is responsible for identifying and implementing changes to business processes, systems, and controls to support disclosure under the new standard and evaluate any effect the new guidance will have on the Company's consolidated financial position.

In February 2016, the FASB issued ASU No. 2016-02 - *Leases (Topic 842)*. ASU 2016-02 requires that a lease liability and a related right-of-use asset representing the lessee's right to use or control the asset be recorded on the balance sheet upon the commencement of all leases except for short-term leases. Leases will be classified as either finance leases or operating leases, which are substantially similar to the classification criteria for distinguishing between capital leases and operating leases in existing lease accounting guidance. As a result, the effect of leases in the statement of operations and the statement of cash flows will be substantially unchanged from the existing lease accounting guidance. ASU 2016-02 is effective for fiscal years beginning after December 15, 2019, which would be the fiscal year ending June 30, 2021 for the Company. Early adoption is permitted. The Company has not elected to adopt this standard early. The Company has estimated that if they were to adopt the standard, a non-current operating lease right-of-use asset of approximately $22 million and corresponding current and non-current operating lease liabilities of $4 million and $18 million, respectively, would be recorded in the accompanying consolidated balance sheet as of June 30, 2019. The estimate was calculated using the minimum future lease payments (see Note 10) and a risk-free rate of 1.87%. In accordance with ASU 2016-02, operating leases are expected to record a single lease cost, identified as lease expense, in the statement of operations, and payments arising from such operating leases are generally included within operating activities in the statement of cash flows.

Subsequent events - The Company has evaluated subsequent events through September 30, 2019, which is the date the consolidated financial statements were available to be issued.

(2) Receivables

Total receivables consist of the following:

	2019	2018	2017
Contracts receivable:			
State and corporate contracts	$ 15,809,864	$ 12,579,493	$ 13,359,504
Federal contracts	12,948,024	12,692,318	8,209,376
Total contracts receivable	28,757,888	25,271,811	21,568,880
Receivable for tenant improvement allowance	1,112,508	-	-
Other receivables	222,754	279,671	179,454
Total receivables	$ 30,093,150	$ 25,551,482	$ 21,748,334

(2) Receivables (continued)

The contracts receivable amounts above include billed and unbilled amounts as follows:

	2019	2018	2017
Billed	$ 23,727,602	$ 21,384,886	$ 17,607,304
Unbilled	3,339,387	2,348,515	2,534,096
Retainage	1,690,899	1,538,410	1,427,480
Total contracts receivable	$ 28,757,888	$ 25,271,811	$ 21,568,880

(3) Property and equipment

Property and equipment consists of:

	2019	2018	2017
Cost:			
Furniture and equipment	$ 7,373,217	$ 7,693,627	$ 8,266,735
Leasehold improvements	2,536,654	2,269,465	2,172,755
Assets in process	1,412,930	4,652	4,849
Total cost	11,322,801	9,967,744	10,444,339
Accumulated depreciation and amortization	(7,142,736)	(6,557,854)	(5,983,047)
Net property and equipment	$ 4,180,065	$ 3,409,890	$ 4,461,292

Depreciation and amortization expense charged to operations was $1,596,387, $1,598,445, and $1,618,846, for the years ended June 30, 2019, 2018, and 2017, respectively.

Assets in process primarily represent construction to date on the expansion and remodel of the Company's leased headquarters. The construction is funded through a tenant improvement allowance as stipulated per the leasing arrangement. Expected costs to complete were approximately $156,000 and the construction was completed in August 2019.

(4) Lines of credit

In May 2015, the Company executed an amended and restated revolving line of credit with a borrowing capacity of $6,150,000. The revolving line of credit matured in May 2019 and was not renewed. The line of credit bore an interest rate of LIBOR plus 2.50% (4.48% and 3.92% at June 30, 2018 and 2017, respectively), and was secured by property and equipment, receivables and common stock of the Company. The line of credit was also guaranteed personally by certain stockholders of the Company and was subject to various financial and non-financial covenants. At June 30, 2018 and 2017, there was $0 of borrowings outstanding.

Effective June 28, 2019, the Company executed a liquidity access line agreement ("LAL Agreement") with a separate financial institution with a borrowing capacity of $7,000,000. The LAL Agreement bears a variable interest rate of LIBOR plus 1.50% (3.90% at June 30, 2019) and is due on demand. The LAL Agreement is guaranteed personally by the majority stockholder of the Company. At June 30, 2019, there was $2,500,000 of borrowings outstanding. Subsequent to year end, the Company increased the borrowing capacity under the LAL Agreement to $9,616,000.

(4) Lines of credit (continued)

The Company had unexpired financial standby letters of credit through its financial institutions at June 30, 2019, 2018, and 2017. The letters of credit expire annually, with automatic annual extensions unless notification is made 60 to 90 days in advance. The Company had standby letters of credit available of approximately $332,000 at June 30, 2019 and $222,000 at June 30, 2018 and 2017. On July 23, 2019, the Company increased the credit available under one of the letters of credit to $3,040,620.

(5) Notes payable - stockholders

The Company has unsecured borrowings outstanding from the majority stockholder of the Company. Unpaid principal on the note accrues interest at 4% per annum, compounded annually, and the outstanding principal and interest is due on June 30, 2020. The outstanding principal and interest balance was $2,819,592, $2,711,146, and $2,606,869, at June 30, 2019, 2018, and 2017, respectively.

During 2016, the Company borrowed an additional $3,000,000 from the majority stockholder of the Company. Unpaid principal accrues at 5% per annum, compounded annually. The outstanding principal and interest balance was $3,472,875, $3,307,500, and $3,150,000 at June 30, 2019, 2018, and 2017, respectively. The note is unsecured and matures on March 30, 2020.

Effective June 30, 2019, the Company extended the maturity dates on the notes payable – stockholders for an additional five year term, maturing on March 30, 2025 and June 30, 2025.

Annual maturities on the outstanding notes payable - stockholders are as follows:

Fiscal Year	
2020	$ -
2021	-
2022	-
2023	-
2024	-
Thereafter	6,292,467
Total annual maturities	$ 6,292,467

Total interest expense recognized on these notes payable was $273,821, $261,777, and $250,264 for the years ended June 30, 2019, 2018, and 2017, respectively.

(6) Other current liabilities

During the years ended June 30, 2007 through 2015 and during the year ended June 30, 2017, the Defense Contract Audit Agency ("DCAA"), working under directive from the Centers for Medicare and Medicaid Services ("CMS"), audited the costs charged to a CMS contract and recommended to CMS that certain costs be disallowed that were included in the general and administration cost pool as well as employee compensation costs. Included within these disallowed costs are certain costs related to the final settlement of a lawsuit from one former executive and the partial settlement of a lawsuit from another executive. While CMS is not obligated to follow the recommendations of the DCAA, management has determined that CMS will disallow the costs.

During the year ended June 30, 2018, the Company closed out a contract with CMS for a payment of $1,059,524. The final payment reduced disallowed costs related to legal settlements and DCAA audit accruals by $854,313. The payment further reduced deferred revenue and other revenue related to the contract by $152,200 and $53,011, respectively.

The liabilities recognized as a result of these matters consist of the following:

	2019	2018	2017
Disallowed costs related to legal settlements	$ -	$ -	$ 744,698
DCAA audit accrual for 2007 and 2008	83,937	83,937	140,497
DCAA audit accrual for 2008	331,804	331,804	331,804
DCAA audit accrual for 2010 and 2011	76,461	76,461	76,461
DCAA audit accrual for 2011	269,251	269,251	322,306
DCAA audit accrual for 2012	290,375	290,375	290,375
DCAA audit accrual for 2013	75,091	75,091	75,091
DCAA audit accrual for 2014	171,254	171,254	171,254
	$ 1,298,173	$ 1,298,173	$ 2,152,486

(7) Other income (expense)

Other income (expense) consists of:

	2019	2018	2017
Interest expense	$ (277,449)	$ (272,903)	$ (263,166)
Interest income	19,749	141,944	106,741
DCAA audit accruals (Note 6)	-	(380,391)	-
Other income (expense)	7,369	304,716	(364,467)
Total other expense	$ (250,331)	$ (206,634)	$ (520,892)

(8) Income taxes

Income taxes are provided for the tax effects of transactions reported in the consolidated financial statements and consist of taxes currently due plus deferred income taxes related primarily to differences between the financial and tax basis of property and equipment, deferred rent and certain accrued expenses, and the availability of net operating loss carryovers. The deferred taxes represent the future tax return consequences of these differences, which will either be taxable or deductible when the assets and liabilities are recovered or settled.

Deferred income tax assets are attributable to the following:

- Obligations for certain accrued expenses have no tax basis. Those accrued expenses will be deductible as payments are made in future periods.

- Temporary differences for property and equipment between the financial reporting basis and the tax basis are primarily attributable to accelerated methods of depreciation for tax purposes, certain leasehold improvements not capitalized and depreciated for tax purposes, and certain leasehold improvements classified as real property for tax purposes that will be depreciated over a longer period than that used in the financial reporting basis.

  The basis of property and equipment as of June 30, 2019 for tax purposes exceeds its financial reporting basis by the cumulative amount of the financial reporting depreciation and amortization over income tax depreciation and amortization. The excess will be taxable in future periods through reduced depreciation and amortization deductions for book purposes.

- Expenses recorded for rents related to the deferred rent liability have no tax basis. The rent expense will be deductible as payments are made in future periods.

Deferred income tax liabilities are attributable to the following:

- The basis of property and equipment as of June 30, 2018 and 2017 exceeds its basis for tax purposes by the cumulative amount of the income tax depreciation and amortization over financial reporting depreciation and amortization. The excess will be taxable in future periods through reduced depreciation and amortization deductions for tax purposes.

- Retainage included as revenue in the consolidated statements of income and retained earnings is taxed when collected. The retainage recognized for income tax purposes is adjusted to exclude the amount of uncollected retainage that has yet to be recognized for tax purposes.

(8) Income taxes (continued)

The provision for income taxes consist of:

	2019	2018	2017
Current provision:			
Federal	$ 946,536	$ 292,467	$ 471,458
State	255,757	81,376	99,001
Total current provision	1,202,293	373,843	570,459
Deferred provision (benefit):			
Federal	(831,729)	1,017,174	(416,125)
State	(247,166)	126,643	(67,315)
Total deferred provision (benefit)	(1,078,895)	1,143,817	(483,440)
Total income taxes	$ 123,398	$ 1,517,660	$ 87,019

The components of deferred tax assets and liabilities included in the accompanying consolidated balance sheets are as follows:

	2019	2018	2017
Deferred income tax assets (liabilities):			
Accrued expenses	$ 2,783,833	$ 1,971,476	$ 3,263,331
Property and equipment	60,900	(115,104)	(449,952)
Contracts receivable, retainage	(112,104)	(86,214)	(153,460)
Deferred rent	449,040	332,616	586,672
Net deferred income tax assets	$ 3,181,669	$ 2,102,774	$ 3,246,591

The provision for federal income taxes differs from that computed by applying federal statutory rates to income before federal income tax expense, as indicated in the following analysis:

	2019	2018	2017
Federal statutory income tax at 21%, 27.5%, and 34% as of June 30, 2019, 2018, and 2017, respectively	$ 95,448	$ 457,363	$ 96,197
Effect of state income taxes	21,674	116,420	11,927
Adjustments related to prior year true-ups	(8,475)	(18,691)	(7,280)
Effect of non-deductible meals, travel, and entertainment	23,496	17,050	11,999
State tax credit	-	-	(20,845)
Other	(8,745)	(36,319)	(4,979)
Tax effect of Federal US tax law change	-	981,837	-
Total provision for income taxes	$ 123,398	$ 1,517,660	$ 87,019

(8) Income taxes (continued)

The Tax Cuts and Jobs Act signed December 22, 2017 reduced federal tax rates for the Company as of the year ended June 30, 2019 and 2018 to 21%. The Company's federal statutory rate for the year ended June 30, 2018 was 27.5%, which is a blended rate due to the change in the federal statutory rate from 34% to 21% during course of the 2018 fiscal year. For 2018, the deferred tax asset was reduced to reflect the newly enacted federal rates.

(9) Employee benefit plans

The Company maintains a 401(k) defined contribution benefit plan covering employees who meet specified age and service requirements. The matching contributions made by the Company were $994,854, $899,951, and $758,247 for the years ended June 30, 2019, 2018, and 2017, respectively.

The Company has an employee stock ownership plan covering employees who meet specified age and service requirements. Contributions are determined annually at the discretion of the Company's Board of Directors.

The Health Services Holdings, Inc. Employee Stock Ownership Plan (the "ESOP") is funded through contributions authorized by the Company. The Company made contributions to the ESOP of $423,821, $2,036,634, and $1,761,860 for the years ended June 30, 2019, 2018, and 2017, respectively.

As of June 30, 2017, all 970 shares held by the ESOP have been released and allocated to the ESOP's participants. The participants have a limited put option right to the Company that would require the Company to repurchase its common stock from participants in the ESOP who are eligible to receive benefits under the terms of the plan and elect to receive cash for their common stock. The potential commitment for the put option at June 30, 2019 is approximately $11,000,000, which is based on the fair value of the ESOP shares as of June 30, 2018. As of the date the consolidated financial statements were available to be issued, management is in the process of preparing a third-party opinion of value for the fair market value of the ESOP shares as of June 30, 2019.

(10) Leases

The Company leases office space and equipment under operating leases expiring in various years through fiscal year 2026. Minimum future rental payments under noncancellable operating leases having remaining terms in excess of one year including leases entered into by the Company through the date of this report are as follows:

Years Ending June 30,	Gross Minimum Rent Due	Sublease Income	Net Minimum Rental Due
2020	$ 3,824,257	$ 139,000	$ 3,685,257
2021	2,965,733	60,000	2,905,733
2022	3,941,841	-	3,941,841
2023	4,041,669	-	4,041,669
2024	3,430,351	-	3,430,351
Thereafter	5,117,686	-	5,117,686
Total minimum future rental payments	$ 23,321,537	$ 199,000	$ 23,122,537

(10) Leases (continued)

Total rental expense under operating leases with terms in excess of one month was $4,368,795, $3,379,532, and $3,254,154 for the years ended June 30, 2019, 2018, and 2017, respectively.

Some of the operating leases above contain renewal options while others make no provision for renewal options. In the normal course of business the Company will either renew leases or seek other arrangements.

(11) Concentrations

The Company generates a substantial portion of its revenues from contracts with the federal government. The Company is the sole provider of Quality Improvement Network ("QIN") review services in Arizona, Florida California, Ohio, and the U.S. Virgin Islands under specific contracts with the federal government's CMS. In addition, the Company holds several contracts with CMS, or a subcontractor to CMS.

During the years ended June 30, 2019, 2018, and 2017 revenues from contracts with CMS were $79,456,547, $73,234,706, and $70,792,328, respectively. Amounts due from CMS contracts included in receivables were $12,948,024, $12,692,318, and $8,209,376 as of June 30, 2019, 2018, and 2017, respectively.

If the Company were unable to maintain current or future contracts, the Company's operations could be substantially affected.

(12) Commitments and contingencies

As of June 30, 2018 and 2017, all of the Company's assets and stock were pledged as collateral on certain debt arrangements held by the Company that matured during 2019.

Contract revenue received on government contracts is subject to future audits and adjustments by government audit agencies. Any disallowed costs, including amounts already collected, may constitute a liability of the Company. The amount of costs and related revenue that may be disallowed by future government audits cannot be determined at this time. However, the Company expects such amounts, if any, to be immaterial.

ADDITIONAL INFORMATION

HSAG HEALTH SERVICES ADVISORY GROUP

HEALTH SERVICES HOLDINGS, INC. AND
HEALTH SERVICES ADVISORY GROUP, INC.

CONSOLIDATING BALANCE SHEET

June 30, 2019
(with consolidated totals for June 30, 2018, and 2017)

ASSETS

	Health Services Holdings, Inc.	Health Services Advisory Group, Inc.	Eliminations	Consolidated totals 2019	2018	2017
CURRENT ASSETS						
Cash and cash equivalents	$ 58,639	$ 3,872,215	$ -	$ 3,930,854	$ 3,323,879	$ 4,799,329
Receivables	3,773	30,089,377	-	30,093,150	25,551,482	21,748,334
Due from affiliates	669,261	(3,165,472)	2,496,211	-	-	-
Prepaid expenses and other current assets	1,039,569	849,145	-	1,888,714	2,194,358	1,360,018
Income taxes receivable	-	-	-	-	182,973	-
TOTAL CURRENT ASSETS	1,771,242	31,645,265	2,496,211	35,912,718	31,252,692	27,907,681
PROPERTY AND EQUIPMENT, net	303,506	3,876,559	-	4,180,065	3,409,890	4,461,292
DEFERRED INCOME TAXES	2,264,855	916,814	-	3,181,669	2,102,774	3,246,591
OTHER ASSETS	-	167,454	-	167,454	167,454	179,354
TOTAL ASSETS	$ 4,339,603	$ 36,606,092	$ 2,496,211	$ 43,441,906	$ 36,932,810	$ 35,794,918

LIABILITIES AND STOCKHOLDERS' EQUITY

CURRENT LIABILITIES						
Accounts payable	$ 127,124	$ 2,442,338	$ -	$ 2,569,462	$ 2,366,943	$ 1,966,951
Accrued expenses	9,331,494	5,125,645	-	14,457,139	12,729,059	13,210,756
Income tax payable	935,804	5,787	-	941,591	-	110,131
Deferred revenues	-	3,298,778	-	3,298,778	4,351,664	2,299,145
Other current liabilities	-	1,298,173	-	1,298,173	1,298,173	2,152,486
Lines of credit	-	2,500,000	-	2,500,000	-	-
Due to affiliates	(2,496,211)	-	2,496,211	-	-	-
TOTAL CURRENT LIABILITIES	7,898,211	14,670,721	2,496,211	25,065,143	20,745,839	19,739,469
DEFERRED RENT	-	2,823,264	-	2,823,264	1,238,410	1,514,144
NOTES PAYABLE - STOCKHOLDERS	6,292,467	-	-	6,292,467	6,018,646	5,756,869
TOTAL LIABILITIES	14,190,678	17,493,985	2,496,211	34,180,874	28,002,895	27,010,482
COMMON STOCK	-	3,232	-	3,232	3,232	3,232
ADDITIONAL PAID-IN CAPITAL	16,970	-	-	16,970	16,970	16,970
RETAINED EARNINGS (ACCUMULATED DEFICIT)	(9,868,045)	19,108,875	-	9,240,830	8,909,713	8,764,234
TOTAL STOCKHOLDERS' EQUITY (DEFICIT)	(9,851,075)	19,112,107	-	9,261,032	8,929,915	8,784,436
TOTAL LIABILITIES AND STOCKHOLDERS' EQUITY	$ 4,339,603	$ 36,606,092	$ 2,496,211	$ 43,441,906	$ 36,932,810	$ 35,794,918

HEALTH SERVICES HOLDINGS, INC. AND HEALTH SERVICES ADVISORY GROUP, INC.

CONSOLIDATING STATEMENT OF INCOME AND RETAINED EARNINGS

Year Ended June 30, 2019
(with consolidated totals for the years ended June 30, 2018 and 2017)

	Health Services Holdings Inc.	Health Services Advisory Group, Inc.	Eliminations	Consolidated totals 2019	2018	2017
SERVICE REVENUES						
Federal contracts	$ -	$ 82,043,112	$ -	$ 82,043,112	$ 74,779,550	$ 71,064,634
State and corporate contracts	-	32,532,889	-	32,532,889	26,228,813	24,282,179
TOTAL SERVICE REVENUES	-	114,576,001	-	114,576,001	101,008,363	95,346,813
DIRECT EXPENSES	-	66,537,412	-	66,537,412	62,301,774	58,831,488
GROSS MARGIN	-	48,038,589	-	48,038,589	38,706,589	36,515,325
ADMINISTRATIVE EXPENSES	1,311,306	46,022,437	-	47,333,743	36,836,816	35,711,502
INCOME (LOSS) FROM OPERATIONS	(1,311,306)	2,016,152	-	704,846	1,869,773	803,823
OTHER INCOME (EXPENSE)	(268,534)	18,203	-	(250,331)	(206,634)	(520,892)
INCOME (LOSS) BEFORE INCOME TAXES	(1,579,840)	2,034,355	-	454,515	1,663,139	282,931
INCOME TAXES						
Current provision	479,450	722,843	-	1,202,293	373,843	570,459
Deferred provision (benefit)	(948,900)	(129,995)	-	(1,078,895)	1,143,817	(483,440)
TOTAL INCOME TAXES	(469,450)	592,848	-	123,398	1,517,660	87,019
NET INCOME (LOSS)	(1,110,390)	1,441,507	-	331,117	145,479	195,912
RETAINED EARNINGS (DEFICIT), BEGINNING OF YEAR	(8,757,655)	17,667,368	-	8,909,713	8,764,234	8,568,322
RETAINED EARNINGS (DEFICIT), END OF YEAR	$ (9,868,045)	$ 19,108,875	$ -	$ 9,240,830	$ 8,909,713	$ 8,764,234

Appendix 2: Banking Reference

Tempe Wholesdale CORE
Middle Market Banking
64 E Broadway Rd, Ste 101
Tempe, AZ 85282
Phone: 928-607-3672 (cell)
EFax: 866-608-3320

August 19, 2020

Joellen M Tenison, CFO
Health Services Advisory Group Inc.
3133 E Camelback Road, Suite 100
Phoenix, AZ 85016

Dear Ms. Tenison:

Health Services Advisory Group, Inc. has had a long standing relationship with Wells Fargo Bank, N.A., maintaining a checking account in a satisfactory manner since March 2012. Health Services Advisory Group, Inc. is a valued customer, averaging balances in the six (6) figure range on their depository services.

Please feel fee to contact me at 928-607-3642 or via email at curtisrh@wellsfargo.com, should you have additional questions.

Sincerely,

Rhonda K Curtis

Rhonda K Curtis,
Principal Relationship Manager
Tempe Wholesale CORE Middle Market Banking Group

RKC/mll

Appendix 3: Licensing and Certification

NCQA Measuring quality. Improving health care.

National Committee for Quality Assurance

recognizes

Health Services Advisory Group, Inc. (HSAG)

for fulfilling all necessary requirements to conduct NCQA HEDIS® Surveys

CERTIFIED NCQA HEDIS® SURVEY VENDOR 2020

MARGARET E. O'KANE
PRESIDENT
NATIONAL COMMITTEE FOR QUALITY ASSURANCE

November 1, 2019	October 31, 2020
DATE GRANTED	EXPIRATION DATE

2020

Health Services Advisory Group, Inc.

Appendix 4: QIN-QIO Documentation

ORDER FOR SUPPLIES OR SERVICES

PAGE OF PAGES: 1 | 10

IMPORTANT: Mark all packages and papers with contract and/or order numbers.

1. DATE OF ORDER	2. CONTRACT NO. (If any): 75FCMC19D0026
3. ORDER NO.: 75FCMC20F0001	4. REQUISITION/REFERENCE NO.: CCSQ-393-2020-0006
5. ISSUING OFFICE (Address correspondence to): CMS, OAGM, ASG, DQC 7500 SECURITY BLVD., MS: B3-30-03 BALTIMORE MD 21244-1850	6. SHIP TO: a. NAME OF CONSIGNEE: Not Applicable b. STREET ADDRESS c. CITY / d. STATE / e. ZIP CODE
7. TO: MARY ELLEN DALTON a. NAME OF CONTRACTOR: Health Services Advisory Group, Inc. b. COMPANY NAME c. STREET ADDRESS: 3133 EAST CAMELBACK RD SUITE 100 d. CITY: PHOENIX / e. STATE: AZ / f. ZIP CODE: 850164545	f. SHIP VIA 8. TYPE OF ORDER ☐ a. PURCHASE REFERENCE YOUR: Please furnish the following on the terms and conditions specified on both sides of this order and on the attached sheet, if any, including delivery as indicated. ☒ b. DELIVERY Except for billing instructions on the reverse, this delivery order is subject to instructions contained on this side only of this form and is issued subject to the terms and conditions of the above-numbered contract.
9. ACCOUNTING AND APPROPRIATION DATA: P-209-20-005170-006	10. REQUISITIONING OFFICE: Quality Improvement & Innovation
11. BUSINESS CLASSIFICATION (Check appropriate box(es)): ☐ a. SMALL ☒ b. OTHER THAN SMALL ☐ c. DISADVANTAGED ☐ d. WOMEN-OWNED ☐ e. HUBZone ☐ f. SERVICE-DISABLED VETERAN-OWNED ☐ g. WOMEN-OWNED SMALL BUSINESS (WOSB) ELIGIBLE UNDER THE WOSB PROGRAM ☐ h. EDWOSB	12. F.O.B. POINT
13. PLACE OF: a. INSPECTION: Destination / b. ACCEPTANCE: Destination	14. GOVERNMENT B/L NO. / 15. DELIVER TO F.O.B. POINT ON OR BEFORE (Date): 11/07/2024 / 16. DISCOUNT TERMS

17. SCHEDULE (See reverse for Rejections)

ITEM NO. (a)	SUPPLIES OR SERVICES (b)	QUANTITY ORDERED (c)	UNIT (d)	UNIT PRICE (e)	AMOUNT (f)	QUANTITY ACCEPTED (g)
	Tax ID Number: 86-0440007 DUNS Number: 114443260 Quality Innovation Network-Quality Improvement Organization (QIN-QIO) Continued ...					

18. SHIPPING POINT	19. GROSS SHIPPING WEIGHT	20. INVOICE NO.	17(h) TOTAL (Cont. pages)
21. MAIL INVOICE TO: a. NAME: DHHS, CMS, OFM, AMG SEE BILLING INSTRUCTIONS ON REVERSE b. STREET ADDRESS (or P.O. Box): Div. of Financial Operations P.O. Box 7520 c. CITY: Baltimore / d. STATE: MD / e. ZIP CODE: 21207-0520			17(i) GRAND TOTAL

22. UNITED STATES OF AMERICA BY (Signature): Kelley S. Williams-vollmer -S — Digitally signed by Kelley S. Williams-vollmer -S Date: 2019.11.07 17:02:00 -05'00'

23. NAME (Typed): Kelley Williams-Vollmer
TITLE: CONTRACTING/ORDERING OFFICER

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PREVIOUS EDITION NOT USABLE

OPTIONAL FORM 347 (Rev. 2/2012)
Prescribed by GSA/FAR 48 CFR 53.213(f)

ORDER FOR SUPPLIES OR SERVICES
SCHEDULE - CONTINUATION

PAGE NO 2

IMPORTANT: Mark all packages and papers with contract and/or order numbers.

DATE OF ORDER	CONTRACT NO.	ORDER NO.
	75FCMC19D0026	75FCMC20F0001

ITEM NO. (a)	SUPPLIES/SERVICES (b)	QUANTITY ORDERED (c)	UNIT (d)	UNIT PRICE (e)	AMOUNT (f)	QUANTITY ACCEPTED (g)
	HSAG's QIN-QIO Service Area Arizona [redacted] California [redacted] Req Identifier: P CAN Number: 5991400 Appropriation: 75-20/0519 Object Class: 25235 Component ID: 209 Fiscal Year: 20 Project #: 005170 Sequence #: 006 Period of Performance: 11/08/2019 to 11/07/2024					
0001	Nursing Home Arizona [redacted] California [redacted]				[redacted]	
0002	Community Coalitions Arizona [redacted] California [redacted]				[redacted]	
0003	Quality Improvement Initiatives Arizona [redacted] California [redacted]				[redacted]	
	TOTAL CARRIED FORWARD TO 1ST PAGE (ITEM 17(H))				[redacted]	

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OPTIONAL FORM 348 (Rev. 4/2006)
Prescribed by GSA FAR (48 CFR) 53.213(f)

NQIIC QIN-QIO Task Order
75FCMC19D0026/75FCMC20F0001

Pursuant to the terms and conditions of Contract 75FCMC19D0026 and the special clause provided under this task order 75FCMC20F0001, the Contractor shall perform the work required in accordance with the attached Statement of Work (SOW) entitled, "Quality Innovation Network-Quality Improvement Organization (QIN-QIO)."

Signature of the Contractor represents acceptance of this task order.

Signature	Print Name/Title	Date
Mary Ellen Dalton	Mary Ellen Dalton, PhD, MBA, RN Chief Executive Officer	11-7-19

1. BRIEF DESCRIPTION OF SERVICES

The CMS Quality Improvement Organization (QIO) 12th Statement of Work (SOW) mission is to increase performance of the health care system both by increasing quality and reducing burden associated with achieving that quality. While the program is established by statute, CMS achieves this mission through voluntary, non-regulatory programs that reduce provider burden by systematically spreading proven practices. CMS contracts and partners with innovators in the field to achieve national and local goals for Medicare Beneficiaries.

The QIO 12th SOW leverages the extensive reach and proven track record of this program and its partners to advance national priorities put forth by CMS and the HHS Administration:

- Combating the opioid crisis (7% reduction in opioid related adverse events including deaths)
- Driving value-based approaches to transforming healthcare by using the Medicare program as a powerful platform for driving change, especially where improved quality and systematic population management can have a high impact, including:
  - Prevent 238,464 individuals from developing CKD or progressing to ESRD;
  - Prevent 1 million cardiovascular events;
  - Prevent 25,171 Medicare beneficiaries from developing diabetes;
  - Reduce by 9.75% all cause harm in hospitals;
  - Reduce hospital admissions by 4.1% nationally, and reduce hospital readmissions by 5.4% nationally; and
  - Improve long-term care quality in 8,700 nursing homes, especially one- and two-star homes.

2. TYPE OF TASK ORDER

This task order is a hybrid of Firm Fixed Price and Time and Material.

Appendix 5: Communications Plan

Health Services Advisory Group, Inc.

and

Nebraska Department of Health and Human Services

Communications Plan

External Quality Review Activities

October 2020

—Draft Copy for Review—

Table of Contents

1. Communications Plan Overview

Purpose

The overall purpose and objective of the Communications Plan is to promote the success of the External Quality Review (EQR) Contract (Contract) by meeting the information needs of the State of Nebraska, Department of Health and Humans Services (DHHS), Division of Medicaid and Long Term Care. The Communications Plan outlines the actions and processes necessary to facilitate effective communication between DHHS and Health Services Advisory Group, Inc. (HSAG) and other stakeholders, includes a framework for the management and timeliness of ongoing progress reporting, and provides guidelines for preparing and distributing EQR-related deliverables.

Approach

At the start of the Contract and prior to implementation of all requested EQR activities, the HSAG project director will schedule a meeting with DHHS to confirm key contract and activity contacts, establish regular status meetings, determine appropriate lines of communication, and affirm the activity goals and objectives.

The HSAG project director is responsible for the Contract's success and DHHS' satisfaction. Under the project director's leadership, the HSAG assistant project director and all HSAG activity project managers and team members will function to fulfill the requirements of the DHHS EQR contract, including all EQR activities, meetings, reporting, and communications with DHHS, the Medicaid managed care organizations (MCOs) and the dental benefits manager (DBM), and other stakeholders as applicable. At a minimum, the HSAG project director, assistant project director, activity project managers, and team members will adhere to the protocols established in this Communications Plan.

Communication with DHHS Staff Members

The HSAG project director, assistant project director, and activity project managers will be available to DHHS staff members during business hours as well as during night and weekend hours, as necessary, to complete the expectations under the Contract. At the start of the Contract and prior to implementing EQR-related activities, the HSAG project director or assistant project director will provide DHHS staff members with all pertinent staff member contact information. HSAG staff members will respond to all telephonic or email communications and informational requests from DHHS staff members within 24 hours of receipt. In the event an HSAG staff member is out of the office for more than 24 hours, DHHS staff members will be notified of an alternate contact. This practice ensures continuity of the Contract, activity, and any related tasks.

For ongoing operations under the Contract, the DHHS contract manager, or a designee, will be available to HSAG via telephone and email to answer questions regarding policy and procedures; coordinate responses to questions; and refer HSAG to the appropriate staff member, when necessary, to accomplish a task.

Communication with Other Parties

During the implementation of an EQR-related activity, HSAG may need to converse through email, telephone, or in-person with MCO and DBM staff members or other stakeholders, as applicable. If at any time communication between HSAG and MCO and DBM staff members or other stakeholders is deemed necessary by HSAG and/or DHHS, HSAG and DHHS will agree, in advance, on the method and content of communication. HSAG will also have all pertinent communications with MCO and DBM staff members or other stakeholders approved by DHHS prior to delivery.

Communication and Exchange of Information

HSAG will ensure that all documents and electronic files are exchanged with DHHS staff members in DHHS compatible formats. HSAG primarily uses Microsoft Office products; however, HSAG will ensure that all documents or files are delivered in a format compatible with DHHS systems.

In the event that HSAG, DHHS, and/or the MCOs and DBM need to exchange files that are exceptionally large or that contain protected health information (PHI), HSAG will use its Secure Access File Exchange (SAFE) site. HSAG's SAFE site contains enhanced security protocols, including two-factor authentication, automated file expiration, and SAFE activity notifications. At the start of the Contract and prior to implementing any EQR activity, HSAG will enable individual login names and passwords, as needed, for DHHS and MCO and DBM personnel to access the SAFE site. Access to the SAFE site will comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations for

allowing password protected access to folders based on job descriptions and need for the information to complete work tasks.

Communication of Staffing Changes

HSAG will maintain a Communication Protocol document that includes a list of:

- HSAG staff members, with telephone numbers, and email addresses for the individuals working on the EQR activities described in the Scope of Work for Request for Proposal (RFP) 6303 Z1.
- DHHS staff members who are primarily responsible for each EQR activity with telephone numbers and email addresses.
- DHHS contracted Medicaid MCO and DBM staff members with telephone numbers, email addresses, and an indication of the EQR activity for which each individual is responsible.

HSAG will make changes to the Communication Protocol related to staffing changes at HSAG, DHHS, and the MCOs and DBM, as needed and as requested by DHHS.

If HSAG experiences turnover of staff members key to the Contract, HSAG will provide notice to DHHS in writing within one business day after initial knowledge of the change. HSAG will take immediate action to replace the staff member to ensure minimal disruption and overall continuity of the activity and/or Contract. Prior to assigning any new staff members to the Contract, HSAG will submit resumes for DHHS' approval.

Communication of EQR-Related Activities

The HSAG project director oversees the development of all Contract and activity work plans and deliverables and maintains responsibility for the quality and timely delivery of all work performed by activity project managers. HSAG will draft work plans for each identified EQR activity and provide the draft work plans to the DHHS contract manager for approval annually prior to initiating any EQR activity. HSAG will submit any variations from the approved work plans to DHHS for review and approval.

Contract and Activity Planning and Meetings

HSAG will provide forums such as teleconferences, webinars, or face-to-face meetings to initiate and subsequently communicate the status of EQR activities with DHHS' staff members. In addition to working directly with the HSAG project director and assistant project director, DHHS staff members have direct access to each EQR activity project manager and are encouraged to maintain direct, regular communication with the activity project managers for the duration of the activity. Additionally, at the start of the Contract, prior to implementation of each EQR activity, and ongoing through the duration of the Contract, the following meetings will occur (unless directed otherwise by DHHS):

- **Kick-Off Meeting**—At a time agreed to by DHHS and as documented in the Detailed Work Plan, HSAG will hold a kick-off meeting with DHHS staff members. HSAG will introduce its project director, assistant project director, and EQR activity project managers to DHHS staff members at this meeting and will discuss the Contract and activity objectives, Detailed Work Plan, timelines, and the EQR strategy for each task scheduled for Year One of the contract. The kick-off meeting also will enable HSAG staff members to clarify DHHS' expectations for each deliverable, gain knowledge regarding the initiatives in progress, obtain DHHS' input for initial and ongoing activity timelines and deliverables, and finalize the Detailed Work Plan.
- **Monthly Progress Meeting**—HSAG's project director or assistant project director will facilitate, at a minimum, monthly telephonic progress meetings between DHHS staff members and the EQR activity project managers. DHHS will determine the dates and times for the meetings, and the HSAG project director or manager will send a recurring teleconference meeting invitation to all applicable attendees. During the progress meetings, HSAG and DHHS staff members will review the status of each EQR activity detailed in the DHHS-approved Detailed Work Plan, discuss milestones associated with each activity, and discuss the challenges and accomplishments of the prior period in addition to outstanding issues that have the potential to impact the timeline. The progress meeting will allow a designated time for the HSAG project director, assistant project director, and/or project manager to provide recommendations and guidance for solutions. Additionally, the progress meeting will provide a forum for the DHHS contract manager and DHHS staff members to direct decisions regarding critical milestones, provide guidance on ongoing activities, and help resolve issues that may impact an activity. For the progress meeting, HSAG will also do the following:
  - At least two business days prior to each scheduled progress meeting, the HSAG project director or assistant project director will provide DHHS with a recommended agenda for the progress meeting and will solicit DHHS feedback for any additional agenda items.
  - The HSAG assistant project director, or designee, will take minutes at all meetings and will distribute the minutes to all meeting participants no later than two business days after conclusion of each meeting. The minutes will include a summary of any key discussion items and decisions made during the meeting. If requested by DHHS, HSAG will also resend copies of the meeting minutes no later than five business days prior to the next scheduled progress meeting.
  - As requested by DHHS, HSAG will facilitate meetings more often than monthly to ensure successful completion of all EQR activities.
- **Monthly Progress Report**—HSAG will prepare and submit to DHHS, at a minimum, a monthly progress report that will include the status of major activities and tasks in relation to the DHHS-approved EQR work plan. The progress report will provide a status for each activity since the prior period, a status update and target completion dates for remaining and upcoming tasks and activities, and challenges and accomplishments since the prior period. If the need arises to revise the overall work schedule, the HSAG project director will discuss the need with DHHS and seek approval for a revision.
  - As requested by DHHS, HSAG will provide progress reports more often than monthly to ensure successful completion of all EQR activities.

- **Quarterly Operational Meeting**—In conjunction with DHHS, HSAG will participate in the quarterly operational meetings with the MCOs and DBM. As requested by DHHS and/or at the recommendation of the MCOs and/or DBM, HSAG will be prepared to discuss upcoming or existing EQR activities, any pertinent updates to Medicaid managed care such as any changes to existing regulations and/or protocols, and/or any best practices within the Medicaid managed care industry.
- **Ad Hoc Meetings and Technical Assistance**—HSAG will facilitate ad hoc meetings and provide technical assistance to DHHS and/or MCO and DBM staff members, as necessary, to complete the objectives of the Contract and specifically to ensure successful completion of EQR activities and deliverables. HSAG will identify and provide the necessary technical assistance and training to the MCOs and DBM—individually or as a group, as needed—to ensure that each MCO and DBM is fully prepared for the role it will play within an activity. HSAG will review for the MCO or DBM the timelines and due dates for its active participation; the staff members, information, and other resources it will need for the activity; and how it will communicate the outcome and results of the activity (usually a report). If HSAG discovers that MCO or DBM staff members are struggling with EQR concepts or with meeting data submission requirements, it will notify DHHS and recommend a specific technical assistance or training strategy specific for the MCO or DBM to guide them through the EQR activity. Additionally, MCOs and DBM can request technical assistance from HSAG at any time during the duration of each EQR activity. For example, the MCOs and DBM may consult with HSAG when developing performance improvement projects, obtain guidance from HSAG on the interpretation of State and/or federal regulations as part of the compliance review activity, and/or discuss development of appropriate corrective action plans in response to any noted deficiencies identified through the annual EQR or EQR-related activities.
  - When identified through the annual EQR or EQR-related activities, HSAG will report to DHHS in writing any problems or deficiencies with the administration of the MCO or the DBM contracts and will propose a corrective action plan to help mitigate those problems and deficiencies. As directed by DHHS, HSAG will request that the MCO or DBM provide a response to the corrective action plan and return to HSAG and DHHS within a DHHS-agreed upon time frame.

EQR-Related Deliverables

The HSAG project director will manage each EQR activity's tasks and subtasks to ensure the activity stays on schedule and written deliverables are professional, accurate, and completed according to the scope of work. Upon initiation of the Contract, HSAG's assigned project director will manage the EQR contract and associated activities according to the DHHS-approved work plan to ensure that activities, tasks, and deliverables remain on schedule and any threat to the schedule can be mitigated in advance to avoid delays. Deliverable due dates for all requested EQR activities included in the work plan ensure that HSAG will deliver the annual EQR technical report to DHHS no later than October 15 of each contract year. Additionally, all EQR-related activity deliverables will adhere to the following:

- **EQR Protocols**—HSAG performs all EQR activities in accordance with the most current EQR protocols published by the Centers for Medicare & Medicaid Services (CMS). The written deliverable will provide reference to the applicable protocol.

- **Recommendations for Improvement**—HSAG will identify MCOs and DBM and/or program-level deficiencies and will include recommendations for mitigating the deficiencies and improving MCO and DBM-specific or statewide performance in each activity deliverable.
- **Reports and Validation Teams Review**—HSAG will conduct a robust editing and validation review of all initial and final deliverables prior to submission to DHHS and/or the MCOs and DBM. This process ensures that reports are free from typographical and grammatical errors, and that all referenced data and numbers go through a quality assurance review prior to delivery.
- **Work Plan Compliance**—HSAG staff members will use the DHHS-approved work plan as the guide for completing all EQR activity deliverables. To that end, all activity-specific draft reports will be submitted to DHHS for review and approval approximately 90 days prior to the final deliverable due date as follows:
  - HSAG will provide draft reports to DHHS with a minimum of two months for DHHS review.
  - HSAG will respond to DHHS' feedback and requested corrections of any noted deficiencies within two weeks of receiving the draft report back from DHHS.
  - HSAG will provide the final report deliverable in accordance with the approved work plan.
  - Upon request from DHHS, HSAG will schedule a meeting with DHHS staff members and conduct a walk-through of each deliverable produced to provide DHHS with an overview of the findings and the potential impact those findings have on enrollees receiving services through the Heritage Health program.
- **Deliverable Approval—**HSAG will not consider any deliverable as final until the approval is communicated in writing from DHHS.
  - DHHS will provide approval for each deliverable within 15 business days of receipt of the final (noted as "F1") deliverable.
  - DHHS will reject the deliverable if the deliverable is not of sufficient quality or does not meet the requirements under the Scope of Work section of the RFP. DHHS will communicate the reasons for the rejection in writing within 15 business days of receipt of the final (noted as "F1") deliverable.
  - DHHS will not disperse payment for the deliverable until the deliverable is approved.

Communication of the Annual EQR Technical Report

HSAG will produce a detailed technical report annually that describes the manner in which the data from all EQR-related activities conducted in accordance with Title 42 of the Code of Federal Regulations (CFR) §438.358 were aggregated and analyzed, and conclusions drawn as to the quality, timeliness, and access to care furnished to Medicaid managed care enrollees. HSAG will produce and finalize this report by October 15 of each year to ensure DHHS has sufficient time to meet the annual April 30 deadline for posting the final EQR technical report and submitting to CMS. The detailed technical report will adhere to 42 CFR §438.364—External quality review results, and include at a minimum:

- **EQR Activities**—Summary of each mandatory and optional EQR activity conducted by HSAG, DHHS, and/or another qualified entity used for the annual EQR. For each EQR-related activity:
  - Objectives
  - Technical methods of data collection and analysis
  - Description of the data obtained, including validated performance measurement data for the performance improvement project validation and performance measure validation activities
  - Conclusions drawn from the data
- **Assessment of Performance**—Detailed information about each MCO's and DBM's strengths and weaknesses for the quality, timeliness, and access to healthcare services furnished to Medicaid enrollees.
- **Recommendations for** MCO and DBM **and Program Improvement**—Detailed and actionable recommendations for how each MCO and DBM and/or DHHS can improve the quality of healthcare services furnished to Medicaid enrollees. The report will also include recommendations for how DHHS can target goals and objectives in the Quality Strategy.
  - HSAG will also provide recommendations for improvement on an ongoing basis as identified through each EQR activity.
- **Statewide** MCO and DBM **Comparisons**—Methodologically appropriate, comparative information about MCOs and DBM performance.
- **Follow-Up to EQR Recommendations**—Annual assessment of the degree to which each MCO and DBM has effectively addressed the recommendations for quality improvement made by the external quality review organization during the previous year's EQR.
  - HSAG will provide each MCO and DBM with a template to complete that will identify the steps and initiatives taken to address the previous year's recommendations. The completed templates will be evaluated by HSAG, and both the MCOs' and DBM's responses and HSAG's assessments will be included in the annual report.
- **Ad-Hoc Studies and Reports**—Upon request from DHHS, ad hoc studies and associated reports will be completed by HSAG. This information will be included in the annual technical report as requested by DHHS.

The annual EQR technical report will not disclose the identity of any Medicaid enrollee or any other information protected by law.

Distribution of the Annual EQR Technical Report

Upon completion of the annual EQR technical report, HSAG will provide DHHS with a 508 compliant Portable Document Format (PDF) to upload to DHHS' website in adherence with the requirements under 42 CFR §438.364. Additionally, HSAG will consult with DHHS to determine the number of hard copies that should be printed for distribution to DHHS staff members, MCOs and DBM, providers, enrollees, advocacy groups, members of the general public, and/or any other identified stakeholders as follows:

- HSAG will not share or deliver any EQR-related reports, including the annual EQR technical report, or any supporting data to any other individual or entity without prior written approval from DHHS.
- DHHS will specify the schedule, number of copies, and media for reports.
- HSAG will not disclose in the EQR-related reports the identity of any Medicaid enrollee or any other information protected by law.
- HSAG will develop, update, and maintain a report distribution list during the contract period to incorporate changes required by DHHS.

Appendix A. Communication Protocol

Upon initiation of the Contract, HSAG will develop a Communication Protocol document that will include HSAG and DHHS EQR activity project teams, HSAG and DHHS project team contact information, MCO and DBM contact information per EQR activity, and users assigned to the SAFE site. The Communication Protocol document provides a centralized location for maintaining the staff members associated with each activity under the Contract. The Communication Protocol will be updated with any changes made throughout the duration of the contract and resubmitted to HSAG and DHHS staff members, as appropriate. Table A-1 provides an example of the HSAG EQR activity project team.

Table A-1—Example of HSAG EQR Activity Project Team

HSAG Contact	Responsibility	Phone	Email
Nebraska EQR Contract Management Team			
Kim Elliott, Ph.D., CPHQ, CHCA *Executive Director, State and Corporate Services (S&CS)*	Project director with overall responsibility for all Nebraska EQR activities	602.801.6759	kelliott@hsag.com
Kari Vanderslice, MBA *Project Manager III, S&CS*	Assistant project director serving as back-up to the project director	602.801.6967	kvanderslice@hsag.com
Protocol 1. Validation of Performance Improvement Projects (PIPs)			
Christi Melendez, RN, CPHQ *Associate Executive Director, PIPs*	PIP validation activity project manager	602.801.6875	cmelendez@hsag.com
Kristine Stolte Hartmann, MS, BS *Project Manager III, PIPs*	PIP validation activity project lead	602.801.6885	khartmann@hsag.com
Jennifer Montano *Project Manager II, PIPs*	Project manager of the PIP team and project coordination	602.801.6851	jmontano@hsag.com
Protocol 2. Validation of Performance Measures (PMV)			
Thomas Miller, MA, CHCA *Executive Director, Data Science & Advanced Analytics (DSAA) Audits*	Operational lead and activity project manager for the HEDIS* and PMV activities	602.801.6860	tmiller@hsag.com
Jacilyn Daniel, BS *Healthcare Quality Manager, DSAA Audits*	Lead auditor for HEDIS and PMV activities	602.801.6562	jdaniel@hsag.com
Tammy GianFrancisco, CHCA *HEDIS Project Manager, Audits*	Project manager and project coordinator for HEDIS and PMV activities	602.801.6841	tgianfrancisco@hsag.com

HSAG Contact	Responsibility	Phone	Email
Protocol 3. Compliance Review			
Kim Elliott, Ph.D., CPHQ, CHCA *Executive Director, S&CS*	Compliance review activity project manager and lead compliance auditor	602.801.6759	kelliott@hsag.com
Kari Vanderslice, MBA *Project Manager III, S&CS*	Assistant project manager and compliance auditor	602.801.6967	kvanderslice@hsag.com
Protocol 4. Validation of Network Adequacy			
Amy Kearney, BA *Director, DSAA*	Network adequacy activity project manager	602.801.6886	akearney@hsag.com
Alana Berrett, MPH *Associate Director, DSAA*	Network adequacy activity lead	602.801.6866	aberrett@hsag.com
Prashanthinie (Prashi) Mohan, DrPH, MBA *Analyst II, DSAA*	Network adequacy data analyst	602.801.6516	pmohan@hsag.com
Joe Mireles, MPH *Analyst II, DSAA*	Network adequacy quantitative and statistical analysis analyst	602.801.6798	jmireles@hsag.com

* Healthcare Effectiveness Data and Information Set (HEDIS®) is a registered trademark of the National Committee for Quality Assurance (NCQA).

Appendix 6: Work Plan

Work Plan

Table 1—External Quality Review (EQR) Technical Report Work Plan					
Task Description	**Anticipated Start Date**	**Actual Start Date**	**Anticipated End Date**	**Actual End Date**	**Responsible Party**
Contract Year 1: April 1, 2021–December 31, 2021					
Contract Planning					
Initial meeting with DHHS to discuss EQR activities and confirm DHHS expectations: • Introduction of HSAG and DHHS key staff • Communication protocol • Timeline for implementation of EQR activities	04/01/21		04/09/21		DHHS/ HSAG
Provide detailed Work Plan and Communication Plan to DHHS.	04/02/21		04/12/21		HSAG
Review draft Work Plan and Communication Plan and provide feedback.	04/12/21		04/16/21		DHHS
Incorporate DHHS feedback on Work Plan and Communication Plan and submit for approval.	04/19/21		04/21/21		HSAG
Provide approval on Work Plan and Communication Plan.	04/22/21		04/29/21		DHHS
Develop Annual Technical Report Templates					
Consult with DHHS to determine the quality initiatives information, focus areas, optional activity information, etc. that should be included as part of the Technical Reports.	04/01/21		04/12/21		DHHS/ HSAG
Develop and submit to DHHS for feedback the draft Technical Report templates (one for each MCO and DBM, and one aggregate).	04/12/21		05/07/21		HSAG

Table 1—External Quality Review (EQR) Technical Report Work Plan					
Task Description	**Anticipated Start Date**	**Actual Start Date**	**Anticipated End Date**	**Actual End Date**	**Responsible Party**
Develop Follow-Up to Prior Year EQR Recommendations template.	04/12/21		05/07/21		HSAG
Review draft Technical Report templates and provide feedback.	05/10/21		06/07/21		DHHS
Review draft Follow-Up to Prior Year EQR Recommendations template and provide feedback.	05/10/21		06/07/21		DHHS
Review and incorporate DHHS' feedback and submit to DHHS final Technical Report and Follow-Up to Prior Year EQR Recommendations templates.	06/08/21		06/11/21		HSAG
Information Request					
Submit to the MCOs and DBM the instructions and Follow-Up to Prior Year EQR Recommendations template for documenting activities and/or interventions that were implemented from prior year's technical report.	06/14/21		06/14/21		HSAG
Upload completed Follow-Up to Prior Year EQR Recommendations template to HSAG's SAFE site.	06/15/21		07/13/21		MCOs/DBM
Obtain any additional documentation from DHHS as applicable.	06/15/21		07/13/21		DHHS/ HSAG
Produce Reports					
Draft reports that include findings, analyses, conclusions, and recommendations from 2020 EQR activities.	07/14/21		08/05/21		HSAG
Submit draft reports to DHHS for review.	08/06/21		08/06/21		HSAG
Receive DHHS feedback on draft technical reports.	08/09/21		10/04/21		DHHS

Table 1—External Quality Review (EQR) Technical Report Work Plan					
Task Description	**Anticipated Start Date**	**Actual Start Date**	**Anticipated End Date**	**Actual End Date**	**Responsible Party**
Incorporate DHHS feedback and submit final 508-compliant reports to DHHS and other stakeholders, as requested.	10/05/21		10/15/21		HSAG
Presentation of Findings					
Conduct webinar with DHHS, MCOs, DBM, and other stakeholders, as applicable, to share EQR results and recommendations.	10/18/21		12/30/21		HSAG
Contract Year 2: January 01, 2021–December 31, 2022					
Contract Planning					
Kick-off meeting to discuss Year 2 EQR activities and confirm DHHS expectations: • Introduction of HSAG and DHHS key staff • Communication protocol • Timeline for implementation of EQR activities	01/03/22		01/21/22		DHHS/ HSAG
Provide detailed Work Plan and Communication Plan to DHHS.	01/04/22		01/28/22		HSAG
Review draft Work Plan and Communication Plan and provide feedback.	01/31/22		02/11/22		DHHS
Incorporate DHHS feedback on Work Plan and Communication Plan and submit for approval.	02/14/22		02/16/22		HSAG
Provide approval on Work Plan and Communication Plan.	02/16/22		02/16/22		DHHS
Develop Annual Technical Report Templates					
Develop and submit to DHHS for feedback the draft Technical Report templates (one for each MCO and DBM, and one aggregate), based on feedback from prior year's report.	01/03/22		02/18/22		HSAG

Table 1—External Quality Review (EQR) Technical Report Work Plan					
Task Description	**Anticipated Start Date**	**Actual Start Date**	**Anticipated End Date**	**Actual End Date**	**Responsible Party**
Consult with DHHS to determine the quality initiatives information, focus areas, optional activity information, etc. that should be included as part of the Technical Reports.	01/03/22		02/18/22		DHHS/ HSAG
Develop Follow-Up to Prior Year EQR Recommendations template.	01/03/22		02/18/22		HSAG
Review draft Technical Report templates and provide feedback.	02/21/22		03/14/22		DHHS
Review draft Follow-Up to Prior Year EQR Recommendations template and provide feedback.	02/21/22		03/14/22		DHHS
Review and incorporate DHHS' feedback and submit to DHHS final Technical Report and Follow-Up to Prior Year EQR Recommendations templates.	03/15/22		03/22/22		HSAG
Information Request					
Submit to MCOs and DBM the instructions and Follow-Up to Prior Year EQR Recommendations template for documenting activities and/or interventions that were implemented from prior year's technical report.	05/16/22		05/16/22		HSAG
Upload completed Follow-Up to Prior Year EQR Recommendations template to HSAG's SAFE site.	05/17/22		06/14/22		MCOs/DBM
Obtain any additional documentation from DHHS as applicable.	05/17/22		06/14/22		DHHS/ HSAG

Table 1—External Quality Review (EQR) Technical Report Work Plan					
Task Description	**Anticipated Start Date**	**Actual Start Date**	**Anticipated End Date**	**Actual End Date**	**Responsible Party**
Produce Reports					
Draft reports that include findings, analyses, conclusions, and recommendations from 2020 EQR activities.	06/15/22		07/29/22		HSAG
Submit draft reports to DHHS for review.	07/29/22		07/29/22		HSAG
Receive DHHS feedback on draft technical reports.	08/01/22		10/03/21		DHHS
Incorporate DHHS feedback and submit final 508-compliant reports to DHHS and other stakeholders, as requested.	10/04/22		10/14/22		HSAG
Presentation of Findings					
Conduct webinar with DHHS, MCOs, DBM, and other stakeholders, as applicable, to share EQR results and recommendations.	10/17/22		12/30/22		HSAG

Note: Subsequent contract years will follow a similar timeline.

Table 2—Compliance Review Work Plan MCOs and DBM					
Task Description	**Anticipated Start Date**	**Actual Start Date**	**Anticipated End Date**	**Actual End Date**	**Responsible Party**
Contract Year 1: April 1, 2021–December 31, 2021					
Contract Planning					
Initial meeting with DHHS to discuss EQR activities and confirm DHHS expectations: • Introduction of HSAG and DHHS key staff • Communication protocol • Timeline for implementation of EQR activities • Discussion transition of compliance review activities, including methodology, tools,	04/01/21		04/09/21		DHHS/ HSAG

Table 2—Compliance Review Work Plan MCOs and DBM					
Task Description	**Anticipated Start Date**	**Actual Start Date**	**Anticipated End Date**	**Actual End Date**	**Responsible Party**
communication documents, etc.					
Provide draft Work Plan, Communications Plan, and methodology documents to DHHS.	04/02/21		04/12/21		HSAG
DHHS reviews draft Work Plan, Communications Plan, and methodology documents, and provides feedback to HSAG.	04/12/21		04/16/21		DHHS
Incorporate DHHS feedback.	04/19/21		04/21/21		HSAG
DHHS provides approval on Work Plan, Communications Plan, and methodology documents.	04/21/21		04/23/21		DHHS
Finalize Work Plan, Communications Plan, and methodology documents.	04/26/21		04/28/21		HSAG
Conduct DHHS-Specific Training for HSAG Staff					
Develop training curriculums and train HSAG staff on DHHS-Specific requirements.	04/01/21		04/28/21		HSAG

Table 2—Compliance Review Work Plan MCOs and DBM					
Task Description	**Anticipated Start Date**	**Actual Start Date**	**Anticipated End Date**	**Actual End Date**	**Responsible Party**
Collect Compliance Review Data from MCOs and DBM					
Send request letter, tools, and on-site review agenda to the MCOs and DBM, if these documents were not sent prior to contract start date.	04/27/21		04/30/21		HSAG
Host webinar with the MCOs and DBM to prepare for review.	05/03/21		05/07/21		HSAG/ MCOs/ DBM
Upload compliance review completed tools and supporting documentation to HSAG's SAFE site. **Please note that HSAG typically allows 6-8 weeks for the MCOs and DBM to submit documentation, and this timeline assumes that the MCOs and DBM will have been notified of the compliance review requirements prior to April 1.*	05/10/21		05/14/21		MCOs/ DBM
Pre-On-Site Compliance Review Activities					
Complete a desk review of the MCO- and DBM-completed tool and supporting documentation and generate follow-up questions for the on-site review.	05/12/21		06/11/21		HSAG
On-Site Compliance Review Activities					
Conduct interviews and system reviews with key MCO and DBM staff members.	06/14/21		06/18/21		HSAG
Document findings from the desk review and on-site review activities, and discuss findings among reviewers to ensure accuracy.	06/21/21		07/09/21		HSAG
Produce Compliance Review Reports					
Develop MCO- and DBM-specific reports that include findings, completed review tools, and corrective action plan (CAP) template. Submit report to HSAG editorial and quality assurance teams.	07/12/21		07/23/21		HSAG

Table 2—Compliance Review Work Plan MCOs and DBM					
Task Description	**Anticipated Start Date**	**Actual Start Date**	**Anticipated End Date**	**Actual End Date**	**Responsible Party**
Submit draft reports to DHHS for review.	07/26/21		07/26/21		HSAG
Receive DHHS feedback on draft.	07/26/21		09/27/21		DHHS
Incorporate DHHS feedback and submit final reports to DHHS and the MCOs and DBM.	10/12/21		10/12/21		HSAG
Facilitate CAP Submission by MCOs and DBM					
Submit completed CAPs to HSAG's SAFE site.	10/13/21		11/12/21		MCOs/ DBM
Review CAPs for completeness and appropriateness, and provide feedback on CAP to DHHS for input and approval.	11/12/21		12/01/21		HSAG/ DHHS
Provide CAP approval or required actions to MCOs and DBM. • The MCOs and DBM will receive feedback on submitted CAP. CAP will indicate *approved* or *revisions required*.	12/02/21		12/02/21		HSAG
CAP resubmission and approval. • The MCOs and DBM that received *revisions required* will review feedback and resubmit an updated CAP for approval.	12/03/21		12/17/21		MCOs/ DBM/ HSAG
Provide technical assistance. Please note: HSAG provides technical assistance to ensure the MCOs and DBM have an appropriate CAP to mitigate deficiencies identified through the compliance review.	12/03/21		12/17/21		HSAG
Contract Year 2: January 1, 2022–December 31, 2022					
Compliance Review Initiation					
Meet with DHHS to discuss Year 2 objectives, approach, and deliverables.	01/03/22		01/18/22		DHHS/ HSAG

Table 2—Compliance Review Work Plan MCOs and DBM					
Task Description	**Anticipated Start Date**	**Actual Start Date**	**Anticipated End Date**	**Actual End Date**	**Responsible Party**
Prepare and submit draft methodology, timeline, CAP review tools, and MCO and DBM communication documents to DHHS for review and comment.	01/19/22		01/31/22		HSAG
Receive DHHS feedback on draft methodology, timeline, CAP review tools, and MCO and DBM communication documents.	02/01/22		02/15/22		DHHS
Incorporate DHHS' feedback and submit final methodology, timeline, CAP review tools, and MCO and DBM communication documents to DHHS for approval.	02/16/22		02/28/22		HSAG
Send initial notification of compliance review activity to the MCOs and DBM, along with CAP review tools, timeline, and other applicable documents.	02/16/22		02/28/22		HSAG/or DHHS
Participate in a kick-off meeting with the MCOs and DBM to introduce the Year 2 compliance review activities and facilitate a question/answer session.	03/01/22		03/11/22		DHHS/ MCOs/ DBM/ HSAG
Pre-On-Site Review Activities					
Submit completed documents, including CAP tools and supporting documents to HSAG's SAFE site.	03/01/22		04/15/22		MCOs/ DBM
Conduct desk review of MCO and DBM document submissions and follow up with MCOs and DBM as necessary to obtain additional information.	04/18/22		05/06/22		HSAG
On-Site Compliance Review Activities					
Conduct on-site CAP compliance reviews, system reviews, and document preliminary findings.	05/09/22		05/13/22		MCOs/ DBM/ HSAG

Table 2—Compliance Review Work Plan MCOs and DBM					
Task Description	**Anticipated Start Date**	**Actual Start Date**	**Anticipated End Date**	**Actual End Date**	**Responsible Party**
Document findings from the desk review and on-site review activities, and discuss findings among reviewers to ensure accuracy.	05/16/22		05/27/22		HSAG
Produce Compliance Review Reports					
Develop MCO- and DBM-specific reports that include findings, completed review tools, and corrective action plan (CAP) template. Submit report to HSAG editorial and quality assurance teams.	05/30/22		06/10/22		HSAG
Submit draft CAP compliance review reports to DHHS for review.	06/10/22		06/10/22		HSAG
Receive DHHS feedback on draft.	06/13/22		08/15/22		DHHS
Incorporate DHHS feedback and submit final reports to DHHS and the MCOs and DBM.	08/16/22		08/29/22		HSAG
Provide Technical Assistance					
Schedule and conduct technical assistance calls with any MCO or DBM not receiving 100 percent overall compliance on CAP elements to develop a plan and remediate deficiencies from the three-year compliance review cycle.	08/30/22		09/30/22		MCOs/ DBM/ HSAG
Plan Three-Year Cycle					
Conduct planning meeting with DHHS to discuss options for Year 3, and the next three-year cycle compliance review.	10/03/22		10/31/22		DHHS/ HSAG

Note: Subsequent contract years will follow a similar timeline.

Table 3—Performance Improvement Project (PIP) Work Plan MCOs and DBM					
Task Description	**Anticipated Start Date**	**Actual Start Date**	**Anticipated End Date**	**Actual End Date**	**Responsible Party**
Contract Year 1: April 1, 2021–December 31, 2021					
Contract Planning					
Initial meeting with DHHS to discuss EQR activities and confirm DHHS expectations: • Introduction of HSAG and DHHS key staff • Communication protocol • Timeline for implementation of EQR activities	04/01/21		04/30/21		DHHS/ HSAG
Provide detailed Work Plan and Communication Plan to DHHS.	04/01/21		04/16/21		HSAG
Receive Work Plan and Communication Plan approval from DHHS.	04/30/21		05/07/21		DHHS
Transition of PIP Validation Activities					
Meeting with DHHS to discuss transition of PIP activities: • Process for HSAG to assume current PIP activities	04/01/21		04/30/21		DHHS/HSAG
Annual Validation and MCO- and DBM-Specific PIP Report					
Send PIP submission letter to the MCOs and DBM four weeks prior to submission date.	06/07/21		06/07/21		HSAG
MCOs and DBM submit PIP to HSAG for annual validation.	07/06/21		07/06/21		MCOs/ DBM
Provide DHHS and the MCOs and DBM with draft validation tools.	07/23/21		07/23/21		HSAG
Provide technical assistance/guidance on initial validation findings.	07/26/21		07/30/21		HSAG
MCOs and DBM resubmit PIP, if required, for final validation.	08/13/21		08/13/21		MCOs/ DBM
Forward final validation tools to DHHS and the MCOs and DBM.	08/31/21		08/31/21		HSAG

Table 3—Performance Improvement Project (PIP) Work Plan MCOs and DBM					
Task Description	**Anticipated Start Date**	**Actual Start Date**	**Anticipated End Date**	**Actual End Date**	**Responsible Party**
Submit draft MCO- and DBM-specific PIP validation reports to DHHS.	10/01/21		10/01/21		HSAG
Receive DHHS feedback/approval on reports.	12/01/21		12/01/21		DHHS
Provide final reports to DHHS.	12/17/21		12/17/21		HSAG
Technical Assistance/Guidance					
Provide ongoing technical assistance and guidance to MCOs, DBM, and DHHS.	04/01/21		12/31/21		HSAG
Contract Year 2: January 1, 2022–December 31, 2022					
Pre-Validation Activities					
Present HSAG's approach to PIP validation to DHHS.	01/10/22		01/21/22		HSAG
Submit HSAG PIP templates to DHHS for review and approval.	01/24/22		01/24/22		HSAG
Receive DHHS feedback on templates.	02/07/22		02/07/22		DHHS
Finalize templates for distribution to DHHS and the MCOs and DBM.	02/08/22		02/11/22		HSAG
Present HSAG's PIP approach to the MCOs and DBM.	03/01/22		03/18/22		HSAG
Forward PIP templates to DHHS and the MCOs and DBM.	03/21/22		03/21/22		HSAG
Provide technical assistance and guidance to MCOs and DBM prior to PIP submission date.	03/28/22		07/08/22		HSAG
Annual Validation and MCO- and DBM-Specific Reports					
Send PIP submission letter to the MCOs and DBM four weeks prior to PIP submission date.	06/06/22		06/06/22		HSAG
MCOs and DBM submit PIP to HSAG for annual validation.	07/11/22		07/11/22		MCOs/ DBM

Table 3—Performance Improvement Project (PIP) Work Plan MCOs and DBM					
Task Description	**Anticipated Start Date**	**Actual Start Date**	**Anticipated End Date**	**Actual End Date**	**Responsible Party**
Provide DHHS and the MCOs and DBM with draft validation tools.	08/01/22		08/01/22		HSAG
Provide technical assistance/guidance on initial validation findings.	08/02/22		08/08/22		HSAG
MCOs and DBM resubmit PIP, if required, for final validation.	08/22/22		08/22/22		MCOs/ DBM
Forward final validation tools to DHHS and the MCOs and DBM.	09/02/22		09/02/22		HSAG
Submit draft MCO- and DBM-specific PIP validation reports to DHHS.	10/03/22		10/03/22		HSAG
Receive DHHS feedback/approval on reports.	12/05/22		12/05/22		DHHS
Provide final reports to DHHS.	12/16/22		12/16/22		HSAG
Technical Assistance/Guidance					
Provide ongoing technical assistance and guidance to MCOs and DBM and DHHS.	01/01/22		12/31/22		HSAG

Table 4—Performance Measure Valication (PMV) Work Plan MCOs and DBM					
Task Description	**Anticipated Start Date**	**Actual Start Date**	**Anticipated End Date**	**Actual End Date**	**Responsible Party**
Contract Year 1: April 1, 2021–December 31, 2021					
Transition Activities					
Transition of current PMV activities.	04/01/21		04/30/21		DHHS/ HSAG
PMV Initiation and Planning					
Identify and determine scope of the PMV activity and audit protocol.	04/05/21		04/16/21		DHHS/ HSAG
Develop MCO and DBM Document Request Packet. • Overview of PMV audit process • PMV Timeline • List of PMV performance measures • Request for final audit information • Contact information	04/19/21		04/30/21		HSAG
Submit Document Request Packet to MCOs and DBM.	05/03/21		05/03/21		HSAG
Prepare PMV plan-specific report template; submit to DHHS.	05/04/21		05/28/21		HSAG
Review and submit feedback on PMV plan-specific report template to HSAG.	06/01/21		08/02/21		DHHS
Incorporate feedback and finalize PMV plan-specific report template.	08/03/21		08/10/21		HSAG
Data Collection and Validation					
Submit completed Document Request Packet to HSAG.	05/28/21		05/28/21		MCOs/ DBM
Confirm receipt of valid and complete data from MCOs and DBM.	05/28/21		06/09/21		HSAG

Table 4—Performance Measure Valication (PMV) Work Plan MCOs and DBM					
Task Description	**Anticipated Start Date**	**Actual Start Date**	**Anticipated End Date**	**Actual End Date**	**Responsible Party**
Conduct evaluation of submitted PMV documentation, including: • Roadmap and/or ISCAT • Final Audit Report • Performance Measure Results	06/10/21		06/24/21		HSAG
Conduct site visit with MCOs and DBM.	TBD*		TBD*		HSAG/ MCOs/DBM
Synthesize and determine PMV validation designations.	07/01/21		08/02/21		HSAG
Reporting					
Draft plan-specific PMV reports for MCOs and DBM.	08/03/21		09/07/21		HSAG
Submit plan-specific PMV reports to DHHS.	09/08/21		09/08/21		HSAG
Review draft plan-specific PMV reports, submit feedback to HSAG.	09/09/21		11/09/21		DHHS
Incorporate and address feedback on draft PMV plan-specific reports.	11/10/21		11/30/21		HSAG
Submit final PMV plan-specific reports to DHHS and the MCOs and DBM.	12/01/21		12/01/21		HSAG
Contract Year 2: January 1, 2022–December 31, 2022					
PMV Initiation and Planning					
Identify and determine scope of the PMV activity and audit protocol.	01/24/22		02/25/22		DHHS/ HSAG

Table 4—Performance Measure Valication (PMV) Work Plan MCOs and DBM					
Task Description	**Anticipated Start Date**	**Actual Start Date**	**Anticipated End Date**	**Actual End Date**	**Responsible Party**
Develop MCO and DBM Document Request Packet. • Overview of PMV audit process • PMV Timeline • List of PMV performance measures • Request for final audit information • Contact information	02/28/22		03/30/22		HSAG
Submit Document Request Packet to MCOs and DBM.	03/31/22		03/31/22		HSAG
Prepare PMV plan-specific report template; submit to DHHS.	04/01/22		04/15/22		HSAG
Review and submit feedback on PMV plan-specific report template to HSAG.	04/18/22		06/20/22		DHHS
Incorporate feedback and finalize PMV plan-specific report template.	06/21/22		07/01/22		HSAG
Data Collection and Validation					
Submit completed Document Request Packet to HSAG.	04/29/22		04/29/22		MCOs/ DBM
Confirm receipt of valid and complete data from MCOs and DBMs.	05/02/22		05/23/22		HSAG
Conduct evaluation of submitted PMV documentation, including: • Roadmap and/or ISCAT • Final Audit Report • Performance Measure Results	05/24/22		06/07/22		HSAG
Conduct site visit with MCOs and DBM.	TBD*		TBD*		HSAG/ MCOs/DBM
Synthesize and determine PMV validation designations.	07/01/22		07/29/22		HSAG

Table 4—Performance Measure Valication (PMV) Work Plan MCOs and DBM					
Task Description	**Anticipated Start Date**	**Actual Start Date**	**Anticipated End Date**	**Actual End Date**	**Responsible Party**
Reporting					
Draft plan-specific PMV reports for MCOs and DBM.	08/01/22		09/06/22		HSAG
Submit plan-specific PMV reports to DHHS.	09/07/22		09/07/22		HSAG
Review draft plan-specific PMV reports, submit feedback to HSAG.	09/08/22		11/08/22		DHHS
Incorporate and address feedback on draft PMV plan-specific reports.	11/09/22		11/30/22		HSAG
Submit final PMV plan-specific reports to DHHS and the MCOs and DBM.	12/01/22		12/01/22		HSAG

**The site visit will coincide with the compliance review activity to reduce burden on the plans; therefore, the site visit will occur between April and June, as required by DHHS.*

Note: Contract Year 1 follows a compressed timeline; subsequent contract years will follow a similar timeline to Contract Year 2

Table 5—Network Adequacy Validation (NAV) Work Plan MCOs and DBM					
Task Description	**Anticipated Start Date**	**Actual Start Date**	**Anticipated End Date**	**Actual End Date**	**Responsible Party**
Contract Year 1: April 1, 2021—December 31, 2021					
Contract Planning					
Initial meeting with DHHS to discuss EQR activities and confirm DHHS expectations: • Introduction of HSAG and DHHS key staff • Communication protocol • Timeline for implementation of EQR activities	04/01/21		04/30/21		DHHS/ HSAG
Provide detailed Work Plan and Communication Plan to DHHS.	04/01/21		04/16/21		HSAG
Receive Work Plan and Communication Plan approval from DHHS.	04/19/21		04/30/21		DHHS
Transition of NAV Activities					
Meeting with DHHS to discuss transition of NAV activities: • Process for HSAG to assume current NAV activities	04/01/21		04/30/21		DHHS/ HSAG
Project Initiation					
Prepare and submit draft methodology and timeline to DHHS for review and comment.	05/03/21		05/14/21		HSAG
Receive DHHS feedback on draft methodology and timeline.	05/17/21		05/28/21		DHHS
Incorporate DHHS' feedback and submit final methodology and timeline to DHHS for approval.	06/01/21		06/08/21		HSAG
Receive DHHS documentation on existing network standards.	06/01/21		06/18/21		DHHS
Receive and review DHHS' network adequacy documentation and MCO and DBM reporting examples.	06/01/21		06/30/21		DHHS/ HSAG

Table 5—Network Adequacy Validation (NAV) Work Plan MCOs and DBM					
Task Description	**Anticipated Start Date**	**Actual Start Date**	**Anticipated End Date**	**Actual End Date**	**Responsible Party**
Participate in a kick-off meeting with the MCOs and DBM to introduce the NAV activities.	06/21/21		07/02/21		DHHS/ MCOs/DBM/ HSAG
Data Collection – Data Structure Questionnaire					
Draft data structure questionnaire and submit to DHHS for review and comment.	06/09/21		6/18/21		HSAG
DHHS review and approve the data structure questionnaire.	06/21/21		07/06/21		DHHS
Distribute the data structure questionnaire to the MCOs and DBM.	07/07/21		07/07/21		HSAG
Complete the data structure questionnaire and submit to HSAG.	07/08/21		07/28/21		MCOs/DBM
Review the MCOs' and DBM's data structure questionnaires, including follow-up with the MCOs and/or DBM, if needed.	07/29/21		08/13/21		HSAG
Analyze and summarize data structure questionnaire findings.	08/16/21		09/08/21		HSAG
Reporting					
Draft and submit report outline for MCO- and DBM-Specific NAV reports.	07/12/21		07/22/20		HSAG
Receive DHHS feedback on report outline.	07/22/21		08/05/21		DHHS
Revise draft report outline based on DHHS' feedback; submit final report outline to DHHS for approval.	08/06/21		08/18/21		HSAG
Draft MCO- and DBM-Specific NAV reports.	09/09/21		09/30/21		HSAG
Submit MCO- and DBM-Specific NAV reports to DHHS for review and comment.	10/01/21		10/01/21		HSAG

Table 5—Network Adequacy Validation (NAV) Work Plan MCOs and DBM					
Task Description	**Anticipated Start Date**	**Actual Start Date**	**Anticipated End Date**	**Actual End Date**	**Responsible Party**
Receive DHHS' feedback on MCO- and DBM-specific NAV reports.	12/03/21		12/03/21		DHHS
Submit final MCO and DBM-specific NAV reports to DHHS.	12/17/21		12/17/21		HSAG
Contract Year 2: January 1, 2022—December 31, 2022					
Project Initiation					
Meet with DHHS to discuss NAV objectives, data sources, approach, and deliverables.	01/03/22		01/18/22		DHHS/ HSAG
Prepare and submit draft methodology and timeline to DHHS for review and comment.	01/19/22		01/31/22		HSAG
Receive DHHS feedback on draft methodology and timeline..	02/01/22		02/15/22		DHHS
Incorporate DHHS' feedback and submit final methodology and timeline to DHHS for approval.	02/16/22		02/28/22		HSAG
Participate in a kick-off meeting with the MCOs and DBM to introduce the MCO- and DBM-Specific NAV activities.	03/01/22		03/08/22		DHHS/ MCOs/DBM/ HSAG
Data Request, Acquisition, and Analysis					
Produce and submit draft data requirements document to DHHS.	03/01/22		03/09/22		HSAG
Receive DHHS feedback on draft data requirements document.	03/10/22		03/25/22		DHHS
Review and incorporate DHHS' feedback and submit to DHHS the final data requirements document.	03/28/22		04/06/22		HSAG
Submit data requirements document to DHHS and MCOs and DBM, as needed.	04/08/22		04/08/22		HSAG

Table 5—Network Adequacy Validation (NAV) Work Plan MCOs and DBM					
Task Description	**Anticipated Start Date**	**Actual Start Date**	**Anticipated End Date**	**Actual End Date**	**Responsible Party**
Submit data to HSAG, including MCOs' and DBM's Quarterly Network Adequacy Reports.	04/11/22		05/06/22		DHHS/ MCOs/DBM
Review submitted data and work with DHHS and the MCOs and DBM to resolve any issues identified in submitted data files.	05/09/22		05/27/22		DHHS/ MCOs/DBM/ HSAG
Conduct analyses.	05/31/22		07/20/22		HSAG
Generate and validate tables and charts.	07/21/22		08/25/22		HSAG
Reporting					
Draft and submit report outline for MCO- and DBM-Specific NAV reports.	07/06/22		07/20/20		HSAG
Receive DHHS feedback on report outline.	07/20/22		08/04/22		DHHS
Revise draft report outline based on DHHS' feedback; submit final report outline to DHHS for approval.	08/05/22		08/18/22		HSAG
Draft MCO- and DBM-Specific NAV reports based on network analyses.	09/09/22		09/30/22		HSAG
Submit draft MCO and DBM-Specific NAV reports to DHHS for review and comment.	10/03/22		10/03/22		HSAG
Receive DHHS' feedback on MCO- and DBM-specific NAV reports.	12/05/22		12/05/22		DHHS
Submit final MCO- and DBM-specific NAV reports to DHHS.	12/20/22		12/20/22		HSAG

Note: Subsequent contract years will follow a similar timeline.

Appendix 7: HSAG Staff Resumes

Kim M. Elliott, PhD, CPHQ, CHCA
Executive Director, State & Corporate Services

Qualification Highlights

Dr. Elliott has more than 27 years of experience in the healthcare industry. She is a Certified Healthcare Effectiveness Data and Information Set (HEDIS®)[1] Compliance Auditor (CHCA) and conducts HEDIS audits and performance measure validation (PMV) audits including behavioral health, oral health, long-term care, and pharmacy. Dr. Elliott has significant experience in healthcare quality and operations, including the development, implementation, and monitoring of compliance with state codes, rules, and policies. She is proficient in writing and monitoring compliance with managed care organization (MCO) Medicaid contracts and served as the administrator over the clinical and quality programs for Arizona's Medicaid program. Dr. Elliott is an expert in improving Medicaid healthcare systems. She is a national speaker on quality, developmental disability programs, behavioral health, long-term services and supports, maternal and child health, and program integrity. Dr. Elliott has advanced knowledge of Medicaid managed care programs.

Relevant Experience

HSAG, Executive Director, State & Corporate Services (S&CS): Dr. Elliott serves as an executive director of external quality review organization (EQRO) contracts and coordinates internal and external resources to achieve contract goals and objectives. Dr. Elliott conducts HEDIS and PMV audits. She is accountable for state and subcontractor communications, staffing, and completion of all contracted activities. Dr. Elliott provides technical assistance to state Medicaid programs regarding federal rules and requirements, state plan amendments, and Section 1115 and 1915 waivers; and provides state Medicaid agencies with assistance in responding to Centers for Medicare & Medicaid Services (CMS) requests and ensuring compliance with federal requirements. Dr. Elliott provides actionable recommendations for systems improvement and serves as a subject matter expert (SME) on external quality review, Medicaid managed care, HEDIS, performance measurement, performance improvement, care coordination, care integration, special needs populations, healthcare delivery, grant implementation, and CMS regulations and requirements.

HSAG, Executive Director, HEDIS & Performance Measure (PM) Audits Team, S&CS: Dr. Elliott directed the HEDIS and PM Audits Team. In addition to conducting HEDIS and PMV audits, Dr. Elliott was responsible for applying National Committee for Quality Assurance (NCQA) requirements, CMS core measure set requirements, and state and federal Medicaid managed care regulations to daily activities. Dr. Elliott analyzed data; measured project progress against project requirements, objectives, and success criteria; made recommendations; and developed strategies and solutions.

Arizona Health Care Cost Containment System (AHCCCS), Administrator, Clinical Quality Management: Dr. Elliott led the clinical quality management division consisting of quality management; PMV; quality improvement; developmental disabilities; long-term services and supports; behavioral health; maternal and child health; Early and Periodic, Screening, Diagnostic and Treatment (EPSDT); behavioral health quality; and electronic health record

[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

incentive project teams for the Medicaid program and the Children's Health Insurance Program (CHIP) in Arizona. She led and participated in federal, state, and legislative reporting related to quality activities and performance metrics. Dr. Elliott also oversaw and maintained clinical and operational policies according to the standard of care and in compliance with federal and state requirements, and the CMS waiver and state plan requirements. Dr. Elliott led and participated in teams focused on MCO contract development, policy development, waiver amendments, waiver evaluations, and implementation of new federal and state requirements. She represented the agency at the federal, state, and local levels, including work with community organizations, other state agencies, federal programs, and stakeholder groups with a focus on aligning and achieving positive outcomes. Dr. Elliott served on federal SME panels, including those focused on CMS core measure sets, access to care, behavioral health, and long-term care.

Arizona Physicians IPA (now UnitedHealthcare), Director, Prevention and Wellness; Manager, Prevention and Wellness; Project Manager/Systems Operations Manager: Dr. Elliott was responsible for meeting state and federal requirements for an acute care, long-term care, and developmentally disabled population. She provided leadership, direction, and management of the quality management, prevention and wellness, maternal and child health, and behavioral health programs for the acute, long-term care, developmentally disabled, CHIP, and special needs programs. Dr. Elliott was responsible for HEDIS activities. Dr. Elliott developed and implemented care coordination and disease management programs for chronic conditions. She led quality review, peer review, and compliance review teams to meet federal/state requirements.

Professional History

HSAG, Phoenix, Arizona: Executive Director, S&CS (11/2016–present); Executive Director, HEDIS & PM Audits Team, S&CS (03/2016–10/2016); 03/2016–present

AHCCCS, Phoenix, Arizona: Administrator, Clinical Quality Management (11/2012–03/2016); Manager, Clinical Quality Management (07/2001–11/2012); 07/2001–03/2016

Arizona Physicians IPA (now UnitedHealthcare), Phoenix, Arizona: Director, Prevention and Wellness (06/1999–07/2001); Manager, Prevention and Wellness (07/1995–06/1999); Project Manager/Systems Operations Manager (05/1993–07/1995); 05/1993–07/2001

Education

Doctor of Philosophy, Health Sciences, Emphasis in Preventive Health, Honolulu University, 2001

Master of Arts, Organizational Management, University of Phoenix, 1988

Bachelor of Science, Business Administration, University of Phoenix, 1986

Certifications

Certified Professional in Healthcare Quality (CPHQ), National Association for Healthcare Quality

Certified HEDIS Compliance Auditor (CHCA)

Certified in the Science of Improvement, Quality Improvement and Patient Safety, Institute for Healthcare Improvement, Open School

Professional Training & Organizations

Master Trainer, Chronic Disease Self-Management, Stanford University, 2006–present

References

Below are three references who can attest to Dr. Elliott's competence and skill level.

Reference #1

Name, Title:	Mark Leib, MD, JD, Retired AHCCCS Chief Medical Officer
Address:	Private (retired) Phoenix, AZ
Phone #:	602.708.8455
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Reference #2

Name, Title:	Peggy Stemmler, MD, MBA, Director
Address:	Frameshift Group 1645 East Missouri Avenue Phoenix, AZ 85016
Phone #:	602.314.5660
Email:	peggy@frameshiftgroup.com

Reference #3

Name, Title:	Barbara Lang, MAPC, LPC, LISAC, CCSOTS, Deputy Chief of Standards and Compliance
Address:	Community Bridges 1855 West Baseline Road, #100 Mesa, AZ 85202
Phone #:	480.831.7566
Email:	blang@cbridges.com

Kari Vanderslice, MBA, BS
Project Manager III, State & Corporate Services

Qualification Highlights

Ms. Vanderslice has over 20 years of experience in the healthcare industry with expertise in program and project management for quality improvement (QI) activities, health innovation initiatives, and information technology programs. She has provided project management for EQR activities for five states, and technical assistance to more than 500 providers and physician offices (POs) via one-on-one and virtual support.

Relevant Experience

HSAG, Project Manager III (previously I and II), State & Corporate Services (S&CS): Ms. Vanderslice oversees the day-to-day operations of designated projects and coordinates project activities for the S&CS team such as project initiations, client relations, project planning, budgeting, meeting project timelines and deliverables, training, and report preparation and finalization. She acts as a primary contact for communications for state contracts and subcontracts and ensures timely, accurate, and courteous responses to all requests. She coordinates logistics for meetings with other departments, health plans, and contracted entities; conducts information systems reviews; and develops written technical reports, project timelines, and task schedules. Additionally, Ms. Vanderslice identifies opportunities to improve the project process and manages the access and use of the project's Microsoft (MS) SharePoint and secure file transfer protocol site.

HSAG, Health Informatics Specialist III: Ms. Vanderslice coordinated and implemented QI activities for specified projects involving PO QI. This included working directly with providers on various electronic health record (EHR) systems and recommending improvements to achieve compliance. She led POs through QI activities to develop strategies to succeed in the Centers for Medicare & Medicaid Services (CMS) Merit-based Incentive Payment System (MIPS), and identified and helped overcome barriers to a successful implementation of pay-for-performance initiatives. In addition, Ms. Vanderslice assisted POs in establishing procedures for reporting quality measures to CMS.

HSAG, Health Informatics Specialist II: Ms. Vanderslice worked with physician practices engaged in Medicare QI initiatives. This included generating quality reports from various EHR systems, testing immunization interfaces, and recommending improvements to increase performance rates. She implemented programs for the CMS Quality Innovation Network-Quality Improvement Organization (QIN-QIO) and Rural Extension Centers (RECs) in Arizona for more than six years. Ms. Vanderslice also provided support for CMS EHR incentive programs, the Physicians Quality Reporting System (PQRS), the CMS Electronic Prescribing (eRx) incentive program, and the Million Hearts® national quality initiative.

Arizona State University, Technology Program Manager: Ms. Vanderslice managed the Arizona Technology Angel Investors group, and implemented software and processes benefiting members, investors, entrepreneurs, and students.

Accenture Technology Solutions, Senior Systems Analyst: Ms. Vanderslice led 10 technology projects and implementations following Six Sigma methodology. She documented processes,

workflows, and applications in the Knowledge Transfer initiative, and was an opening team member of the Testing Center of Excellence.

Quality Care Solutions, Inc., Quality Analyst: Ms. Vanderslice provided quality analysis for a healthcare software company testing and implementing healthcare claims systems (QNXT), case management initiatives, and trained end-users on software.

Amerigroup Corporation, Senior Reporting Analyst: Ms. Vanderslice implemented Health Insurance Portability and Accountability Act (HIPAA) privacy, security, disaster recovery, and transaction code sets for a Medicaid managed care plan serving 850,000 members in 10 markets.

Professional History

HSAG, Phoenix, Arizona: Project Manager III, S&CS (07/2020–present); Project Manager II, S&CS (07/2019–06/2020); Project Manager I, S&CS (03/2018–06/2019); Health Informatics Specialist III (10/2017–03/2018); Health Informatics Specialist II (01/2011–10/2017); 01/2011–present

Arizona State University, Tempe, Arizona: Technology Program Manager; 2008–2009

Accenture Technology Solutions, Phoenix, Arizona: Senior Systems Analyst; 2006–2007

Quality Care Solutions, Inc. (now Cognizant), Phoenix, Arizona: Quality Analyst; 2004–2006

Amerigroup Corporation, Virginia Beach, Virginia: Senior Reporting Analyst; 2001–2004

Education

Master of Business Administration, Old Dominion University, Norfolk, Virginia, 1999

Bachelor of Science, Dietetics, magna cum laude, University of Wisconsin-Stout, Menomonie, Wisconsin, 1987

Certifications

National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home Certified Content Expert, 2013–2017

AHIMA Certified Healthcare Technology Specialist Implementation Manager, 2011–2013

Management of Clinical Information Technology Certifications, 2010: Clinical Technology Consulting; Health IT Training; Health IT Technical Support; Practice Workflow & Redesign; Implementation Management; Implementation Support

Professional Organizations

HIMSS Arizona Chapter, Member

Valley Leadership, Class 32

Skills

Technologies/EHRs: Allscripts, Amazing Charts, Aprima, Athena, Cerner, ClaimTrak, eClinicalWorks, e-MDs, Centricity, Greenway, Intergy, Impact Pro, IMS Meditab, McKesson, MediTouch, NextGen, Practice Fusion, SuiteMed, QNXT, AMISYS, Dynamics CRM, Salesforce, MS SharePoint, MS Office, Smartsheet, HL7, SQL, HIPAA EDI Transactions

References

Below are three references who can attest to Ms. Vanderslice's competence and skill level.

Reference #1

Name, Title:	Lance Donkerbrook, MBA, CEO
Address:	Commonwealth Primary Care ACO, LLC 4801 South Lakeshore Drive, #106 Tempe, AZ 85282
Phone #:	602.492.8388
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Reference #2

Name, Title:	Emilie Sundie, MCIS, Director
Address:	Health Services Advisory Group, Inc. 3133 East Camelback Road, Suite 100 Phoenix, AZ 85016
Phone #:	602.315.2589
Email:	emilie@sundie.com

Reference #3

Name, Title:	Emily Larpenteur, CST, BAS/ISS, HIS Manager
Address:	Marana Main Health Center 13395 North Marana Main Street Marana, AZ 85653
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Christi L. Melendez, ASN, RN, CPHQ
Associate Executive Director, Performance Improvement Projects, State & Corporate Services

Qualification Highlights

Ms. Melendez has more than 30 years of experience in the healthcare industry, with expertise in quality improvement (QI), performance improvement projects (PIPs), technical assistance, on-site training, healthcare policy and processes, and clinical case management, and in working directly with Medicaid and Medicare populations. She works closely with state Medicaid agencies and their contracted managed care organizations (MCOs) to ensure PIPs are structured in a methodologically sound manner, follow industry-recognized practices, and have the potential to bring about real and sustained improvement and better health outcomes for beneficiaries. Ms. Melendez is a subject matter expert in QI science and in using rapid-cycle technique improvement. She spearheaded the development and implementation of HSAG's innovative rapid-cycle approach for implementing and validating PIPs, and she led the process to obtain Centers for Medicare & Medicaid Services' (CMS') approval and endorsement of the rapid-cycle approach.

Relevant Experience

HSAG, Associate Executive Director, PIPs, State & Corporate Services (S&CS): Ms. Melendez plans, directs, and manages the overall operations for PIP activities related to analytics projects that support external quality review (EQR) and PIP validation activities. She is responsible for using internal and external resources to achieve corporate, departmental, and project goals and objectives, including working with the project director to ensure deliverables are on time and of high quality. Ms. Melendez provides research leadership, analytics expertise, technical interpretive writing, and mentoring to her staff members, and she ensures the scientific soundness of study design, analysis, and interpretation of a variety of healthcare studies. She represents HSAG as needed at regional and national levels and in planning technical assistance meetings, teleconferences, and webinars with state and MCO staffs and assigned clients. Ms. Melendez is responsible for the PIP Team staff and project deliverables and provides technical assistance to health plans throughout the PIP process, including on-site training for health plans and individual states. She is accountable for developing and adhering to project timelines and task schedules.

HSAG, Project Manager, PIP Team: Ms. Melendez provided day-to-day management of the PIP Team and developed in-service trainings for the team. She provided technical assistance to health plans throughout the PIP process and created presentations to train states about the process. Ms. Melendez also assisted an S&CS executive director in writing the PIP Reviewer's Guide and the MCO guides for the PIP process. Ms. Melendez performed validation of physical and behavioral health PIPs and wrote PIP validation reports, explaining the validity and reliability of the PIP findings. In addition, she supported writing PIP annual summary reports and EQR technical reports.

HSAG, PIP Reviewer II, S&CS: Ms. Melendez performed validation of physical and behavioral health PIPs by assessing the implications of the validity and reliability of findings. She was responsible for providing technical assistance to states, as needed.

HSAG, Review Coordinator/Abstractor, S&CS: Ms. Melendez performed review and abstraction of medical records to assess quality of care, practice guidelines, and variation in care and outcome, and to substantiate review findings. She worked on a variety of projects, including the RAND Cost of Cancer Treatment Study, and she assisted in training other registered nurse (RN) abstractors, providing on-site medical reviews for Healthcare Effectiveness Data and Information Set (HEDIS®) auditing.[1]

Banner Home Health, Case Manager: Ms. Melendez performed case management for pregnant, pediatric, and adult home health patients, including infusion patients, and coordinated care with a multidisciplinary team. She was a nurse preceptor and performed new employee preceptor duties. Ms. Melendez performed chart audits for multiple teams, including Medicare/Medicaid.

Gentiva Health Services, Manager of Clinical Practice: Ms. Melendez managed a team of 40 nurses and performed case management for long-term, chronically ill children. She prepared quality assurance and treatment plans and performed medical record/documentation audits. Ms. Melendez was also a member of the Performance Improvement Committee.

Integrated Health Services (IHS) Home Care, Senior Case Manager: Ms. Melendez performed case management for pregnant and pediatric patients, coordinating their care with a multidisciplinary team. She served as the performance improvement coordinator for the pediatric team. Ms. Melendez also performed chart audits for multiple teams, including Medicare and Medicaid.

Professional History

HSAG, Phoenix, Arizona: Associate Executive Director, PIPs, S&CS (09/2011–present); EQRO Project Manager, PIP Team (10/2008–09/2011); Project Leader, PIP Team (01/2007–10/2008); PIP Reviewer II (01/2006–01/2007); Review Coordinator/Abstractor (01/2001–01/2006); 01/2001–present

Banner Home Health, Phoenix, Arizona: Case Manager; 09/2004–11/2007

Centrum Healthcare, Phoenix, Arizona: Pediatric Field Nurse; 05/2002–08/2004

Gentiva Health Services, Phoenix, Arizona: Manager of Clinical Practice; 01/2000–12/2000

Children's Home Care, Phoenix, Arizona: Intermittent Visit Nurse; 03/1999–12/1999

IHS Home Care, Phoenix, Arizona: Senior Case Manager; 02/1991–03/1999

Desert Samaritan Medical Center, Mesa, Arizona: Staff RN; 02/1990–02/1991

Whittier Presbyterian, Whittier, California: Staff RN; 03/1986–12/1989

Education

Associate of Science in Nursing, Cypress College, Cypress, California, 1986

Licenses

Registered Nurse, Arizona, 1986–present

Nurse Licensure Compact: Active, Unencumbered, Multi-state, 1990–present

Certifications

Certified Professional in Healthcare Quality by the Healthcare Quality Certification Board, 2009

[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

References

Below are three references who can attest to Ms. Melendez's competence and skill level.

Reference #1

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Reference #3

Name, Title:	Virginia Rouse, Director, Quality Management
Address:	AmeriHealth Caritas, New Hampshire 25 Sundial Avenue Manchester, NH 03103
Phone #:	603.548.8160
Email:	Vrouse@amerihealthcaritas.com

Kristine Stolte Hartmann, MS, BS
Project Manager III, Performance Improvement Project Team

Qualification Highlights

Ms. Hartmann has more than 20 years of experience in the healthcare and public health industries with expertise in evaluations and report writing for quality and performance improvement projects (PIPs), managing research studies and data collection activities, and epidemiology.

Relevant Experience

HSAG, Project Manager III (previously II), PIP Team: Ms. Hartmann leads, directs, and conducts/validates quality improvement (QI) projects and PIPs for Medicaid managed care plans for the external quality review organization (EQRO) contracts in Colorado, New Hampshire, and Oregon. She performs project management duties for PIP validation including project planning and timeline development, and monitoring and reporting of progress on deliverables. Ms. Hartmann evaluates PIPs and provides technical guidance to state Medicaid agencies and Medicaid health plans. Ms. Hartmann also serves as a subject matter expert for the design and implementation of quality PIPs and use of quality improvement science tools and processes.

HSAG, Healthcare Analyst I and II, PIP Team: Ms. Hartmann was the PIP team lead for the EQRO contracts in Colorado, Florida, and New Hampshire. She performed project management duties related to PIP validation for the states of Georgia and Illinois including project planning and timeline development, and monitoring and reporting of progress on deliverables. Ms. Hartmann provided analytic guidance and expertise to the PIP team and to external clients. Ms. Hartmann evaluated PIPs, composed PIP-specific reports, analyzed and reported statewide PIP validation results for external quality review (EQR) technical reports, and provided technical assistance to multiple states and managed care organizations (MCOs).

Arizona State University, College of Nursing and Health Innovation, Management Research Analyst: Ms. Hartmann managed the data activities for a federally-funded prospective research study of behavioral and mental health adolescents with nearly 800 subjects. She facilitated meetings that included the principal investigator, statistician, and data management staff, as well as maintained historical documentation of all data decisions. She provided training on research protocols and data management methods, established and tracked project timelines, and supervised a data management team.

Arizona Department of Health Services (ADHS), Office of HIV, STD, and Hepatitis Services, Epidemiologist Specialist II: Ms. Hartmann was responsible for coordinating the data collection for the human immunodeficiency virus (HIV) Incidence Surveillance Program. She provided technical assistance to laboratory, clinical, and health department staff members on data collection and reporting procedures. Ms. Hartmann authored the narrative portion of a competitive grant application for the Centers for Disease Control and Prevention (CDC) that ensured the continuation of HIV incidence surveillance in Arizona with a budget increase, allowing the program to grow from one to four support staff persons.

Professional History

HSAG, Phoenix, Arizona: Project Manager III, PIP Team (07/2020–present); Project Manager II, PIP Team (07/2018–07/2020); Healthcare Analyst II, PIP Team (07/2016–07/2018); Healthcare Analyst I, PIP Team (06/2013–07/2016); 06/2013–present

Arizona State University, College of Nursing and Health Innovation, Tempe, Arizona: Management Research Analyst; 04/2010–06/2013

ADHS, Office of HIV, STD, and Hepatitis Services, Phoenix, Arizona: Epidemiologist Specialist II; 11/2005–04/2010

Education

Master of Science, Epidemiology, School of Public Health, University of Illinois at Chicago, Chicago, Illinois, 2000

Bachelor of Science, Psychology, University of Wisconsin-Madison, Madison, Wisconsin, 1997

References

Below are three references who can attest to Ms. Hartmann's competence and skill level.

Reference #1

Name, Title:	Curt Curnow, Quality Improvement Section Manager
Address:	Colorado Department of Health Care Policy & Financing 1570 Grant Street Denver, CO 80203
Phone #:	303.866.5879
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Reference #2

Name, Title:	Lisa Bui, Quality Improvement Director
Address:	Oregon Health Authority 421 SW Oak Street, Suite 875 Portland, OR 97204
Phone #:	971.673.3397
Email:	lisa.t.bui@state.or.us

Reference #3

Name, Title:	Melissa Isavoran, Director, State & Corporate Services
Address:	HSAG 3133 East Camelback Road, Suite 100 Phoenix, AZ 85016
Phone #:	503.839.9070
Email:	misavoran@hsag.com

Jennifer Montano
Project Manager II, State & Corporate Services

Qualification Highlights

Ms. Montano has more than 25 years of experience in the healthcare industry, with expertise in performance improvement projects (PIPs), administrative support and project coordination/management, and the administration and coordination of federal and state contracts.

Relevant Experience

Health Services Advisory Group, Inc. (HSAG), Project Manager II, State & Corporate Services (S&CS): Ms. Montano provides day-to-day management of the PIP Team. She maintains the master database for outcome-focused PIP validation tools, is responsible for project management of the rapid-cycle PIP process, and provides technical support to health plans throughout their PIP process. Ms. Montano also assists in the editing and formatting of PIP validation tools and report preparation and finalization, and maintains several PIP tracking documents. She acts as a liaison with health plans to coordinate meetings, webinars, and technical assistance calls. Ms. Montano provides support to all PIP Team members as needed. In addition to her PIP responsibilities, Ms. Montano also supports the executive director for external quality review organization (EQRO) contracts for New Hampshire, Tennessee, and Vermont. She is responsible for compliance review database assistance, report production and formatting, as well as meeting coordination, travel scheduling, and expense report processing. She also supports the chief operating officer with meeting coordination, travel scheduling, expense report processing, as well as other duties as assigned.

HSAG, Project Manager I, S&CS: Ms. Montano provided day-to-day management of the PIP Team. She acted as a liaison with health plans to coordinate meetings, webinars, and technical assistance calls. In addition to her PIP responsibilities, Ms. Montano also supported the executive director for EQRO contracts for New Hampshire, Tennessee, and Vermont. She also supported the senior executive director with meeting coordination, travel scheduling, expense report processing, as well as other duties as assigned.

HSAG, Project Coordinator, S&CS: Ms. Montano provided project coordination and administrative support to the executive director and the project director for Florida, Nevada, and Tennessee EQRO contracts. She was responsible for compliance review database assistance, report production and formatting, file transfer protocol (FTP) site maintenance, timeline monitoring, as well as meeting coordination and travel scheduling. Ms. Montano supported several EQRO contracts for the corporate communications team, responsible for creating, producing, and maintaining corporate marketing materials, business cards, and corporate stationery for all HSAG office locations. She created and edited flyers, posters, ads, report covers, and brochures as requested. Ms. Montano provided Federal Division administrative support to the director of health education & publications, director of health communications, as well as the communications project manager as needed. Her responsibilities also included maintaining, monitoring, and coordinating Xerox contract activities, which included new equipment purchases, equipment updates, equipment moves, off-site production assistance, and staff coverage. She was responsible for monthly invoice reconciliation and account job coding for the production center in the Phoenix, Arizona, location.

Professional History

HSAG, Phoenix, Arizona: Project Manager II, S&CS (06/2020–present); Project Manager I, S&CS (06/2015–06/2020); Project Coordinator, S&CS (06/2009–06/2015); Administrative Assistant I/II/III, Communications & Administration (02/1996–06/2009); Staff Secretary I/II, Federal Case Review (10/1993–02/1996); Medical Records File Clerk, Federal Case Review (05/1991–10/1993); 05/1991–present

Terry Campbell & Associates, Phoenix, Arizona: Assistant/Tax Preparer: 06/1989–05/1991

References

Below are three references who can attest to Ms. Montano's competence and skill level.

Reference #1

Name, Title:	Gretchen Thompson, Chief Operating Officer, S&CS
Address:	Health Services Advisory Group, Inc. 3133 East Camelback Road, Suite 100 Phoenix, AZ 85016
Phone #:	602.317.6224
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Reference #2

Name, Title:	Carol Smallwood, MPH, Retired
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Phone #:	602.402.8671
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Reference #3

Name, Title:	Tonya P. Taylor, MBA, BSN, RN Manager, Quality Improvement
Address:	Virginia Premier 10800 Nuckols Road Glen Allen, VA 23060
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Thomas Miller, MA, BS, CHCA
Practice Leader & Executive Director, Audit Operations

Qualification Highlights

Mr. Miller has 20 years of experience in healthcare operations, data analysis, healthcare information technology, and auditing across a variety of healthcare delivery systems and payers. He serves as a subject matter expert on Medicaid managed care and fee-for-service programs, pharmacy operations and pharmacy benefit management, disease management, claims and encounter processing, and healthcare auditing services. Mr. Miller is experienced in managing external quality review (EQR) services and working with federal and state agencies, health plans, and community stakeholders to evaluate, measure, and improve healthcare services and programs. His expertise includes overall contract and client management, business development, and management of EQR and non-EQR activities including performance measure validation audits and calculation (Healthcare Effectiveness Data and Information Set [HEDIS®],[1] Adult and Child Medicaid Core Measures), performance improvement projects (PIPs), healthcare surveys, compliance and operational readiness reviews, information systems capabilities assessments, program evaluations, provider profiles, and data mining and analysis.

He is adept at translating quantitative and qualitative research into operational goals, standards, and improvement activities.

Relevant Experience

HSAG, Practice Leader & Executive Director, Audit Operations: Mr. Miller currently serves as HSAG's Audits Team operational lead, accountable for the management and oversight of all audit lines of business including HEDIS Compliance Audit™,[2] services, AMP (Align. Measure. Perform.) Audit Review™,[3] audit services, performance measure validation, CMS data validation for Medicare Part C and Part D, and information systems assessment/readiness reviews for EQR and private clients. His responsibilities include contract and client management along with being the technical lead and division trainer for HSAG's auditor services. Mr. Miller works with Audits Team staff members to enhance operations, incorporate process improvements, and develop and implement a comprehensive training program. Mr. Miller is also a National Committee for Quality Assurance (NCQA) Certified HEDIS Compliance Auditor (CHCA).

HSAG, Executive Director, State & Corporate Services (S&CS): Previously, Mr. Miller was responsible for managing a portfolio of EQR services for two states and several special projects. His responsibilities included overall contract and client management, business development, administration of satellite offices, and management of EQR and non-EQR activities including performance measure validation and calculation (HEDIS, Adult and Child Medicaid Core Measures), PIPs, healthcare surveys, compliance monitoring reviews, program evaluations, provider profiles, and data mining.

[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[2] HEDIS Compliance Audit™ is a trademark of NCQA.
[3] AMP Audit Review™ is a registered trademark of NCQA.

Mr. Miller also served as the executive director of HSAG's State Analytics Team, where he provided oversight of EQR Medicaid evaluation and analytic activities and was responsible for the oversight of HSAG analysis activities and staff members, including coordinating all analytic activities; implementing quality control processes; as well as training, mentoring, and oversight of analysis. This included presenting findings and analytic interpretations in reports, graphs, and charts. Mr. Miller continues to provide research leadership, analytical expertise, technical interpretive writing, and mentoring for the analytical staff members at HSAG.

HSAG, Director, S&CS Analysis: Mr. Miller was responsible for coordinating HSAG analytic activities, including study design, analysis, and interpretations. He was also responsible for oversight and training of S&CS analysts and quality control process implementation.

HSAG, Senior Healthcare Analyst, Surveys, Research, and Analysis: Mr. Miller was responsible for the scientific soundness of study design, analysis, and interpretations of a variety of healthcare studies.

AdvancePCS, Senior Research Analyst: As a member of the Customer & Quality Research Division, Mr. Miller designed, implemented, and managed sampling protocols for internal and external customer satisfaction projects. He performed all aspects of the survey process including sampling, data management, analysis, and reporting. Mr. Miller also conducted cross-sectional and longitudinal retrospective database analyses using pharmaceutical and medical claims data and provided analytical, methodological, and statistical consulting and support for internal and external research projects.

Professional History

HSAG, Phoenix, Arizona: Practice Leader & Executive Director, Audit Operations (10/2019–present); Executive Director, S&CS (11/2007–09/2019); Director, S&CS Analysis (03/2004–11/2007); Senior Healthcare Analyst, Surveys, Research, and Analysis (12/2003–03/2004); 12/2003–present

AdvancePCS, Scottsdale, Arizona: Senior Research Analyst; 02/2001–12/2003

Southwest Catholic Health Network, Phoenix, Arizona: Research Analyst, Department of Research and Evaluation; 02/1999–02/2001

IMPACT Program, Hamilton County Alcohol and Drug Addiction Services, Cincinnati, Ohio: Consultant; 06/1997–12/1998

Kunz Center for the Study of Work and Family, University of Cincinnati, Cincinnati, Ohio: Research Assistant; 09/1997–06/1998

Education

Master of Arts, Sociology, University of Cincinnati, Cincinnati, Ohio, 1999

Bachelor of Science, Sociology and Psychology, Northern Arizona University, Flagstaff, Arizona, 1996

Certifications

NCQA Certified HEDIS Compliance Auditor (CHCA)

References

Below are three references who can attest to Mr. Miller's competence and skill level.

Reference #1

Name, Title:	Suzanne Turla, Nurse Consultant, Quality and Member Relations Improvement Section
Address:	Department of Human Services, Med-QUEST Division 601 Kamokila Boulevard, Suite 506B Kakuhihewa Kapolei State Building Kapolei, HI 96707-2021
Phone #:	808.692.8110
Email:	sturla@dhs.hawaii.gov

Reference #2

Name, Title:	Gina Redford, Manager, Analytic Services
Address:	Arkansas Foundation for Medical Care 1020 W. 4th St, Suite 300 Little Rock, AR 72201
Phone #:	501.212.8722
Email:	Gina.Redford@AMFC.org

Reference #3

Name, Title:	Dana Keller, PhD, President
Address:	Halcyon Research, Inc. 4250 Brackenwood Court Sarasota, FL 34232
Phone #:	941.228.5104
Email:	Dana@HalcyonResearch.com

Jacilyn Daniel, BS
Healthcare Quality Manager I, Data Science & Advanced Analytics

Qualification Highlights

Ms. Daniel has more than six years of experience in the healthcare industry with expertise in electronic medical record (EMR) systems, medical billing, patient scheduling, training, Healthcare Effectiveness Data and Information Set (HEDIS®)[1] measures, and integrated medical systems analyses.

Relevant Experience

HSAG, Healthcare Quality Manager I, Data Science & Advanced Analytics (DSAA): Ms. Daniel serves as lead and secondary auditor on external quality review (EQR) performance measure validation and HEDIS audit-related projects through various stages including implementation, project management, analysis, reports, orientation, and training. Ms. Daniel also conducts pre-on-site, on-site, and post-on-site activities as directed including report writing and report validation. Ms. Daniel is also the performance measure validation lead for the Financial Alignment Initiative project, performance measure validation lead for the State of Michigan, and the medical record review validation lead for HEDIS.

HSAG, Health Informatics Specialist, Quality Innovation Network-Quality Improvement Organization (QIN-QIO): Ms. Daniel was a member of a project team responsible for providing resources and tools to help with the identification and treatment of depression and alcohol use disorder, as well as coordinate and implement quality improvement activities with collaborators for specified projects involving physician office quality improvement. This included generating quality reports from various electronic health record (EHR) systems in physician practices. She provided education on billing and proper billing codes and technical assistance for providers and staff members. Ms. Daniel maintained the currency of databases related to assigned projects, and was responsible for evaluating efficiency and effectiveness and recommending improvements for all work activities that fell within the team responsibilities.

Integrated Medical Services, Electronic Health Record Trainer and Analyst/Interface Specialist: Ms. Daniel provided help desk and end-user support with hardware and Allscripts software including the EHR, patient management system Patient Portal, and ScanLive. She provided daily interface maintenance with diagnostic vendors, remote and on-site training for physicians and end users, and daily analyses and maintenance of all company software systems and databases.

Bellingham Urology Group, Medical Biller/Referrals Specialist: Ms. Daniel was responsible for insurance follow-up, working reports, obtaining prior authorization for surgical procedures, verifying insurance, and checking benefits.

PeaceHealth Cardiology, Patient Access Representative/Scheduler: Ms. Daniel registered patients, verified patient demographic and financial data including insurance coverage, obtained prior authorizations, responded to patient inquiries, scheduled appointments, and managed the physician surgical appointment schedule.

[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Bozeman Deaconess Hospital, Medical Biller/Health Services Trainer: Ms. Daniel completed an internship working in the hospital financial services department as a medical biller. She was then hired as a health services trainer for the finance department for new hires and provided them with training on the medical billing process.

Professional History

HSAG, Phoenix, Arizona: Healthcare Quality Manager I, DSAA (07/2018–present); Health Informatics Specialist, QIN-QIO (11/2017–07/2018); 11/2017–present

Integrated Medical Services, Phoenix, Arizona: Electronic Health Record Trainer and Analyst/Interface Specialist; 03/2017–11/2017

Bellingham Urology Group, Bellingham, Washington: Medical Biller/Referrals Specialist; 10/2016–03/2017

PeaceHealth Cardiology, Bellingham, Washington: Patient Access Representative/Scheduler (College Practicum); 10/2015–10/2016

Bozeman Deaconess Hospital, Bozeman, Montana: Medical Biller/Health Services Trainer (College Internship); 07/2014–10/2015

Education

Master of Science, Health Informatics, Arizona State University, Tempe, Arizona, anticipated 2021

Bachelor of Science, Health Informatics, Montana Tech, Bozeman, Montana, 2016

Skills

NextGen; Meditech; Epic; SQL; Microsoft Word, Excel, and Access; Allscripts; CRM; and Centricity

References

Below are three references who can attest to Ms. Daniel's competence and skill level.

Reference #1

Name, Title:	Elisabeth Hunt, Executive Director, DSAA Management
Address:	Health Services Advisory Group, Inc. 3133 East Camelback Road, Suite 100 Phoenix, AZ 85016
Phone #:	614.300.1453
Email:	ehunt@hsag.com

Reference #2

Name, Title:	Jenny Starbuck, Director Quality Management
Address:	Magellan Complete Care of Arizona 4801 East Washington Street, Suite 225 Phoenix, AZ 85034
Phone #:	480.296.5379
Email:	starbuckj@magellanhealth.com

Reference #3

Name, Title:	Suzanne Teply, Information Technology Director
Address:	Bayless Integrated Healthcare 9014 South Central Avenue Phoenix, AZ 85042
Phone #:	480.306.0037
Email:	Steply@baylesshealthcare.com

Tammy GianFrancisco, CHCA
Project Manager II, Data Science & Advanced Analytics

Qualification Highlights

Ms. GianFrancisco has more than 16 years of experience in the healthcare industry, with expertise in project management and coordination of Healthcare Effectiveness Data and Information Set (HEDIS®)[1], performance measure validation (PMV), Centers for Medicare & Medicaid Services (CMS) Medicare Parts C and D data validation, and AMP [Align. Measure. Perform] Audit Review™,[2] audit activities throughout all process stages.

Relevant Experience

HSAG, Project Manager II, Data Science & Advanced Analytics (DSAA) / HEDIS Manager, Audits, State & Corporate Services (S&CS): Ms. GianFrancisco oversees designated HEDIS and S&CS projects through various stages, including responding to requests for proposal (RFPs); project initiation; recruitment, selection, orientation, training, and supervision of staff members; project planning and budgeting; completion of field work; and report preparation and finalization. Her primary responsibilities include managing project timelines and monitoring completion of all aspects of the audit activities, including HEDIS Compliance Audits, PMV audits, AMP Audit Reviews, CMS Medicare Parts C and D data validation audits, and other external quality review (EQR) deliverables. She assists with contract preparation and proposals, manages source code review activities, prepares audit-related documentation and tools, and assists with report writing and validation for the various audit projects and State EQR aggregate and technical reports. Ms. GianFrancisco assists lead auditors with pre-on-site, on-site, and post-on-site activities including disseminating information to health plans and medical groups, preliminary audit documentation tracking and review, and follow-up. She has led and served as a secondary auditor for PMV audits. She prepares training materials and communication for clients for audit-related activities and conducts webinar trainings for plans and auditors. She manages the rate review process activities for the Audits Team, including working with HSAG's internal analytics team, provides technical assistance to internal and external clients related to the various audit processes and deadlines, and manages the source code review activities. During the HEDIS season, she provides technical assistance to both internal and external clients based on a thorough understanding of NCQA HEDIS specifications. Ms. GianFrancisco develops training materials and audit tools, as well as web-based solutions for HEDIS work. She monitors all NCQA audit timelines and ensures auditors and organizations meet the timelines.

HSAG, Project Leader, Audits, S&CS: Ms. GianFrancisco assisted the director in overseeing the day-to-day operations of the Audits Team including HEDIS audits, PMV audits, and other external quality review (EQR) deliverables. Her primary responsibilities included project management, analysis, reports, orientation, and training. She drafted audit correspondence, managed the audit schedule, and supported process development. Ms. GianFrancisco managed source code review for the PMV, HEDIS, and AMP audit activities, ensuring the use of accurate specifications. She monitored the completion of all audit activities, developed and adhered to

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[2] AMP Audit Review™ is a registered trademark of the NCQA.

project timelines, identified opportunities for process and quality improvement (internally and with individual states and health plans), and coordinated the development of audit reports. Through these efforts, she ensured that state, plan-specific, and NCQA guidelines were met, when applicable.

HSAG, Project Coordinator, Audits, S&CS / Administrative Assistant, Audits, S&CS: Ms. GianFrancisco oversaw designated HEDIS and S&CS projects through various stages, including responding to requests for proposal (RFPs); project initiation; recruitment, selection, orientation, training, and supervision of staff; client relations; project planning and budgeting; and report preparation and finalization.

Cardinal Health, Executive Assistant to Vice President of Quality and Vice President of Communications: Provided administrative support and worked with various internal teams to organize meetings. Tracked issues from various sites nationwide for the VP of Quality to ensure quality standards were being met and issues were being resolved with the Pyxus medical equipment. Drafted correspondence, coordinated travel arrangements for team members, managed multiple team schedules/calendars, including the Vice President of Quality and Vice President of Communications.

Professional History

HSAG, Phoenix, Arizona: Project Manager II, Audits, DSAA (10/2019–present); HEDIS Manager, S&CS (12/2016–10/2019); Project Manager, Audits, S&CS (06/2014–12/2016); Project Coordinator/Project Leader, Audits, S&CS (04/2011–06/2014); Administrative Assistant III (06/2007–04/2011); Administrative Assistant II (03/2003–06/2007); 03/2003–present

Cardinal Health, Inc., San Diego, California: Executive Assistant to Vice President of Quality and Vice President of Communications; 06/2002–01/2003

New Horizons, Tempe, Arizona: Operations Assistant; 09/1998–04/2002

Choice Cellular Communications, Phoenix, Arizona: Customer Service; 08/1995–10/1996

Allstate Cellular Communications, San Diego, California: Office Manager and Assistant Store Manager; 01/1990–08/1995

Education

Business Administration, Palomar Community College, San Marcos, California, 1987–1988

Psychology, Mesa Community College, San Diego, California, 1988–1989

Certifications

NCQA Certified HEDIS Compliance Auditor (CHCA)

Skills

Proficient in Microsoft Office (Outlook, Word, PowerPoint, Excel, Access), Microsoft SharePoint, Windows, and Adobe Acrobat Professional.

References

Below are three references who can attest to Ms. GianFrancisco's competence and skill level.

Reference #1

Name, Title:	Wendy Talbot, Assistant Vice President—Measure Collection & Audit
Address:	National Committee for Quality Assurance 1100 13th Street NW, Third Floor Washington, DC 20005
Phone #:	202.955.1708
Email:	talbot@ncqa.org

Reference #2

Name, Title:	Judy Yip-Reyes, Director of Institutional Effectiveness
Address:	Northland Pioneer College 1001 West Deuce of Clubs Show Low, AZ 85801
Phone #:	928.532.6148
Email:	Judy.yip-reyes@npc.edu

Reference #3

Name, Title:	Elisabeth Hunt, Executive Director, DSAA Management
Address:	Health Services Advisory Group, Inc. 3133 East Camelback Road, Suite 100 Phoenix, AZ 85016
Phone #:	614.300.1453
Email:	ehunt@hsag.com

Amy Kearney, BA
Director, Data Science & Advanced Analytics

Qualification Highlights

Ms. Kearney has nearly 30 years of experience in the healthcare industry, with expertise in Medicaid programs and data. She has overseen the development and completion of annual encounter data validation (EDV) studies, focused studies, and network adequacy studies for numerous state Medicaid agencies during the last seven years.

Relevant Experience

HSAG, Director, Data Science & Advanced Analytics (DSAA): Ms. Kearney directs and coordinates analysts' daily activities related to DSAA projects in support of external quality review (EQR) activities. She provides research leadership, analytics expertise, and mentoring to analytic staff members. Ms. Kearney acts as an internal and external liaison for analytic activities by planning, executing, and monitoring projects; supervising staff members; managing client relations; and providing technical assistance. She is responsible for maintaining and monitoring relationships with customers and ensuring ongoing customer satisfaction for assigned contracts. She is the administrative lead for the team designing and conducting numerous EDV studies, focused studies, and network adequacy studies in various states. Ms. Kearney also oversees the case review team and manages the daily activities for the reviewers. She provides guidance for the development of medical record review tools for the EDV studies. Ms. Kearney assists in developing and implementing staff training related to conducting EQR activities, study design, and execution. She is accountable for ensuring the completion of assigned analytics tasks according to contract specifications and ensuring those tasks meet client and budget requirements.

HSAG, Associate Director, Informatics, Research and Analysis Team: Ms. Kearney directed work related to State & Corporate Services' projects. As the administrative team lead for numerous EDV activities, focused studies, and network adequacy studies, she provided leadership, expertise, and mentoring to the staff. She provided analytics expertise by planning and executing projects and ensuring the tasks met budget requirements.

TriWest Healthcare Alliance, Director, ICD-10/HIPAA 5010: Ms. Kearney served as project leader with overall responsibility for the 5010/International Classification of Diseases, 10th Revision (ICD-10) conversions. She facilitated a steering committee and provided regular project status updates, action plans, and contingency plans, and she escalated issues to senior leadership. She oversaw a clinical decision support tool that supported the authorization approval process and claims processing. Ms. Kearney led a project team to become Health Insurance Portability and Accountability Act of 1996 (HIPAA) 5010-compliant by the deadline.

TriWest Healthcare Alliance, Manager, Data Reporting and Analysis: Ms. Kearney managed healthcare data reporting and workflow of ad hoc data requests from internal and external customers. She provided management and direction in overseeing the performance of data analysts and coordinated the reporting needs of key customers from claims, provider services, accounting, healthcare services, TRICARE-Regional Office West, TRICARE Management Activity, and military treatment facilities. Ms. Kearney oversaw the creation and submission of more than 500 monthly government reports.

TriWest Healthcare Alliance, Manager, Health Care Data-Actuarial Services: Ms. Kearney was responsible for managing healthcare data reporting for the actuarial services department. She developed key reports to track healthcare costs and provided analysis to the executive team. Ms. Kearney trained department staff members on data querying in DB2, government reporting, and document standardization; and she coordinated healthcare cost reporting for government change orders.

TriWest Healthcare Alliance, Senior Health Care Analyst/Health Care Analyst: Ms. Kearney maintained reporting for healthcare claims, provider discounts, beneficiary counts, and utilization and costs for applicable areas. She supervised the staff, provided analysis and recommendations for monthly reports and other ad hoc reporting, and provided data expertise on claims and data integrity to transition from querying in a mainframe environment with an outside subcontractor to an in-house data warehouse. Ms. Kearney also created SQL queries, developed a process to analyze and evaluate healthcare change orders for cost impact, and worked with a subcontractor and information technology staff members to resolve data integrity issues with claims data on the mainframe.

Professional History

HSAG, Phoenix, Arizona: Director, DSAA (07/2014–present); Associate Director, Informatics, Research and Analysis Team (04/2013–06/2014); 04/2013–present

TriWest Healthcare Alliance, Phoenix, Arizona: Director, ICD-10/HIPAA 5010 (02/2010–03/2013); Manager, Data Reporting and Analysis (02/2003–01/2010); Manager, Health Care Data-Actuarial Services (02/2002–01/2003); Senior Health Care Analyst/Health Care Analyst (09/1998–01/2002); 09/1998–03/2013

Horizon Healthcare Corporation, Albuquerque, New Mexico: Reimbursement Team Leader (12/1997–09/1998); Reimbursement Analyst (12/1996–11/1997); Assistant Reimbursement Analyst (12/1990–11/1996); 12/1990–09/1998

Education

Bachelor of Business Administration, University of New Mexico–Anderson School of Management, Albuquerque, New Mexico, 1996

Crucial Conversations Training

TriWest Path to Leadership Excellence

Certifications

Certified, Licensed Analyst of the Predictive Index System

TriWest Lean Six Sigma Yellow Belt Certification

TriWest Project Management Certification

Skills

Proficient in the use of Microsoft (MS) Office Suite, MS Reporting Services, Cognos Report & Query Studio, DB2 UDB, and SQL/QMF.

References

Below are three references who can attest to Ms. Kearney's competence and skill level.

Reference #1

Name, Title:	David Brooks, Vice President, Provider Services
Address:	TriWest Healthcare Alliance 16010 North 28th Avenue Phoenix, AZ 85053
Phone #:	602-763-6727
Email:	dbrooks@triwest.com

Reference #2

Name, Title:	Lisa Stevens Anderson, President, Q Point Health
Address:	Equality Health 521 South 3rd Street Phoenix, AZ 85004
Phone #:	602-319-2545
Email:	LSAnderson@equalityhealth.com

Reference #3

Name, Title:	Malgorzata Skinner, Senior Associate
Address:	Mercer 2325 East Camelback, Suite 600 Phoenix, Arizona 85016
Phone #:	480-238-1377
Email:	malgorzata.skinner@mercer.com

Alana Berrett, MPH, BA
Associate Director, Data Science & Advanced Analytics

Qualification Highlights

Ms. Berrett is an experienced epidemiologist and statistical analyst with more than 15 years of healthcare and public health industry experience, providing research leadership; analytic expertise; mentoring of staff members; and acting as an internal and external liaison for analytic activities by planning, executing, and monitoring studies of physical and behavioral healthcare quality among Medicaid beneficiaries.

Relevant Experience

HSAG, Associate Director, Data Science & Advanced Analytics (DSAA): Ms. Berrett manages work activities for analytic teams in support of Medicaid managed care external quality review (EQR) activities for multiple state clients, including Arizona, California, Colorado, Michigan, New Hampshire, Oregon, and Virginia. Specific projects include focused studies, encounter data validation (EDV) studies, and network adequacy assessments, with a recent focus on helping state Medicaid agencies develop and enhance network adequacy validation systems. Ms. Berrett has also supervised staff members conducting medical record procurement and abstraction for use in EDV studies and performance measure calculations. Ms. Berrett leads analytic teams in translating quantitative study results into meaningful reports with actionable recommendations. Her direct responsibilities include assisting in the development and implementation of staff training related to conducting EQR activities, analytic programming, study design, and execution. Ms. Berrett assists in the development of internal policies, procedures, and quality control processes that ensure scientifically sound and valid products. She prepares and delivers technical assistance and scientific presentations to corporate staff members and to HSAG clients, managed care organizations, and their contractors. Ms. Berrett is responsible for maintaining and monitoring client relationships and ongoing client satisfaction for assigned contracts and is accountable to ensure that completed tasks meet client and budget requirements. She conducts day-to-day project management tasks, including planning, budget analysis, staffing, communication (written and verbal), coaching, and training for assigned projects. Ms. Berrett provides leadership and accountability for the project design, data abstraction and collection, monitoring, and report preparation.

HSAG, Senior Healthcare Analyst, Research & Analysis: Ms. Berrett conducted focused studies, EDV studies, data mining projects, and program evaluations for Arkansas, Colorado, Michigan, Tennessee, and Ohio. Ms. Berrett's responsibilities included developing project methodologies and providing meaningful input to states throughout the development, execution, and reporting of healthcare quality projects. She worked with the State of Colorado to develop and execute a multi-year Member Health Messages quality activity targeting members who had not received recommended preventive services. Using a pseudo-control group, she evaluated the impact of an intervention to inform quality improvement activities. Ms. Berrett led extensive data mining and evaluation projects for the State of Arkansas, including the use of claims data to address utilization of dental services among children with respect to changes in prior authorization policies. She also led an assessment of utilization and expenditures associated with rehabilitative services for members with mental illnesses.

HSAG, Healthcare Analyst III, Research & Analysis: Ms. Berrett was responsible for conducting descriptive and statistical analysis of patterns of care and outcomes, validating results from other analysts, and preparing reports for dissemination and presentations. She conducted literature searches and reviews, assisted in designing statistical analysis plans, and defined case selection criteria and variable parameters.

Arizona Department of Health Services (ADHS), Bureau of Women's and Children's Health, Injury Epidemiologist (Epidemiologist II): Ms. Berrett was responsible for statewide surveillance of mortality and morbidity resulting from injuries using the State and Territorial Injury Prevention Directors Association (STIPDA)-recommended injury surveillance data sources in an SAS programming environment. Working with a small team, she completed and presented findings from the annual Child Fatality Review Report required by Arizona Revised Statute §36-3501 to support the development of actionable injury prevention recommendations. She facilitated the timely fulfillment of injury data requests and authored data products for ADHS health priorities and injury prevention program evaluations. Ms. Berrett also used geographic information system (GIS) software to support stakeholders in building statewide injury prevention capacity.

Maricopa County Department of Public Health, Quantitative Epidemiologist, Office of Epidemiology: Ms. Berrett generated annual health status reports, including the cleaning and analysis of natality, mortality, and infectious disease data. She used SAS 9.1 to create automated quality assurance reports for vital registration data. She was responsible for the timely fulfillment of data requests from internal and public entities. Ms. Berrett used GIS software to geocode data points and create maps for presentation to department directors.

Professional History

HSAG, Phoenix, Arizona: Associate Director, DSAA (06/2015–present); Senior Healthcare Analyst, Research & Analysis (07/2012–06/2015); Healthcare Analyst III, Research & Analysis (12/2011–07/2012); 12/2011–present

ADHS, Phoenix, Arizona: Bureau of Women's and Children's Health, Injury Epidemiologist (Epidemiologist II); 07/2008–12/2011

Maricopa County Department of Public Health, Phoenix, Arizona: Quantitative Epidemiologist, Office of Epidemiology; 04/2006–07/2008

Arizona Cancer Center, Tucson, Arizona: Student Assistant, Quantitative Histopathology Laboratory; 09/2004–05/2006

Education

Master of Public Health, Epidemiology, University of Arizona, Tucson, Arizona, 2006

Bachelor of Arts, History, Washington University in St. Louis, St. Louis, Missouri, 2004

Skills

SAS; ArcGIS software suite; Quest Analytics Suite; Microsoft Office Suite, ICD-9-CM and ICD-10-CM coding

References

Below are three references who can attest to Ms. Berrett's competence and skill level.

Reference #1

Name, Title:	Barbara McConnell, Executive Director, State & Corporate Services
Address:	Health Services Advisory Group, Inc. 3133 East Camelback Road, Suite 100 Phoenix, AZ 85016
Phone #:	720.697.7903
Email:	bmcconnell@hsag.com

Reference #2

Name, Title:	Jay Dunkleberger, Network Administrator, Division of Health Care Management
Address:	Arizona Health Care Cost Containment System 701 East Jefferson Street, Mail Drop 6100 Phoenix, AZ 85034
Phone #:	602.417.4249
Email:	jay.dunkleberger@azahcccs.gov

Reference #3

Name, Title:	Curt Curnow, Quality Improvement Section Manager, Office of Cost Control & Quality Improvement
Address:	Colorado Department of Health Care Policy & Financing 1570 Grant Street Denver, CO 80203
Phone #:	303.887.3001
Email:	curt.curnow@state.co.us

Prashanthinie Mohan, DrPH, MBA
Analyst II, Data Science & Advanced Analytics

Qualification Highlights

Dr. Mohan has over 10 years of experience in the healthcare industry with expertise in research, data analysis, and project management. She has led data analysis for multiple healthcare projects focused on assessing large datasets to identify opportunities for process improvement, cost optimization, and patient engagement at the hospital, county, state, and national levels. She has also published several papers and policy briefs on varied health topics.

Relevant Experience

HSAG, Analyst II, Data Science & Advanced Analytics (DSAA): Dr. Mohan is involved with developing and executing analytic plans for various types of health data. Her responsibilities include designing studies, developing statistical models, manipulating complex databases, performing data analyses and validation, and communicating project findings both internally and externally.

University of Arizona, Research/Program Coordinator, UA Health Sciences/Liver Research Institute: Dr. Mohan designed quantitative models to assess cost-effectiveness and return on investment on various patient-focused programs such as pharmacogenetic screening and patient navigation. She analyzed national-level health datasets using programs such as Microsoft (MS) Excel, SAS, and ArcGIS mapping software. She co-led a research study to assess the economic burden of hospitalization on cirrhosis patients. She supported multiple research studies by assisting with data collection, statistical analysis, manuscript preparation, and publication.

University of Arizona, Graduate Research Assistant, Center for Population Health: Dr. Mohan assessed feasibility of insurance coverage for various women-focused initiatives such as doula birth support, Medicaid dental coverage for pregnant women, and contraceptives for Arizona. She prepared policy briefs for the Director of Arizona Department of Health Services and state legislators to report study findings. She managed a research study in a large hospital to evaluate the impact of social support systems and care transition programs on patient readmission rates and quality of life. Dr. Mohan researched and analyzed population health indicators for Arizona counties using primary and secondary sources to identify health priorities and gaps in data.

Professional History

HSAG, Phoenix, Arizona: Analyst II, DSAA; 05/2020–present

University of Arizona, Tucson, Arizona: Research/Program Coordinator, UA Health Sciences (11/2018–03/2020); Research/Program Coordinator, Liver Research Institute (01/2018–06/2018); Graduate Research Assistant, Center for Population Health (08/2015–12/2017); 08/2015–03/2020

HomeFoodFinder.com, Chennai, India: Co-Founder, Chief Technology Officer; 08/2013–04/2015

Hallmark Healthcare Solutions, Dallas, Texas: Project Manager; 10/2010–02/2015

Independent, Dallas, Texas: Consultant; 12/2009–09/2010

Deloitte, Deloitte, India: Senior Analyst; 05/2007–09/2009

Education

Doctor of Public Health, Policy & Management, Minor in Health and Pharmaceutical Outcomes, University of Arizona, Tucson, Arizona, 2020

Master of Business Administration, Finance, Symbiosis Center for Management and Human Resource Development, Pimpri-Chinchwad, India, 2007

Bachelor of Commerce, Madras University, Chennai, India, 2004

Certifications

Certified Management Accountant, Institute of Cost Accountants of India, 2008

Select Publications

Mohan, P., Roubal, A., Humble, W., Calhoun, E. (2016). Doula Coverage to Help Minimize Arizona's Birth Woes. Published by UA Center for Population Science & Discovery.

Mohan, P., Roubal, A., Humble, W., Calhoun, E. (2016). A Case for Medicaid Dental Coverage for Pregnant Women. Published by UA Center for Population Science & Discovery.

Mohan, P., Roubal, A., Humble, W., Calhoun, E. (2016). Long Acting Reversible Contraceptives (LARCs): Efficacy & Cost Effectiveness. Published by UA Center for Population Science & Discovery.

Desai, A. P., Mohan, P., Nokes, B., Sheth, D., Knapp, S., Boustani, M., ... & Calhoun, E. A. (2019). Increasing Economic Burden in Hospitalized Patients with Cirrhosis: Analysis of a National Database. Clinical and translational gastroenterology, 10(7).

Molina, Y., Khanna, A.S., Watson, K.S., Villines, D., Bergeron, N., Strayhorn, S., Strahan, D., Skwara, A., Cronin, M., Mohan, P., Walton, S., Wang, T., Schneider, J.A, & Calhoun, E.A. (2019). Leveraging system sciences methods in clinical trial evaluation: An example concerning African American women diagnosed with breast cancer via the Patient Navigation in Medically Underserved Areas Study. Contemporary Clinical Trials Communication. In press.

Mohan, P., Tey, K. R., Liu, X., & Desai, A. P. (2018). Closing the Quality Chasm in Cirrhosis. Clinical Liver Disease, 12(2), 45-49.

Desai, A. P., Mohan, P., Roubal, A., Bettencourt, R., & Loomba, R. (2018). Geographic Variability in Liver Disease Related Mortality Rates in the United States. The American Journal of Medicine.

Miller, J. M., Harvey, E. M., Bedrick, S., Mohan, P., & Calhoun, E. (2018). Simple patient care instructions translate best: Safety guidelines for physician use of Google translate. Journal of Clinical Outcomes Management, 25(1).

Skills

Healthcare research design and hypothesis testing, cost-effectiveness analysis, health outcomes assessment, SAS (data analysis tool).

References

Below are three references who can attest to Dr. Mohan's competence and skill level.

Reference #1

Name, Title:	Leslie Arendell, Associate Director
Address:	Health Services Advisory Group, Inc. 3133 East Camelback Road, Suite 100 Phoenix, AZ 85016
Phone #:	602.801.6877
Email:	LArendell@hsag.com

Reference #2

Name, Title:	Elizabeth Calhoun, Executive Director, Center for Population Health Sciences
Address:	University of Arizona 1515 North Campbell Avenue Tucson, AZ 85724
Phone #:	520.626.9921
Email:	Ecalhoun.arizona.edu

Reference #3

Name, Title:	Patrick Wightman, Director, Health Analytics
Address:	University of Arizona 1515 North Campbell Avenue Tucson, AZ 85724
Phone #:	520.626.9021
Email:	Wightman@arizona.edu

Joe Mireles, MPH, BS
Analyst II, Data Science & Advanced Analytics

Qualification Highlights

Mr. Mireles has more than 12 years of experience in the healthcare and public health industries with expertise in research, informatics, data collection and analysis, technical assistance, and reporting.

Relevant Experience

HSAG, Analyst II, Data Science & Advanced Analytics (DSAA): Mr. Mireles's primary responsibilities include conducting accurate research and literature review, performing quantitative and statistical analysis, and drafting reports for assigned projects that are important to state Medicaid customers. He works as a member of the team to validate results from other analysts and assists in designing methodology and analysis plans. Mr. Mireles also, upon request, assists in developing study methodology, developing appropriate statistical models, determining sample sizes, manipulating complex databases, and tracking and evaluating patterns of care and outcomes. He verifies and ensures the accuracy of all assigned tasks, including the documentation and validation of computer programs.

Arizona Department of Health Services, Epidemiologist II: Mr. Mireles improved the informatics, data collection, and data reporting abilities of the Section of Discharge Data and Cost Reporting. He was tasked with developing the 2014 Hospital Compare website using the Agency for Healthcare Research and Quality (AHRQ) software, SQL server, and the manipulation of hospital discharge datasets. Mr. Mireles also produced data reports based on the analysis and monitoring of discharge data. He produced data sets for internal reports and external data requests and analyzed surveillance system (PRISM) data using SAS and Microsoft Excel to evaluate healthcare outcomes and patterns of care. Mr. Mireles authored the 2011 and 2012 Arizona Sexually Transmitted Disease Yearly Report and worked with county health departments and local American Indian tribes to coordinate public health responses to syphilis outbreaks.

Maricopa County Department of Public Health, Epidemiologist: Mr. Mireles was the lead contact investigator for tuberculosis cases. He presented and summarized patient information for the infectious disease physicians and was responsible for case management.

Professional History

HSAG, Phoenix, Arizona: Analyst II, DSAA; 10/2016–present

Arizona Department of Health Services, Phoenix, Arizona: Epidemiologist II; 04/2011–10/2016

Maricopa County Department of Public Health, Phoenix, Arizona: Epidemiologist; 11/2009–04/2011

Texas Department of State Health Services, El Paso, Texas: Epidemiologist; 06/2008–11/2009

North Texas Institute for Clinical Trials, Fort Worth, Texas: Clinical Research Intern; 01/2008–05/2008

University of North Texas Health Science Center, Fort Worth, Texas: Research Technician; 08/2006–05/2008

University of Texas Health Science Center, San Antonio, Texas: Research Technician; 05/2005–07/2006

Education

Master of Public Health, Epidemiology, University of North Texas Health Science Center, Fort Worth, Texas, 2008

Bachelor of Science, Microbiology, University of Texas at Austin, Texas, 1999

Select Publications

Mireles, J.R., Ereth, R., Taylor, M.M. "Use of Historical Limits Method to Detect Increases in Primary and Secondary Syphilis: An Exploratory Study". Sexually Transmitted Diseases 2016; 43: 402-406.

Mireles, J.R. "Potential unblinding in a crossover trial of cannabis cigarettes for relief of neuropathic pain." Epidemiologic Focus, 1. e4. (2008).

Dhar R, Persaud SD, Mireles JR, Basu A. "Proteolytic cleavage of p70 ribosomal S6 kinase by caspase-3 during DNA damage-induced apoptosis." Biochemistry. 2009 Feb 24;48(7):1474-80.

Ramanujan V.K., Mireles J.R., and Herman B.A. "Time-resolved nanoscale imaging of biomolecules in living cells and tissues: prospects for small animal imaging.", Proc. SPIE Vol. 6089, 608901 (Feb. 15, 2006).

Mireles J.R., Toguchi A., Harshey R.M., "Salmonella enterica serovar typhimurium swarming mutants with altered biofilm-forming abilities: surfactin inhibits biofilm formation.", Journal of Bacteriology. 2001 Oct; 183(20):5848-54.

Skills

SAS statistical software, Quest Analytics software, and ArcGIS mapping software. Fluent in Spanish.

References

Below are three references who can attest to Mr. Mireles' competence and skill level.

Reference #1

Name, Title:	Donna Courtney, Manager, Department of Hospital Discharge Data
Address:	Arizona Department of Health Services 150 North 18th Avenue Phoenix, AZ 85007
Phone #:	602.542.0833
Email:	Donna.Courtney@azdhs.gov

Reference #2

Name, Title:	Roxanne Ereth, Manager, Sexually Transmitted Diseases Department
Address:	Arizona Department of Health Services 150 North 18th Avenue Phoenix, AZ 85007
Phone #:	602.542.0833
Email:	Roxanne.Ereth@azdhs.gov

Reference #3

Name, Title:	Renuka Khurana, MD, Medical Director, Maricopa County STD/TB Clinic
Address:	Maricopa County Department of Public Health 1645 East Roosevelt Street Phoenix, AZ 85006
Phone #:	602.506.1678
Email:	Renuka.Khurana@maricopa.gov

Raymond Berens, BA
Associate Director, Data Science & Advanced Analytics

Qualification Highlights

Mr. Berens has more than nine years of experience performing, designing, and overseeing analyses of healthcare performance measure data and calculating performance measures using administrative and medical record review data. He has experience developing state Medicaid quality rating systems (QRSs) and pay-for-performance (P4P) program algorithms, selecting metrics for inclusion in payment algorithms, and determining P4P incentive payments. He has also evaluated programs across a myriad of evaluation units, including analyses performed at the statewide, health plan, nursing home, and hospital levels.

Relevant Experience

HSAG, Associate Director, Data Science & Advanced Analytics (DSAA): Mr. Berens is responsible for providing process oversight, analytical expertise, technical interpretive writing, and project management support within DSAA. He assists in the day-to-day project management and analytic activities related to state performance measure reporting, the calculation of performance measures, and the California Department of Public Health (CDPH) Skilled Nursing Facility (SNF) Quality and Accountability Supplemental Payment (QASP) Program. In his role leading performance measure calculation activities within DSAA, Mr. Berens has provided oversight of the calculation of Healthcare Effectiveness Data and Information Set (HEDIS®)[1] and HEDIS-like performance measures for multiple state Medicaid agencies including Arizona, Arkansas, California, Colorado, Iowa, Nevada, New Hampshire, Ohio, and Virginia. He has overseen performance measure calculation requiring the use of administrative claims/encounter data, supplemental registry data, medical record review data, and minimum data set (MDS) 3.0 data. Mr. Berens also has experience developing measure specifications for state Medicaid agencies in instances where national measures are not available for a specific focus area. In his oversight of DSAA state reporting activities, Mr. Berens oversees the collection of Centers for Medicare & Medicaid Services (CMS) Adult Core and Child Core performance measure data, Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[2] survey data, HEDIS data for use in the creation of QRSs used by consumers to choose a Medicaid health plan, HEDIS aggregate reports, and the inclusion of performance measure results in external quality review (EQR) technical reports. For the CDPH SNF QASP Program activities, Mr. Berens researches, evaluates, and recommends new measures for inclusion in the program; assists in the development of online quality improvement tools that are provided to SNFs participating in the QASP Program; and oversees the final evaluation of SNFs participating in the program for the determination of incentive payments.

HSAG, Senior Analyst, DSAA: Mr. Berens was responsible for overseeing activities associated with performance measure calculation for the Medicaid agencies in Arizona, Arkansas, Colorado, Iowa, Nevada, New Hampshire, Ohio, and Virginia. He evaluated Medicaid survey data for many state Medicaid agencies including Arizona, Colorado, Hawaii, Michigan, New Hampshire, Ohio, and Washington. Mr. Berens used HEDIS performance measure rates and

[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[2] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

CAHPS survey results to develop QRSs that are issued by states to assist Medicaid beneficiaries in selecting a health plan.

HSAG, Informatics Analyst III, Analytics & Informatics (A&I): Mr. Berens was responsible for leading informatics activities associated with performance measure calculation for various state Medicaid agencies. He calculated performance measure rates and produced reports in a format suitable to meet customers' needs. Mr. Berens was responsible for assisting CDPH in calculating performance measures rates for the implementation of the statutorily required SNF QASP Program.

HSAG, Informatics Analyst II/Lead Analyst, A&I: Mr. Berens wrote code to calculate HEDIS and CMS Adult Core measure rates for Ohio's Adult Medicaid Quality Grant and external quality review organization (EQRO) contracts. He performed analyses for the Arkansas EQRO contract using the New York University algorithm to analyze nonemergent emergency department use in the State. He also worked on CAHPS and provider survey activities for Hawaii's Department of Human Services, Med-QUEST Division.

HSAG, Informatics Analyst I, A&I: As part of the CMS Partnership for Patients (PfP) project evaluation contract, Mr. Berens worked with CMS to evaluate the PfP initiative, which encompassed approximately 4,000 hospitals. He aggregated the most recently available hospital data to aid in evaluating national trends in both adverse event and readmission rates.

HSAG, Informatics Analytic Specialist, A&I: Mr. Berens assisted the lead analyst on the Colorado and Hawaii CAHPS survey activities to validate their results.

Professional History

HSAG, Phoenix, Arizona: Associate Director, DSAA (10/2017–present); Senior Analyst, DSAA (05/2016–10/2017); Informatics Analyst III, A&I (05/2015–05/2016); Informatics Analyst II/Lead Analyst, A&I (06/2013–04/2015); Informatics Analyst I, A&I (08/2012–06/2013); Informatics Analytic Specialist, A&I (08/2011–08/2012); 08/2011–present

University of Phoenix, Phoenix, Arizona: Finance Advisor; 2009–2011

Mesa Unified School District, Mesa, Arizona: Substitute Teacher; 2008–2009

King's Ridge Middle School, Phoenix, Arizona: Math Teacher, 8th Grade; 2005–2008

Education

Bachelor of Arts, Mathematics, magna cum laude, Arizona State University, Tempe, Arizona, 2004

Skills

Experienced SAS user; proficient in calculating and evaluating performance measures and in using Microsoft operating systems.

References

Below are three references who can attest to Mr. Berens' competence and skill level.

Reference #1

Name, Title:	Ryan Fair, Executive Technical Director
Address:	Health Services Advisory Group, Inc. 3133 East Camelback Road, Suite 100 Phoenix, AZ 85016
Phone #:	602.801.6812
Email:	rfair@hsag.com

Reference #2

Name, Title:	Brittany Baarson, Informatics Analyst
Address:	Phoenix Children's Hospital 1919 E. Thomas Road Phoenix, AZ 85016
Phone #:	480.262.9742
Email:	brittanybaarson@gmail.com

Reference #3

Name, Title:	Marianne Clinch, Project Manager, Retired
Address:	Private (retired) Phoenix, AZ 85021
Phone #:	602.618.8705
Email:	maclinch@cox.net

Amber Saldivar, MHSM, BS
Senior Director, Analytics & Surveys, Data Science & Advanced Analytics

Qualification Highlights

Ms. Saldivar has more than 15 years of experience in the healthcare industry, with expertise in research, analysis, and reporting. Ms. Saldivar's experience includes more than 13 years assisting state Medicaid agencies with various external quality review (EQR) activities. She has extensive knowledge and experience analyzing data at various organizational levels, including analyses performed at the patient, provider, health plan, practice, hospital, and nursing home levels. Ms. Saldivar has expertise in survey analytic activities, including Consumer Assessment of Healthcare Providers and Systems (CAHPS®),[1] quality of life, and provider surveys; performance measure development and calculations (e.g., Healthcare Effectiveness Data and Information Set [HEDIS®],[2] Centers for Medicare & Medicaid Services [CMS], and custom measures); and explaining performance variation and trends in metrics.

Ms. Saldivar oversees and directs all Data Science & Advanced Analytics (DSAA) activities for HSAG's Quality Improvement Network-Quality Improvement Organization (QIN-QIO) contract with CMS. She works with multiple teams to assess the organization's performance on the different evaluation metrics set by the QIN-QIO scope of work. Ms. Saldivar also oversees the production of provider-specific analyses and provides technical assistance to support QIN-QIO goals. She has experience working with an array of data sources to support quality improvement efforts across these contracts—including Medicare claims (Parts A, B, and D), National Healthcare Safety Network (NHSN), Minimum Data Set (MDS), and Outcome and Assessment Information Set (OASIS)—and uses these data, in addition to self-reported data, to monitor HSAG's continuous quality improvement plans.

Relevant Experience

HSAG, Senior Director, Analytics & Surveys, DSAA: Ms. Saldivar oversees and directs all Medicaid-targeted survey activities, including CAHPS, provider, and custom surveys. She is responsible for overseeing the data management, sampling, and analysis functions for several Medicaid EQR projects involving the administration of thousands of annual surveys to adult and child members in state Medicaid, waiver, and expansion programs. Ms. Saldivar is responsible for developing sound sampling and analytic methodologies to ensure survey results yield meaningful information. Ms. Saldivar oversees analytic activities related to HSAG's QIN-QIO contracts for Arizona and California. Additionally, she provides technical assistance to support contract goals for Medicare beneficiaries, such as improving beneficiary and family-centered care; reducing healthcare-associated infections, healthcare-acquired conditions, and adverse drug events; and improving prevention, early diagnosis, and care transitions.

HSAG, Director, DSAA: Ms. Saldivar oversaw and directed all Medicaid-targeted survey activities. Her responsibilities also included overseeing the data management and analysis functions for several Medicaid EQR projects, as well as directing survey planning, data submissions, data analysis, and report production. Ms. Saldivar also served as the lead analyst for

[1] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
[2] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

performance measure calculation, and she calculated HEDIS-like measures using state encounter data and nursing home quality measures using MDS data. Ms. Saldivar oversaw analytic activities on HSAG's QIN-QIO contracts for California, Arizona, Florida, Ohio, and the U.S. Virgin Islands. She provided technical assistance to support contract goals for Medicare beneficiaries. In addition, Ms. Saldivar provided support for the CMS Financial Alignment Initiative Support contract, which supported implementation of state demonstration programs for individuals enrolled in both Medicare and Medicaid (dual-eligible) and that tested new approaches to providing high-quality care to dual-eligible beneficiaries while controlling costs. She directed HSAG's activities on this contract, with specific focus on managing the monitoring activities to ensure delivery of consistent, high-quality care and access for new enrollees throughout the demonstration period. Ms. Saldivar developed the reporting requirements documents and data collection system to obtain data on new measures developed for the demonstration.

HSAG, Senior Informatics Analyst, Informatics: Ms. Saldivar provided support with daily CAHPS survey responsibilities, including survey management functions such as subcontractor and customer interactions. Her responsibilities also included assisting with survey planning, data submissions, data analysis, report production, and report automation. In addition, Ms. Saldivar worked on CMS' Hospital Outpatient Quality Reporting Program project. Her responsibilities included coordinating measures and data elements specifications, data management, and data support.

HSAG, Informatics Analyst, Informatics: Ms. Saldivar served as the lead analyst for CAHPS surveys. She performed analyses for several survey activities, including Medicaid CAHPS, care management, and quality of life surveys.

HSAG, Project Coordinator, Informatics: Ms. Saldivar was responsible for the project duties for the CMS special study, Identification and Synthesis of Components Essential to Achieving "High Performers" Status in Various Provider Types. She used a qualitative analysis program to assess data captured through key hospital personnel interviews and developed a report that identified the key elements distinguishing high performers from non-high performers.

Professional History

HSAG, Phoenix, Arizona: Senior Director, Analytics & Surveys, DSAA (07/2019–present); Director, DSAA (10/2012–06/2019); Senior Informatics Analyst, Informatics (01/2011–10/2012); Informatics Analyst, Informatics (10/2007–01/2011); Project Coordinator, Informatics (01/2006–10/2007); Graduate Intern, Informatics (04/2005–12/2005); 04/2005–present

Arizona State University, Tempe, Arizona: Graduate Research Assistant; 08/2004–04/2005

Education & Training

Master of Health Sector Management, Arizona State University, Tempe, Arizona, 2005

Bachelor of Science, Finance, Arizona State University, Tempe, Arizona, 2003

Presentations

Saldivar A. Community Tenure Alternate Methodology. National Coordinating Center Care Coordination Office Hours Call; April 2018

Saldivar A., Dalton T. Data-Driven Approach to QIN-QIO Recruitment. Presented at the CMS Healthcare Quality Conference; December 2014

References

Below are three references who can attest to Ms. Saldivar's competence and skill level.

Reference #1

Name, Title:	Tim Laios, Chief Data Officer & Vice President, DSAA
Address:	Health Services Advisory Group, Inc. 3133 East Camelback Road, Suite 100 Phoenix, AZ 85016
Phone #:	602.801.6822
Email:	tlaios@hsag.com

Reference #2

Name, Title:	Terri Pennington, Nurse Manager, Business Analytics & Information
Address:	North Carolina Medicaid Division of Health Benefits Business & Analytics Office 1985 Umstead Drive, Kirby Building Raleigh, NC 27603
Phone #:	919.527.7127
Email:	terri.pennington@dhhs.nc.gov

Reference #3

Name, Title:	Russell Kennedy, Quality Program Manager
Address:	Colorado Department of Health Care Policy & Financing Cost Control and Quality Improvement Office 1570 Grant Street Denver, CO 80203
Phone #:	303.866.3340
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Alicja Wierzchowska, MA, BA
Associate Director, Reports Team

Qualification Highlights

Ms. Wierzchowska has 20 years of experience in the healthcare industry with expertise in developing, writing, and editing a variety of technical manuals, marketing/advertising copy, journals, and research support data. Ms. Wierzchowska has been a member of the HSAG Reports Team since its inception in 2002.

Relevant Experience

HSAG, Associate Director, Reports Team: Ms. Wierzchowska provides direction and leadership to the Reports Team, including prioritizing critical tasks, scheduling assignments, and measuring progress according to schedules developed in conjunction with executive directors and project managers. She is responsible for working with analysts and management to translate the complexities of data analysis and research findings into direct and concise reports that meet client needs. Ms. Wierzchowska formats, compiles, and reviews a wide variety of reports for state Medicaid programs including California, Colorado, and Michigan. She has worked on external quality review organization (EQRO) contract deliverables, including performance measure validation reports, encounter data validation reports, compliance monitoring reports, and technical reports.

HSAG, Project Manager II, Reports Team: Ms. Wierzchowska created and formatted reports, report templates, and other tools. She edited and published reports. She managed a wide array of deliverables including project/template design and assisted with request for proposal (RFP)-related tasks.

HSAG, Senior Technical Writer/Technical Writer: Ms. Wierzchowska edited, formatted, and prepared reports for publication, creating report templates and other tools. She worked with management and analysts on report organization. She created, organized, managed, and edited technical reports for state Medicaid programs. She held a government clearance to work on TRICARE National Quality Monitoring and Department of Homeland Security reports.

The Hired Pen, Inc., Writer/Editor/Office Manager: Ms. Wierzchowska wrote copy for advertising, marketing, business, and creative purposes. She edited manuscripts, technical manuals, and business material; supervised office staff; and oversaw all office functions.

The Elder Care Journal, Associate Editor/Writer: Ms. Wierzchowska edited, formatted, and prepared the layout of a monthly journal. She wrote articles relevant to the elder care industry, researched topics, and provided ongoing assistance to staff.

Acacia Publishing, Inc., Editor: Ms. Wierzchowska prepared manuscripts for publication, including editing, formatting, and researching. She provided assistance to bolster product appeal and sales.

Professional History

HSAG, Phoenix, Arizona: Associate Director, Reports Team; (03/2014–present); Project Manager II, Reports Team (06/2013–03/2014); Senior Technical Writer (04/2005–06/2013); Technical Writer (01/2002–03/2005); 01/2002–present

The Hired Pen, Inc., Phoenix, Arizona: Writer/Editor/Office Manager; 05/2000–01/2002

The Elder Care Journal, Phoenix, Arizona: Associate Editor/Writer; 05/2000–01/2002

Acacia Publishing, Inc., Phoenix, Arizona: Editor; 05/2000–01/2002

Motorola, Phoenix, Arizona: Contractor; 09/2001–01/2002

Arizona State University Memorial Union, Tempe, Arizona: Building Manager; 02/1998–08/1999

Education

Master of Arts, English Literature, Arizona State University, Tempe, Arizona, 1999

Bachelor of Arts, English Literature, Arizona State University, Tempe, Arizona, 1997

Skills

Proficient in Windows 10; Microsoft Word, Visio, PowerPoint, and Excel.

References

Below are three references who can attest to Ms. Wierzchowska's competence and skill level.

Reference #1

Name, Title:	Patty Ferry, Executive Director, State & Corporate Services
Address:	Health Services Advisory Group, Inc. 3133 East Camelback Road, Suite 100 Phoenix, AZ 85016
Phone #:	517.282.2816
Email:	pferry@hsag.com

Reference #2

Name, Title:	Marilea Rose, Retired, Senior Audit Consultant
Address:	Private (retired) Pine, AZ 85544
Phone #:	602.739.5763
Email:	azmlrose98@gmail.com

Reference #3

Name, Title:	Carrie Gillon, Editor
Address:	Quick Brown Fox Consulting 4005 North 14th Avenue Phoenix, AZ 85013
Phone #:	480.399.9165
Email:	carrie.gillon@gmail.com

Stephanie Mathews, BA
Technical Writer/Editor, Reports Team

Qualification Highlights

Ms. Mathews has 17 years of experience in technical editing/writing, word processing, and document support with recognized strengths in document formatting, template creation, and organization.

Relevant Experience

HSAG, Technical Writer/Editor: Ms. Mathews is responsible for reviewing and editing a variety of reports, proposals, and other documents produced by HSAG for local, state, and federal agencies. She works with key staff members in multiple departments to ensure deliverables meet the highest quality standards in terms of readability, structure, grammar, punctuation, and word use. Ms. Mathews is also responsible for fact-checking, restructuring, and refining written material to produce thorough, clear, and professional reports.

InDepth Corporation, Technical Editor: Ms. Mathews was responsible for editing various company documents—including large reports, proposals, and letters—for content, grammar, syntax, and formatting. She prepared technical reports and proposals with various company divisions and project teams and created templates, marketing documents, and forms. Ms. Mathews also designed, created, and managed internal and external Microsoft (MS) SharePoint sites.

Brown and Caldwell, Word Processor III: Ms. Mathews managed the production of hard copy deliverables and electronic documents. She was responsible for editing various company documents for content, grammar, syntax, and formatting. She completed multiple projects with hard deadlines for several different office locations across the country and designed, wrote, and produced a regional newsletter.

RMT, Inc., Document Processor: Ms. Mathews was responsible for editing all company documents, maintained a document files database, and prepared and produced all hard copy and electronic documents. In addition, she designed, wrote, and produced a quarterly informational newsletter.

EES Group, Technical Writer: Ms. Mathews prepared technical reports from field notes and proofread and formatted all other technical documentation. She also provided research support for expert witness cases.

Professional History

HSAG, Columbus, Ohio: Technical Writer/Editor, Reports Team; 09/2017–present

InDepth Corporation, Columbus, Ohio: Technical Editor; 07/2012–04/2017

Brown and Caldwell, Dublin, Ohio: Word Processor III; 04/2010–07/2012

RMT, Inc., Dublin, Ohio: Document Processor; 04/2005–03/2010

ESS Group, Dublin, Ohio: Technical Writer; 01/2003–05/2005

Education

Bachelor of Arts, English, The Ohio State University, Columbus, Ohio, 2001

Skills

Proficient in Windows 10; MS Word, Excel, PowerPoint, SharePoint, and Visio; and Adobe Acrobat Pro.

References

Below are three references who can attest to Ms. Mathews' competence and skill level.

Reference #1

Name, Title:	Merilee Carter, Technical Writer, Senior
Address:	Health Services Advisory Group, Inc. 3133 East Camelback Road, Suite 100 Phoenix, AZ 85016
Phone #:	614.221.2080
Email:	MCarter@hsag.com

Reference #2

Name, Title:	Kristall Day, Associate Professor of Education
Address:	Ohio Dominican University 1216 Sunbury Road Columbus, OH 43219
Phone #:	614.599.8901
Email:	dayk@ohiodominican.edu

Reference #3

Name, Title:	Mike Skiles, System Administrator
Address:	Porter Wright Morris & Arthur, LLP 41 South High Street, Suites 2800–3200 Columbus, OH 43215
Phone #:	614.227.1905
Email:	MSkiles@porterwright.com

Cost Proposal

Response to Request for Proposal RFP 6303 Z1

State of Nebraska Department of Health and Human Services

External Quality Reviews

October 30, 2020
2:00 pm Central Time

Health Services Advisory Group, Inc. • 3133 East Camelback Road, Suite 100 • Phoenix, Arizona 85016
Phone: 602.801.6600 • Fax: 602.801.6051

COST PROPOSAL

RFP 6303 Z1

Instructions: *Please complete all blank fields in the Cost Proposal below. File should retain formatting and font styles, including a minimum of 12 point Arial-type font with 0.5" margins. An estimate of one hundred twenty (120) hours per year of Ad-hoc Technical Assistance and Consultation will be used to calculate the score for cost.*

Deliverable ID	Description	Period of Review	Due Date	Unit of Measure	Cost per Unit (Initial Term)	Cost per Unit (Renewal 1)	Cost per Unit (Renewal 2)	Cost per Unit (Renewal 3)
1.	EQR Report- MCO	previous three-year period	Annually, by October 15	Each	$44,171	$45,955	$46,874	$47,811
2.	EQR Report Report-DBM	previous three-year period	Annually, by October 15	Each	$44,171	$45,955	$46,874	$47,811
3.	Validation of Performance Improvement Projects (PIPs) Report- MCO	Previous calendar year	Annually, by December 31	Each	$6,388	$6,646	$6,779	$6,915
4.	Validation of Performance Improvement Projects (PIPs) Report- DBM	Previous calendar year	Annually, by December 31	Each	$6,388	$6,646	$6,779	$6,915
5.	Validation of Performance Measures Report-MCO	Previous calendar year	Annually, by December 31	Each	$7,392	$7,691	$7,845	$8,002

6.	Validation of Performance Measures Report-DBM	Previous calendar year	Annually, by December 31	Each	$7,392	$7,691	$7,845	$8,002

Ad-Hoc Services:

Deliverable ID	Description	Period of Review	Due Date	Unit of Measure	Cost per Unit (Initial Term)	Cost per Unit (Optional Renewal 1)	Cost per Unit (Optional Renewal 2)	Cost per Unit (Optional Renewal 3)
7.	Validation of Network Adequacy Report-MCO	Previous calendar year	Per Work Plan	Each	$15,398	$20,622	$21,034	$21,455
8.	Validation of Network Adequacy Report-DBM	Previous calendar year	Per Work Plan	Each	$15,398	$20,622	$21,034	$21,455
9.	Ad-hoc Technical Assistance and Consultation	Not applicable	Upon request	Hour	$145	$151	$154	$157

Optional Services:

Work may be needed that was not originally delineated in this RFP, but considered within the scope of work. This additional work may stem from legislative mandates, emerging technologies, and/or secondary research not otherwise addressed in this RFP or known at the time this RFP was issued. If additional work is needed, the Contractor must submit a Detailed Project Work Plan, Title/Role(s), number of hours, and due dates/deliverables for DHHS review and approval.

Deliverable ID	Description	Period of Review	Due Date	Unit of Measure	Cost per Unit (Initial Term)	Cost per Unit (Optional Renewal 1)	Cost per Unit (Optional Renewal 2)	Cost per Unit (Optional Renewal 3)
10.	Ad-hoc Report	Per Work Plan	Per Work Plan	Each	As needed			

The bidder should provide the hourly rate for each Title/Role used to complete optional services.

Title/Role*	Hourly Rate
Project Director	$197.00
Director, DSAA	$177.00
Project Manager	$147.00
Senior Analyst	$127.00
Analyst	$107.00
Analytics Coordinator	$77.00

*Bidder may add additional lines as needed.

HEALSER-02 MSIDDAPPA

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 2/5/2021

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER License # 0C36861 Phoenix-Alliant Insurance Services, Inc. 2415 E Camelback Rd Ste 950 Phoenix, AZ 85016	CONTACT NAME: Leanne Moyzes PHONE (A/C, No, Ext): (602) 707-1895 FAX (A/C, No): E-MAIL ADDRESS: Leanne.Moyzes@Alliant.com
INSURED Health Services Holdings, Inc. | Health Services Advisory Group, Inc. 3133 East Camelback Rd., Ste 100 Phoenix, AZ 85016	INSURER(S) AFFORDING COVERAGE — NAIC # INSURER A : Hiscox Insurance Company Inc. — 10200 INSURER B : INSURER C : INSURER D : INSURER E : INSURER F :

COVERAGES **CERTIFICATE NUMBER:** **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$
	☐ OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	☐ ANY AUTO						BODILY INJURY (Per person)	$
	☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	☐ UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
	☐ EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DED ☐ RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N						☐ PER STATUTE ☐ OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? ☐ (Mandatory in NH)	N / A					E.L. EACH ACCIDENT	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
A	Cyber Liability			MPL1581928.20	7/1/2020	7/1/2021	Ea Claim/Aggregate	10,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

CYBER LIABILITY: Policy Maximum Limit of Liability: $10,000,000 Each Claim or Event / $10,000,000 Aggregate / Retention: $100,000 Each Claim or Event

CERTIFICATE HOLDER

Department of Health and Human Services
Division of Medicaid and Long-Term Care
Attn: EQRO Contract Manager
301 Centennial Mall S., 5th fl
Lincoln, NE 68509

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

HEALSER-02 MSIDDAPPA

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 2/5/2021

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IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER License # 0C36861
Phoenix-Alliant Insurance Services, Inc.
2415 E Camelback Rd Ste 950
Phoenix, AZ 85016

CONTACT NAME: Leanne Moyzes
PHONE (A/C, No, Ext): (602) 707-1895 FAX (A/C, No):
E-MAIL ADDRESS: Leanne.Moyzes@Alliant.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Hartford Underwriters Insurance Company	30104
INSURER B : Trumbull Insurance Company	27120
INSURER C : Hartford Casualty Insurance Company	29424
INSURER D : Hartford Insurance Group	00914
INSURER E :	
INSURER F :	

INSURED
Health Services Holdings, Inc. | Health Services Advisory Group, Inc.
3133 East Camelback Rd., Ste 100
Phoenix, AZ 85016

COVERAGES **CERTIFICATE NUMBER:** **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$ 1,000,000
	CLAIMS-MADE X OCCUR	X	X	59 UUN ZM6078	7/1/2020	7/1/2021	DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 300,000
							MED EXP (Any one person)	$ 5,000
							PERSONAL & ADV INJURY	$ 1,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$ 2,000,000
	X POLICY PRO-JECT LOC						PRODUCTS - COMP/OP AGG	$ 2,000,000
	OTHER:							$
B	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$ 1,000,000
	ANY AUTO						BODILY INJURY (Per person)	$
	OWNED AUTOS ONLY / SCHEDULED AUTOS	X	X	59 UUN ZM6078	7/1/2020	7/1/2021	BODILY INJURY (Per accident)	$
	X HIRED AUTOS ONLY / X NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
C	X UMBRELLA LIAB X OCCUR						EACH OCCURRENCE	$ 10,000,000
	EXCESS LIAB CLAIMS-MADE			59 RHU ZM4623	7/1/2020	7/1/2021	AGGREGATE	$ 10,000,000
	DED X RETENTION $ 10,000							$
D	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N						X PER STATUTE / OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? N (Mandatory in NH)	N / A	X	59 WE ZJ2839	7/1/2020	7/1/2021	E.L. EACH ACCIDENT	$ 1,000,000
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$ 1,000,000
							E.L. DISEASE - POLICY LIMIT	$ 1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

Certificate Holder and any entity listed below are included as additional insured per written contract or agreement as respects to General Liability per attached forms. General Liability is Primary & Non-Contributory per written contract or agreement and attached forms.
Waiver of Subrogation applies as respects to General Liability per written contract or agreement and attached forms. 30 Day Notice of Cancellation endorsement (except 10 Days for non-payment) applies to General Liability if required by contract; such notice does not apply if not required.

Certificate Holder and any entity listed below are included as additional insured as respects to Automobile Liability per written contract or agreement and attached forms with respect to liability arising out of the activities performed by, or on behalf of the Contractor, including automobiles owned, leased, hired or SEE ATTACHED ACORD 101

CERTIFICATE HOLDER

Department of Health and Human Services
Division of Medicaid and Long-Term Care
Attn: EQRO Contract Manager
301 Centennial Mall S., 5th fl
Lincoln, NE 68509

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

AGENCY CUSTOMER ID: HEALSER-02 MSIDDAPPA

LOC #: 1

ADDITIONAL REMARKS SCHEDULE

AGENCY	License # 0C36861	NAMED INSURED
Phoenix-Alliant Insurance Services, Inc.		Health Services Holdings, Inc. | Health Services Advisory Group, Inc. 3133 East Camelback Rd., Ste 100 Phoenix, AZ 85016
POLICY NUMBER		
SEE PAGE 1		
CARRIER	NAIC CODE	EFFECTIVE DATE: SEE PAGE 1
SEE PAGE 1	SEE P 1	

ADDITIONAL REMARKS

THIS ADDITIONAL REMARKS FORM IS A SCHEDULE TO ACORD FORM,

FORM NUMBER: ACORD 25 FORM TITLE: Certificate of Liability Insurance

Description of Operations/Locations/Vehicles:
borrowed by the Contractor. 30 Day Notice of Cancellation endorsement (except 10 Days for non-payment) applies to General Liability if required by contract; such notice does not apply if not required.

Waiver of Subrogation applies as respects to Workmans Compensation per written contract and attached forms. 30 Day Notice of Cancellation endorsement (except 10 Days for non-payment) applies to General Liability if required by contract; such notice does not apply if not required.

The State of Nebraska and Department of Health and Human Services are included as Additional Insured for all liability arising from the Contract.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

NOTICE OF CANCELLATION TO CERTIFICATE HOLDER(S)

This policy is subject to the following additional Conditions:

A. If this policy is cancelled by the Company, other than for nonpayment of premium, notice of such cancellation will be provided at least thirty (30) days in advance of the cancellation effective date to the certificate holder(s) with mailing addresses on file with the agent of record or the Company.

B. If this policy is cancelled by the Company for nonpayment of premium, or by the insured, notice of such cancellation will be provided within (10) days of the cancellation effective date to the certificate holder(s) with mailing addresses on file with the agent of record or the Company.

If notice is mailed, proof of mailing to the last known mailing address of the certificate holder(s) on file with the agent of record or the Company will be sufficient proof of notice.

Any notification rights provided by this endorsement apply only to active certificate holder(s) who were issued a certificate of insurance applicable to this policy's term.

Failure to provide such notice to the certificate holder(s) will not amend or extend the date the cancellation becomes effective, nor will it negate cancellation of the policy. Failure to send notice shall impose no liability of any kind upon the Company or its agents or representatives.

COMMERCIAL GENERAL LIABILITY COVERAGE FORM

Various provisions in this policy restrict coverage. Read the entire policy carefully to determine rights, duties and what is and is not covered.

Throughout this policy the words "you" and "your" refer to the Named Insured shown in the Declarations, and any other person or organization qualifying as a Named Insured under this policy. The words "we", "us" and "our" refer to the stock insurance company member of The Hartford providing this insurance.

The word "insured" means any person or organization qualifying as such under Section **II** – Who Is An Insured.

Other words and phrases that appear in quotation marks have special meaning. Refer to Section **V** – Definitions.

SECTION I – COVERAGES

COVERAGE A BODILY INJURY AND PROPERTY DAMAGE LIABILITY

1. Insuring Agreement

a. We will pay those sums that the insured becomes legally obligated to pay as damages because of "bodily injury" or "property damage" to which this insurance applies. We will have the right and duty to defend the insured against any "suit" seeking those damages. However, we will have no duty to defend the insured against any "suit" seeking damages for "bodily injury" or "property damage" to which this insurance does not apply. We may, at our discretion, investigate any "occurrence" and settle any claim or "suit" that may result. But:

(1) The amount we will pay for damages is limited as described in Section **III** – Limits Of Insurance; and

(2) Our right and duty to defend ends when we have used up the applicable limit of insurance in the payment of judgments or settlements under Coverages **A** or **B** or medical expenses under Coverage **C.**

No other obligation or liability to pay sums or perform acts or services is covered unless explicitly provided for under Supplementary Payments – Coverages **A** and **B.**

b. This insurance applies to "bodily injury" and "property damage" only if:

(1) The "bodily injury" or "property damage" is caused by an "occurrence" that takes place in the "coverage territory";

(2) The "bodily injury" or "property damage" occurs during the policy period; and

(3) Prior to the policy period, no insured listed under Paragraph **1.** of Section **II** – Who Is An Insured and no "employee" authorized by you to give or receive notice of an "occurrence" or claim, knew that the "bodily injury" or "property damage" had occurred, in whole or in part. If such a listed insured or authorized "employee" knew, prior to the policy period, that the "bodily injury" or "property damage" occurred, then any continuation, change or resumption of such "bodily injury" or "property damage" during or after the policy period will be deemed to have been known prior to the policy period.

c. "Bodily injury" or "property damage" will be deemed to have been known to have occurred at the earliest time when any insured listed under Paragraph **1.** of Section **II** – Who Is An Insured or any "employee" authorized by you to give or receive notice of an "occurrence" or claim:

(1) Reports all, or any part, of the "bodily injury" or "property damage" to us or any other insurer;

(2) Receives a written or verbal demand or claim for damages because of the "bodily injury" or "property damage"; or

(3) Becomes aware by any other means that "bodily injury" or "property damage" has occurred or has begun to occur.

d. Damages because of "bodily injury" include damages claimed by any person or organization for care, loss of services or death resulting at any time from the "bodily injury".

e. Incidental Medical Malpractice And Good Samaritan Coverage

"Bodily injury" arising out of the rendering of or failure to render the following health care services by any "employee" or "volunteer worker" shall be deemed to be caused by an "occurrence" for:

(1) Professional health care services such as:

(a) Medical, surgical, dental, laboratory, x-ray or nursing services or treatment, advice or instruction, or the related furnishing of food or beverages;

(b) Any health or therapeutic service, treatment, advice or instruction; or

(c) The furnishing or dispensing of drugs or medical, dental, or surgical supplies or appliances; or

(2) First aid services, which include:

(a) Cardiopulmonary resuscitation, whether performed manually or with a defibrillator; or

(b) Services performed as a Good Samaritan.

For the purpose of determining the limits of insurance, any act or omission together with all related acts or omissions in the furnishing of these services to any one person will be considered one "occurrence".

However, this Incidental Medical Malpractice And Good Samaritan Coverage provision applies only if you are not engaged in the business or occupation of providing any of the services described in this provision.

2. Exclusions

This insurance does not apply to:

a. Expected Or Intended Injury

"Bodily injury" or "property damage" expected or intended from the standpoint of the insured. This exclusion does not apply to "bodily injury" or "property damage" resulting from the use of reasonable force to protect persons or property.

b. Contractual Liability

"Bodily injury" or "property damage" for which the insured is obligated to pay damages by reason of the assumption of liability in a contract or agreement. This exclusion does not apply to liability for damages:

(1) That the insured would have in the absence of the contract or agreement; or

(2) Assumed in a contract or agreement that is an "insured contract", provided the "bodily injury" or "property damage" occurs subsequent to the execution of the contract or agreement. Solely for the purposes of liability assumed in an "insured contract", reasonable attorney fees and necessary litigation expenses incurred by or for a party other than an insured are deemed to be damages because of "bodily injury" or "property damage", provided:

(a) Liability to such party for, or for the cost of, that party's defense has also been assumed in the same "insured contract"; and

(b) Such attorney fees and litigation expenses are for defense of that party against a civil or alternative dispute resolution proceeding in which damages to which this insurance applies are alleged.

c. Liquor Liability

"Bodily injury" or "property damage" for which any insured may be held liable by reason of:

(1) Causing or contributing to the intoxication of any person;

(2) The furnishing of alcoholic beverages to a person under the legal drinking age or under the influence of alcohol; or

(3) Any statute, ordinance or regulation relating to the sale, gift, distribution or use of alcoholic beverages.

This exclusion applies even if the claims against any insured allege negligence or other wrongdoing in:

(a) The supervision, hiring, employment, training or monitoring of others by that insured; or

(b) Providing or failing to provide transportation with respect to any person that may be under the influence of alcohol;

if the "occurrence" which caused the "bodily injury" or "property damage", involved that which is described in Paragraph **(1)**, **(2)** or **(3)** above.

However, this exclusion applies only if you are in the business of manufacturing, distributing, selling, serving or furnishing alcoholic beverages. For the purposes of this exclusion, permitting a person to bring alcoholic beverages on your premises, for consumption on your premises, whether or not a fee is charged or a license is required for such activity, is not by itself considered the business of selling, serving or furnishing alcoholic beverages.

d. Workers' Compensation And Similar Laws

Any obligation of the insured under a workers' compensation, disability benefits or unemployment compensation law or any similar law.

e. Employer's Liability

"Bodily injury" to:

(1) An "employee" of the insured arising out of and in the course of:

(a) Employment by the insured; or

(b) Performing duties related to the conduct of the insured's business; or

(2) The spouse, child, parent, brother or sister of that "employee" as a consequence of Paragraph (1) above**.**

This exclusion applies:

(1) Whether the insured may be liable as an employer or in any other capacity; and

(2) To any obligation to share damages with or repay someone else who must pay damages because of the injury.

This exclusion does not apply to liability assumed by the insured under an "insured contract".

f. Pollution

(1) "Bodily injury" or "property damage" arising out of the actual, alleged or threatened discharge, dispersal, seepage, migration, release or escape of "pollutants":

(a) At or from any premises, site or location which is or was at any time owned or occupied by, or rented or loaned to, any insured. However, this subparagraph does not apply to:

(i) "Bodily injury" if sustained within a building and caused by smoke, fumes, vapor or soot produced by or originating from equipment that is used to heat, cool or dehumidify the building, or equipment that is used to heat water for personal use, by the building's occupants or their guests;

(ii) "Bodily injury" or "property damage" for which you may be held liable, if you are a contractor and the owner or lessee of such premises, site or location has been added to your policy as an additional insured with respect to your ongoing operations performed for that additional insured at that premises, site or location and such premises, site or location is not and never was owned or occupied by, or rented or loaned to, any insured, other than that additional insured; or

(iii) "Bodily injury" or "property damage" arising out of heat, smoke or fumes from a "hostile fire";

(b) At or from any premises, site or location which is or was at any time used by or for any insured or others for the handling, storage, disposal, processing or treatment of waste;

(c) Which are or were at any time transported, handled, stored, treated, disposed of, or processed as waste by or for:

(i) Any insured; or

(ii) Any person or organization for whom you may be legally responsible;

(d) At or from any premises, site or location on which any insured or any contractors or subcontractors working directly or indirectly on any insured's behalf are performing operations if the "pollutants" are brought on or to the premises, site or location in connection with such operations by such insured, contractor or subcontractor. However, this subparagraph does not apply to:

(i) "Bodily injury" or "property damage" arising out of the escape of fuels, lubricants or other operating fluids which are needed to perform the normal electrical, hydraulic or mechanical functions necessary for the operation of "mobile equipment" or its parts, if such fuels, lubricants or other operating fluids escape from a vehicle part designed to hold, store or receive them. This exception does not apply if the "bodily injury" or "property damage" arises out of the intentional discharge, dispersal or release of the fuels, lubricants or other operating fluids, or if such fuels, lubricants or other operating fluids are brought on or to the premises, site or location with the intent that they be discharged, dispersed or released as part of the operations being performed by such insured, contractor or subcontractor**;**

(ii) "Bodily injury" or "property damage" sustained within a building and caused by the release of gases, fumes or vapors from materials brought into that building in connection with operations being performed by you or on your behalf by a contractor or subcontractor; or

(iii) "Bodily injury" or "property damage" arising out of heat, smoke or fumes from a "hostile fire"; or

(e) At or from any premises, site or location on which any insured or any contractors or subcontractors working

directly or indirectly on any insured's behalf are performing operations if the operations are to test for, monitor, clean up, remove, contain, treat, detoxify or neutralize, or in any way respond to, or assess the effects of, "pollutants".

(2) Any loss, cost or expense arising out of any:

(a) Request, demand, order or statutory or regulatory requirement that any insured or others test for, monitor, clean up, remove, contain, treat, detoxify or neutralize, or in any way respond to, or assess the effects of, "pollutants"; or

(b) Claim or suit by or on behalf of a governmental authority for damages because of testing for, monitoring, cleaning up, removing, containing, treating, detoxifying or neutralizing, or in any way responding to, or assessing the effects of, "pollutants".

However, this paragraph does not apply to liability for damages because of "property damage" that the insured would have in the absence of such request, demand, order or statutory or regulatory requirement, or such claim or "suit" by or on behalf of a governmental authority.

g. Aircraft, Auto Or Watercraft

"Bodily injury" or "property damage" arising out of the ownership, maintenance, use or entrustment to others of any aircraft, "auto" or watercraft owned or operated by or rented or loaned to any insured. Use includes operation and "loading or unloading".

This exclusion applies even if the claims against any insured allege negligence or other wrongdoing in the supervision, hiring, employment, training or monitoring of others by that insured, if the "occurrence" which caused the "bodily injury" or "property damage" involved the ownership, maintenance, use or entrustment to others of any aircraft, "auto" or watercraft that is owned or operated by or rented or loaned to any insured.

This exclusion does not apply to:

(1) A watercraft while ashore on premises you own or rent;

(2) A watercraft you do not own that is:

(a) Less than 51 feet long; and

(b) Not being used to carry persons for a charge;

(3) Parking an "auto" on, or on the ways next to, premises you own or rent, provided the "auto" is not owned by or rented or loaned to you or the insured;

(4) Liability assumed under any "insured contract" for the ownership, maintenance or use of aircraft or watercraft;

(5) "Bodily injury" or "property damage" arising out of:

(a) The operation of machinery or equipment that is attached to, or part of, a land vehicle that would qualify under the definition of "mobile equipment" if it were not subject to a compulsory or financial responsibility law or other motor vehicle insurance law where it is licensed or principally garaged; or

(b) The operation of any of the machinery or equipment listed in Paragraph **f.(2)** or **f.(3)** of the definition of "mobile equipment"; or

(6) An aircraft that is not owned by any insured and is hired, chartered or loaned with a paid crew. However, this exception does not apply if the insured has any other insurance for such "bodily injury" or "property damage", whether the other insurance is primary, excess, contingent or on any other basis.

h. Mobile Equipment

"Bodily injury" or "property damage" arising out of:

(1) The transportation of "mobile equipment" by an "auto" owned or operated by or rented or loaned to any insured; or

(2) The use of "mobile equipment" in, or while in practice for, or while being prepared for, any prearranged racing, speed, demolition, or stunting activity.

i. War

"Bodily injury" or "property damage", however caused, arising, directly or indirectly, out of:

(1) War, including undeclared or civil war;

(2) Warlike action by a military force, including action in hindering or defending against an actual or expected attack, by any government, sovereign or other authority using military personnel or other agents; or

(3) Insurrection, rebellion, revolution, usurped power, or action taken by governmental authority in hindering or defending against any of these.

j. Damage To Property

"Property damage" to:

(1) Property you own, rent, or occupy, including any costs or expenses incurred by you, or any other person, organization or entity, for repair, replacement, enhancement, restoration or maintenance of such property for any reason, including prevention of injury to a person or damage to another's property;

(2) Premises you sell, give away or abandon, if the "property damage" arises out of any part of those premises;

(3) Property loaned to you;

(4) Personal property in the care, custody or control of the insured;

(5) That particular part of real property on which you or any contractors or subcontractors
working directly or indirectly on your behalf are performing operations, if the "property damage" arises out of those operations; or

(6) That particular part of any property that must be restored, repaired or replaced because "your work" was incorrectly performed on it.

Paragraphs **(1), (3)** and **(4)** of this exclusion do not apply to "property damage" (other than damage by fire) to premises, including the contents of such premises, rented to you for a period of seven or fewer consecutive days. A separate limit of insurance applies to Damage To Premises Rented To You as described in Section **III** – Limits Of Insurance.

Paragraph **(2)** of this exclusion does not apply if the premises are "your work" and were never occupied, rented or held for rental by you.

Paragraphs **(3)** and **(4)** of this exclusion do not apply to "property damage" arising from the use of elevators.

Paragraphs **(3), (4), (5)** and **(6)** of this exclusion do not apply to liability assumed under a sidetrack agreement.

Paragraphs **(3)** and **(4)** of this exclusion do not apply to "property damage" to borrowed equipment while not being used to perform operations at the job site.

Paragraph **(6)** of this exclusion does not apply to "property damage" included in the "products-completed operations hazard".

k. Damage To Your Product

"Property damage" to "your product" arising out of it or any part of it.

l. Damage To Your Work

"Property damage" to "your work" arising out of it or any part of it and included in the "products-completed operations hazard".

This exclusion does not apply if the damaged work or the work out of which the damage arises was performed on your behalf by a subcontractor.

m. Damage To Impaired Property Or Property Not Physically Injured

"Property damage" to "impaired property" or property that has not been physically injured, arising out of:

(1) A defect, deficiency, inadequacy or dangerous condition in "your product" or "your work"; or

(2) A delay or failure by you or anyone acting on your behalf to perform a contract or agreement in accordance with its terms.

This exclusion does not apply to the loss of use of other property arising out of sudden and accidental physical injury to "your product" or "your work" after it has been put to its intended use.

n. Recall Of Products, Work Or Impaired Property

Damages claimed for any loss, cost or expense incurred by you or others for the loss of use, withdrawal, recall, inspection, repair, replacement, adjustment, removal or disposal of:

(1) "Your product";

(2) "Your work"; or

(3) "Impaired property";

if such product, work, or property is withdrawn or recalled from the market or from use by any person or organization because of a known or suspected defect, deficiency, inadequacy or dangerous condition in it.

o. Personal And Advertising Injury

"Bodily injury" arising out of "personal and advertising injury".

p. Access or Disclosure Of Confidential Or Personal Information And Data-related Liability

Damages arising out of:

(1) Any access to or disclosure of any person's or organization's confidential or personal information, including patents, trade secrets, processing methods, customer lists, financial information, credit card information, health information or any other type of nonpublic information; or

(2) The loss of, loss of use of, damage to, corruption of, inability to access, or inability to manipulate electronic data.

This exclusion applies even if damages are claimed for notification costs, credit monitoring expenses, forensic expenses,

public relations expenses or any other loss, cost or expense incurred by you or others arising out of that which is described in Paragraph **(1)** or **(2)** above.

However, unless Paragraph **(1)** above applies, this exclusion does not apply to damages because of "bodily injury".

As used in this exclusion, electronic data means information, facts or programs stored as or on, created or used on, or transmitted to or from computer software, including systems and applications software, hard or floppy disks, CD-ROMS, tapes, drives, cells, data processing devices or any other media which are used with electronically controlled equipment.

q. Employment-Related Practices

"Bodily injury" to:

(1) A person arising out of any "employment–related practices"; or

(2) The spouse, child, parent, brother or sister of that person as a consequence of "bodily injury" to that person at whom any "employment-related practices" are directed.

This exclusion applies:

(1) Whether the injury-causing event described in the definition of "employment-related practices" occurs before employment, during employment or after employment of that person;

(2) Whether the insured may be liable as an employer or in any other capacity; and

(3) To any obligation to share damages with or repay someone else who must pay damages because of the injury.

r. Asbestos

(1) "Bodily injury" or "property damage" arising out of the "asbestos hazard".

(2) Any damages, judgments, settlements, loss, costs or expenses that:

(a) May be awarded or incurred by reason of any claim or suit alleging actual or threatened injury or damage of any nature or kind to persons or property which would not have occurred in whole or in part but for the "asbestos hazard";

(b) Arise out of any request, demand, order or statutory or regulatory requirement that any insured or others test for, monitor, clean up, remove, encapsulate, contain, treat, detoxify or neutralize or in any way respond to or assess the effects of an "asbestos hazard"; or

(c) Arise out of any claim or suit for damages because of testing for, monitoring, cleaning up, removing, encapsulating, containing, treating, detoxifying or neutralizing or in any way responding to or assessing the effects of an "asbestos hazard".

s. Recording And Distribution Of Material Or Information In Violation Of Law

"Bodily injury" or "property damage" arising directly or indirectly out of any action or omission that violates or is alleged to violate:

(1) The Telephone Consumer Protection Act (TCPA), including any amendment of or addition to such law;

(2) The CAN-SPAM Act of 2003, including any amendment of or addition to such law;

(3) The Fair Credit Reporting Act (FCRA), and any amendment of or addition to such law, including the Fair and Accurate Credit Transaction Act (FACTA); or

(4) Any federal, state or local statute, ordinance or regulation, other than the TCPA or CAN-SPAM Act of 2003 or FCRA and their amendments and additions, that addresses, prohibits or limits the printing, dissemination, disposal, collecting, recording, sending, transmitting, communicating or distribution of material or information.

Damage To Premises Rented To You – Exception For Damage By Fire, Lightning Or Explosion

Exclusions **c.** through **h.** and **j.** through **n.** do not apply to damage by fire, lightning or explosion to premises while rented to you or temporarily occupied by you with permission of the owner. A separate limit of insurance applies to this coverage as described in Section **III** – Limits Of Insurance.

COVERAGE B PERSONAL AND ADVERTISING INJURY LIABILITY

1. Insuring Agreement

a. We will pay those sums that the insured becomes legally obligated to pay as damages because of "personal and advertising injury" to which this insurance applies. We will have the right and duty to defend the insured against any "suit" seeking those damages. However, we will have no duty to defend the insured against any "suit" seeking damages for "personal and advertising injury" to which this insurance does not apply. We may, at our

discretion, investigate any offense and settle any claim or "suit" that may result. But:

(1) The amount we will pay for damages is limited as described in Section **III** – Limits Of Insurance; and

(2) Our right and duty to defend end when we have used up the applicable limit of insurance in the payment of judgments or settlements under Coverages **A** or **B** or medical expenses under Coverage **C.**

No other obligation or liability to pay sums or perform acts or services is covered unless explicitly provided for under Supplementary Payments – Coverages **A** and **B.**

b. This insurance applies to "personal and advertising injury" caused by an offense arising out of your business but only if the offense was committed in the "coverage territory" during the policy period.

2. Exclusions

This insurance does not apply to:

a. Knowing Violation Of Rights Of Another

"Personal and advertising injury" arising out of an offense committed by, at the direction or with the consent or acquiescence of the insured with the expectation of inflicting "personal and advertising injury".

b. Material Published With Knowledge Of Falsity

"Personal and advertising injury" arising out of oral, written or electronic publication, in any manner, of material, if done by or at the direction of the insured with knowledge of its falsity.

c. Material Published Prior To Policy Period

"Personal and advertising injury" arising out of oral, written or electronic publication, in any manner, of material whose first publication took place before the beginning of the policy period.

d. Criminal Acts

"Personal and advertising injury" arising out of a criminal act committed by or at the direction of the insured.

e. Contractual Liability

"Personal and advertising injury" for which the insured has assumed liability in a contract or agreement. This exclusion does not apply to liability for damages that the insured would have in the absence of the contract or agreement.

f. Breach Of Contract

"Personal and advertising injury" arising out of a breach of contract, except an implied contract to use another's "advertising idea" in your "advertisement".

g. Quality Or Performance Of Goods – Failure To Conform To Statements

"Personal and advertising injury" arising out of the failure of goods, products or services to conform with any statement of quality or performance made in your "advertisement".

h. Wrong Description Of Prices

"Personal and advertising injury" arising out of the wrong description of the price of goods, products or services.

i. Infringement Of Intellectual Property Rights

(1) "Personal and advertising injury" arising out of any actual or alleged infringement or violation of any intellectual property rights such as copyright, patent, trademark, trade name, trade secret, trade dress, service mark or other designation of origin or authenticity; or

(2) Any injury or damage alleged in any clam or "suit" that also alleges an infringement or violation of any intellectual property right, whether such allegation of infringement or violation is made by you or by any other party involved in the claim or "suit", regardless of whether this insurance would otherwise apply.

However, this exclusion does not apply if the only allegation in the claim or "suit" involving any intellectual property right is limited to:

(1) Infringement, in your "advertisement", of:

(a) Copyright;

(b) Slogan; or

(c) Title of any literary or artistic work; or

(2) Copying, in your "advertisement", a person’s or organization’s "advertising idea" or style of "advertisement".

j. Insureds In Media And Internet Type Businesses

"Personal and advertising injury" committed by an insured whose business is:

(1) Advertising, broadcasting, publishing or telecasting;

(2) Designing or determining content of web sites for others; or

(3) An Internet search, access, content or service provider.

However, this exclusion does not apply to Paragraphs **a., b.** and **c.** of the definition of "personal and advertising injury" under the Definitions Section.

For the purposes of this exclusion, the placing of frames, borders or links, or advertising, for you or others anywhere on the Internet, is not by itself, considered the business of advertising, broadcasting, publishing or telecasting.

k. Electronic Chatrooms Or Bulletin Boards

"Personal and advertising injury" arising out of an electronic chatroom or bulletin board the insured hosts, owns, or over which the insured exercises control.

l. Unauthorized Use Of Another's Name Or Product

"Personal and advertising injury" arising out of the unauthorized use of another's name or product in your e-mail address, domain name or metatags, or any other similar tactics to mislead another's potential customers.

m. Pollution

"Personal and advertising injury" arising out of the actual, alleged or threatened discharge, dispersal, seepage, migration, release or escape of "pollutants" at any time.

n. Pollution-Related

Any loss, cost or expense arising out of any:

(1) Request, demand, order or statutory or regulatory requirement that any insured or others test for, monitor, clean up, remove, contain, treat, detoxify or neutralize, or in any way respond to, or assess the effects of, "pollutants"; or

(2) Claim or suit by or on behalf of a governmental authority for damages because of testing for, monitoring, cleaning up, removing, containing, treating, detoxifying or neutralizing, or in any way responding to, or assessing the effects of, "pollutants".

o. War

"Personal and advertising injury", however caused, arising, directly or indirectly, out of:

(1) War, including undeclared or civil war;

(2) Warlike action by a military force, including action in hindering or defending against an actual or expected attack, by any government, sovereign or other authority using military personnel or other agents; or

(3) Insurrection, rebellion, revolution, usurped power, or action taken by governmental authority in hindering or defending against any of these.

p. Internet Advertisements And Content Of Others

"Personal and advertising injury" arising out of:

(1) An "advertisement" for others on your web site;

(2) Placing a link to a web site of others on your web site;

(3) Content, including information, sounds, text, graphics, or images from a web site of others displayed within a frame or border on your web site; or

(4) Computer code, software or programming used to enable:

(a) Your web site; or

(b) The presentation or functionality of an "advertisement" or other content on your web site.

q. Right Of Privacy Created By Statute

"Personal and advertising injury" arising out of the violation of a person's right of privacy created by any state or federal act.

However, this exclusion does not apply to liability for damages that the insured would have in the absence of such state or federal act.

r. Violation Of Anti-Trust law

"Personal and advertising injury" arising out of a violation of any anti-trust law.

s. Securities

"Personal and advertising injury" arising out of the fluctuation in price or value of any stocks, bonds or other securities.

t. Recording And Distribution Of Material Or Information In Violation Of Law

"Personal and advertising injury" arising directly or indirectly out of any action or omission that violates or is alleged to violate:

(1) The Telephone Consumer Protection Act (TCPA), including any amendment of or addition to such law;

(2) The CAN-SPAM Act of 2003, including any amendment of or addition to such law;

(3) The Fair Credit Reporting Act (FCRA), and any amendment of or addition to such law, including the Fair and Accurate Credit Transaction Act (FACTA); or

(4) Any federal, state or local statute, ordinance or regulation, other than the TCPA or CAN-SPAM Act of 2003 or FCRA and their amendments and additions, that addresses, prohibits or limits the printing, dissemination, disposal, collecting, recording, sending, transmitting, communicating or distribution of material or information.

u. Employment-Related Practices

"Personal and advertising injury" to:

(1) A person arising out of any "employment–related practices"; or

(2) The spouse, child, parent, brother or sister of that person as a consequence of "personal and advertising injury" to that person at whom any "employment-related practices" are directed.

This exclusion applies:

(1) Whether the injury-causing event described in the definition of "employment-related practices" occurs before employment, during employment or after employment of that person;

(2) Whether the insured may be liable as an employer or in any other capacity; and

(3) To any obligation to share damages with or repay someone else who must pay damages because of the injury.

v. Asbestos

(1) "Personal and advertising injury" arising out of the "asbestos hazard".

(2) Any damages, judgments, settlements, loss, costs or expenses that:

(a) May be awarded or incurred by reason of any claim or suit alleging actual or threatened injury or damage of any nature or kind to persons or property which would not have occurred in whole or in part but for the "asbestos hazard";

(b) Arise out of any request, demand, order or statutory or regulatory requirement that any insured or others test for, monitor, clean up, remove, encapsulate, contain, treat, detoxify or neutralize or in any way respond to or assess the effects of an "asbestos hazard"; or

(c) Arise out of any claim or suit for damages because of testing for, monitoring, cleaning up, removing, encapsulating, containing, treating, detoxifying or neutralizing or in any way responding to or assessing the effects of an "asbestos hazard".

w. Access Or Disclosure Of Confidential Or Personal Information

"Personal and advertising injury" arising out of any access to or disclosure of any person's or organization's confidential or personal information, including patents, trade secrets, processing methods, customer lists, financial information, credit card information, health information or any other type of nonpublic information.

This exclusion applies even if damages are claimed for notification costs, credit monitoring expenses, forensic expenses, public relations expenses or any other loss, cost or expense incurred by you or others arising out of any access to or disclosure of any person's or organization's confidential or personal information.

COVERAGE C MEDICAL PAYMENTS

1. Insuring Agreement

a. We will pay medical expenses as described below for "bodily injury" caused by an accident:

(1) On premises you own or rent;

(2) On ways next to premises you own or rent; or

(3) Because of your operations;

provided that:

(1) The accident takes place in the "coverage territory" and during the policy period;

(2) The expenses are incurred and reported to us within three years of the date of the accident; and

(3) The injured person submits to examination, at our expense, by physicians of our choice as often as we reasonably require.

b. We will make these payments regardless of fault. These payments will not exceed the applicable limit of insurance. We will pay reasonable expenses for:

(1) First aid administered at the time of an accident;

(2) Necessary medical, surgical, X-ray and dental services, including prosthetic devices; and

(3) Necessary ambulance, hospital, professional nursing and funeral services.

2. Exclusions

We will not pay expenses for "bodily injury":

a. Any Insured

To any insured, except "volunteer workers".

b. Hired Person

To a person hired to do work for or on behalf of any insured or a tenant of any insured.

c. Injury On Normally Occupied Premises

To a person injured on that part of premises you own or rent that the person normally occupies.

d. Workers Compensation And Similar Laws

To a person, whether or not an "employee" of

any insured, if benefits for the "bodily injury" are payable or must be provided under a workers' compensation or disability benefits law or a similar law.

e. Athletics Activities

To a person injured while practicing, instructing or participating in any physical exercises or games, sports, or athletic contests.

f. Products-Completed Operations Hazard

Included within the "products-completed operations hazard".

g. Coverage A Exclusions

Excluded under Coverage **A**.

SUPPLEMENTARY PAYMENTS – COVERAGES A AND B

1. We will pay, with respect to any claim we investigate or settle, or any "suit" against an insured we defend:

a. All expenses we incur.

b. Up to $1,000 for cost of bail bonds required because of accidents or traffic law violations arising out of the use of any vehicle to which the Bodily Injury Liability Coverage applies. We do not have to furnish these bonds.

c. The cost of appeal bonds or bonds to release attachments, but only for bond amounts within the applicable limit of insurance. We do not have to furnish these bonds.

d. All reasonable expenses incurred by the insured at our request to assist us in the investigation or defense of the claim or "suit", including actual loss of earnings up to $500 a day because of time off from work.

e. All court costs taxed against the insured in the "suit". However, such costs do not include attorneys' fees, attorneys' expenses, witness or expert fees, or any other expenses of a party taxed to the insured.

f. Prejudgment interest awarded against the insured on that part of the judgment we pay. If we make an offer to pay the applicable limit of insurance, we will not pay any prejudgment interest based on that period of time after the offer.

g. All interest on the full amount of any judgment that accrues after entry of the judgment and before we have paid, offered to pay, or deposited in court the part of the judgment that is within the applicable limit of insurance.

These payments will not reduce the limits of insurance.

2. If we defend an insured against a "suit" and an indemnitee of the insured is also named as a party to the "suit", we will defend that indemnitee if all of the following conditions are met:

a. The "suit" against the indemnitee seeks damages for which the insured has assumed the liability of the indemnitee in a contract or agreement that is an "insured contract";

b. This insurance applies to such liability assumed by the insured;

c. The obligation to defend, or the cost of the defense of, that indemnitee, has also been assumed by the insured in the same "insured contract";

d. The allegations in the "suit" and the information we know about the "occurrence" are such that no conflict appears to exist between the interests of the insured and the interests of the indemnitee;

e. The indemnitee and the insured ask us to conduct and control the defense of that indemnitee against such "suit" and agree that we can assign the same counsel to defend the insured and the indemnitee; and

f. The indemnitee:

(1) Agrees in writing to:

(a) Cooperate with us in the investigation, settlement or defense of the "suit";

(b) Immediately send us copies of any demands, notices, summonses or legal papers received in connection with the "suit";

(c) Notify any other insurer whose coverage is available to the indemnitee; and

(d) Cooperate with us with respect to coordinating other applicable insurance available to the indemnitee; and

(2) Provides us with written authorization to:

(a) Obtain records and other information related to the "suit"; and

(b) Conduct and control the defense of the indemnitee in such "suit".

So long as the above conditions are met, attorneys' fees incurred by us in the defense of that indemnitee, necessary litigation expenses incurred by us and necessary litigation expenses incurred by the indemnitee at our request will be paid as Supplementary Payments. Notwithstanding the provisions of Paragraph **2.b.(2)** of Section **I** – Coverage **A** – Bodily Injury And Property Damage Liability, such payments will not be deemed to be damages for "bodily injury" and "property damage" and will not reduce the limits of insurance.

Our obligation to defend an insured's indemnitee and to pay for attorneys' fees and necessary litigation expenses as Supplementary Payments ends when:

a. We have used up the applicable limit of insurance in the payment of judgments or settlements; or

b. The conditions set forth above, or the terms of the agreement described in Paragraph **f.** above, are no longer met.

SECTION II – WHO IS AN INSURED

1. If you are designated in the Declarations as:

a. An individual, you and your spouse are insureds, but only with respect to the conduct of a business of which you are the sole owner.

b. A partnership or joint venture, you are an insured. Your members, your partners, and their spouses are also insureds, but only with respect to the conduct of your business.

c. A limited liability company, you are an insured. Your members are also insureds, but only with respect to the conduct of your business. Your managers are insureds, but only with respect to their duties as your managers.

d. An organization other than a partnership, joint venture or limited liability company, you are an insured. Your "executive officers" and directors are insureds, but only with respect to their duties as your officers or directors. Your stockholders are also insureds, but only with respect to their liability as stockholders.

e. A trust, you are an insured. Your trustees are also insureds, but only with respect to their duties as trustees.

2. Each of the following is also an insured:

a. Employees And Volunteer Workers

Your "volunteer workers" only while performing duties related to the conduct of your business, or your "employees", other than either your "executive officers" (if you are an organization other than a partnership, joint venture or limited liability company) or your managers (if you are a limited liability company), but only for acts within the scope of their employment by you or while performing duties related to the conduct of your business.

However, none of these "employees" or "volunteer workers" are insureds for:

(1) "Bodily injury" or "personal and advertising injury":

(a) To you, to your partners or members (if you are a partnership or joint venture), to your members (if you are a limited liability company), to a co-"employee" while in the course of his or her employment or performing duties related to the conduct of your business, or to your other "volunteer workers" while performing duties related to the conduct of your business;

(b) To the spouse, child, parent, brother or sister of that co-"employee" or that "volunteer worker" as a consequence of Paragraph **(1)(a)** above;

(c) For which there is any obligation to share damages with or repay someone else who must pay damages because of the injury described in Paragraphs **(1)(a)** or **(1)(b)** above; or

(d) Arising out of his or her providing or failing to provide professional health care services.

If you are not in the business of providing professional health care services:

(a) Subparagraphs **(1)(a)**, **(1)(b)** and **(1)(c)** above do not apply to any "employee" or "volunteer worker" providing first aid services; and

(b) Subparagraph **(1)(d)** above does not apply to any nurse, emergency medical technician or paramedic employed by you to provide such services.

(2) "Property damage" to property:

(a) Owned, occupied or used by,

(b) Rented to, in the care, custody or control of, or over which physical control is being exercised for any purpose by

you, any of your "employees", "volunteer workers", any partner or member (if you are a partnership or joint venture), or any member (if you are a limited liability company).

b. Real Estate Manager

Any person (other than your "employee" or "volunteer worker"), or any organization while acting as your real estate manager.

c. Temporary Custodians Of Your Property

Any person or organization having proper temporary custody of your property if you die, but only:

(1) With respect to liability arising out of the maintenance or use of that property; and

(2) Until your legal representative has been appointed.

d. Legal Representative If You Die

Your legal representative if you die, but only

with respect to duties as such. That representative will have all your rights and duties under this Coverage Part.

e. Unnamed Subsidiary

Any subsidiary, and subsidiary thereof, of yours which is a legally incorporated entity of which you own a financial interest of more than 50% of the voting stock on the effective date of the Coverage Part.

The insurance afforded herein for any subsidiary not named in this Coverage Part as a named insured does not apply to injury or damage with respect to which such insured is also a named insured under another policy or would be a named insured under such policy but for its termination or the exhaustion of its limits of insurance.

3. Newly Acquired Or Formed Organization

Any organization you newly acquire or form, other than a partnership, joint venture or limited liability company, and over which you maintain financial interest of more than 50% of the voting stock, will qualify as a Named Insured if there is no other similar insurance available to that organization. However:

a. Coverage under this provision is afforded only until the 180th day after you acquire or form the organization or the end of the policy period, whichever is earlier;

b. Coverage **A** does not apply to "bodily injury" or "property damage" that occurred before you acquired or formed the organization; and

c. Coverage **B** does not apply to "personal and advertising injury" arising out of an offense committed before you acquired or formed the organization.

4. Nonowned Watercraft

With respect to watercraft you do not own that is less than 51 feet long and is not being used to carry persons for a charge, any person is an insured while operating such watercraft with your permission. Any other person or organization responsible for the conduct of such person is also an insured, but only with respect to liability arising out of the operation of the watercraft, and only if no other insurance of any kind is available to that person or organization for this liability.

However, no person or organization is an insured with respect to:

a. "Bodily injury" to a co-"employee" of the person operating the watercraft; or

b. "Property damage" to property owned by, rented to, in the charge of or occupied by you or the employer of any person who is an insured under this provision.

5. Additional Insureds When Required By Written Contract, Written Agreement Or Permit

The following person(s) or organization(s) are an additional insured when you have agreed**,** in a written contract, written agreement or because of a permit issued by a state or political subdivision, that such person or organization be added as an additional insured on your policy, provided the injury or damage occurs subsequent to the execution of the contract or agreement.

A person or organization is an additional insured under this provision only for that period of time required by the contract or agreement.

However, no such person or organization is an insured under this provision if such person or organization is included as an insured by an endorsement issued by us and made a part of this Coverage Part.

a. Vendors

Any person(s) or organization(s) (referred to below as vendor), but only with respect to "bodily injury" or "property damage" arising out of "your products" which are distributed or sold in the regular course of the vendor's business and only if this Coverage Part provides coverage for "bodily injury" or "property damage" included within the "products-completed operations hazard".

(1) The insurance afforded the vendor is subject to the following additional exclusions:

This insurance does not apply to:

(a) "Bodily injury" or "property damage" for which the vendor is obligated to pay damages by reason of the assumption of liability in a contract or agreement. This exclusion does not apply to liability for damages that the vendor would have in the absence of the contract or agreement;

(b) Any express warranty unauthorized by you;

(c) Any physical or chemical change in the product made intentionally by the vendor;

(d) Repackaging, except when unpacked solely for the purpose of inspection, demonstration, testing, or the substitution of parts under instructions from the manufacturer, and then repackaged in the original container;

(e) Any failure to make such inspections, adjustments, tests or servicing as the vendor has agreed to make or normally

undertakes to make in the usual course of business, in connection with the distribution or sale of the products;

(f) Demonstration, installation, servicing or repair operations, except such operations performed at the vendor's premises in connection with the sale of the product;

(g) Products which, after distribution or sale by you, have been labeled or relabeled or used as a container, part or ingredient of any other thing or substance by or for the vendor; or

(h) "Bodily injury" or "property damage" arising out of the sole negligence of the vendor for its own acts or omissions or those of its employees or anyone else acting on its behalf. However, this exclusion does not apply to:

(i) The exceptions contained in Sub-paragraphs (**d)** or (**f**); or

(ii) Such inspections, adjustments, tests or servicing as the vendor has agreed to make or normally undertakes to make in the usual course of business, in connection with the distribution or sale of the products.

(2) This insurance does not apply to any insured person or organization, from whom you have acquired such products, or any ingredient, part or container, entering into, accompanying or containing such products.

b. Lessors Of Equipment

(1) Any person(s) or organization(s) from whom you lease equipment; but only with respect to their liability for "bodily injury", "property damage" or "personal and advertising injury" caused, in whole or in part, by your maintenance, operation or use of equipment leased to you by such person(s) or organization(s).

(2) With respect to the insurance afforded to these additional insureds this insurance does not apply to any "occurrence" which takes place after the equipment lease expires.

c. Lessors Of Land Or Premises

Any person or organization from whom you lease land or premises, but only with respect to liability arising out of the ownership, maintenance or use of that part of the land or premises leased to you.

With respect to the insurance afforded these additional insureds the following additional exclusions apply:

This insurance does not apply to:

1. Any "occurrence" which takes place after you cease to lease that land; or

2. Structural alterations, new construction or demolition operations performed by or on behalf of such person or organization.

d. Architects, Engineers Or Surveyors

Any architect, engineer, or surveyor, but only with respect to liability for "bodily injury", "property damage" or "personal and advertising injury" caused, in whole or in part, by your acts or omissions or the acts or omissions of those acting on your behalf:

(1) In connection with your premises; or

(2) In the performance of your ongoing operations performed by you or on your behalf.

With respect to the insurance afforded these additional insureds, the following additional exclusion applies:

This insurance does not apply to "bodily injury", "property damage" or "personal and advertising injury" arising out of the rendering of or the failure to render any professional services by or for you, including:

1. The preparing, approving, or failing to prepare or approve, maps, shop drawings, opinions, reports, surveys, field orders, change orders or drawings and specifications; or

2. Supervisory, inspection, architectural or engineering activities**.**

This exclusion applies even if the claims against any insured allege negligence or other wrongdoing in the supervision, hiring, employment, training or monitoring of others by that insured, if the "occurrence" which caused the "bodily injury" or "property damage", or the offense which caused the "personal and advertising injury", involved the rendering of or the failure to render any professional services by or for you.

e. Permits Issued By State Or Political Subdivisions

Any state or political subdivision, but only with respect to operations performed by you or on your behalf for which the state or political subdivision has issued a permit.

With respect to the insurance afforded these additional insureds, this insurance does not apply to:

(1) "Bodily injury", "property damage" or "personal and advertising injury" arising out of operations performed for the state or municipality; or

(2) "Bodily injury" or "property damage" included within the "products-completed operations hazard".

f. Any Other Party

Any other person or organization who is not an additional insured under Paragraphs **a.** through **e**. above, but only with respect to liability for "bodily injury", "property damage" or "personal and advertising injury" caused, in whole or in part, by your acts or omissions or the acts or omissions of those acting on your behalf:

(1) In the performance of your ongoing operations;

(2) In connection with your premises owned by or rented to you; or

(3) In connection with "your work" and included within the "products-completed operations hazard", but only if

(a) The written contract or agreement requires you to provide such coverage to such additional insured; and

(b) This Coverage Part provides coverage for "bodily injury" or "property damage" included within the "products-completed operations hazard".

However:

(1) The insurance afforded to such additional insured only applies to the extent permitted by law; and

(2) If coverage provided to the additional insured is required by a contract or agreement, the insurance afforded to such additional insured will not be broader than that which you are required by the contract or agreement to provide for such additional insured.

With respect to the insurance afforded to these additional insureds, this insurance does not apply to:

"Bodily injury", "property damage" or "personal and advertising injury" arising out of the rendering of, or the failure to render, any professional architectural, engineering or surveying services, including:

(1) The preparing, approving, or failing to prepare or approve, maps, shop drawings, opinions, reports, surveys, field orders, change orders or drawings and specifications; or

(2) Supervisory, inspection, architectural or engineering activities.

This exclusion applies even if the claims against any insured allege negligence or other wrongdoing in the supervision, hiring, employment, training or monitoring of others by that insured, if the "occurrence" which caused the "bodily injury" or "property damage", or the offense which caused the "personal and advertising injury", involved the rendering of or the failure to render any professional services by or for you.

The limits of insurance that apply to additional insureds is described in Section **III** – Limits Of Insurance.

How this insurance applies when other insurance is available to the additional insured is described in the Other Insurance Condition in Section **IV** – Commercial General Liability Conditions.

No person or organization is an insured with respect to the conduct of any current or past partnership, joint venture or limited liability company that is not shown as a Named Insured in the Declarations.

SECTION III – LIMITS OF INSURANCE

1. The Most We Will Pay

The Limits of Insurance shown in the Declarations and the rules below fix the most we will pay regardless of the number of:

a. Insureds;

b. Claims made or "suits" brought; or

c. Persons or organizations making claims or bringing "suits".

2. General Aggregate Limit

The General Aggregate Limit is the most we will pay for the sum of:

a. Medical expenses under Coverage **C;**

b. Damages under Coverage **A,** except damages because of "bodily injury" or "property damage" included in the "products-completed operations hazard"; and

c. Damages under Coverage **B.**

3. Products-Completed Operations Aggregate Limit

The Products-Completed Operations Aggregate Limit is the most we will pay under Coverage **A** for damages because of "bodily injury" and "property damage" included in the "products-completed operations hazard".

4. Personal And Advertising Injury Limit

Subject to **2.** above, the Personal and Advertising Injury Limit is the most we will pay under Coverage **B** for the sum of all damages because of all "personal and advertising injury" sustained by any one person or organization.

5. Each Occurrence Limit

Subject to **2.** or **3.** above, whichever applies, the Each Occurrence Limit is the most we will pay for the sum of:

a. Damages under Coverage **A;** and

b. Medical expenses under Coverage **C**

because of all "bodily injury" and "property damage" arising out of any one "occurrence".

6. Damage To Premises Rented To You Limit

Subject to **5.** above, the Damage To Premises Rented To You Limit is the most we will pay under Coverage **A** for damages because of "property damage" to any one premises, while rented to you, or in the case of damage by fire, lightning or explosion, while rented to you or temporarily occupied by you with permission of the owner.

In the case of damage by fire, lightning or explosion, the Damage to Premises Rented To You Limit applies to all damage proximately caused by the same event, whether such damage results from fire, lightning or explosion or any combination of these.

7. Medical Expense Limit

Subject to **5.** above, the Medical Expense Limit is the most we will pay under Coverage **C** for all medical expenses because of "bodily injury" sustained by any one person.

8. How Limits Apply To Additional Insureds

If you have agreed in a written contract or written agreement that another person or organization be
added as an additional insured on your policy, the most we will pay on behalf of such additional insured is the lesser of:

a. The limits of insurance specified in the written contract or written agreement; or

b. The Limits of Insurance shown in the Declarations.

Such amount shall be a part of and not in addition to Limits of Insurance shown in the Declarations and described in this Section.

The Limits of Insurance of this Coverage Part apply separately to each consecutive annual period and to any remaining period of less than 12 months, starting with the beginning of the policy period shown in the Declarations, unless the policy period is extended after issuance for an additional period of less than 12 months. In that case, the additional period will be deemed part of the last preceding period for purposes of determining the Limits of Insurance.

SECTION IV – COMMERCIAL GENERAL LIABILITY CONDITIONS

1. Bankruptcy

Bankruptcy or insolvency of the insured or of the insured's estate will not relieve us of our obligations under this Coverage Part.

2. Duties In The Event Of Occurrence, Offense, Claim Or Suit

a. Notice Of Occurrence Or Offense

You or any additional insured must see to it that we are notified as soon as practicable of an "occurrence" or an offense which may result in a claim. To the extent possible, notice should include:

(1) How, when and where the "occurrence" or offense took place;

(2) The names and addresses of any injured persons and witnesses; and

(3) The nature and location of any injury or damage arising out of the "occurrence" or offense.

b. Notice Of Claim

If a claim is made or "suit" is brought against any insured, you or any additional insured must:

(1) Immediately record the specifics of the claim or "suit" and the date received; and

(2) Notify us as soon as practicable.

You or any additional insured must see to it that we receive written notice of the claim or "suit" as soon as practicable.

c. Assistance And Cooperation Of The Insured

You and any other involved insured must:

(1) Immediately send us copies of any demands, notices, summonses or legal papers received in connection with the claim or "suit";

(2) Authorize us to obtain records and other information;

(3) Cooperate with us in the investigation or settlement of the claim or defense against the "suit"; and

(4) Assist us, upon our request, in the enforcement of any right against any person or organization which may be liable to the insured because of injury or damage to which this insurance may also apply.

d. Obligations At The Insureds Own Cost

No insured will, except at that insured's own cost, voluntarily make a payment, assume any obligation, or incur any expense, other than for first aid, without our consent.

e. Additional Insureds Other Insurance

If we cover a claim or "suit" under this Coverage Part that may also be covered by other insurance available to an additional insured, such additional insured must submit such claim or "suit" to the other insurer for defense and indemnity.

However, this provision does not apply to the extent that you have agreed in a written

contract or written agreement that this insurance is primary and non-contributory with the additional insured's own insurance.

f. Knowledge Of An Occurrence, Offense, Claim Or Suit

Paragraphs **a.** and **b.** apply to you or to any additional insured only when such "occurrence", offense, claim or "suit" is known to:

(1) You or any additional insured that is an individual;

(2) Any partner, if you or the additional insured is a partnership;

(3) Any manager, if you or the additional insured is a limited liability company;

(4) Any "executive officer" or insurance manager, if you or the additional insured is a corporation;

(5) Any trustee, if you or the additional insured is a trust; or

(6) Any elected or appointed official, if you or the additional insured is a political subdivision or public entity.

This duty applies separately to you and any additional insured.

3. Legal Action Against Us

No person or organization has a right under this Coverage Part:

a. To join us as a party or otherwise bring us into a "suit" asking for damages from an insured; or

b. To sue us on this Coverage Part unless all of its terms have been fully complied with.

A person or organization may sue us to recover on an agreed settlement or on a final judgment against an insured; but we will not be liable for damages that are not payable under the terms of this Coverage Part or that are in excess of the applicable limit of insurance. An agreed settlement means a settlement and release of liability signed by us, the insured and the claimant or the claimant's legal representative.

4. Other Insurance

If other valid and collectible insurance is available to the insured for a loss we cover under Coverages **A** or **B** of this Coverage Part, our obligations are limited as follows:

a. Primary Insurance

This insurance is primary except when **b.** below applies. If other insurance is also primary, we will share with all that other insurance by the method described in **c.** below.

b. Excess Insurance

This insurance is excess over any of the other insurance, whether primary, excess, contingent or on any other basis:

(1) Your Work

That is Fire, Extended Coverage, Builder's Risk, Installation Risk or similar coverage for "your work";

(2) Premises Rented To You

That is fire, lightning or explosion insurance for premises rented to you or temporarily occupied by you with permission of the owner;

(3) Tenant Liability

That is insurance purchased by you to cover your liability as a tenant for "property damage" to premises rented to you or temporarily occupied by you with permission of the owner;

(4) Aircraft, Auto Or Watercraft

If the loss arises out of the maintenance or use of aircraft, "autos" or watercraft to the extent not subject to Exclusion g. of Section **I** – Coverage A – Bodily Injury And Property Damage Liability;

(5) Property Damage To Borrowed Equipment Or Use Of Elevators

If the loss arises out of "property damage" to borrowed equipment or the use of elevators to the extent not subject to Exclusion **j.** of Section **I** - Coverage **A** - Bodily Injury And Property Damage Liability;

(6) When You Are Added As An Additional Insured To Other Insurance

Any other insurance available to you covering liability for damages arising out of the premises or operations, or products and completed operations, for which you have been added as an additional insured by that insurance; or

(7) When You Add Others As An Additional Insured To This Insurance

Any other insurance available to an additional insured.

However, the following provisions apply to other insurance available to any person or organization who is an additional insured under this coverage part.

(a) Primary Insurance When Required By Contract

This insurance is primary if you have agreed in a written contract or written agreement that this insurance be primary. If other insurance is also

primary, we will share with all that other insurance by the method described in **c.** below.

(b) Primary And Non-Contributory To Other Insurance When Required By Contract

If you have agreed in a written contract, written agreement, or permit that this insurance is primary and non-contributory with the additional insured's own insurance, this insurance is primary and we will not seek contribution from that other insurance.

Paragraphs **(a)** and **(b)** do not apply to other insurance to which the additional insured has been added as an additional insured.

When this insurance is excess, we will have no duty under Coverages **A** or **B** to defend the insured against any "suit" if any other insurer has a duty to defend the insured against that "suit". If no other insurer defends, we will undertake to do so, but we will be entitled to the insured's rights against all those other insurers.

When this insurance is excess over other insurance, we will pay only our share of the amount of the loss, if any, that exceeds the sum of:

(1) The total amount that all such other insurance would pay for the loss in the absence of this insurance; and

(2) The total of all deductible and self-insured amounts under all that other insurance.

We will share the remaining loss, if any, with any other insurance that is not described in this Excess Insurance provision and was not bought specifically to apply in excess of the Limits of Insurance shown in the Declarations of this Coverage Part.

c. Method Of Sharing

If all of the other insurance permits contribution by equal shares, we will follow this method also. Under this approach each insurer contributes equal amounts until it has paid its applicable limit of insurance or none of the loss remains, whichever comes first.

If any of the other insurance does not permit contribution by equal shares, we will contribute by limits. Under this method, each insurer's share is based on the ratio of its applicable limit of insurance to the total applicable limits of insurance of all insurers.

5. Premium Audit

a. We will compute all premiums for this Coverage Part in accordance with our rules and rates.

b. Premium shown in this Coverage Part as advance premium is a deposit premium only. At the close of each audit period we will compute the earned premium for that period and send notice to the first Named Insured. The due date for audit and retrospective premiums is the date shown as the due date on the bill. If the sum of the advance and audit premiums paid for the policy period is greater than the earned premium, we will return the excess to the first Named Insured.

c. The first Named Insured must keep records of the information we need for premium computation, and send us copies at such times as we may request.

6. Representations

a. When You Accept This Policy

By accepting this policy, you agree:

(1) The statements in the Declarations are accurate and complete;

(2) Those statements are based upon representations you made to us; and

(3) We have issued this policy in reliance upon your representations.

b. Unintentional Failure To Disclose Hazards

If unintentionally you should fail to disclose all hazards relating to the conduct of your business that exist at the inception date of this Coverage Part, we shall not deny coverage under this Coverage Part because of such failure.

7. Separation Of Insureds

Except with respect to the Limits of Insurance, and any rights or duties specifically assigned in this Coverage Part to the first Named Insured, this insurance applies:

a. As if each Named Insured were the only Named Insured; and

b. Separately to each insured against whom claim is made or "suit" is brought.

8. Transfer Of Rights Of Recovery Against Others To Us

a. Transfer Of Rights Of Recovery

If the insured has rights to recover all or part of any payment, including Supplementary Payments, we have made under this Coverage Part, those rights are transferred to us. The insured must do nothing after loss to

impair them. At our request, the insured will bring "suit" or transfer those rights to us and help us enforce them.

b. Waiver Of Rights Of Recovery (Waiver Of Subrogation)

If the insured has waived any rights of recovery against any person or organization for all or part of any payment, including Supplementary Payments, we have made under this Coverage Part, we also waive that right, provided the insured waived their rights of recovery against such person or organization in a contract, agreement or permit that was executed prior to the injury or damage.

9. When We Do Not Renew

If we decide not to renew this Coverage Part, we will mail or deliver to the first Named Insured shown in the Declarations written notice of the nonrenewal not less than 30 days before the expiration date.

If notice is mailed, proof of mailing will be sufficient proof of notice.

SECTION V – DEFINITIONS

1. "Advertisement" means the widespread public dissemination of information or images that has the purpose of inducing the sale of goods, products or services through:

a. (1) Radio;

(2) Television;

(3) Billboard;

(4) Magazine;

(5) Newspaper; or

b. Any other publication that is given widespread public distribution.

However, "advertisement" does not include:

a. The design, printed material, information or images contained in, on or upon the packaging or labeling of any goods or products; or

b. An interactive conversation between or among persons through a computer network.

2. "**Advertising idea"** means any idea for an "advertisement".

3. "Asbestos hazard" means an exposure or threat of exposure to the actual or alleged properties of asbestos and includes the mere presence of asbestos in any form.

4. "Auto" means:

a. A land motor vehicle, trailer or semitrailer designed for travel on public roads, including any attached machinery or equipment; or

b. Any other land vehicle that is subject to a compulsory or financial responsibility law or other motor vehicle insurance law where it is licensed or principally garaged.

However, "auto" does not include "mobile equipment".

5. "Bodily injury" means physical:

a. Injury;

b. Sickness; or

c. Disease

sustained by a person and, if arising out of the above, mental anguish or death at any time.

6. "Coverage territory" means:

a. The United States of America (including its territories and possessions), Puerto Rico and Canada;

b. International waters or airspace, but only if the injury or damage occurs in the course of travel or transportation between any places included in **a.** above; or

c. All other parts of the world if the injury or damage arises out of:

(1) Goods or products made or sold by you in the territory described in **a.** above;

(2) The activities of a person whose home is in the territory described in **a.** above, but is away for a short time on your business; or

(3) "Personal and advertising injury" offenses that take place through the Internet or similar electronic means of communication

provided the insured's responsibility to pay damages is determined in the United States of America (including its territories and possessions), Puerto Rico or Canada, in a "suit" on the merits according to the substantive law in such territory or in a settlement we agree to.

7. "Employee" includes a "leased worker". "Employee" does not include a "temporary worker".

8. "Employment-Related Practices" means:

a. Refusal to employ that person;

b. Termination of that person's employment; or

c. Employment-related practices, policies, acts or omissions, such as coercion, demotion, evaluation, reassignment, discipline, defamation, harassment, humiliation, discrimination or malicious prosecution directed at that person.

9. "Executive officer" means a person holding any of the officer positions created by your charter, constitution, by-laws or any other similar governing document.

10. "Hostile fire" means one which becomes uncontrollable or breaks out from where it was intended to be.

11. **"Impaired property"** means tangible property, other than "your product" or "your work", that cannot be used or is less useful because:

    a. It incorporates "your product" or "your work" that is known or thought to be defective, deficient, inadequate or dangerous; or

    b. You have failed to fulfill the terms of a contract or agreement;

    if such property can be restored to use by the repair, replacement, adjustment or removal of "your product" or "your work", or your fulfilling the terms of the contract or agreement.

12. **"Insured contract"** means:

    a. A contract for a lease of premises. However, that portion of the contract for a lease of premises that indemnifies any person or organization for damage by fire, lightning or explosion to premises while rented to you or temporarily occupied by you with permission of the owner is subject to the Damage to Premises Rented To You Limit described in Section **III** – Limits of Insurance;

    b. A sidetrack agreement;

    c. Any easement or license agreement, including an easement or license agreement in connection with construction or demolition operations on or within 50 feet of a railroad;

    d. An obligation, as required by ordinance, to indemnify a municipality, except in connection with work for a municipality;

    e. An elevator maintenance agreement;

    f. That part of any other contract or agreement pertaining to your business (including an indemnification of a municipality in connection with work performed for a municipality) under which you assume the tort liability of another party to pay for "bodily injury" or "property damage" to a third person or organization, provided the "bodily injury" or "property damage" is caused, in whole or in part, by you or by those acting on your behalf. Tort liability means a liability that would be imposed by law in the absence of any contract or agreement.

    Paragraph **f.** includes that part of any contract or agreement that indemnifies a railroad for "bodily injury" or "property damage" arising out of construction or demolition operations, within 50 feet of any railroad property and affecting any railroad bridge or trestle, tracks, road-beds, tunnel, underpass or crossing.

    However, Paragraph **f.** does not include that part of any contract or agreement:

    (1) That indemnifies an architect, engineer or surveyor for injury or damage arising out of:

    (a) Preparing, approving, or failing to prepare or approve, maps, shop drawings, opinions, reports, surveys, field orders, change orders or drawings and specifications; or

    (b) Giving directions or instructions, or failing to give them, if that is the primary cause of the injury or damage; or

    (2) Under which the insured, if an architect, engineer or surveyor, assumes liability for an injury or damage arising out of the insured's rendering or failure to render professional services, including those listed in **(1)** above and supervisory, inspection, architectural or engineering activities.

13. **"Leased worker"** means a person leased to you by a labor leasing firm under an agreement between you and the labor leasing firm, to perform duties related to the conduct of your business. "Leased worker" does not include a "temporary worker".

14. **"Loading or unloading"** means the handling of property:

    a. After it is moved from the place where it is accepted for movement into or onto an aircraft, watercraft or "auto";

    b. While it is in or on an aircraft, watercraft or "auto"; or

    c. While it is being moved from an aircraft, watercraft or "auto" to the place where it is finally delivered;

    but "loading or unloading" does not include the movement of property by means of a mechanical device, other than a hand truck, that is not attached to the aircraft, watercraft or "auto".

15. **"Mobile equipment"** means any of the following types of land vehicles, including any attached machinery or equipment:

    a. Bulldozers, farm machinery, forklifts and other vehicles designed for use principally off public roads;

    b. Vehicles maintained for use solely on or next to premises you own or rent;

    c. Vehicles that travel on crawler treads;

    d. Vehicles, whether self-propelled or not, maintained primarily to provide mobility to permanently mounted:

    (1) Power cranes, shovels, loaders, diggers or drills; or

    (2) Road construction or resurfacing equipment such as graders, scrapers or rollers;

    e. Vehicles not described in **a., b., c.** or **d.** above that are not self-propelled and are maintained

primarily to provide mobility to permanently attached equipment of the following types:

(1) Air compressors, pumps and generators, including spraying, welding, building cleaning, geophysical exploration, lighting and well servicing equipment; or

(2) Cherry pickers and similar devices used to raise or lower workers;

f. Vehicles not described in **a., b., c.** or **d.** above maintained primarily for purposes other than the transportation of persons or cargo.

However, self-propelled vehicles with the following types of permanently attached equipment are not "mobile equipment" but will be considered "autos":

(1) Equipment designed primarily for:

(a) Snow removal;

(b) Road maintenance, but not construction or resurfacing; or

(c) Street cleaning;

(2) Cherry pickers and similar devices mounted on automobile or truck chassis and used to raise or lower workers; and

(3) Air compressors, pumps and generators, including spraying, welding, building cleaning, geophysical exploration, lighting and well servicing equipment.

However, "mobile equipment" does not include any land vehicle that is subject to a compulsory or financial responsibility law or other motor vehicle insurance law where it is licensed or principally garaged. Land vehicles subject to a compulsory or financial responsibility law or other motor vehicle insurance law are considered "autos".

16. "Occurrence" means an accident, including continuous or repeated exposure to substantially the same general harmful conditions.

17. "Personal and advertising injury" means injury, including consequential "bodily injury", arising out of one or more of the following offenses:

a. False arrest, detention or imprisonment;

b. Malicious prosecution;

c. The wrongful eviction from, wrongful entry into, or invasion of the right of private occupancy of a room, dwelling or premises that a person or organization occupies, committed by or on behalf of its owner, landlord or lessor;

d. Oral, written or electronic publication, in any manner, of material that slanders or libels a person or organization or disparages a person's or organization's goods, products or services;

e. Oral, written or electronic publication, in any manner, of material that violates a person's right of privacy;

f. Copying, in your "advertisement", a person's or organization's "advertising idea" or style of "advertisement"; or

g. Infringement of copyright, slogan, or title of any literary or artistic work, in your "advertisement".

18. "Pollutants" mean any solid, liquid, gaseous or thermal irritant or contaminant, including smoke, vapor, soot, fumes, acids, alkalis, chemicals and waste. Waste includes materials to be recycled, reconditioned or reclaimed.

19. "Products-completed operations hazard":

a. Includes all "bodily injury" and "property damage" occurring away from premises you own or rent and arising out of "your product" or "your work" except:

(1) Products that are still in your physical possession; or

(2) Work that has not yet been completed or abandoned. However, "your work" will be deemed completed at the earliest of the following times:

(a) When all of the work called for in your contract has been completed.

(b) When all of the work to be done at the job site has been completed if your contract calls for work at more than one job site.

(c) When that part of the work done at a job site has been put to its intended use by any person or organization other than another contractor or subcontractor working on the same project.

Work that may need service, maintenance, correction, repair or replacement, but which is otherwise complete, will be treated as completed.

b. Does not include "bodily injury" or "property damage" arising out of:

(1) The transportation of property, unless the injury or damage arises out of a condition in or on a vehicle not owned or operated by you, and that condition was created by the "loading or unloading" of that vehicle by any insured;

(2) The existence of tools, uninstalled equipment or abandoned or unused materials; or

(3) Products or operations for which the classification, listed in the Declarations or in a policy Schedule, states that products-

completed operations are subject to the General Aggregate Limit.

20. "Property damage" means:

a. Physical injury to tangible property, including all resulting loss of use of that property. All such loss of use shall be deemed to occur at the time of the physical injury that caused it; or

b. Loss of use of tangible property that is not physically injured. All such loss of use shall be deemed to occur at the time of the "occurrence" that caused it.

As used in this definition, computerized or electronically stored data, programs or software are not tangible property. Electronic data means information, facts or programs:

a. Stored as or on;

b. Created or used on; or

c. Transmitted to or from;

computer software, including systems and applications software, hard or floppy disks, CD-ROMS, tapes, drives, cells, data processing devices or any other media which are used with electronically controlled equipment.

21. "Suit" means a civil proceeding in which damages because of "bodily injury", "property damage" or "personal and advertising injury" to which this insurance applies are alleged. "Suit" includes:

a. An arbitration proceeding in which such damages are claimed and to which the insured must submit or does submit with our consent; or

b. Any other alternative dispute resolution proceeding in which such damages are claimed and to which the insured submits with our consent.

22. "Temporary worker" means a person who is furnished to you to substitute for a permanent "employee" on leave or to meet seasonal or short-term workload conditions.

23. "Volunteer worker" means a person who

a. Is not your "employee";

b. Donates his or her work;

c. Acts at the direction of and within the scope of duties determined by you; and

d. Is not paid a fee, salary or other compensation by you or anyone else for their work performed for you.

24. "Your product":

a. Means:

(1) Any goods or products, other than real property, manufactured, sold, handled, distributed or disposed of by:

(a) You;

(b) Others trading under your name; or

(c) A person or organization whose business or assets you have acquired; and

(2) Containers (other than vehicles), materials, parts or equipment furnished in connection with such goods or products.

b. Includes

(1) Warranties or representations made at any time with respect to the fitness, quality, durability, performance or use of "your product"; and

(2) The providing of or failure to provide warnings or instructions.

c. Does not include vending machines or other property rented to or located for the use of others but not sold.

25. "Your work":

a. Means:

(1) Work or operations performed by you or on your behalf; and

(2) Materials, parts or equipment furnished in connection with such work or operations.

b. Includes

(1) Warranties or representations made at any time with respect to the fitness, quality, durability, performance or use of "your work", and

(2) The providing of or failure to provide warnings or instructions.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

COMMERCIAL AUTOMOBILE BROAD FORM ENDORSEMENT

This endorsement modifies insurance provided under the following:

BUSINESS AUTO COVERAGE FORM

To the extent that the provisions of this endorsement provide broader benefits to the "insured" than other provisions of the Coverage Form, the provisions of this endorsement apply.

1. BROAD FORM INSURED

A. Subsidiaries and Newly Acquired or Formed Organizations

The Named Insured shown in the Declarations is amended to include:

(1) Any legal business entity other than a partnership or joint venture, formed as a subsidiary in which you have an ownership interest of more than 50% on the effective date of the Coverage Form. However, the Named Insured does not include any subsidiary that is an "insured" under any other automobile policy or would be an "insured" under such a policy but for its termination or the exhaustion of its Limit of Insurance.

(2) Any organization that is acquired or formed by you and over which you maintain majority ownership. However, the Named Insured does not include any newly formed or acquired organization:

(a) That is a partnership or joint venture,

(b) That is an "insured" under any other policy,

(c) That has exhausted its Limit of Insurance under any other policy, or

(d) 180 days or more after its acquisition or formation by you, unless you have given us notice of the acquisition or formation.

Coverage does not apply to "bodily injury" or "property damage" that results from an "accident" that occurred before you formed or acquired the organization.

B. Employees as Insureds

Paragraph A.1. - WHO IS AN INSURED - of SECTION II - LIABILITY COVERAGE is amended to add:

d. Any "employee" of yours while using a covered "auto" you don't own, hire or borrow in your business or your personal affairs.

C. Lessors as Insureds

Paragraph A.1. - WHO IS AN INSURED - of Section II - Liability Coverage is amended to add:

e. The lessor of a covered "auto" while the "auto" is leased to you under a written agreement if:

(1) The agreement requires you to provide direct primary insurance for the lessor and

(2) The "auto" is leased without a driver.

Such a leased "auto" will be considered a covered "auto" you own and not a covered "auto" you hire.

D. Additional Insured if Required by Contract

(1) Paragraph A.1. - WHO IS AN INSURED - of Section II - Liability Coverage is amended to add:

f. When you have agreed, in a written contract or written agreement, that a person or organization be added as an additional insured on your business auto policy, such person or organization is an "insured", but only to the extent such person or organization is liable for "bodily injury" or "property damage" caused by the conduct of an "insured" under paragraphs a. or b. of Who Is An Insured with regard to the ownership, maintenance or use of a covered "auto."

The insurance afforded to any such additional insured applies only if the "bodily injury" or "property damage" occurs:

(1) During the policy period, and

(2) Subsequent to the execution of such written contract, and

(3) Prior to the expiration of the period of time that the written contract requires such insurance be provided to the additional insured.

(2) How Limits Apply

If you have agreed in a written contract or written agreement that another person or organization be added as an additional insured on your policy, the most we will pay on behalf of such additional insured is the lesser of:

(a) The limits of insurance specified in the written contract or written agreement; or

(b) The Limits of Insurance shown in the Declarations.

Such amount shall be a part of and not in addition to Limits of Insurance shown in the Declarations and described in this Section.

(3) Additional Insureds Other Insurance

If we cover a claim or "suit" under this Coverage Part that may also be covered by other insurance available to an additional insured, such additional insured must submit such claim or "suit" to the other insurer for defense and indemnity.

However, this provision does not apply to the extent that you have agreed in a written contract or written agreement that this insurance is primary and non-contributory with the additional insured's own insurance.

(4) Duties in The Event Of Accident, Claim, Suit or Loss

If you have agreed in a written contract or written agreement that another person or organization be added as an additional insured on your policy, the additional insured shall be required to comply with the provisions in LOSS CONDITIONS 2. - DUTIES IN THE EVENT OF ACCIDENT, CLAIM , SUIT OR LOSS – OF SECTION IV – BUSINESS AUTO CONDITIONS, in the same manner as the Named Insured.

E. Primary and Non-Contributory if Required by Contract

Only with respect to insurance provided to an additional insured in 1.D. - Additional Insured If Required by Contract, the following provisions apply:

(3) Primary Insurance When Required By Contract

This insurance is primary if you have agreed in a written contract or written agreement that this insurance be primary. If other insurance is also primary, we will share with all that other insurance by the method described in Other Insurance 5.d.

(4) Primary And Non-Contributory To Other Insurance When Required By Contract

If you have agreed in a written contract or written agreement that this insurance is primary and non-contributory with the additional insured's own insurance, this insurance is primary and we will not seek contribution from that other insurance.

Paragraphs **(3)** and **(4)** do not apply to other insurance to which the additional insured has been added as an additional insured.

When this insurance is excess, we will have no duty to defend the insured against any "suit" if any other insurer has a duty to defend the insured against that "suit". If no other insurer defends, we will undertake to do so, but we will be entitled to the insured's rights against all those other insurers.

When this insurance is excess over other insurance, we will pay only our share of the amount of the loss, if any, that exceeds the sum of:

(1) The total amount that all such other insurance would pay for the loss in the absence of this insurance; and

(2) The total of all deductible and self-insured amounts under all that other insurance.

We will share the remaining loss, if any, by the method described in Other Insurance 5.d.

2. AUTOS RENTED BY EMPLOYEES

Any "auto" hired or rented by your "employee" on your behalf and at your direction will be considered an "auto" you hire.

The OTHER INSURANCE Condition is amended by adding the following:

If an "employee's" personal insurance also applies on an excess basis to a covered "auto" hired or rented by your "employee" on your behalf and at your direction, this insurance will be primary to the "employee's" personal insurance.

3. AMENDED FELLOW EMPLOYEE EXCLUSION

EXCLUSION 5. - FELLOW EMPLOYEE - of SECTION II - LIABILITY COVERAGE does not apply if you have workers' compensation insurance in-force covering all of your "employees".

Coverage is excess over any other collectible insurance.

4. HIRED AUTO PHYSICAL DAMAGE COVERAGE

If hired "autos" are covered "autos" for Liability Coverage and if Comprehensive, Specified Causes of Loss, or Collision coverages are provided under this Coverage Form for any "auto" you own, then the Physical Damage Coverages provided are extended to "autos" you hire or borrow, subject to the following limit.

The most we will pay for "loss" to any hired "auto" is:

(1) $100,000;

(2) The actual cash value of the damaged or stolen property at the time of the "loss"; or

(3) The cost of repairing or replacing the damaged or stolen property,

whichever is smallest, minus a deductible. The deductible will be equal to the largest deductible applicable to any owned "auto" for that coverage. No deductible applies to "loss" caused by fire or lightning. Hired Auto Physical Damage coverage is excess over any other collectible insurance. Subject to the above limit, deductible and excess provisions, we will provide coverage equal to the broadest coverage applicable to any covered "auto" you own.

We will also cover loss of use of the hired "auto" if it results from an "accident", you are legally liable and the lessor incurs an actual financial loss, subject to a maximum of $1000 per "accident".

This extension of coverage does not apply to any "auto" you hire or borrow from any of your "employees", partners (if you are a partnership), members (if you are a limited liability company), or members of their households.

5. PHYSICAL DAMAGE - ADDITIONAL TEMPORARY TRANSPORTATION EXPENSE COVERAGE

Paragraph A.4.a. of SECTION III - PHYSICAL DAMAGE COVERAGE is amended to provide a limit of $50 per day and a maximum limit of $1,000.

6. LOAN/LEASE GAP COVERAGE

Under SECTION III - PHYSICAL DAMAGE COVERAGE, in the event of a total "loss" to a covered "auto", we will pay your additional legal obligation for any difference between the actual cash value of the "auto" at the time of the "loss" and the "outstanding balance" of the loan/lease.

"Outstanding balance" means the amount you owe on the loan/lease at the time of "loss" less any amounts representing taxes; overdue payments; penalties, interest or charges resulting from overdue payments; additional mileage charges; excess wear and tear charges; lease termination fees; security deposits not returned by the lessor; costs for extended warranties, credit life Insurance, health, accident or disability insurance purchased with the loan or lease; and carry-over balances from previous loans or leases.

7. AIRBAG COVERAGE

Under Paragraph B. EXCLUSIONS - of SECTION III - PHYSICAL DAMAGE COVERAGE, the following is added:

The exclusion relating to mechanical breakdown does not apply to the accidental discharge of an airbag.

8. ELECTRONIC EQUIPMENT - BROADENED COVERAGE

a. The exceptions to Paragraphs B.4 - EXCLUSIONS - of SECTION III - PHYSICAL DAMAGE COVERAGE are replaced by the following:

Exclusions **4.c.** and **4.d.** do not apply to equipment designed to be operated solely by use of the power from the "auto's" electrical system that, at the time of "loss", is:

(1) Permanently installed in or upon the covered "auto";

(2) Removable from a housing unit which is permanently installed in or upon the covered "auto";

(3) An integral part of the same unit housing any electronic equipment described in Paragraphs (1) and (2) above; or

(4) Necessary for the normal operation of the covered "auto" or the monitoring of the covered "auto's" operating system.

b. Section III – Version CA 00 01 03 10 of the Business Auto Coverage Form, Physical Damage Coverage, Limit of Insurance, Paragraph C.2 and Version CA 00 01 10 01 of the Business Auto Coverage Form, Physical Damage Coverage, Limit of Insurance, Paragraph C are each amended to add the following:

$1,500 is the most we will pay for "loss" in any one "accident" to all electronic equipment (other than equipment designed solely for the reproduction of sound, and accessories used with such equipment) that reproduces, receives or transmits audio, visual or data signals which, at the time of "loss", is:

(1) Permanently installed in or upon the covered "auto" in a housing, opening or other location that is not normally used by the "auto" manufacturer for the installation of such equipment;

(2) Removable from a permanently installed housing unit as described in Paragraph 2.a. above or is an integral part of that equipment; or

(3) An integral part of such equipment.

c. For each covered "auto", should loss be limited to electronic equipment only, our obligation to pay for, repair, return or replace damaged or stolen electronic equipment will be reduced by the applicable deductible shown in the Declarations, or $250, whichever deductible is less.

9. EXTRA EXPENSE - BROADENED COVERAGE

Under Paragraph A. - COVERAGE - of SECTION III - PHYSICAL DAMAGE COVERAGE, we will pay for the expense of returning a stolen covered "auto" to you.

10. GLASS REPAIR - WAIVER OF DEDUCTIBLE

Under Paragraph D. - DEDUCTIBLE - of SECTION III - PHYSICAL DAMAGE COVERAGE, the following is added:

No deductible applies to glass damage if the glass is repaired rather than replaced.

11. TWO OR MORE DEDUCTIBLES

Under Paragraph D. - DEDUCTIBLE - of SECTION III - PHYSICAL DAMAGE COVERAGE, the following is added:

If another Hartford Financial Services Group, Inc. company policy or coverage form that is not an automobile policy or coverage form applies to the same "accident", the following applies:

(1) If the deductible under this Business Auto Coverage Form is the smaller (or smallest) deductible, it will be waived;

(2) If the deductible under this Business Auto Coverage Form is not the smaller (or smallest) deductible, it will be reduced by the amount of the smaller (or smallest) deductible.

12. AMENDED DUTIES IN THE EVENT OF ACCIDENT, CLAIM, SUIT OR LOSS

The requirement in LOSS CONDITIONS 2.a. - DUTIES IN THE EVENT OF ACCIDENT,CLAIM, SUIT OR LOSS - of SECTION IV - BUSINESS AUTO CONDITIONS that you must notify us of an "accident" applies only when the "accident" is known to:

(1) You, if you are an individual;

(2) A partner, if you are a partnership;

(3) A member, if you are a limited liability company; or

(4) An executive officer or insurance manager, if you are a corporation.

13. UNINTENTIONAL FAILURE TO DISCLOSE HAZARDS

If you unintentionally fail to disclose any hazards existing at the inception date of your policy, we will not deny coverage under this Coverage Form because of such failure.

14. HIRED AUTO - COVERAGE TERRITORY

Paragraph e. of GENERAL CONDITIONS 7. - POLICY PERIOD, COVERAGE TERRITORY - of SECTION IV - BUSINESS AUTO CONDITIONS is replaced by the following:

e. For short-term hired "autos", the coverage territory with respect to Liability Coverage is anywhere in the world provided that if the "insured's" responsibility to pay damages for "bodily injury" or "property damage" is determined in a "suit," the "suit" is brought in the United States of America, the territories and possessions of the United States of America, Puerto Rico or Canada or in a settlement we agree to.

15. WAIVER OF SUBROGATION

TRANSFER OF RIGHTS OF RECOVERY AGAINST OTHERS TO US - of SECTION IV - BUSINESS AUTO CONDITIONS is amended by adding the following:

We waive any right of recovery we may have against any person or organization with whom you have a written contract that requires such waiver because of payments we make for damages under this Coverage Form.

16. RESULTANT MENTAL ANGUISH COVERAGE

The definition of "bodily injury" in SECTION V-DEFINITIONS is replaced by the following:

"Bodily injury" means bodily injury, sickness or disease sustained by any person, including mental anguish or death resulting from any of these.

17. EXTENDED CANCELLATION CONDITION

Paragraph 2. of the COMMON POLICY CONDITIONS - CANCELLATION - applies except as follows:

If we cancel for any reason other than nonpayment of premium, we will mail or deliver to the first Named Insured written notice of cancellation at least 60 days before the effective date of cancellation.

18. HYBRID, ELECTRIC, OR NATURAL GAS VEHICLE PAYMENT COVERAGE

In the event of a total loss to a "non-hybrid" auto for which Comprehensive, Specified Causes of Loss, or Collision coverages are provided under this Coverage Form, then such Physical Damage Coverages are amended as follows:

a. If the auto is replaced with a "hybrid" auto or an auto powered solely by electricity or natural gas, we will pay an additional 10%, to a maximum of $2,500, of the "non-hybrid" auto's actual cash value or replacement cost, whichever is less,

b. The auto must be replaced and a copy of a bill of sale or new lease agreement received by us within 60 calendar days of the date of "loss,"

c. Regardless of the number of autos deemed a total loss, the most we will pay under this Hybrid, Electric, or Natural Gas Vehicle Payment Coverage provision for any one "loss" is $10,000.

For the purposes of the coverage provision,

a. A "non-hybrid" auto is defined as an auto that uses only an internal combustion engine to move the auto but does not include autos powered solely by electricity or natural gas.

b. A "hybrid" auto is defined as an auto with an internal combustion engine and one or more electric motors; and that uses the internal combustion engine and one or more electric motors to move the auto, or the internal combustion engine to charge one or more electric motors, which move the auto.

19. VEHICLE WRAP COVERAGE

In the event of a total loss to an "auto" for which Comprehensive, Specified Causes of Loss, or Collision coverages are provided under this Coverage Form, then such Physical Damage Coverages are amended to add the following:

In addition to the actual cash value of the "auto", we will pay up to $1,000 for vinyl vehicle wraps which are displayed on the covered "auto" at the time of total loss. Regardless of the number of autos deemed a total loss, the most we will pay under this Vehicle Wrap Coverage provision for any one "loss" is $5,000. For purposes of this coverage provision, signs or other graphics painted or magnetically affixed to the vehicle are not considered vehicle wraps.

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

NOTICE OF CANCELLATION TO DESIGNATED CERTIFICATE HOLDER

Policy Number: 59 WE ZJ2839 **Endorsement Number:**
Effective Date: 07/01/20 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: HEALTH SERVICES HOLDINGS INC
3133 E CAMELBACK RD STE 100
PHOENIX AZ 85016

This policy is subject to the following additional Conditions when a number of days are shown in the schedule for any of the below Parts:

A. If this policy is cancelled by the Company for non-payment of premium, notice of such cancellation will be provided to the certificate holder in the schedule within the number of days notice of the cancellation effective date, as shown in Part A.

B. If this policy is cancelled by the insured, notice of such cancellation will be provided to the certificate holder in the schedule, within the number of days notice of the cancellation effective date, as shown in Part B.

If notice is mailed, proof of mailing notice to the certificate holder's mailing address as shown in the schedule will be sufficient proof of notice. If the number of days notice in the schedule for any Part is left blank or is shown as zero, no notice will be provided to the scheduled certificate holder under that Part.

Any notification rights provided by this endorsement apply only to active certificate holder(s) who were issued a certificate of insurance applicable to this policy's term.

Failure to provide such notice to the certificate holder(s) will not amend or extend the date the cancellation becomes effective, nor will it negate cancellation of the policy. Failure to send notice shall impose no liability of any kind upon the company or its agents or representatives.

Schedule

Number of Days Notice:	**Name and Mailing Address of Certificate Holder**
Part A: 10	TO BE PROVIDED
Part B: 30	TO BE PROVIDED

Form WC 99 05 35 Printed in U.S.A.
Process Date: 07/02/20 **Policy Expiration Date:** 07/01/21

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

WAIVER OF OUR RIGHT TO RECOVER FROM OTHERS ENDORSEMENT

Policy Number: 59 WE ZJ2839 **Endorsement Number:**
Effective Date: 07/01/20 Effective hour is the same as stated on the Information Page of the policy.
Named Insured and Address: HEALTH SERVICES HOLDINGS INC
3133 E CAMELBACK RD STE 100
PHOENIX AZ 85016

We have the right to recover our payments from anyone liable for an injury covered by this policy. We will not enforce our right against the person or organization named in the Schedule.

This agreement shall not operate directly or indirectly to benefit anyone not named in the Schedule.

SCHEDULE

Any person or organization from whom you are required by contract or agreement to obtain this waiver from us. Endorsement is not applicable in KY, NH, NJ or for any MO construction risk

Countersigned by _____
Authorized Representative

STATE OF NEBRASKA

United States of America, } ss.
State of Nebraska }

Secretary of State
State Capitol
Lincoln, Nebraska

I, Robert B. Evnen, Secretary of State of the State of Nebraska, do hereby certify that

HEALTH SERVICES ADVISORY GROUP, INC.

a Arizona corporation is authorized to transact business in Nebraska;

that no occupation taxes due from and assessable against the Corporation are unpaid and have become delinquent;

that no annual or biennial report required to be forwarded by the Corporation to the Secretary of State has become delinquent;

that a Certificate of Withdrawal has not been filed.

This certificate is not to be construed as an endorsement, recommendation, or notice of approval of the entity's financial condition or business activities and practices.

In Testimony Whereof,

I have hereunto set my hand and affixed the Great Seal of the State of Nebraska on this date of

February 5, 2021

Secretary of State

Verification ID 45e100f has been assigned to this document. Go to ne.gov/go/validate to validate authenticity for up to 12 months.

State of Nebraska, Department of Health and Human Services
REQUEST FOR PROPOSAL FOR CONTRACTUAL SERVICES

RETURN TO:
Keith Roland
301 Centennial Mall S., Lower Level
Lincoln, NE 68509
(402) 471-0727

SOLICITATION NUMBER	RELEASE DATE
RFP 6303 Z1	June 1, 2020
OPENING DATE AND TIME	**PROCUREMENT CONTACT**
July 31, 2020 2:00 p.m. Central Time	Keith Roland

PLEASE READ CAREFULLY!
SCOPE OF SERVICE

The State of Nebraska (State), Department of Health and Human Services, is issuing this Request for Proposal (RFP) Number 6303 Z1 for the purpose of selecting a qualified Contractor to provide External Quality Reviews (EQR) of contracted managed care organizations (MCOs) and a Dental Benefits Manager (DBM). A more detailed description can be found in Section V. The resulting contract may not be an exclusive contract as the State reserves the right to contract for the same or similar services from other sources now or in the future.

The term of the contract will be three (3) years commencing upon execution of the contract by the State and the Contractor (Parties). The Contract includes the option to renew for three (3) additional one (1) year periods upon mutual agreement of the Parties. The State reserves the right to extend the period of this contract beyond the termination date when mutually agreeable to the Parties.

ALL INFORMATION PERTINENT TO THIS REQUEST FOR PROPOSAL CAN BE FOUND ON THE INTERNET AT: **http://das.nebraska.gov/materiel/purchasing.html**.

IMPORTANT NOTICE: Pursuant to Neb. Rev. Stat. § 84-602.04, State contracts in effect as of January 1, 2014, and contracts entered into thereafter, must be posted to a public website. The resulting contract, the solicitation, and the successful contractor's proposal or response will be posted to a public website managed by DAS, which can be found at http://statecontracts.nebraska.gov.

In addition and in furtherance of the State's public records Statute (Neb. Rev. Stat. § 84-712 et seq.), all proposals or responses received regarding this solicitation will be posted to the State Purchasing Bureau public website.

These postings will include the entire proposal or response. Contractor must request that proprietary information be excluded from the posting. The contractor must identify the proprietary information, mark the proprietary information according to state law, and submit the proprietary information in a separate container or envelope marked conspicuously using an indelible method with the words "PROPRIETARY INFORMATION" or if submitting the proposal or response electronically, as a separate electronic file that is named "PROPRIETARY INFORMATION". The contractor must submit a detailed written document showing that the release of the proprietary information would give a business advantage to named business competitor(s) and explain how the named business competitor(s) will gain an actual business advantage by disclosure of information. The mere assertion that information is proprietary or that a speculative business advantage might be gained is not sufficient. (See Attorney General Opinion No. 92068, April 27, 1992) THE SUPPLIER MAY NOT ASSERT THAT THE ENTIRE PROPOSAL IS PROPRIETARY. COST PROPOSALS WILL NOT BE CONSIDERED PROPRIETARY AND ARE A PUBLIC RECORD IN THE STATE OF NEBRASKA. The State will determine, in its sole discretion, if the disclosure of the information designated by the Bidder as proprietary would 1) give advantage to business competitors and 2) serve no public purpose. The Bidder will be notified of the State's decision. Absent a determination by the State that the information may be withheld pursuant to Neb. Rev. Stat. § 84-712.05, the State will consider all information a public record subject to disclosure.

If the agency determines it is required to release proprietary information, the contractor will be informed. It will be the contractor's responsibility to defend the contractor's asserted interest in non-disclosure.

To facilitate such public postings, with the exception of proprietary information, the State of Nebraska reserves a royalty-free, nonexclusive, and irrevocable right to copy, reproduce, publish, post to a website, or otherwise use any contract, proposal, or response to this solicitation for any purpose, and to authorize others to use the documents. Any individual or entity awarded a contract, or who submits a proposal or response to this solicitation, specifically waives any copyright or other protection the contract, proposal, or response to the solicitation may have; and, acknowledges that they have the ability and authority to enter into such waiver. This reservation and waiver is a prerequisite for submitting a proposal or response to this solicitation, and award of a contract. Failure to agree to the reservation and waiver will result in the proposal or response to the solicitation being found non-responsive and rejected.

Any entity awarded a contract or submitting a proposal or response to the solicitation agrees not to sue, file a claim, or make a demand of any kind, and will indemnify and hold harmless the State and its employees, volunteers, agents, and its elected and appointed officials from and against any and all claims, liens, demands, damages, liability, actions, causes of action, losses, judgments, costs, and expenses of every nature, including investigation costs and expenses, settlement costs, and attorney

fees and expenses, sustained or asserted against the State, arising out of, resulting from, or attributable to the posting of the contract or the proposals and responses to the solicitation, awards, and other documents.

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GLOSSARY OF TERMS

Acceptance Test Procedure: Benchmarks and other performance criteria, developed by the State of Nebraska or other sources of testing standards, for measuring the effectiveness of products or services and the means used for testing such performance.

Addendum: Something to be added or deleted to an existing document; a supplement.

Agency: Any state agency, board, or commission other than the University of Nebraska, the Nebraska State colleges, the courts, the Legislature, or any other office or agency established by the Constitution of Nebraska.

Agent/Representative: A person authorized to act on behalf of another.

Amend: To alter or change by adding, subtracting, or substituting.

Amendment: A written correction or alteration to a document.

Appropriation: Legislative authorization to expend public funds for a specific purpose. Money set apart for a specific use.

Automated Clearing House: (ACH) Electronic network for financial transactions in the United States

Award: All purchases, leases, or contracts which are based on competitive proposals will be awarded according to the provisions in the solicitation.

Best and Final Offer (BAFO): In a competitive proposal, the final offer submitted which contains the contractor's most favorable terms for price.

Bid Bond: An insurance agreement, accompanied by a monetary commitment, by which a third party (the surety) accepts liability and guarantees that the contractor will not withdraw the bid.

Bidder: A contractor who submits a proposal in response to a written solicitation.

Breach: Violation of a contractual obligation by failing to perform or repudiation of one's own promise.

Business: Any corporation, partnership, individual, sole proprietorship, joint-stock company, joint venture, or any other private legal entity.

Business Day: Any weekday, except State-recognized holidays.

Calendar Day: Every day shown on the calendar including Saturdays, Sundays, and State/Federal holidays.

Cancellation: To call off or revoke a purchase order without expectation of conducting or performing it at a later time.

Central Processing Unit (CPU): Any computer or computer system that is used by the State to store, process, or retrieve data or perform other functions using Operating Systems and applications software.

Change Order: Document that provides amendments to an executed purchase order or contract.

Collusion: An agreement or cooperation between two or more persons or entities to accomplish a fraudulent, deceitful, or unlawful purpose.

Commodities: Any equipment, material, supply or goods; anything movable or tangible that is provided or sold.

Commodities Description: Detailed descriptions of the items to be purchased; may include information necessary to obtain the desired quality, type, color, size, shape, or special characteristics necessary to perform the work intended to produce the desired results.

Competition: The effort or action of two or more commercial interests to obtain the same business from third parties.

Confidential Information: Unless otherwise defined below, "Confidential Information" shall also mean proprietary trade secrets, academic and scientific research work which is in progress and unpublished, and other information which if released would give advantage to business competitors and serve no public purpose (see Neb. Rev. Stat. §84-712.05(3)). In accordance with Nebraska Attorney General Opinions 92068 and 97033, proof that information is proprietary requires identification of specific, named competitor(s) who would be advantaged by release of the information and the specific

advantage the competitor(s) would receive.

Contract: An agreement between two or more parties creating obligations that are enforceable or otherwise recognizable at law; the writing that sets forth such an agreement.

Contract Administration: The management of the contract which includes and is not limited to; contract signing, contract amendments and any necessary legal actions.

Contract Award: Occurs upon execution of the State document titled "Service Contract Award" by the proper authority.

Contract Management: The management of day to day activities at the agency which includes and is not limited to ensuring deliverables are received, specifications are met, handling meetings and making payments to the Contractor.

Contract Period: The duration of the contract.

Contractor: An individual or entity lawfully conducting business in the State, or licensed to do so, who seeks to provide goods or services under the terms of a written solicitation.

Cooperative Purchasing: The combining of requirements of two or more political entities to obtain advantages of volume purchases, reduction in administrative expenses or other public benefits.

Copyright: A property right in an original work of authorship fixed in any tangible medium of expression, giving the holder the exclusive right to reproduce, adapt and distribute the work.

Critical Program Error: Any Program Error, whether or not known to the State, which prohibits or significantly impairs use of the Licensed Software as set forth in the documentation and intended in the contract.

Customer Service: The process of ensuring customer satisfaction by providing assistance and advice on those products or services provided by the Contractor.

Default: The omission or failure to perform a contractual duty.

Dental Benefits Manager: A Dental Benefits Manager (DBM) manages and delivers dental benefits and services to eligible Nebraska Medicaid members. Dental providers have contracted with the DBM as part of its provider network. The DBM handles claims payment and prior authorizations and works with providers and Medicaid clients to coordinate a member's dental care. Managed Care of North America, Inc. (MCNA) is the Nebraska Medicaid and Long-term Care DBM.

Deviation: Any proposed change(s) or alteration(s) to either the terms and conditions or deliverables within the scope of the written solicitation or contract.

Evaluation: The process of examining an offer after opening to determine the contractor's responsibility, responsiveness to requirements, and to ascertain other characteristics of the offer that relate to determination of the successful award.

Evaluation Committee: Committee(s) appointed by the requesting agency that advises and assists the procuring office in the evaluation of proposals (offers made in response to written solicitations).

Extension: Continuance of a contract for a specified duration upon the agreement of the parties beyond the original Contract Period. Not to be confused with "Renewal Period".

External Quality Review (EQR): The analysis and evaluation by an EQRO, utilizing aggregated information on quality, timeliness, and access to the health care services that an MCO or DBM or its contractors furnish to Title XIX Medicaid and Title XXI SCHIP recipients.

External Quality Review Organization (EQRO): An organization that meets the competence and independence requirements set forth in 42 CFR §438.354 and performs external quality review, other EQR-related activities as set forth in 42 CFR §438.358, or both.

Financial Relationship: (1) A direct or indirect ownership or investment interest (including an option or nonvested interest) in any entity. This direct or indirect interest may be in the form of equity, debt, or other means and includes any indirect ownership or investment interest no matter how may levels removed from a direct interest; or (2) a compensation arrangement with an entity.

Free on Board (F.O.B.) Destination: The delivery charges are included in the quoted price and prepaid by the contractor. Contractor is responsible for all claims associated with damages during delivery of product.

Free on Board (F.O.B.) Point of Origin: The delivery charges are not included in the quoted price and are the responsibility of the agency. Agency is responsible for all claims associated with damages during delivery of product.

Foreign Corporation: A foreign corporation that was organized and chartered under the laws of another state, government, or country.

Indian: Any individual defined at 25 U.S.C. 1603, 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 CFR 136.12.

Indicators: Measures or measurement tools used to monitor and/or measure some component of health care delivery.

Installation Date: The date when the procedures described in "Installation by Contractor", and "Installation by State", as found in the solicitation, or contract, are completed.

Interested Party: A person, acting in their personal capacity, or an entity entering into a contract or other agreement creating a legal interest therein.

Invalid Proposal: A proposal that does not meet the requirements of the solicitation or cannot be evaluated against the other proposals.

Late Proposal: An offer received after the Opening Date and Time.

Licensed Software Documentation: The user manuals and any other materials in any form or medium customarily provided by the Contractor to the users of the Licensed Software which will provide the State with sufficient information to operate, diagnose, and maintain the Licensed Software properly, safely, and efficiently.

Managed Care Organizations (MCO): A managed care organization as set forth in 42 CFR§438.2. Nebraska has three MCOs at the time this RFP was issued. There are multiple MCO's serving all 93 Nebraska counties. Current contracts are located on the State Purchasing Bureau website at http://das.nebraska.gov/materiel/purchasing/.

Mandatory/Must: Required, compulsory, or obligatory.

May: Discretionary, permitted; used to express possibility.

Module (see System): A collection of routines and data structures that perform a specific function of software.

Must: See Mandatory/Must and Shall/Will/Must.

National Institute for Governmental Purchasing (NIGP): National Institute of Governmental Purchasing – Source used for assignment of universal commodity codes to goods and services.

Open Market Purchase: Authorization may be given to an agency to purchase items above direct purchase authority due to the unique nature, price, quantity, location of the using agency, or time limitations by the AS Materiel Division, State Purchasing Bureau.

Opening Date and Time: Specified date and time for the public opening of electronically received, labeled, or paper receive, labeled, sealed formal proposals.

Operating System: The control program in a computer that provides the interface to the computer hardware and peripheral devices, and the usage and allocation of memory resources, processor resources, input/output resources, and security resources.

Outsourcing: The contracting out of a business process which an organization may have previously performed internally or has a new need for, to an independent organization from which the process is purchased back.

Payroll & Financial Center (PFC): Electronic procurement system of record.

Performance Bond: An insurance agreement, accompanied by a monetary commitment, by which a third party (the surety) accepts liability and guarantees that the Contractor fulfills any and all obligations under the contract.

Platform: A specific hardware and Operating System combination that is different from other hardware and Operating System combinations to the extent that a different version of the Licensed Software product is required to execute properly in

the environment established by such hardware and Operating System combination.

Point of Contact (POC): The person designated to receive communications and to communicate.

Prepaid Ambulatory Health Plan (PAHP): an entity as defined under 42 CFR § 438.2.

Prepaid Inpatient Health Plan (PIHP): an entity as defined under 42 CFR § 438.2.

Pre-Proposal Conference: A meeting scheduled for the purpose of clarifying a written solicitation and related expectations.

Product: Something that is distributed commercially for use or consumption and that is usually (1) tangible personal property, (2) the result of fabrication or processing, and (3) an item that has passed through a chain of commercial distribution before ultimate use or consumption.

Program Error: Code in Licensed Software which produces unintended results or actions, or which produces results or actions other than those described in the specifications. A program error includes, without limitation, any Critical Program Error.

Program Set: The group of programs and products, including the Licensed Software specified in the solicitation, plus any additional programs and products licensed by the State under the contract for use by the State.

Project: The total scheme, program, or method worked out for the accomplishment of an objective, including all documentation, commodities, and services to be provided under the contract.

Proposal: An offer, bid, or quote submitted by a contractor/vendor in a response to a written solicitation

Proprietary Information: Proprietary information is defined as trade secrets, academic and scientific research work which is in progress and unpublished, and other information which if released would give advantage to business competitors and serves no public purpose (see Neb. Rev. Stat. § 84-712.05(3)). In accordance with Attorney General Opinions 92068 and 97033, proof that information is proprietary requires identification of specific named competitor(s) advantaged by release of the information and the demonstrated advantage the named competitor(s) would gain by the release of information.

Protest/Grievance: A complaint about a governmental action or decision related to a solicitation or resultant contract, brought by a contractor who has timely submitted a proposal response in connection with the award in question, to AS Materiel Division or another designated agency with the intention of achieving a remedial result.

Public Proposal Opening: The process of opening correctly submitted offers at the time and place specified in the written solicitation and in the presence of anyone who wished to attend.

Quality: Quality is the degree to which health services for individuals and populations increase the likelihood of desired outcomes and are consistent with current professional knowledge. As it pertains to external quality review, means the degree to which an MCO increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge.

Quality Indicators: Quality indicators are disease, condition, or situation; specific statements that represent areas of consensus and are related to process/outcomes of care. These can incorporate guidelines, standards of care, and/or practice parameters and must be grounded in literature where available.

Recommended Hardware Configuration: The data processing hardware (including all terminals, auxiliary storage, communication, and other peripheral devices) to the extent utilized by the State as recommended by the Contractor.

Release Date: The date of public release of the written solicitation to seek offers.

Renewal Period: Optional contract periods subsequent to the original Contract Period for a specified duration with previously agreed to terms and conditions. Not to be confused with Extension.

Request for Proposal (RFP): A written solicitation utilized for obtaining competitive offers.

Responsible Contractor: A contractor who has the capability in all respects to perform fully and lawfully all requirements with integrity and reliability to assure good faith performance.

Responsive Contractor: A contractor who has submitted a proposal which conforms to all requirements of the solicitation document.

Shall/Will/Must: An order/command; mandatory.

Should: Expected; suggested, but not necessarily mandatory.

Software License: Legal instrument with or without printed material that governs the use or redistribution of licensed software.

Specifications: The detailed statement, especially of the measurements, quality, materials, and functional characteristics, or other items to be provided under a contract.

Statutory: These clauses are controlled by state law and are not subject to negotiation.

Subcontractor: Individual or entity with whom the contractor enters a contract to perform a portion of the work awarded to the contractor.

System (see Module): Any collection or aggregation of two (2) or more Modules that is designed to function, or is represented by the Contractor as functioning or being capable of functioning, as an entity.

Termination: Occurs when either Party, pursuant to a power created by agreement or law, puts an end to the contract prior to the stated expiration date. All obligations which are still executory on both sides are discharged but any right based on prior breach or performance survives.

Third Party: Any person or entity, including but not limited to fiduciaries, shareholders, owners, officers, managers, employees, legally disinterested persons, and sub-contractors or agents, and their employees. It shall not include any entity or person who is an interested Party to the contract or agreement.

Trade Secret: Information, including, but not limited to, a drawing, formula, pattern, compilation, program, device, method, technique, code, or process that (a) derives independent economic value, actual or potential, from not being known to, and not being ascertainable by proper means by, other persons who can obtain economic value from its disclosure or use; and (b) is the subject of efforts that are reasonable under the circumstances to maintain its secrecy (see Neb. Rev. Stat. §87-502(4)).

Trademark: A word, phrase, logo, or other graphic symbol used by a manufacturer or contractor to distinguish its product from those of others, registered with the U.S. Patent and Trademark Office.

Upgrade: Any change that improves or alters the basic function of a product or service.

Validation: The review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accordance with standards for data collection and analysis.

Vendor Performance Report: A report completed by the using agency and submitted to State Purchasing Bureau documenting products or services delivered or performed which exceed or fail to meet the terms of the purchase order, contract, and/or solicitation specifications.

Vendor: Inclusive term for any Bidder or Contractor

Will: See Mandatory/Shall/Will/Must.

Work Day: See Business Day.

ACRONYM LIST

ARO – After Receipt of Order

ACH – Automated Clearing House

BAFO – Best and Final Offer

CMS – Centers for Medicare and Medicaid Services

COI – Certificate of Insurance

CPU – Central Processing Unit

DAS – Department of Administrative Services

DBM – Dental Benefits Manager

DHHS – The State of Nebraska, Department of Health and Human Services, Division of Medicaid and Long Term Care

F.O.B. – Free on Board

MCO – Managed Care Organization

MCNA – Managed Care of North America, Inc.

NCQA – National Committee for Quality Assurance

NIGP – National Institute for Governmental Purchasing

PA – Participating Addendum

PAHP – Prepaid Ambulatory Health Plan

PIP – Performance Improvement Plan

RFP – Request for Proposal

SPB – State Purchasing Bureau

I. PROCUREMENT PROCEDURE

A. GENERAL INFORMATION

The solicitation is designed to solicit proposals from qualified Contractor who will be responsible for providing External Quality Reviews at a competitive and reasonable cost. Terms and Conditions, Project Description and Scope of Work, and Proposal instructions may be found in Sections II through VI.

Proposals shall conform to all instructions, conditions, and requirements included in the solicitation. Prospective contractors are expected to carefully examine all documents, schedules, and requirements in this solicitation, and respond to each requirement in the format prescribed. Proposals may be found non-responsive if they do not conform to the solicitation.

B. PROCURING OFFICE AND COMMUNICATION WITH STATE STAFF AND EVALUATORS

Procurement responsibilities related to this solicitation reside with DHHS. The point of contact (POC) for the procurement is as follows:

Name: Keith Roland
Agency: Department of Health and Human Services
Address: 301 Centennial Mall S.
Lincoln, NE 68509

Telephone: 402-471-0727

E-Mail: dhhs.rfpquestions@nebraska.gov

From the date the solicitation is issued until the Intent to Award is issued, communication from the Contractor is limited to the POC listed above. After the Intent to Award is issued, the Contractor may communicate with individuals the State has designated as responsible for negotiating the contract on behalf of the State. No member of the State Government, employee of the State, or member of the Evaluation Committee is empowered to make binding statements regarding this solicitation. The POC will issue any answers, clarifications or amendments regarding this solicitation in writing. Only the SPB or awarding agency can award a contract. Contractors shall not have any communication with, or attempt to communicate or influence any evaluator involved in this solicitation.

The following exceptions to these restrictions are permitted:

1. Contact made pursuant to pre-existing contracts or obligations;
2. Contact required by the schedule of events or an event scheduled later by the solicitation POC; and
3. Contact required for negotiation and execution of the final contract.

The State reserves the right to reject a contractor's proposal, withdraw an Intent to Award, or terminate a contract if the State determines there has been a violation of these procurement procedures.

C. **SCHEDULE OF EVENTS**

The State expects to adhere to the procurement schedule shown below, but all dates are approximate and subject to change.

ACTIVITY		DATE/TIME
1.	Release Solicitation	June 1, 2020
2.	Last day to submit written questions	June 15, 2020
3.	State responds to written questions through Solicitation "Addendum" and/or "Amendment" to be posted to the Internet at: http://das.nebraska.gov/materiel/purchase_bureau/vendor/agency-rfp.html	June 30, 2020
4.	Last day to submit "Notification of Intent To Submit a Proposal"	July 15, 2020
5.	Proposal Opening Location for mailed/hand-delivered submissions: Department of Health and Human Services 301 Centennial Mall S., 3rd floor Lincoln, NE 68509 Electronic submissions: https://nebraskastategov.sharefile.com/r-r4058b5be7e64e798	July 31, 2020 2:00 PM Central Time
6.	Review for conformance to solicitation requirements	August 1, 2020
7.	Evaluation period	August 1, 2020- August 31, 2020
8.	"Oral Interviews/Presentations and/or Demonstrations" (if required)	To be announced if required
9.	Post "Notification of Intent to Award" to Internet at: http://das.nebraska.gov/materiel/purchase_bureau/vendor/agency-rfp.html	September 1, 2020
10.	Contract finalization period	September 15, 2020
11.	Contract award	September 30, 2020
12.	Contractor start date	October 1, 2020

D. **WRITTEN QUESTIONS AND ANSWERS**

Questions regarding the meaning or interpretation of any solicitation provision must be submitted in writing to DHHS and clearly marked "RFP Number 6303 Z1; External Quality Review Questions". The POC is not obligated to respond to questions that are received late per the Schedule of Events.

Contractors should present, as questions, any assumptions upon which the Contractor's proposal is or might be developed. Proposals will be evaluated without consideration of any known or unknown assumptions of a contractor. The contract will not incorporate any known or unknown assumptions of a contractor.

It is preferred that questions be sent via e-mail to dhhs.rfpquestions@nebraska.gov, but may be delivered by hand or by U.S. Mail. It is recommended that Contractors submit questions using the following format.

Solicitation Section Reference	Solicitation Page Number	Question

Written answers will be posted at http://das.nebraska.gov/materiel/purchase_bureau/vendor/agency-rfp.html per the Schedule of Events.

E. **SECRETARY OF STATE/TAX COMMISSIONER REGISTRATION REQUIREMENTS (Statutory)**

All contractors must be authorized to transact business in the State of Nebraska and comply with all Nebraska Secretary of State Registration requirements. The contractor who is the recipient of an Intent to Award will be required to certify that it has complied and produce a true and exact copy of its current (within ninety (90) calendar days of the intent to award) Certificate or Letter of Good Standing, or in the case of a sole proprietorship, provide written documentation of sole proprietorship and complete the United States Citizenship Attestation Form, available on the Department of Administrative Services website at http://das.nebraska.gov/materiel/purchasing.html. This must be accomplished prior to execution of the contract.

F. **ETHICS IN PUBLIC CONTRACTING**

The State reserves the right to reject proposals, withdraw an intent to award or award, or terminate a contract if a contractor commits or has committed ethical violations, which include, but are not limited to:

1. Offering or giving, directly or indirectly, a bribe, fee, commission, compensation, gift, gratuity, or anything of value to any person or entity in an attempt to influence the bidding process;
2. Utilize the services of lobbyists, attorneys, political activists, or consultants to influence or subvert the bidding process;
3. Being considered for, presently being, or becoming debarred, suspended, ineligible, or excluded from contracting with any state or federal entity:
4. Submitting a proposal on behalf of another Party or entity; and
5. Collude with any person or entity to influence the bidding process, submit sham proposals, preclude bidding, fix pricing or costs, create an unfair advantage, subvert the proposal, or prejudice the State.

The Contractor shall include this clause in any subcontract entered into for the exclusive purpose of performing this contract.

Contractor shall have an affirmative duty to report any violations of this clause by the Contractor throughout the bidding process, and throughout the term of this contract for the successful Contractor and their subcontractors.

G. **DEVIATIONS FROM THE REQUEST FOR PROPOSAL**

The requirements contained in the solicitation (Sections II thru VI) become a part of the terms and conditions of the contract resulting from this solicitation. Any deviations from the solicitation in Sections II through VI must be clearly defined by the contractor in its proposal and, if accepted by the State, will become part of the contract. Any specifically defined deviations must not be in conflict with the basic nature of the solicitation, requirements, or applicable state or federal laws or statutes. "Deviation", for the purposes of this solicitation, means any proposed changes or alterations to either the contractual language or deliverables within the scope of this solicitation. The State discourages deviations and reserves the right to reject proposed deviations.

H. **SUBMISSION OF PROPOSALS**

The State is accepting either electronically submitted responses or hard copy, paper responses for this RFP.

For bidders submitting electronic responses:

1. Bidders submitting electronically can upload the response via ShareFile here:
   a. https://nebraskastategov.sharefile.com/r-r4058b5be7e64e798

b. ShareFile works with Firefox, Internet Explorer and Chrome. It does not work with Microsoft Edge.

2. The Technical, Cost Proposal and Proprietary information should be uploaded as separate and distinct files. If multiple proposals are submitted, the State will retain only the most recently submitted response. It is the bidder's responsibility to submit the proposal by the date and time indicated in the Schedule of Events. Electronic proposals must be received by SPB by the date and time of the proposal opening per the Schedule of Events. No late proposals will be accepted

3. ELECTRONIC PROPOSAL FILE NAMES
The bidder should clearly identify the uploaded RFP proposal files. To assist in identification please use the following naming convention:

- **a.** RFP 6264 Z1 ABC Company
- **b.** If multiple files are submitted for one RFP proposal, add number of files to file names: RFP 6264 Z1 ABC Company File 1 of 2.
- **c.** If multiple RFP proposals are submitted for the same RFP, add the proposal number to the file names: RFP 6264 Z1 ABC Company Proposal 1 File 1 of 2.

For bidders submitting paper/hard copy responses:

4. Bidders who are submitting a paper response should submit one proposal marked on the first page: "ORIGINAL". If multiple proposals are submitted, the State will retain one copy marked "ORIGINAL" and destroy the other copies. The Contractor is solely responsible for any variance between the copies submitted. Proposal responses should include the completed Form A, "Contractor Proposal Point of Contact". Proposals must reference the RFP number and be sent to the specified address. Please note that the address label should appear as specified in Section I B. on the face of each container or contractor's proposal response packet. If a recipient phone number is required for delivery purposes, 402-471-0727 should be used. The RFP number should be included in all correspondence. The State will not furnish packaging and sealing materials. It is the contractor's responsibility to ensure the solicitation is received in a sealed envelope or container and submitted by the date and time indicated in the Schedule of Events. Sealed proposals must be received in the State Purchasing Bureau by the date and time of the proposal opening per the Schedule of Events. No late proposals will be accepted.

United States Postal Services (USPS) delivered proposal responses shall be mailed to:

ATTN: Keith Roland
DHHS - Central Procurement Services
PO BOX 94926
Lincoln, NE 68509

Hand delivered proposal responses or responses delivered by Federal Express (FedEx), United Parcel Service (UPS), etc. shall be delivered to:

ATTN: Keith Roland
DHHS - 3rd Floor Reception Desk
301 Centennial Mall South
Lincoln, NE 68509

5. The Technical, Cost Proposal, and Proprietary Information should be presented in separate sections (loose-leaf binders are preferred) on standard 8 ½" x 11" paper, except that charts, diagrams and the like may be on fold-outs which, when folded, fit into the 8 ½" by 11" format. Pages may be consecutively numbered for the entire proposal, or may be numbered consecutively within sections. Figures and tables should be numbered consecutively within sections. Figures and tables should be numbered and referenced in the text by that number. They should be placed as close as possible to the referencing text.

The Technical Proposal should not contain any reference to dollar amounts. However, information such as data concerning labor hours and categories, materials, subcontracts and so forth, shall be considered in the Technical Proposal so that the bidder's understanding of the scope of work may be evaluated. The Technical Proposal shall disclose the bidder's technical approach in as much detail as possible, including, but not limited to, the information required by the Technical Proposal instructions. Bidder must use the State's Cost Proposal Form.

The State will not furnish packaging or sealing materials. It is the bidder's responsibility to ensure the solicitation is received either electronically or in a sealed envelope or container and submitted by the date and time indicated in the

Schedule of Events. Sealed proposals must be received in the State Purchasing Bureau by the date and time of the proposal opening per the Schedule of Events.

The Request for Proposal form must be manually signed in an indelible manner or by DocuSign and returned by the proposal opening date and time along with the contractor's Request for Proposal along with any other requirements as stated in the Request for Proposal document in order for the contractor's Request for Proposal response to be evaluated.

It is the responsibility of the contractor to check the website for all information relevant to this Request for Proposal to include addenda and/or amendments issued prior to the opening date. Website address is as follows: http://das.nebraska.gov/materiel/purchase_bureau/vendor/agency-rfp.html.

Emphasis should be concentrated on conformance to the solicitation instructions, responsiveness to requirements, completeness, and clarity of content. If the contractor's proposal is presented in such a fashion that makes evaluation difficult or overly time consuming the State reserves the right to reject the proposal as non-conforming.

The State shall not incur any liability for any costs incurred by contractors in replying to this solicitation, in the demonstrations and/or oral presentations, or in any other activity related to bidding on this solicitation.

By signing the "Request for Proposal for Contractual Services" form, the contractor guarantees compliance with the provisions stated in this solicitation.

I. **PROPOSAL PREPARATION COSTS**

The State shall not incur any liability for any costs incurred by Contractors in replying to this solicitation, including any activity related to bidding on this solicitation.

J. **FAILURE TO COMPLY WITH REQUEST FOR PROPOSAL**

Violation of the terms and conditions contained in this solicitation or any resultant contract, at any time before or after the award, shall be grounds for action by the State which may include, but is not limited to, the following:

1. Rejection of a contractor's proposal;
2. Withdrawal of the Intent to Award;
3. Withdrawal of the Award;
4. Negative Vendor Performance Report(s)
5. Termination of the resulting contract;
6. Legal action; and
7. Suspension of the contractor from further bidding with the State for the period of time relative to the seriousness of the violation, such period to be within the sole discretion of the State.

K. **PROPOSAL CORRECTIONS**

A contractor may correct a mistake in a proposal prior to the time of opening by giving written notice to the State of intent to withdraw the proposal for modification or to withdraw the proposal completely. Changing a proposal after opening may be permitted if the change is made to correct a minor error that does not affect price, quantity, quality, delivery, or contractual conditions. In case of a mathematical error in extension of price, unit price shall govern.

L. **LATE PROPOSALS**

Proposals received after the time and date of the proposal opening will be considered late proposals. Late proposals will be returned unopened, if requested by the contractor and at contractor's expense. The State is not responsible for proposals that are late or lost regardless of cause or fault.

M. **PROPOSAL OPENING**

The opening of proposals will be public and the contractors will be announced. Proposals **WILL NOT** be available for viewing by those present at the proposal opening. Proposals will be posted to the State Purchasing Bureau website once an Intent to Award has been posted to the website. Information identified as proprietary by the submitting contractor, in accordance with the solicitation and state statute, will not be posted. If the state determines submitted information should not be withheld, in accordance with the Public Records Act, or if ordered to release any withheld information, said information may then be released. The submitting contractor will be notified of the release and it shall be the obligation of the submitting contractor to take further action, if it believes the information should not be released. (See RFP signature page for further details) Contractors may contact the State to schedule an appointment for viewing proposals after the Intent to Award has been posted to the website. Once proposals are opened, they become the property of the State of Nebraska and will not be returned.

N. REQUEST FOR PROPOSAL/PROPOSAL REQUIREMENTS

The proposals will first be examined to determine if all requirements listed below have been addressed and whether further evaluation is warranted. Proposals not meeting the requirements may be rejected as non-responsive. The requirements are:

1. Original Request for Proposal for Contractual Services form signed using an indelible method;
2. Clarity and responsiveness of the proposal;
3. Completed Form A – Contractor Proposal Point of Contact;
4. Completed Corporate Overview;
5. Completed Sections II through IV;
6. Completed Attachment 1 - Technical Approach Narrative;
7. Draft Work Plan;
8. Draft Communications Plan; and
9. Completed Cost Proposal.

O. EVALUATION COMMITTEE

Proposals are evaluated by members of an Evaluation Committee(s). The Evaluation Committee(s) will consist of individuals selected at the discretion of the State. Names of the members of the Evaluation Committee(s) will not be published prior to the intent to award.

Any contact, attempted contact, or attempt to influence an evaluator that is involved with this solicitation may result in the rejection of this proposal and further administrative actions.

P. EVALUATION OF PROPOSALS

All proposals that are responsive to the solicitation will be evaluated. Each evaluation category will have a maximum point potential. The State will conduct a fair, impartial, and comprehensive evaluation of all proposals in accordance with the criteria set forth below. Areas that will be addressed and scored during the evaluation include:

1. Corporate Overview should include but is not limited to:
  a. the ability, capacity, and skill of the contractor to deliver and implement the system or project that meets the requirements of the solicitation;
  b. the character, integrity, reputation, judgment, experience, and efficiency of the contractor;
  c. whether the contractor can perform the contract within the specified time frame;
  d. the quality of vendor performance on prior contracts;
  e. such other information that may be secured and that has a bearing on the decision to award the contract;
2. Technical Approach, including Draft Work and Communications Plans and,
3. Cost Proposal.

Neb. Rev. Stat. §81-161 allows the quality of performance of previous contracts to be considered when evaluating responses to competitively bid solicitations in determining the lowest responsible bidder. Information obtained from any Vendor Performance Report (See Terms & Conditions, Section H) may be used in evaluating responses to solicitations for goods and services to determine the best value for the State.

Neb. Rev. Stat. §73-107 allows for a preference for a resident disabled veteran or business located in a designated enterprise zone. When a state contract is to be awarded to the lowest responsible contractor, a resident disabled veteran or a business located in a designated enterprise zone under the Enterprise Zone Act shall be allowed a preference over any other resident or nonresident contractor, if all other factors are equal.

Resident disabled veterans means any person (a) who resides in the State of Nebraska, who served in the United States Armed Forces, including any reserve component or the National Guard, who was discharged or otherwise separated with a characterization of honorable or general (under honorable conditions), and who possesses a disability rating letter issued by the United States Department of Veterans Affairs establishing a service-connected disability or a disability determination from the United States Department of Defense and (b)(i) who owns and controls a business or, in the case of a publicly owned business, more than fifty percent of the stock is owned by one or more persons described in subdivision (a) of this subsection and (ii) the management and daily business operations of the business are controlled by one or more persons described in subdivision(a) of this subsection. Any contract entered into without compliance with this section shall be null and void.

Therefore, if a resident disabled veteran or business located in a designated enterprise zone submits a proposal in accordance with Neb. Rev. Stat. §73-107 and has so indicated on the solicitation cover page under “Contractor must

complete the following" requesting priority/preference to be considered in the award of this contract, the following will need to be submitted by the contractor within ten (10) business days of request:

1. Documentation from the United States Armed Forces confirming service;
2. Documentation of discharge or otherwise separated characterization of honorable or general (under honorable conditions);
3. Disability rating letter issued by the United States Department of Veterans Affairs establishing a service-connected disability or a disability determination from the United States Department of Defense; and
4. Documentation which shows ownership and control of a business or, in the case of a publicly owned business, more than fifty percent of the stock is owned by one or more persons described in subdivision (a) of this subsection; and the management and daily business operations of the business are controlled by one or more persons described in subdivision (a) of this subsection.

Failure to submit the requested documentation within ten (10) business days of notice will disqualify the contractor from consideration of the preference.

Evaluation criteria will be released with the solicitation.

Q. ORAL INTERVIEWS/PRESENTATIONS AND/OR DEMONSTRATIONS

The State may determine after the completion of the Technical and Cost Proposal evaluation that oral interviews/presentations and/or demonstrations are required. Every contractor may not be given an opportunity to interview/present and/or give demonstrations; the State reserves the right, in its discretion, to select only the top scoring contractors to present/give oral interviews. The scores from the oral interviews/presentations and/or demonstrations will be added to the scores from the Technical and Cost Proposals. The presentation process will allow the contractors to demonstrate their proposal offering, explaining and/or clarifying any unusual or significant elements related to their proposals. Contractors' key personnel, identified in their proposal, may be requested to participate in a structured interview to determine their understanding of the requirements of this proposal, their authority and reporting relationships within their firm, and their management style and philosophy. Only representatives of the State and the presenting contractor will be permitted to attend the oral interviews/presentations and/or demonstrations. A written copy or summary of the presentation, and demonstrative information (such as briefing charts, et cetera) may be offered by the contractor, but the State reserves the right to refuse or not consider the offered materials. Contractors shall not be allowed to alter or amend their proposals.

Once the oral interviews/presentations and/or demonstrations have been completed, the State reserves the right to make an award without any further discussion with the contractors regarding the proposals received.

Any cost incidental to the oral interviews/presentations and/or demonstrations shall be borne entirely by the contractor and will not be compensated by the State.

R. BEST AND FINAL OFFER

If best and final offers (BAFO) are requested by the State and submitted by the contractor, they will be evaluated (using the stated BAFO criteria), scored, and ranked by the Evaluation Committee. The State reserves the right to conduct more than one Best and Final Offer. The award will then be granted to the highest scoring contractor. However, a contractor should provide its best offer in its original proposal. Contractors should not expect that the State will request a best and final offer.

S. REFERENCE AND CREDIT CHECKS

The State reserves the right to conduct and consider reference and credit checks. The State reserves the right to use third parties to conduct reference and credit checks. By submitting a proposal in response to this solicitation, the contractor grants to the State the right to contact or arrange a visit in person with any or all of the contractor's clients. Reference and credit checks may be grounds to reject a proposal, withdraw an intent to award, or rescind the award of a contract.

T. AWARD

The State reserves the right to evaluate proposals and award contracts in a manner utilizing criteria selected at the State's discretion and in the State's best interest. After evaluation of the proposals, or at any point in the solicitation process, the State of Nebraska may take one or more of the following actions:

1. Amend the solicitation;
2. Extend the time of or establish a new proposal opening time;
3. Waive deviations or errors in the State's solicitation process and in contractor proposals that are not material, do not compromise the solicitation process or a contractor's proposal, and do not improve a contractor's competitive position;
4. Accept or reject a portion of or all of a proposal;

5. Accept or reject all proposals;
6. Withdraw the solicitation;
7. Elect to rebid the solicitation;
8. Award single lines or multiple lines to one or more contractors; or,
9. Award one or more all-inclusive contracts.

The solicitation does not commit the State to award a contract. Once intent to award decision has been determined, it will be posted to the Internet at:
http://das.nebraska.gov/materiel/purchase_bureau/vendor/agency-rfp.html

Any protests must be filed by a contractor within ten (10) business days after the intent to award decision is posted to the Internet. Grievance and protest procedure is available on the Internet at:
http://das.nebraska.gov/materiel/purchasing.html

U. **ALTERNATE/EQUIVALENT PROPOSALS**

Contractor may offer proposals which are at variance from the express specifications of the solicitation. The State reserves the right to consider and accept such proposals if, in the judgment of the Materiel Administrator, the proposal will result in goods and/or services equivalent to or better than those which would be supplied in the original proposal specifications. Contractor must indicate on the solicitation the manufacturer's name, number and shall submit with their proposal, sketches, descriptive literature and/or complete specifications. Reference to literature submitted with a previous proposal will not satisfy this provision. Proposals which do not comply with these requirements are subject to rejection. In the absence of any stated deviation or exception, the proposal will be accepted as in strict compliance with all terms, conditions and specification, and the Contractor shall be held liable therefore.

V. **LUMP SUM OR "ALL OR NONE" PROPOSALS**

The State reserves the right to purchase item-by-item, by groups or as a total when the State may benefit by so doing. Contractors may submit a proposal on an "all or none" or "lump sum" basis, but should also submit a proposal on an item-by-item basis. The term "all or none" means a conditional proposal which requires the purchase of all items on which proposals are offered and Contractor declines to accept award on individual items; a "lump sum" proposal is one in which the Contractor offers a lower price than the sum of the individual proposals if all items are purchased, but agrees to deliver individual items at the prices quoted.

W. **EMAIL SUBMISSIONS**

SPB will not accept proposals by email, electronic, voice, or telephone proposals except for one-time purchases under $50,000.00.

X. **REJECTION OF PROPOSALS**

The State reserves the right to reject any or all proposals, wholly or in part, in the best interest of the State.

Y. **RESIDENT BIDDER**

Pursuant to Neb. Rev. Stat. §§ 73-101.01 through 73-101.02, a Resident Bidder shall be allowed a preference against a Non-resident Bidder from a state which gives or requires a preference to Bidders from that state. The preference shall be equal to the preference given or required by the state of the Nonresident Bidders. Where the lowest responsible bid from a resident Bidder is equal in all respects to one from a nonresident Bidder from a state which has no preference law, the resident Bidder shall be awarded the contract. The provision of this preference shall not apply to any contract for any project upon which federal funds would be withheld because of the provisions of this preference.

II. TERMS AND CONDITIONS

Contractors should complete Sections II through VI as part of their proposal. Contractor is expected to read the Terms and Conditions and should initial either accept, reject, or reject and provide alternative language for each clause. The contractor should also provide an explanation of why the contractor rejected the clause or rejected the clause and provided alternate language. By signing the solicitation, contractor is agreeing to be legally bound by all the accepted terms and conditions, and any proposed alternative terms and conditions submitted with the proposal. The State reserves the right to negotiate rejected or proposed alternative language. If the State and contractor fail to agree on the final Terms and Conditions, the State reserves the right to reject the proposal. The State of Nebraska is soliciting proposals in response to this solicitation. The State of Nebraska reserves the right to reject proposals that attempt to substitute the contractor's commercial contracts and/or documents for this solicitation.

The contractors should submit with their proposal any license, user agreement, service level agreement, or similar documents that the contractor wants incorporated in the Contract. The State will not consider incorporation of any document not submitted with the contractor's proposal as the document will not have been included in the evaluation process. These documents shall be subject to negotiation and will be incorporated as addendums if agreed to by the Parties.

If a conflict or ambiguity arises after the Addendum to Contract Award have been negotiated and agreed to, the Addendum to Contract Award shall be interpreted as follows:

1. If only one Party has a particular clause then that clause shall control;
2. If both Parties have a similar clause, but the clauses do not conflict, the clauses shall be read together;
3. If both Parties have a similar clause, but the clauses conflict, the State's clause shall control.

A. GENERAL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

The contract resulting from this solicitation shall incorporate the following documents:

1. Request for Proposal and Addenda;
2. Amendments to the solicitation;
3. Questions and Answers;
4. Contractor's proposal (Solicitation and properly submitted documents);
5. The executed Contract and Addendum One to Contract, if applicable; and,
6. Amendments/Addendums to the Contract.

These documents constitute the entirety of the contract.

Unless otherwise specifically stated in a future contract amendment, in case of any conflict between the incorporated documents, the documents shall govern in the following order of preference with number one (1) receiving preference over all other documents and with each lower numbered document having preference over any higher numbered document: 1) Amendment to the executed Contract with the most recent dated amendment having the highest priority, 2) executed Contract and any attached Addenda, 3) Amendments to solicitation and any Questions and Answers, 4) the original solicitation document and any Addenda, and 5) the Contractor's submitted Proposal.

Any ambiguity or conflict in the contract discovered after its execution, not otherwise addressed herein, shall be resolved in accordance with the rules of contract interpretation as established in the State of Nebraska.

B. **NOTIFICATION**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

Contractor and State shall identify the contract manager who shall serve as the point of contact for the executed contract.

Communications regarding the executed contract shall be in writing and shall be deemed to have been given if delivered personally or mailed, by U.S. Mail, postage prepaid, return receipt requested, to the parties at their respective addresses set forth below, or at such other addresses as may be specified in writing by either of the parties. All notices, requests, or communications shall be deemed effective upon personal delivery or five (5) calendar days following deposit in the mail.

Either party may change its address for notification purposes by giving notice of the change, and setting forth the new address and an effective date.

C. **NOTICE (POC)**

The State reserves the right to appoint a Buyer's Representative to manage [or assist the Buyer in managing] the contract on behalf of the State. The Buyer's Representative will be appointed in writing, and the appointment document will specify the extent of the Buyer's Representative authority and responsibilities. If a Buyer's Representative is appointed, the Contractor will be provided a copy of the appointment document, and is expected to cooperate accordingly with the Buyer's Representative. The Buyer's Representative has no authority to bind the State to a contract, amendment, addendum, or other change or addition to the contract.

D. **GOVERNING LAW (Statutory)**

Notwithstanding any other provision of this contract, or any amendment or addendum(s) entered into contemporaneously or at a later time, the parties understand and agree that, (1) the State of Nebraska is a sovereign state and its authority to contract is therefore subject to limitation by the State's Constitution, statutes, common law, and regulation; (2) this contract will be interpreted and enforced under the laws of the State of Nebraska; (3) any action to enforce the provisions of this agreement must be brought in the State of Nebraska per state law; (4) the person signing this contract on behalf of the State of Nebraska does not have the authority to waive the State's sovereign immunity, statutes, common law, or regulations; (5) the indemnity, limitation of liability, remedy, and other similar provisions of the final contract, if any, are entered into subject to the State's Constitution, statutes, common law, regulations, and sovereign immunity; and, (6) all terms and conditions of the final contract, including but not limited to the clauses concerning third party use, licenses, warranties, limitations of liability, governing law and venue, usage verification, indemnity, liability, remedy or other similar provisions of the final contract are entered into specifically subject to the State's Constitution, statutes, common law, regulations, and sovereign immunity.

The Parties must comply with all applicable local, state and federal laws, ordinances, rules, orders, and regulations.

E. **BEGINNING OF WORK**

The contractor shall not commence any billable work until a valid contract has been fully executed by the State and the successful Contractor. The Contractor will be notified in writing when work may begin.

F. **AMENDMENT**

This Contract may be amended in writing, within scope, upon the agreement of both parties.

G. **CHANGE ORDERS OR SUBSTITUTIONS**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

The State and the Contractor, upon the written agreement, may make changes to the contract within the general scope of the solicitation. Changes may involve specifications, the quantity of work, or such other items as the State may find necessary or desirable. Corrections of any deliverable, service, or work required pursuant to the contract shall not be deemed a change. The Contractor may not claim forfeiture of the contract by reasons of such changes.

The Contractor shall prepare a written description of the work required due to the change and an itemized cost sheet for the change. Changes in work and the amount of compensation to be paid to the Contractor shall be determined in accordance with applicable unit prices if any, a pro-rated value, or through negotiations. The State shall not incur a price increase for changes that should have been included in the Contractor's proposal, were foreseeable, or result from difficulties with or failure of the Contractor's proposal or performance.

No change shall be implemented by the Contractor until approved by the State, and the Contract is amended to reflect the change and associated costs, if any. If there is a dispute regarding the cost, but both parties agree that immediate implementation is necessary, the change may be implemented, and cost negotiations may continue with both Parties retaining all remedies under the contract and law.

In the event any product is discontinued or replaced upon mutual consent during the contract period or prior to delivery, the State reserves the right to amend the contract or purchase order to include the alternate product at the same price.

*****Contractor will not substitute any item that has been awarded without prior written approval of SPB*****

H. VENDOR PERFORMANCE REPORT(S)

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

The State may document any instance(s) of products or services delivered or performed which exceed or fail to meet the terms of the purchase order, contract, and/or solicitation specifications. The State Purchasing Bureau may contact the Vendor regarding any such report. Vendor performance report(s) will become a part of the permanent record of the Vendor.

I. NOTICE OF POTENTIAL CONTRACTOR BREACH

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

If Contractor breaches the contract or anticipates breaching the contract, the Contractor shall immediately give written notice to the State. The notice shall explain the breach or potential breach, a proposed cure, and may include a request for a waiver of the breach if so desired. The State may, in its discretion, temporarily or permanently waive the breach. By granting a waiver, the State does not forfeit any rights or remedies to which the State is entitled by law or equity, or pursuant to the provisions of the contract. Failure to give immediate notice, however, may be grounds for denial of any request for a waiver of a breach.

J. **BREACH**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

Either Party may terminate the contract, in whole or in part, if the other Party breaches its duty to perform its obligations under the contract in a timely and proper manner. Termination requires written notice of default and a thirty (30) calendar day (or longer at the non-breaching Party's discretion considering the gravity and nature of the default) cure period. Said notice shall be delivered by Certified Mail, Return Receipt Requested, or in person with proof of delivery. Allowing time to cure a failure or breach of contract does not waive the right to immediately terminate the contract for the same or different contract breach which may occur at a different time. In case of default of the Contractor, the State may contract the service from other sources and hold the Contractor responsible for any excess cost occasioned thereby. OR In case of breach by the Contractor, the State may, without unreasonable delay, make a good faith effort to make a reasonable purchase or contract to purchased goods in substitution of those due from the contractor. The State may recover from the Contractor as damages the difference between the costs of covering the breach. Notwithstanding any clause to the contrary, the State may also recover the contract price together with any incidental or consequential damages defined in UCC Section 2-715, but less expenses saved in consequence of Contractor's breach.

The State's failure to make payment shall not be a breach, and the Contractor shall retain all available statutory remedies and protections.

K. **NON-WAIVER OF BREACH**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

The acceptance of late performance with or without objection or reservation by a Party shall not waive any rights of the Party nor constitute a waiver of the requirement of timely performance of any obligations remaining to be performed.

L. **SEVERABILITY**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

If any term or condition of the contract is declared by a court of competent jurisdiction to be illegal or in conflict with any law, the validity of the remaining terms and conditions shall not be affected, and the rights and obligations of the parties shall be construed and enforced as if the contract did not contain the provision held to be invalid or illegal.

M. **INDEMNIFICATION**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

1. GENERAL
The Contractor agrees to defend, indemnify, and hold harmless the State and its employees, volunteers, agents, and its elected and appointed officials ("the indemnified parties") from and against any and all third party claims, liens, demands, damages, liability, actions, causes of action, losses, judgments, costs, and expenses of every nature, including investigation costs and expenses, settlement costs, and attorney fees and expenses ("the claims"), sustained or asserted against the State for personal injury, death, or property loss or damage, arising out of, resulting from, or attributable to the willful misconduct, negligence, error, or omission of the Contractor, its employees, Subcontractors, consultants, representatives, and agents, resulting from this contract, except to the extent such Contractor liability is attenuated by any action of the State which directly and proximately contributed to the claims.

2. INTELLECTUAL PROPERTY
The Contractor agrees it will, at its sole cost and expense, defend, indemnify, and hold harmless the indemnified parties from and against any and all claims, to the extent such claims arise out of, result from, or are attributable to, the actual or alleged infringement or misappropriation of any patent, copyright, trade secret, trademark, or confidential information of any third party by the Contractor or its employees, Subcontractors, consultants, representatives, and agents; provided, however, the State gives the Contractor prompt notice in writing of the claim. The Contractor may not settle any infringement claim that will affect the State's use of the Licensed Software without the State's prior written consent, which consent may be withheld for any reason.

If a judgment or settlement is obtained or reasonably anticipated against the State's use of any intellectual property for which the Contractor has indemnified the State, the Contractor shall, at the Contractor's sole cost and expense, promptly modify the item or items which were determined to be infringing, acquire a license or licenses on the State's behalf to provide the necessary rights to the State to eliminate the infringement, or provide the State with a non-infringing substitute that provides the State the same functionality. At the State's election, the actual or anticipated judgment may be treated as a breach of warranty by the Contractor, and the State may receive the remedies provided under this solicitation.

3. PERSONNEL
The Contractor shall, at its expense, indemnify and hold harmless the indemnified parties from and against any claim with respect to withholding taxes, worker's compensation, employee benefits, or any other claim, demand, liability, damage, or loss of any nature relating to any of the personnel, including subcontractor's and their employees, provided by the Contractor.

4. SELF-INSURANCE
The State of Nebraska is self-insured for any loss and purchases excess insurance coverage pursuant to Neb. Rev. Stat. § 81-8,239.01 (Reissue 2008). If there is a presumed loss under the provisions of this agreement, Contractor may file a claim with the Office of Risk Management pursuant to Neb. Rev. Stat. §§ 81-8,829 – 81-8,306 for review by the State Claims Board. The State retains all rights and immunities under the State Miscellaneous (Section 81-8,294), Tort (Section 81-8,209), and Contract Claim Acts (Section 81-8,302), as outlined in Neb. Rev. Stat. § 81-8,209 et seq. and under any other provisions of law and accepts liability under this agreement to the extent provided by law.

5. ALL REMEDIES AT LAW
Nothing in this agreement shall be construed as an indemnification by one Party of the other for liabilities of a Party or third parties for property loss or damage or death or personal injury arising out of and during the performance of this contract. Any liabilities or claims for property loss or damages or for death or personal injury by a Party or its agents, employees, contractors or assigns or by third persons, shall be determined according to applicable law.

6. The Parties acknowledge that Attorney General for the State of Nebraska is required by statute to represent the legal interests of the State, and that any provision of this indemnity clause is subject to the statutory authority of the Attorney General.

N. **ATTORNEY'S FEES**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

In the event of any litigation, appeal, or other legal action to enforce any provision of the contract, the Parties agree to pay all expenses of such action, as permitted by law and if ordered by the court, including attorney's fees and costs, if the other Party prevails.

O. **ASSIGNMENT, SALE, OR MERGER**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

Either Party may assign the contract upon mutual written agreement of the other Party. Such agreement shall not be unreasonably withheld.

The Contractor retains the right to enter into a sale, merger, acquisition, internal reorganization, or similar transaction involving Contractor's business. Contractor agrees to cooperate with the State in executing amendments to the contract to allow for the transaction. If a third party or entity is involved in the transaction, the Contractor will remain responsible for performance of the contract until such time as the person or entity involved in the transaction agrees in writing to be contractually bound by this contract and perform all obligations of the contract.

P. **CONTRACTING WITH OTHER NEBRASKA POLITICAL SUB-DIVISIONS OF THE STATE OR ANOTHER STATE**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

The Contractor may, but shall not be required to, allow agencies, as defined in Neb. Rev. Stat. §81-145, to use this contract. The terms and conditions, including price, of the contract may not be amended. The State shall not be contractually obligated or liable for any contract entered into pursuant to this clause. A listing of Nebraska political subdivisions may be found at the website of the Nebraska Auditor of Public Accounts.

The Contractor may, but shall not be required to, allow other states, agencies or divisions of other states, or political subdivisions of other states to use this contract. The terms and conditions, including price, of this contract shall apply to any such contract, but may be amended upon mutual consent of the Parties. The State of Nebraska shall not be contractually or otherwise obligated or liable under any contract entered into pursuant to this clause. The State shall be notified if a contract is executed based upon this contract.

Q. **FORCE MAJEURE**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

Neither Party shall be liable for any costs or damages, or for default resulting from its inability to perform any of its obligations under the contract due to a natural or manmade event outside the control and not the fault of the affected Party ("Force Majeure Event"). The Party so affected shall immediately make a written request for relief to the other Party, and shall have the burden of proof to justify the request. The other Party may grant the relief requested; relief may not be unreasonably withheld. Labor disputes with the impacted Party's own employees will not be considered a Force Majeure Event.

R. **CONFIDENTIALITY**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

All materials and information provided by the Parties or acquired by a Party on behalf of the other Party shall be regarded as confidential information. All materials and information provided or acquired shall be handled in accordance with federal and state law, and ethical standards. Should said confidentiality be breached by a Party, the Party shall notify the other Party immediately of said breach and take immediate corrective action.

It is incumbent upon the Parties to inform their officers and employees of the penalties for improper disclosure imposed by the Privacy Act of 1974, 5 U.S.C. 552a. Specifically, 5 U.S.C. 552a (i)(1), which is made applicable by 5 U.S.C. 552a (m)(1), provides that any officer or employee, who by virtue of his/her employment or official position has possession of or access to agency records which contain individually identifiable information, the disclosure of which is prohibited by the Privacy Act or regulations established thereunder, and who knowing that disclosure of the specific material is prohibited, willfully discloses the material in any manner to any person or agency not entitled to receive it, shall be guilty of a misdemeanor and fined not more than $5,000.

S. **OFFICE OF PUBLIC COUNSEL (Statutory)**
If it provides, under the terms of this contract and on behalf of the State of Nebraska, health and human services to individuals; service delivery; service coordination; or case management, Contractor shall submit to the jurisdiction of the Office of Public Counsel, pursuant to Neb. Rev. Stat. §§ 81-8,240 et seq. This section shall survive the termination of this contract.

T. **LONG-TERM CARE OMBUDSMAN (Statutory)**
Contractor must comply with the Long-Term Care Ombudsman Act, per Neb. Rev. Stat. §§ 81-2237 et seq. This section shall survive the termination of this contract.

U. **EARLY TERMINATION**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

The contract may be terminated as follows:

1. The State and the Contractor, by mutual written agreement, may terminate the contract at any time.

2. The State, in its sole discretion, may terminate the contract for any reason upon thirty (30) calendar days written notice to the Contractor. Such termination shall not relieve the Contractor of warranty or other service obligations incurred under the terms of the contract. In the event of termination the Contractor shall be entitled to payment, determined on a pro rata basis, for products or services satisfactorily performed or provided.

3. The State may terminate the contract immediately for the following reasons:

   a. if directed to do so by statute;
   b. Contractor has made an assignment for the benefit of creditors, has admitted in writing its inability to pay debts as they mature, or has ceased operating in the normal course of business;
   c. a trustee or receiver of the Contractor or of any substantial part of the Contractor's assets has been appointed by a court;
   d. fraud, misappropriation, embezzlement, malfeasance, misfeasance, or illegal conduct pertaining to performance under the contract by its Contractor, its employees, officers, directors, or shareholders;
   e. an involuntary proceeding has been commenced by any Party against the Contractor under any one of the chapters of Title 11 of the United States Code and (i) the proceeding has been pending for at least sixty (60) calendar days; or (ii) the Contractor has consented, either expressly or by operation of law, to the entry of an order for relief; or (iii) the Contractor has been decreed or adjudged a debtor;
   f. a voluntary petition has been filed by the Contractor under any of the chapters of Title 11 of the United States Code;
   g. Contractor intentionally discloses confidential information;
   h. Contractor has or announces it will discontinue support of the deliverable; and,
   i. In the event funding is no longer available.

V. CONTRACT CLOSEOUT

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

Upon contract closeout for any reason the Contractor shall within 30 days, unless stated otherwise herein:

1. Transfer all completed or partially completed deliverables to the State;
2. Transfer ownership and title to all completed or partially completed deliverables to the State;
3. Return to the State all information and data, unless the Contractor is permitted to keep the information or data by contract or rule of law. Contractor may retain one copy of any information or data as required to comply with applicable work product documentation standards or as are automatically retained in the course of Contractor's routine back up procedures;
4. Cooperate with any successor Contactor, person or entity in the assumption of any or all of the obligations of this contract;
5. Cooperate with any successor Contactor, person or entity with the transfer of information or data related to this contract;
6. Return or vacate any state owned real or personal property; and,
7. Return all data in a mutually acceptable format and manner.

Nothing in this Section should be construed to require the Contractor to surrender intellectual property, real or personal property, or information or data owned by the Contractor for which the State has no legal claim.

III. CONTRACTOR DUTIES

A. INDEPENDENT CONTRACTOR / OBLIGATIONS

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

It is agreed that the Contractor is an independent contractor and that nothing contained herein is intended or should be construed as creating or establishing a relationship of employment, agency, or a partnership.

The Contractor is solely responsible for fulfilling the contract. The Contractor or the Contractor's representative shall be the sole point of contact regarding all contractual matters.

The Contractor shall secure, at its own expense, all personnel required to perform the services under the contract. The personnel the Contractor uses to fulfill the contract shall have no contractual or other legal relationship with the State; they shall not be considered employees of the State and shall not be entitled to any compensation, rights or benefits from the State, including but not limited to, tenure rights, medical and hospital care, sick and vacation leave, severance pay, or retirement benefits.

By-name personnel commitments made in the Contractor's proposal shall not be changed without the prior written approval of the State. Replacement of these personnel, if approved by the State, shall be with personnel of equal or greater ability and qualifications.

All personnel assigned by the Contractor to the contract shall be employees of the Contractor or a subcontractor, and shall be fully qualified to perform the work required herein. Personnel employed by the Contractor or a subcontractor to fulfill the terms of the contract shall remain under the sole direction and control of the Contractor or the subcontractor respectively.

With respect to its employees, the Contractor agrees to be solely responsible for the following:

1. Any and all pay, benefits, and employment taxes and/or other payroll withholding;
2. Any and all vehicles used by the Contractor's employees, including all insurance required by state law;
3. Damages incurred by Contractor's employees within the scope of their duties under the contract;
4. Maintaining Workers' Compensation and health insurance that complies with state and federal law and submitting any reports on such insurance to the extent required by governing law;
5. Determining the hours to be worked and the duties to be performed by the Contractor's employees; and,
6. All claims on behalf of any person arising out of employment or alleged employment (including without limit claims of discrimination alleged against the Contractor, its officers, agents, or subcontractors or subcontractor's employees)

If the Contractor intends to utilize any subcontractor, the subcontractor's level of effort, tasks, and time allocation should be clearly defined in the contractor's proposal. The Contractor shall agree that it will not utilize any subcontractors not specifically included in its proposal in the performance of the contract without the prior written authorization of the State.

The State reserves the right to require the Contractor to reassign or remove from the project any Contractor or subcontractor employee.

Contractor shall insure that the terms and conditions contained in any contract with a subcontractor does not conflict with the terms and conditions of this contract.

The Contractor shall include a similar provision, for the protection of the State, in the contract with any Subcontractor engaged to perform work on this contract.

B. **EMPLOYEE WORK ELIGIBILITY STATUS**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

The Contractor is required and hereby agrees to use a federal immigration verification system to determine the work eligibility status of employees physically performing services within the State of Nebraska. A federal immigration verification system means the electronic verification of the work authorization program authorized by the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, 8 U.S.C. 1324a, known as the E-Verify Program, or an equivalent federal program designated by the United States Department of Homeland Security or other federal agency authorized to verify the work eligibility status of an employee.

If the Contractor is an individual or sole proprietorship, the following applies:

1. The Contractor must complete the United States Citizenship Attestation Form, available on the Department of Administrative Services website at http://das.nebraska.gov/materiel/purchasing.html
2. The completed United States Attestation Form should be submitted with the solicitation response.
3. If the Contractor indicates on such attestation form that he or she is a qualified alien, the Contractor agrees to provide the US Citizenship and Immigration Services documentation required to verify the Contractor's lawful presence in the United States using the Systematic Alien Verification for Entitlements (SAVE) Program.
4. The Contractor understands and agrees that lawful presence in the United States is required and the Contractor may be disqualified or the contract terminated if such lawful presence cannot be verified as required by Neb. Rev. Stat. §4-108.

C. **COMPLIANCE WITH CIVIL RIGHTS LAWS AND EQUAL OPPORTUNITY EMPLOYMENT / NONDISCRIMINATION (Statutory)**

The Contractor shall comply with all applicable local, state, and federal statutes and regulations regarding civil rights laws and equal opportunity employment. The Nebraska Fair Employment Practice Act prohibits Contractors of the State of Nebraska, and their Subcontractors, from discriminating against any employee or applicant for employment, with respect to hire, tenure, terms, conditions, compensation, or privileges of employment because of race, color, religion, sex, disability, marital status, or national origin (Neb. Rev. Stat. §48-1101 to 48-1125). The Contractor guarantees compliance with the Nebraska Fair Employment Practice Act, and breach of this provision shall be regarded as a material breach of contract. The Contractor shall insert a similar provision in all Subcontracts for goods and services to be covered by any contract resulting from this solicitation.

D. **COOPERATION WITH OTHER CONTRACTORS**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

Contractor may be required to work with or in close proximity to other contractors or individuals that may be working on same or different projects. The Contractor shall agree to cooperate with such other contractors or individuals, and shall not commit or permit any act which may interfere with the performance of work by any other contractor or individual. Contractor is not required to compromise Contractor's intellectual property or proprietary information unless expressly required to do so by this contract.

E. **DISCOUNTS**

Prices quoted shall be inclusive of ALL trade discounts. Cash discount terms of less than thirty (30) days will not be considered as part of the proposal. Cash discount periods will be computed from the date of receipt of a properly executed claim voucher or the date of completion of delivery of all items in a satisfactory condition, whichever is later.

F. **PRICES**

Prices quoted shall be net, including transportation and delivery charges fully prepaid by the contractor, F.O.B. destination named in the solicitation. No additional charges will be allowed for packing, packages, or partial delivery costs. When an arithmetic error has been made in the extended total, the unit price will govern.

All prices, costs, and terms and conditions submitted in the proposal shall remain fixed and valid commencing on the opening date of the proposal until the contract terminates or expires.

The State reserves the right to deny any requested price increase. No price increases are to be billed to any State Agencies prior to written amendment of the contract by the parties.

The State will be given full proportionate benefit of any decreases for the term of the contract.

G. **COST CLARIFICATION**

The State reserves the right to review all aspects of cost for reasonableness and to request clarification of any proposal where the cost component shows significant and unsupported deviation from industry standards or in areas where detailed pricing is required.

H. **PERMITS, REGULATIONS, LAWS**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

The contract price shall include the cost of all royalties, licenses, permits, and approvals, whether arising from patents, trademarks, copyrights or otherwise, that are in any way involved in the contract. The Contractor shall obtain and pay for all royalties, licenses, and permits, and approvals necessary for the execution of the contract. The Contractor must guarantee that it has the full legal right to the materials, supplies, equipment, software, and other items used to execute this contract.

I. **OWNERSHIP OF INFORMATION AND DATA / DELIVERABLES**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

The State shall have the unlimited right to publish, duplicate, use, and disclose all information and data developed or obtained by the Contractor on behalf of the State pursuant to this contract.

The State shall own and hold exclusive title to any deliverable developed as a result of this contract. Contractor shall have no ownership interest or title, and shall not patent, license, or copyright, duplicate, transfer, sell, or exchange, the design, specifications, concept, or deliverable.

J. **INSURANCE REQUIREMENTS**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

The Contractor shall throughout the term of the contract maintain insurance as specified herein and provide the State a current Certificate of Insurance/Acord Form (COI) verifying the coverage. The Contractor shall not commence work on the contract until the insurance is in place. If Contractor subcontracts any portion of the Contract the Contractor must, throughout the term of the contract, either:

1. Provide equivalent insurance for each subcontractor and provide a COI verifying the coverage for the subcontractor;
2. Require each subcontractor to have equivalent insurance and provide written notice to the State that the Contractor has verified that each subcontractor has the required coverage; or,
3. Provide the State with copies of each subcontractor's Certificate of Insurance evidencing the required coverage.

The Contractor shall not allow any Subcontractor to commence work until the Subcontractor has equivalent insurance. The failure of the State to require a COI, or the failure of the Contractor to provide a COI or require subcontractor insurance shall not limit, relieve, or decrease the liability of the Contractor hereunder.

In the event that any policy written on a claims-made basis terminates or is canceled during the term of the contract or within two (2) years of termination or expiration of the contract, the contractor shall obtain an extended discovery or reporting period, or a new insurance policy, providing coverage required by this contract for the term of the contract and two (2) years following termination or expiration of the contract.

If by the terms of any insurance a mandatory deductible is required, or if the Contractor elects to increase the mandatory deductible amount, the Contractor shall be responsible for payment of the amount of the deductible in the event of a paid claim.

Notwithstanding any other clause in this Contract, the State may recover up to the liability limits of the insurance policies required herein.

1. WORKERS' COMPENSATION INSURANCE

The Contractor shall take out and maintain during the life of this contract the statutory Workers' Compensation and Employer's Liability Insurance for all of the contactors' employees to be engaged in work on the project under this contract and, in case any such work is sublet, the Contractor shall require the Subcontractor similarly to provide Worker's Compensation and Employer's Liability Insurance for all of the Subcontractor's employees to be engaged in such work. This policy shall be written to meet the statutory requirements for the state in which the work is to be performed, including Occupational Disease. **The policy shall include a waiver of subrogation in favor of the State. The COI shall contain the mandatory COI subrogation waiver language found hereinafter**. The amounts of such insurance shall not be less than the limits stated hereinafter. For employees working in the State of Nebraska, the policy must be written by an entity authorized by the State of Nebraska Department of Insurance to write Workers' Compensation and Employer's Liability Insurance for Nebraska employees.

2. COMMERCIAL GENERAL LIABILITY INSURANCE AND COMMERCIAL AUTOMOBILE LIABILITY INSURANCE

The Contractor shall take out and maintain during the life of this contract such Commercial General Liability Insurance and Commercial Automobile Liability Insurance as shall protect Contractor and any Subcontractor performing work covered by this contract from claims for damages for bodily injury, including death, as well as from claims for property damage, which may arise from operations under this contract, whether such operation be by the Contractor or by any Subcontractor or by anyone directly or indirectly employed by either of them, and the amounts of such insurance shall not be less than limits stated hereinafter.

The Commercial General Liability Insurance shall be written on an **occurrence basis**, and provide Premises/Operations, Products/Completed Operations, Independent Contractors, Personal Injury, and Contractual Liability coverage. **The policy shall include the State, and others as required by the contract documents, as Additional Insured(s). This policy shall be primary, and any insurance or self-insurance carried by the State shall be considered secondary and non-contributory**. **The COI shall contain the mandatory COI liability waiver language found hereinafter.** The Commercial Automobile Liability Insurance shall be written to cover all Owned, Non-owned, and Hired vehicles.

REQUIRED INSURANCE COVERAGE	
COMMERCIAL GENERAL LIABILITY	
General Aggregate	$2,000,000
Products/Completed Operations Aggregate	$2,000,000
Personal/Advertising Injury	$1,000,000 per occurrence
Bodily Injury/Property Damage	$1,000,000 per occurrence
Medical Payments	$10,000 any one person
Damage to Rented Premises (Fire)	$50,000 each occurrence
Contractual	Included
Independent Contractors	Included
Abuse & Molestation	Included
If higher limits are required, the Umbrella/Excess Liability limits are allowed to satisfy the higher limit.	
WORKER'S COMPENSATION	
Employers Liability Limits	$500K/$500K/$500K
Statutory Limits- All States	Statutory - State of Nebraska
Voluntary Compensation	Statutory
COMMERCIAL AUTOMOBILE LIABILITY	
Bodily Injury/Property Damage	$1,000,000 combined single limit
Include All Owned, Hired & Non-Owned Automobile liability	Included
Motor Carrier Act Endorsement	Where Applicable
UMBRELLA/EXCESS LIABILITY	
Over Primary Insurance	$1,000,000 per occurrence
CYBER LIABILITY	
Breach of Privacy, Security Breach, Denial of Service, Remediation, Fines and Penalties	$1,000,000
Includes Non-Owned Disposal Sites	
MANDATORY COI SUBROGATION WAIVER LANGUAGE	
"Workers' Compensation policy shall include a waiver of subrogation in favor of the State of Nebraska."	
MANDATORY COI LIABILITY WAIVER LANGUAGE	
"Commercial General Liability & Commercial Automobile Liability policies shall name the State of Nebraska as an Additional Insured and the policies shall be primary and any insurance or self-insurance carried by the State shall be considered secondary and non-contributory as additionally insured."	

4. EVIDENCE OF COVERAGE

The Contractor shall furnish the Contract Manager, with a certificate of insurance coverage complying with the above requirements prior to beginning work at:

Department of Health and Human Services
Division of Medicaid and Long-Term Care
Attn: EQRO Contract Manager
301 Centennial Mall S., 5th floor
Lincoln, NE 68509

These certificates or the cover sheet shall reference the RFP number, and the certificates shall include the name of the company, policy numbers, effective dates, dates of expiration, and amounts and types of coverage afforded. If the State is damaged by the failure of the Contractor to maintain such insurance, then the Contractor shall be responsible for all reasonable costs properly attributable thereto.

Reasonable notice of cancellation of any required insurance policy must be submitted to the contract manager as listed above when issued and a new coverage binder shall be submitted immediately to ensure no break in coverage.

5. DEVIATIONS

The insurance requirements are subject to limited negotiation. Negotiation typically includes, but is not necessarily limited to, the correct type of coverage, necessity for Workers' Compensation, and the type of automobile coverage carried by the Contractor.

K. **ANTITRUST**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

The Contractor hereby assigns to the State any and all claims for overcharges as to goods and/or services provided in connection with this contract resulting from antitrust violations which arise under antitrust laws of the United States and the antitrust laws of the State.

L. **CONFLICT OF INTEREST**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

By submitting a proposal, bidder certifies that no relationship exists between the bidder and any person or entity which either is, or gives the appearance of, a conflict of interest related to this Request for Proposal or project.

Bidder further certifies that bidder will not employ any individual known by bidder to have a conflict of interest nor shall bidder take any action or acquire any interest, either directly or indirectly, which will conflict in any manner or degree with the performance of its contractual obligations hereunder or which creates an actual or appearance of conflict of interest.

If there is an actual or perceived conflict of interest, bidder shall provide with its proposal a full disclosure of the facts describing such actual or perceived conflict of interest and a proposed mitigation plan for consideration. The State will then consider such disclosure and proposed mitigation plan and either approve or reject as part of the overall bid evaluation.

M. **STATE PROPERTY**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

The Contractor shall be responsible for the proper care and custody of any State-owned property which is furnished for the Contractor's use during the performance of the contract. The Contractor shall reimburse the State for any loss or damage of such property; normal wear and tear is expected.

N. **SITE RULES AND REGULATIONS**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

The Contractor shall use its best efforts to ensure that its employees, agents, and Subcontractors comply with site rules and regulations while on State premises. If the Contractor must perform on-site work outside of the daily operational hours set forth by the State, it must make arrangements with the State to ensure access to the facility and the equipment has been arranged. No additional payment will be made by the State on the basis of lack of access, unless the State fails to provide access as agreed to in writing between the State and the Contractor.

O. **ADVERTISING**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

The Contractor agrees not to refer to the contract award in advertising in such a manner as to state or imply that the company or its goods or services are endorsed or preferred by the State. Any publicity releases pertaining to the project shall not be issued without prior written approval from the State.

P. **NEBRASKA TECHNOLOGY ACCESS STANDARDS (Statutory)**

Contractor shall review the Nebraska Technology Access Standards, found at https://nitc.nebraska.gov/standards and ensure that products and/or services provided under the contract are in compliance or will comply with the applicable standards to the greatest degree possible. In the event such standards change during the Contractor's performance, the State may create an amendment to the contract to request the contract comply with the changed standard at a cost mutually acceptable to the parties.

Q. **DISASTER RECOVERY/BACK UP PLAN**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

The Contractor shall have a disaster recovery and back-up plan, of which a copy should be provided upon request to the State, which includes, but is not limited to equipment, personnel, facilities, and transportation, in order to continue delivery of goods and services as specified under the specifications in the contract in the event of a disaster.

R. **DRUG POLICY**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

Contractor certifies it maintains a drug free work place environment to ensure worker safety and workplace integrity. Contractor agrees to provide a copy of its drug free workplace policy at any time upon request by the State.

S. **WARRANTY**

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

Despite any clause to the contrary, the Contractor represents and warrants that its services hereunder shall be performed by competent personnel and shall be of professional quality consistent with generally accepted industry standards for the performance of such services and shall comply in all respects with the requirements of this Agreement. For any breach of this warranty, the Contractor shall, for a period of ninety (90) days from performance of the service, perform the services again, at no cost to Customer, or if Contractor is unable to perform the services as warranted, Contractor shall reimburse Customer the fees paid to Contractor for the unsatisfactory services. The rights and remedies of the parties under this warranty are in addition to any other rights and remedies of the parties provided by law or equity, including, without limitation actual damages, and, as applicable and awarded under the law, to a prevailing party, reasonable attorneys' fees and costs.

IV. PAYMENT

A. PROHIBITION AGAINST ADVANCE PAYMENT (Statutory)

Neb. Rev. Stat. §§81-2403 states, "[n]o goods or services shall be deemed to be received by an agency until all such goods or services are completely delivered and finally accepted by the agency."

B. TAXES (Statutory)

The State is not required to pay taxes and assumes no such liability as a result of this solicitation. The Contractor may request a copy of the Nebraska Department of Revenue, Nebraska Resale or Exempt Sale Certificate for Sales Tax Exemption, Form 13 for their records. Any property tax payable on the Contractor's equipment which may be installed in a state-owned facility is the responsibility of the Contractor

C. INVOICES

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

Invoices for payments must be submitted by the Contractor to the agency requesting the services with sufficient detail to support payment. **Contractor shall submit invoices to the DHHS Contract Manager for payment at the fixed rate for services provided in accordance with the Contractor's statement of work upon completion of deliverables. Contractor shall submit invoices within thirty (30) calendar days following the date of deliverable completion and no later than thirty (30) calendar days following the end of each contract term.** The terms and conditions included in the Contractor's invoice shall be deemed to be solely for the convenience of the parties. No terms or conditions of any such invoice shall be binding upon the State, and no action by the State, including without limitation the payment of any such invoice in whole or in part, shall be construed as binding or estopping the State with respect to any such term or condition, unless the invoice term or condition has been previously agreed to by the State as an amendment to the contract.

D. INSPECTION AND APPROVAL

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

Final inspection and approval of all work required under the contract shall be performed by the designated State officials.

The State and/or its authorized representatives shall have the right to enter any premises where the Contractor or Subcontractor duties under the contract are being performed, and to inspect, monitor or otherwise evaluate the work being performed. All inspections and evaluations shall be at reasonable times and in a manner that will not unreasonably delay work.

E. PAYMENT (Statutory)

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

Payment will be made by the responsible agency in compliance with the State of Nebraska Prompt Payment Act (See Neb. Rev. Stat. §81-2403). The State may require the Contractor to accept payment by electronic means such as ACH deposit. In no event shall the State be responsible or liable to pay for any goods and services provided by the Contractor prior to the Effective Date of the contract, and the Contractor hereby waives any claim or cause of action for any such services.

F. **LATE PAYMENT (Statutory)**

The Contractor may charge the responsible agency interest for late payment in compliance with the State of Nebraska Prompt Payment Act (See Neb. Rev. Stat. §81-2401 through 81-2408).

G. **SUBJECT TO FUNDING / FUNDING OUT CLAUSE FOR LOSS OF APPROPRIATIONS (Statutory)**

The State's obligation to pay amounts due on the Contract for a fiscal years following the current fiscal year is contingent upon legislative appropriation of funds. Should said funds not be appropriated, the State may terminate the contract with respect to those payments for the fiscal year(s) for which such funds are not appropriated. The State will give the Contractor written notice thirty (30) calendar days prior to the effective date of termination. All obligations of the State to make payments after the termination date will cease. The Contractor shall be entitled to receive just and equitable compensation for any authorized work which has been satisfactorily completed as of the termination date. In no event shall the Contractor be paid for a loss of anticipated profit.

H. **RIGHT TO AUDIT (First Paragraph is Statutory)**

The State shall have the right to audit the Contractor's performance of this contract upon a thirty (30) days' written notice. Contractor shall utilize generally accepted accounting principles, and shall maintain the accounting records, and other records and information relevant to the contract (Information) to enable the State to audit the contract. (Neb. Rev. Stat. §84-304 et seq.) The State may audit and the Contractor shall maintain, the Information during the term of the contract and for a period of five (5) years after the completion of this contract or until all issues or litigation are resolved, whichever is later. The Contractor shall make the Information available to the State at Contractor's place of business or a location acceptable to both Parties during normal business hours. If this is not practical or the Contractor so elects, the Contractor may provide electronic or paper copies of the Information. The State reserves the right to examine, make copies of, and take notes on any Information relevant to this contract, regardless of the form or the Information, how it is stored, or who possesses the Information. Under no circumstance will the Contractor be required to create or maintain documents not kept in the ordinary course of contractor's business operations, nor will contractor be required to disclose any information, including but not limited to product cost data, which is confidential or proprietary to contractor.

Accept (Initial)	Reject (Initial)	Reject & Provide Alternative within Solicitation Response (Initial)	NOTES/COMMENTS:

The Parties shall pay their own costs of the audit unless the audit finds a previously undisclosed overpayment by the State. If a previously undisclosed overpayment exceeds one-half of one percent (0.5%) of the total contract billings, or if fraud, material misrepresentations, or non-performance is discovered on the part of the Contractor, the Contractor shall reimburse the State for the total costs of the audit. Overpayments and audit costs owed to the State shall be paid within ninety (90) days of written notice of the claim. The Contractor agrees to correct any material weaknesses or condition found as a result of the audit.

V. PROJECT DESCRIPTION AND SCOPE OF WORK

A. PROJECT OVERVIEW

DHHS is seeking a Contractor to provide the following services:

1. Provide the DHHS and the Federal Government with an annual external and independent review of access to, timeliness, and quality outcomes of the services included in the contract between the DHHS the Managed Care Organizations (MCOs) and Dental Benefits Manager (DBM) providing integrated health care to DHHS consumers enrolled in Medicaid managed care programs. The Contractor must meet requirements established in 42 CFR §438, Subpart E.

2. Monitor the MCOs and DBMs internal Quality Assurance and Performance Improvement programs (QAPI) and standards on a continuing basis.

B. PROJECT ENVIRONMENT

Currently physical health, behavioral health, and pharmacy services are provided by three (3) MCOs; United Healthcare Community Plan, Nebraska Total Care and Anthem (WellCare). The State's dental health care is provided by one (1) Dental Benefits Manager (DBM) contract with Managed Care of North America, Inc. (MCNA). For all three MCOs and the DBM, the National Committee for Quality Assurance (NCQA) is the accrediting authority. Current contracts are located on the State Purchasing Bureau website at http://das.nebraska.gov/materiel/purchasing.html.

C. BUSINESS REQUIREMENTS

The External Quality Review Organization (EQRO) must meet the competence and independence requirements as specified in 42 CFR §438.354(b) and 42 CFR §438.354(c).

1. Independence.

The EQRO and subcontractors must be independent from the State Medicaid agency, MCOs and DBMs entities that they review. To qualify as "independent":

a. If the Contractor is a State Agency, Department, University, or other State entity, the Contractor
   i. May not have Medicaid purchasing or managed care licensing authority; and
   ii. Must be governed by a Board or similar body the majority of whose members are not government employees.
b. The Contractor may not:
   i. Review any MCO or DBM entity or a competitor operating in the State, over which the EQRO exerts control or which the exerts control over the EQRO ("control" has the meaning given the term in 48 CFR 19.101) through:
      a) Stock ownership,
      b) Stock options and convertible debentures,
      c) Voting trusts,
      d) Common management, including interlocking management, and
      e) Contractual relationships.
c. The Contractor may not deliver any health care services to Medicaid beneficiaries.
d. The Contractor may not conduct, on the State's behalf, ongoing Medicaid managed care program operations related to oversight of the quality of MCO or DBM entity services, except for EQR-related activities specified at 42 CFR § 438.358.
e. The Contractor may not review any MCO or DBM entity for which it is conducting or has conducted an accreditation review within the previous three (3) years.
f. The Contractor may not have a present, or future, direct or indirect financial relationship with an MCO or DBM entity that it will review as an EQRO.
   i. Financial relationship means a direct or indirect ownership or investment interest, including an option or non-vested interest, in any entity. This direct or indirect interest may be in the form of equity, debt, or other means and includes any indirect ownership or investment interest no matter how many levels removed from a direct interest; or a compensation arrangement with an entity.

2. Non-duplication.

Contractors must ensure mandatory activities with Medicare or accreditation review are not duplicated. The State may use information from a Medicare or private accreditation review of an MCO or DBM to provide information for the annual EQR instead of conducing one or more of the EQR activities relating to the validation of performance improvement projects, validation of performance measures, and compliance review.

42 CFR § 438.360 Non-duplication of mandatory activities with Medicare or accreditation review, details the conditions that must be met to use the information from a private accreditation instead of conducting one or more of the EQR activities.

D. PROJECT REQUIREMENTS

The Request for Proposal is designed to solicit proposals from qualified vendors who will be responsible for providing an annual external and independent review service as a component of the contract between DHHS and the Managed Care Organizations (MCOs) and Dental Benefits Managers (DBMs) providing health care to DHHS consumers enrolled in managed care at a competitive and reasonable cost.

1. Protocols.

The protocols required to be used by State Medicaid Agencies and the EQRO in conducting EQR activities are outlined in 42 CFR § 438, subpart E. In the event these protocols are revised by CMS, the Contractor shall ensure current versions are utilized in performance of duties under this contract.

The revised CMS EQR Protocols and updated EQR Technical Report Toolkit are available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. CMS also developed a web page devoted to Quality Strategies which includes an updated State Quality Strategy Toolkit, available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/state-quality-strategy/index.html.

a. The Contractor will perform contract activity consistent with these protocols (§438.352), specifying:
   i. The data to be gathered;
   ii. The sources of the data;
   iii. The activities and steps to be followed in collecting the data to promote its accuracy, validity and reliability;
   iv. The proposed method(s) for analyzing and interpreting
   v. The data once obtained; and
   vi. Instructions, guidelines, worksheets, and other documents or tools necessary for implementing the protocol.
b. The Contractor will report any problems with the administration of the MCO or the DBM Contracts and will propose a corrective action plan for any problems directly related to the performance of this Contract.

2. EQRO Activities.

The EQRO shall be responsible for all of the following activities, performed by utilization of EQR protocols.

a. Conduct an annual external quality review of the Managed Care Organizations (MCO) and the Dental Benefits Mangers (DBM) in Nebraska and produce the required report(s). The quality review must use information from mandatory activities as set forth in 42 CFR § 438.358(b).
   i. The Contractor will provide a review, conducted annually, to determine the MCO's/DBM's compliance with standards (except with respect to standards under 42 CFR §438.240(b)(1) and (2), for conducting performance improvement projects and calculations of performance measures, respectively) established by the State to comply with the requirements of 42 CFR § 438.204(g).
   ii. The Contractor will conduct the on-site review of each MCO and DBM in the second calendar quarter of each year. The Contractor will establish and provide a schedule for documentation requests of the MCOs and DBMs ahead of reviews.
   iii. The Contractor will deliver a draft review report to DHHS within ninety (90) days of the on-site review, in electronic format and will deliver a final report to DHHS within thirty (30) days of the draft report delivery, in electronic format.
b. The Contractor will perform validation of Performance Improvement Projects (PIPs) required by the State to comply with requirements set forth in 42 CFR § 438.330(b)(1), that were underway during the preceding calendar year.
c. The Contractor will provide validation of MCO and DBM performance measures reported (as required by the State) or MCO and DBM performance measures calculated by the State during the preceding calendar year to comply with requirements set forth in 42 CFR § 438.330(b)(2). Some performance measures may be required by the State to be continued, based on specific outcomes for a specified period of time.

d. The Contractor will perform a review, conducted within the previous 3-year period, to determine the MCOs and DBMs compliance with the standards set forth in 42 CFR 438, subpart D and the quality assessment and performance improvement requirements described in 42 CFR § 438.330.
e. The Contractor will perform validation of MCO and DBM network adequacy during the preceding calendar year to comply with requirements set forth in 42 CFR § 438.68.

3. Technical Assistance.

a. The Contractor will, at the State's direction, provide technical guidance to groups of MCOs or the DBM to assist them in conducting activities related to the mandatory and additional activities that provide information for the EQR.
b. The Contractor will report in writing any problems with the administration of the MCO or the DBM Contracts and will propose a corrective action plan for any problems directly related to the performance of this Contract.
c. The Contractor will provide technical guidance in the development of performance improvement projects.

4. Reporting.

The Contractor shall be responsible for providing accurate, complete written reports and recommendations to DHHS. The Contractor must provide the following reports, assessments, and recommendations as specified in 42 CFR § 438.364.

a. For each MCO and DBM, the Contractor will provide an annual detailed technical report that summarizes findings on access and quality of care, including a description of the manner in which the data from all activities conducted in accordance with 42 CFR § 438.358 were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCO and DBM entity.
    i. This report shall be provided to DHHS annually, by October 15th.
    ii. The report must also include the following for each activity conducted in accordance with 42 CFR § 438.358:
        a) Objectives.
        b) Technical methods of data collection and analysis.
        c) Description of data obtained including validated performance measurement data for each activity conducted in accordance with 42 CFR § 438.358(b)(1)(i) and (ii); and
        d) Conclusions drawn from the data.
b. The Contractor will provide DHHS with an annual assessment of each MCO's or DBM's strengths and weaknesses for the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries.
c. The Contractor will provide DHHS with recommendations for improving the quality of health care services furnished by each MCO or DBM including how the State can target goals and objectives in the quality strategy, under 42 CFR § 438.340, to better support improvement in the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries at least quarterly, or with more frequency, as necessary.
d. The Contractor will provide DHHS with methodologically appropriate, comparative information about all MCOs and DBMs, upon request by the State.
e. The Contractor will provide DHHS with an annual assessment of the degree to which each MCO or DBM has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR.
f. The Contractor will provide ad hoc studies and reports as required by DHHS. The billable hours for each ad hoc study and report will be mutually agreed upon between DHHS and the Contractor and billed at the hourly contracted consultant rate.

5. Distribution of the EQR reports, assessments, and recommendations.

a. The Contractor must provide copies of the information specified in Section V.D.4. above, upon request, through print or electronic media, to interested parties such as participating health care providers, enrollees, and potential enrollees of the MCO or DBM, beneficiary advocacy groups and members of the general public.
    i. This information must be made available in alternative formats for persons with disabilities, when requested.
    ii. The information released must not disclose the identity of any patient or any other information protected by law.

iii. The Contractor will not share or deliver to any other individual or entity without prior written approval of DHHS, reports and any data utilized for reporting purposes. The schedule, number of copies, and media for reports shall be specified by DHHS.

b. The Contractor will be required to develop, update, and maintain a report distribution list during the contract period to incorporate changes required by DHHS.

6. Meetings.

a. The Contractor will establish monthly technical assistance meetings or conference calls with DHHS staff.
b. The Contractor will prepare agendas ahead of meetings.
c. The Contractor is responsible for taking and distributing minutes at all meetings required under this contract. Distribution will be no less than five (5) business days before the meeting.
d. The Contractor will participate, in conjunction with DHHS, in the quarterly operational meetings with the MCOs and DBM.

7. Quality Review.

The quality review may use information from additional activities as set forth in 42 CFR § 438.358(c), including information derived during the preceding calendar year from the following activities. Contractors outline pricing in **Form C Cost Proposal.**

a. The Contractor will provide, at the State's direction, validation of encounter data reported by the MCOs and the DBM.
b. The Contractor will perform administration or validation of consumer or provider surveys of quality of care.
c. The Contractor will, at the State's direction, calculate performance measures in addition to those reported by an MCO or DBM and validated by an EQRO in accordance with 42 CFR §438.358(b)(1)(ii).
d. The Contractor will, at the State's direction, conduct performance improvement projects in addition to those conducted by an MCO or DBM and validated by an EQRO in accordance with 42 CFR §438.358(b)(1)(i) .
e. The Contractor will, at the State's direction, conduct studies on quality that focus on a particular aspect of clinical or nonclinical services at a point in time.
f. The Contractor will, at the State's direction, assist with the quality rating of the MCOs and DBM consistent with 42 CFR § 438.334.
g. The Contractor will, at the State's direction, provide technical guidance to MCOs or DBMs, to assist n conducting activities related to the mandatory and optional activities that provide information for the EQR and the resulting EQR technical report.

E. SCOPE OF WORK

1. Mandatory EQR-related activities.

The Contractor shall do the following mandatory EQR-related activities, using the most recent federally-approved EQR protocol:

a. Review, within the previous three-year period, to determine MCO/DBM compliance with State standards for access to care, structure and operations, and quality measurement and improvement.
b. Validation of performance measures.
c. Validation of performance improvement projects (PIPs).

2. Other EQR-related activities.

At the request of DHHS, the Contractor shall perform the following EQR-related activities, using the most recent federally approved EQR protocol:

a. Validation of encounter data reported by an MCO or DBM.
b. Administration or validation of consumer or provider surveys of quality of care.
c. Calculation of performance measures in addition to those reported by an MCO or DBM and validated by an EQRO.
d. Conduct PIPs in addition to those conducted by an MCO or DBM and validated by an EQRO.
e. Conduct studies on quality that focus on an aspect of clinical or nonclinical services as a point in time.

F. DELIVERABLES

1. Deliverables.

Contractor shall provide all EQR-related services necessary to analyze and evaluate aggregated information on quality, timeliness, and access to the health care services that a managed care plan, or its contractors, furnish to Medicaid beneficiaries in a way that meets or exceeds the minimum requirements of section V.

a. Deliverable 1: Annual EQR Report- MCO.
   i. Fixed cost per report. One (1) annual report for each MCO.

b. Deliverable 2: Annual EQR Report- DBM.
   i. Fixed cost per report. One (1) annual report for each DBM

c. Deliverable 3: Annual Validation of PIP Report- MCO.
   i. Fixed cost per report. One (1) annual report for each MCO.

d. Deliverable 4: Annual Validation of PIP Report- DBM.
   i. Fixed cost per report. One (1) annual report for each DBM.

e. Deliverable 5: Annual Validation of Performance Measures Report- MCO.
   i. Fixed cost per report. One (1) annual report for each MCO.

f. Deliverable 6: Annual Validation of Performance Measures Report- DBM.
   i. Fixed cost per report. One (1) annual report for each DBM.

g. Ad-Hoc Deliverable 7: Annual Validation of Network Adequacy Report, at DHHS request- MCO.
   i. Fixed cost per report. One (1) annual report for each MCO.

h. Ad-Hoc Deliverable 8: Annual Validation of Network Adequacy Report, at DHHS request- DBM.
   i. Fixed cost per report. One (1) annual report for each DBM.

i. Ad-Hoc Deliverable 9: Ad-hoc technical assistance and consultation, at DHHS request.
   i. Services at a fixed hourly rate. All rates shall be prorated for any fraction of an hour spent actually providing services, which shall be rounded to the nearest 15-minute increment for each hour worked pursuant this contract.

j. Optional Deliverable 10: Ad-hoc reports, at DHHS request.
   i. Fixed cost per project based on hourly rate. Work may be needed that was not originally delineated in this RFP, but considered within the scope of work. This additional work may stem from legislative mandates, emerging technologies, and/or secondary research not otherwise addressed in this RFP or known at the time this RFP was issued. If additional work is needed, the Contractor must submit a Detailed Project Work Plan, Title/Role(s), number of hours, and due dates/deliverables for DHHS review and approval prior to commencing work.

2. Deadlines.

The Contractor shall meet the following deadlines:

a. Deliverable due dates as listed in the most current and DHHS-approved Contractor Detailed Work Plan.
b. All Annual EQR Reports shall be provided to DHHS annually, by October 15th.
   a. The Contractor will deliver a draft review report to DHHS within ninety (90) days of the on-site review, in electronic format and will deliver a final report to DHHS within thirty (30) days of the draft report delivery, in electronic format.
c. Unless otherwise approved in writing by DHHS, all deliverables must be complete no later than December 31st of each contract term.
d. Contractor shall submit invoices within thirty (30) calendar days following the date of deliverable completion and no later than thirty (30) calendar days following the end of each contract term.

3. Deliverable Approval Process.

a. DHHS must review all deliverables submitted by Contractor. DHHS must approve a deliverable submitted by Contractor if it is of sufficient quality and meets the requirements in section V. Approval of a deliverable must be communicated by DHHS to Contractor in writing within fifteen (15) State business days. DHHS will not disburse payment for a deliverable until the deliverable is approved.
b. DHHS must reject the deliverable submitted by Contractor if it is not of sufficient quality or does not meet the requirements in section V. Rejection of a deliverable must be communicated by DHHS to Contractor in writing within fifteen (15) State business days, and DHHS's written communication must include its reasons for rejection.
c. Within a time period established by DHHS and the Contractor, Contractor may correct the defects identified by DHHS and re-submit the rejected deliverable. Any corrections or improvements requested by DHHS are not changes in scope of this Contract. If a rejected deliverable requires more than two corrections, DHHS may permanently reject the deliverable and deny payment for the deliverable. Nothing in this section limits any other remedies available to DHHS under this Contract or at law.

G. WORK PLAN

No later than two (2) weeks after the contract start date, the contractor must develop and submit a Detailed Work Plan that includes a schedule for all deliverable tasks, subtasks, and activities, and deliverable milestones and submission timelines listed in Section V.F. The contractor's Project Work Plan must also maintain the following date-sensitive information:

1. Originally scheduled Start and End dates for all tasks, subtasks, and activities (including milestones and deliverables);
2. Anticipated Start dates for tasks, subtasks, and activities, if schedule fluctuation has occurred;
3. Anticipated End dates for tasks, subtasks, and activities, if schedule fluctuation has occurred;
4. Actual Start dates for all current and completed tasks, subtasks, and activities;
5. Actual End dates for all completed tasks, subtasks, and activities, and;
6. Descriptions of tasks.

DHHS may approve or reject, in writing, the Detailed Projected Work Plan or any proposed updates to the Detailed Project Work Plan.

The contractor shall submit a progress report in writing on the status of work completed from the Detailed Project Work Plan to DHHS for review on at least a monthly basis.

H. PROJECT PLANNING AND MANAGEMENT

1. Communication Planning.

No later than two (2) weeks after the contract start date, the contractor must develop and submit a Detailed Communications Plan meeting the requirements of Section V.D. The Detailed Communications Plan must include but is not limited to the following:

a. Contract communication protocols, including formal and informal communications with DHHS staff and communication with other parties other than DHHS staff.
  i. Protocols must include notification to DHHS in writing of any key staff hiring, resignations and dismissals within one (1) business day after initial knowledge of the change.
  ii. Protocols must include distribution of the EQR reports, assessments, and recommendations that meet the requirements of Section V.D.5.
  iii. Protocols must include meeting planning that meet the requirements of Section V.D.6.
  iv. Protocols must include technical assistance planning that meets the requirements of Section V.D.3 of this RFP
b. Deliverable submission and DHHS draft report review protocols.
  i. Protocols must include submission of draft reports to DHHS with a minimum of two (2) months lead time for review and a correction of any noted deficiencies identified by DHHS within two (2) weeks.
c. Ad-hoc deliverable request and initiation protocols.
  i. Protocols must include responses to DHHS EQR-related informational requests within one (1) business day, or as agreed upon with DHHS, throughout the Contract.
d. Work plan progress review protocols.

i. Protocols must include conference calls with DHHS monthly or as directed by DHHS throughout the Contract to review contract deliverables.

DHHS may approve or reject, in writing, the Detailed Communications Plan or any proposed updates to the Detailed Communications Plan.

I. DHHS RESPONSIBILITIES

Primary and overall responsibility for administration of the External Quality Review for Medicaid Managed Care contract will remain with DHHS. DHHS will:

1. Ensure that the EQRO is provided with sufficient and accurate information to use in reporting on the State-conducted annual review. The information provided will be obtained through methods consistent with EQR-related activities and protocols specified by CMS.

2. For ongoing operations, the DHHS Contract Manager, or a designee, shall be available via telephone and email to the Contractor to answer questions regarding policy and procedures, to coordinate responses to Contractor questions, and to refer the Contractor to appropriate staff, when necessary.

3. Attend scheduled meetings with the Contractor to discuss issues, changes, deliverables' status, and specific agenda items proposed by either DHHS or the Contractor. The Contractor will chair the meetings, however, DHHS will retain the option to chair the meetings, as necessary. The schedule for the regular meetings will be determined by DHHS. The State will provide space for such meetings.

4. Share with the Contractor information relative to changes in federal and state law, rules or regulations, or the judicial interpretation of any such laws, rules, or regulations that can be reasonably expected to have an impact on the performance of the Contract.

5. Review and approve all reports and publications prior to public release.

J. ADDENDA

The following Addenda apply to this RFP and are hereby incorporated as additional terms and conditions of the contractual services to be rendered.

A. DHHS HIPAA Business Associate Agreement Provisions
B. DHHS Data Use Agreement

VI. PROPOSAL INSTRUCTIONS

This section documents the requirements that should be met by bidders in preparing the Technical and Cost Proposal. Bidders should identify the subdivisions of "Project Description and Scope of Work" clearly in their proposals; failure to do so may result in disqualification. Failure to respond to a specific requirement may be the basis for elimination from consideration during the State's comparative evaluation. See Section I.H. of this RFP for additional information regarding proposal submission.

Proposals are due by the date and time shown in the Schedule of Events. Content requirements for the Technical and Cost Proposal are presented separately in the following subdivisions; format and order:

A. PROPOSAL SUBMISSION

1. CORPORATE OVERVIEW

The Corporate Overview section of the Technical Proposal should consist of the following subdivisions:

a. CONTRACTOR IDENTIFICATION AND INFORMATION

The contractor should provide the full company or corporate name, address of the company's headquarters, entity organization (corporation, partnership, proprietorship), state in which the contractor is incorporated or otherwise organized to do business, year in which the contractor first organized to do business and whether the name and form of organization has changed since first organized.

b. FINANCIAL STATEMENTS

The contractor should provide financial statements applicable to the firm. If publicly held, the contractor should provide a copy of the corporation's most recent audited financial reports and statements, and the name, address, and telephone number of the fiscally responsible representative of the contractor's financial or banking organization.

If the contractor is not a publicly held corporation, either the reports and statements required of a publicly held corporation, or a description of the organization, including size, longevity, client base, areas of specialization and expertise, and any other pertinent information, should be submitted in such a manner that proposal evaluators may reasonably formulate a determination about the stability and financial strength of the organization. Additionally, a non-publicly held firm should provide a banking reference.

The contractor must disclose any and all judgments, pending or expected litigation, or other real or potential financial reversals, which might materially affect the viability or stability of the organization, or state that no such condition is known to exist.

The State may elect to use a third party to conduct credit checks as part of the corporate overview evaluation.

c. CHANGE OF OWNERSHIP

If any change in ownership or control of the company is anticipated during the twelve (12) months following the proposal due date, the contractor should describe the circumstances of such change and indicate when the change will likely occur. Any change of ownership to an awarded contractor(s) will require notification to the State.

d. OFFICE LOCATION

The contractor's office location responsible for performance pursuant to an award of a contract with the State of Nebraska should be identified.

e. RELATIONSHIPS WITH THE STATE

The contractor should describe any dealings with the State over the previous ten (10) years. If the organization, its predecessor, or any Party named in the contractor's proposal response has contracted with the State, the contractor should identify the contract number(s) and/or any other information available to identify such contract(s). If no such contracts exist, so declare.

f. CONTRACTOR'S EMPLOYEE RELATIONS TO STATE

If any Party named in the contractor's proposal response is or was an employee of the State within the past sixty (60) months, identify the individual(s) by name, State agency with whom employed, job title or position held with the State, and separation date. If no such relationship exists or has existed, so declare.

If any employee of any agency of the State of Nebraska is employed by the contractor or is a Subcontractor to the contractor, as of the due date for proposal submission, identify all such persons by name, position held with the contractor, and position held with the State (including job title and agency). Describe the responsibilities of such persons within the proposing organization. If, after review of this information by the State, it is determined that a conflict of interest exists or may exist, the contractor may be disqualified from further consideration in this proposal. If no such relationship exists, so declare.

g. CONTRACT PERFORMANCE

If the contractor or any proposed Subcontractor has had a contract terminated for default during the past ten (10) years, all such instances must be described as required below. Termination for default is defined as a notice to stop performance delivery due to the contractor's non-performance or poor performance, and the issue was either not litigated due to inaction on the part of the contractor or litigated and such litigation determined the contractor to be in default.

It is mandatory that the contractor submit full details of all termination for default experienced during the past ten (10) years, including the other Party's name, address, and telephone number. The response to this section must present the contractor's position on the matter. The State will evaluate the facts and will score the contractor's proposal accordingly. If no such termination for default has been experienced by the contractor in the past ten (10) years, so declare.

If at any time during the past ten (10) years, the contractor has had a contract terminated for convenience, non-performance, non-allocation of funds, or any other reason, describe fully all circumstances surrounding such termination, including the name and address of the other contracting Party.

h. SUMMARY OF CONTRACTOR'S CORPORATE EXPERIENCE

The contractor should provide a summary matrix listing the contractor's previous projects similar to this solicitation in size, scope, and complexity. The State will use no more than three (3) narrative project descriptions submitted by the contractor during its evaluation of the proposal.

The contractor should address the following:

i. Provide narrative descriptions to highlight the similarities between the contractor's experience and this solicitation. These descriptions should include:

- **a)** The time period of the project;
- **b)** The scheduled and actual completion dates;
- **c)** The Contractor's responsibilities;
- **d)** For reference purposes, a customer name (including the name of a contact person, a current telephone number, a facsimile number, and e-mail address); and
- **e)** Each project description should identify whether the work was performed as the prime Contractor or as a Subcontractor. If a contractor performed as the prime Contractor, the description should provide the originally scheduled completion date and budget, as well as the actual (or currently planned) completion date and actual (or currently planned) budget.

ii. Contractor and Subcontractor(s) experience should be listed separately. Narrative descriptions submitted for Subcontractors should be specifically identified as Subcontractor projects.

iii. If the work was performed as a Subcontractor, the narrative description should identify the same information as requested for the Contractors above. In addition, Subcontractors should identify what share of contract costs, project responsibilities, and time period were performed as a Subcontractor.

i. SUMMARY OF CONTRACTOR'S PROPOSED PERSONNEL/MANAGEMENT APPROACH

In order to be an EQRO, the Contractor must have the following:

i. Staff with demonstrated experience and knowledge of Medicaid beneficiaries, policies, data systems and processes;

ii. Staff with demonstrated experience and knowledge of managed care delivery systems, organizations, and financing;

iii. Staff with demonstrated experience and knowledge of quality assessment and improvement methods;
iv. Staff with demonstrated experience and knowledge of research design and methodology, including statistical analysis;
v. Physical, technological, and financial resources to conduct EQR or EQR-related activities; and,
vi. Other clinical and nonclinical skills necessary to carry out EQR or EQR-related activities and to oversee the work of any subcontractors.

The contractor should present a detailed description of its proposed approach to the management of the project.

The contractor should identify the specific professionals who will work on the State's project if their company is awarded the contract resulting from this solicitation. The names and titles of the team proposed for assignment to the State project should be identified in full, with a description of the team leadership, interface and support functions, and reporting relationships. The primary work assigned to each person should also be identified.

The contractor should provide resumes for all personnel proposed by the contractor to work on the project. The State will consider the resumes as a key indicator of the contractor's understanding of the skill mixes required to carry out the requirements of the solicitation in addition to assessing the experience of specific individuals.

Resumes should not be longer than three (3) pages. Resumes should include, at a minimum, academic background and degrees, professional certifications, understanding of the process, and at least three (3) references (name, address, and telephone number) who can attest to the competence and skill level of the individual. Any changes in proposed personnel shall only be implemented after written approval from the State.

j. SUBCONTRACTORS

If the contractor intends to Subcontract any part of its performance hereunder, the contractor should provide:

i. name, address, and telephone number of the Subcontractor(s);
ii. specific tasks for each Subcontractor(s);
iii. percentage of performance hours intended for each Subcontract; and
iv. total percentage of Subcontractor(s) performance hours.

Form A
Contractor Proposal Point of Contact
Request for Proposal Number 6303 Z1

Form A should be completed and submitted with each response to this solicitation. This is intended to provide the State with information on the contractor's name and address, and the specific person(s) who are responsible for preparation of the contractor's response.

Preparation of Response Contact Information	
Contractor Name:	
Contractor Address:	
Contact Person & Title:	
E-mail Address:	
Telephone Number (Office):	
Telephone Number (Cellular):	
Fax Number:	

Each contractor should also designate a specific contact person who will be responsible for responding to the State if any clarifications of the contractor's response should become necessary. This will also be the person who the State contacts to set up a presentation/demonstration, if required.

Communication with the State Contact Information	
Contractor Name:	
Contractor Address:	
Contact Person & Title:	
E-mail Address:	
Telephone Number (Office):	
Telephone Number (Cellular):	
Fax Number:	

REQUEST FOR PROPOSAL FOR CONTRACTUAL SERVICES FORM

By signing this Request for Proposal for Contractual Services form, the contractor guarantees compliance with the procedures stated in this Solicitation, and agrees to the terms and conditions unless otherwise indicated in writing and certifies that contractor maintains a drug free work place.

CONTRACTOR MUST COMPLETE THE FOLLOWING

Per Nebraska's Transparency in Government Procurement Act, Neb. Rev Stat § 73-603 DAS is required to collect statistical information regarding the number of contracts awarded to Nebraska Contractors. This information is for statistical purposes only and will not be considered for contract award purposes.

_____ NEBRASKA CONTRACTOR AFFIDAVIT: Bidder hereby attests that bidder is a Nebraska Contractor. "Nebraska Contractor" shall mean any bidder who has maintained a bona fide place of business and at least one employee within this state for at least the six (6) months immediately preceding the posting date of this Solicitation.

_____ I hereby certify that I am a Resident disabled veteran or business located in a designated enterprise zone in accordance with Neb. Rev. Stat. § 73-107 and wish to have preference, if applicable, considered in the award of this contract.

_____ I hereby certify that I am a blind person licensed by the Commission for the Blind & Visually Impaired in accordance with Neb. Rev. Stat. §71-8611 and wish to have preference considered in the award of this contract.

FORM MUST BE SIGNED USING AN INDELIBLE METHOD (NOT ELECTRONICALLY)

FIRM:	
COMPLETE ADDRESS:	
TELEPHONE NUMBER:	
FAX NUMBER:	
DATE:	
SIGNATURE:	
TYPED NAME & TITLE OF SIGNER:	

COST PROPOSAL

RFP 6303 Z1

Instructions: *Please complete all blank fields in the Cost Proposal below. File should retain formatting and font styles, including a minimum of 12 point Arial-type font with 0.5" margins. An estimate of one hundred twenty (120) hours per year of Ad-hoc Technical Assistance and Consultation will be used to calculate the score for cost.*

Deliverable ID	Description	Period of Review	Due Date	Unit of Measure	Cost per Unit (Initial Term)	Cost per Unit (Renewal 1)	Cost per Unit (Renewal 2)	Cost per Unit (Renewal 3)
1.	EQR Report- MCO	previous three-year period	Annually, by October 15	Each				
2.	EQR Report Report-DBM	previous three-year period	Annually, by October 15	Each				
3.	Validation of Performance Improvement Projects (PIPs) Report- MCO	Previous calendar year	Annually, by December 31	Each				
4.	Validation of Performance Improvement Projects (PIPs) Report- DBM	Previous calendar year	Annually, by December 31	Each				
5.	Validation of Performance Measures Report-MCO	Previous calendar year	Annually, by December 31	Each				
6.	Validation of Performance Measures Report-DBM	Previous calendar year	Annually, by December 31	Each				

Ad-Hoc Services:

Deliverable ID	Description	Period of Review	Due Date	Unit of Measure	Cost per Unit (Initial Term)	Cost per Unit (Optional Renewal 1)	Cost per Unit (Optional Renewal 2)	Cost per Unit (Optional Renewal 3)
7.	Validation of Network Adequacy Report-MCO	Previous calendar year	Per Work Plan	Each				
8.	Validation of Network Adequacy Report-DBM	Previous calendar year	Per Work Plan	Each				
9.	Ad-hoc Technical Assistance and Consultation	Not applicable	Upon request	Hour				

Optional Services:

Work may be needed that was not originally delineated in this RFP, but considered within the scope of work. This additional work may stem from legislative mandates, emerging technologies, and/or secondary research not otherwise addressed in this RFP or known at the time this RFP was issued. If additional work is needed, the Contractor must submit a Detailed Project Work Plan, Title/Role(s), number of hours, and due dates/deliverables for DHHS review and approval.

Deliverable ID	Description	Period of Review	Due Date	Unit of Measure	Cost per Unit (Initial Term)	Cost per Unit (Optional Renewal 1)	Cost per Unit (Optional Renewal 2)	Cost per Unit (Optional Renewal 3)
10.	Ad-hoc Report	Per Work Plan	Per Work Plan	Each	As needed			

The bidder should provide the hourly rate for each Title/Role used to complete optional services.

Title/Role*	**Hourly Rate**

*Bidder may add additional lines as needed.

ADDENDUM A

DHHS HIPAA BUSINESS ASSOCIATE AGREEMENT PROVISIONS

RFP 6303 Z1

1. BUSINESS ASSOCIATE. "Business Associate" shall generally have the same meaning as the term "business associate" at 45 CFR § 160.103, and in reference to the party in this Contract, shall mean Contractor.

2. COVERED ENTITY. "Covered Entity" shall generally have the same meaning as the term "covered entity" at 45 CFR § 160.103, and in reference to the party to this Contract, shall mean DHHS.

3. HIPAA RULES. "HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

4. SECURITY INCIDENT. "Security Incident" shall mean the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

5. OTHER TERMS. The following terms shall have the same meaning as those terms in the HIPAA Rules: Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required by Law, Secretary, Subcontractor, Unsecured Protected Health Information, and Use.

6. THE CONTRACTOR shall do the following:
   - 6.1. Not use or disclose Protected Health Information other than as permitted or required by this Contract or as required by law. Contractor may use Protected Health Information for the purposes of managing its internal business processes relating to its functions and performance under this Contract. Use or disclosure must be consistent with DHHS' minimum necessary policies and procedures.
   - 6.2. Implement and maintain appropriate administrative, physical, and technical safeguards to prevent access to and the unauthorized use and disclosure of Protected Health Information. Comply with Subpart C of 45 CFR Part 164 with respect to electronic Protected Health Information, to prevent use or disclosure of Protected Health Information other than as provided for in this Contract and assess potential risks and vulnerabilities to the individual health data in its care and custody and develop, implement, and maintain reasonable security measures.
   - 6.3. To the extent Contractor is to carry out one or more of the DHHS' obligations under Subpart E of 45 CFR Part 164, comply with the requirements of Subpart E that apply to DHHS in the performance of such obligations. Contractor may not use or disclosure Protected Health Information in a manner that would violate Subpart E of 45 CFR Part 164 if done by DHHS.
   - 6.4. In accordance with 45 CFR §§ 164.502(E)(1)(ii) and 164.308(b)(2), if applicable, ensure that any agents and subcontractors that create, receive, maintain, or transmit Protected Health Information received from DHHS, or created by or received from the Contractor on behalf of DHHS, agree in writing to the same restrictions, conditions, and requirements relating to the confidentiality, care, custody, and minimum use of Protected Health Information that apply to the Contractor with respect to such information.
   - 6.5. Obtain reasonable assurances from the person to whom the information is disclosed that the information will remain confidential and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies the Contractor of any instances of which it is aware that the confidentiality of the information has been breached.
   - 6.6. Contractor shall maintain and make available within fifteen (15) days in a commonly used electronic format:
     - 6.6.1. Protected Health Information to DHHS as necessary to satisfy DHHS' obligations under 45 CFR § 164.524;

6.6.2. Any amendment(s) to Protected Health Information as directed or agreed to by DHHS pursuant to 45 CFR § 164.526, or take other measures as necessary to satisfy DHHS' obligations under 45 CFR § 164.526;

6.6.3. The information required to provide an accounting of disclosures to DHHS as necessary to satisfy DHHS' obligations under 45 CFR § 164.528.

6.7. Make its internal practices, books, and records relating to the use and disclosure of Protected Heath Information received from, or created or received by the Contractor on behalf of the DHHS available to the Secretary or DHHS for purposes of determining compliance with the HIPAA rules. Contractor shall provide DHHS with copies of the information it has made available to the Secretary at the same time as it was made available to the Secretary.

6.8. Report to DHHS within fifteen (15) days of which the Contractor becomes aware, any unauthorized use or disclosure of Protected Health Information made in violation of this Contract, or the HIPAA rules, including any security incident that may put electronic Protected Health Information at risk. Contractor shall, as instructed by DHHS, take immediate steps to mitigate any harmful effect of such unauthorized disclosure of Protected Health Information pursuant to the conditions of this Contract through the preparation and completion of a written Corrective Action Plan subject to the review and approval by DHHS. The Contractor shall be responsible for all breach notifications in accordance with HIPAA rules and regulations and all costs associated with security incident investigations and breach notification procedures.

6.9. Business Associate shall indemnify, defend, and hold harmless DHHS for any financial loss as a result of claims brought by third parties and which are caused by the failure of Contractor, its officers, directors, agents or subcontractors to comply with the terms of this Contract or for penalties imposed by the HHS Office of Civil Rights for any violations of the HIPAA rules caused by Contractor, its officers, directors, agents or subcontractors. Additionally, Contractor shall indemnify DHHS for any time and expenses it may incur from breach notifications that are necessary under the HIPAA Breach Notification Rule, which are caused by a failure of Contractor, its officers, directors, agents or subcontractors to comply with the terms of this Contract.

7. TERMINATION.

7.1. DHHS may immediately terminate this Contract and any and all associated contracts if DHHS determines that the Contractor has violated a material term of this Contract.

7.2. Within thirty (30) days of expiration or termination of this Contract, or as agreed, unless Contractor requests and DHHS authorizes a longer period of time, Contractor shall return or at the written direction of DHHS destroy all Protected Health Information received from DHHS (or created or received by Contractor on behalf of DHHS) that Contractor still maintains in any form and retain no copies of such Protected Health Information. Contractor shall provide a written certification to DHHS that all such Protected Health Information has been returned or destroyed (if so instructed), whichever is deemed appropriate. If such return or destruction is determined by DHHS to be infeasible, Contractor shall use such Protected Health Information only for purposes that makes such return or destruction infeasible and the provisions of this Contract shall survive with respect to such Protected Health Information.

7.3. The obligations of the Contractor under the Termination Section shall survive the termination of this Contract.

ADDENDUM B

DATA USE AGREEMENT (DUA) PROVISIONS

RFP 6303 Z1

1. PURPOSE; APPLICABILITY; ORDER OF PRECEDENCE

1.1. The purpose of this DUA is to facilitate access to, creation, receipt, maintenance, use, disclosure or transmission of Confidential Information with Contractor, and set forth Contractor's rights and obligations with respect to the Confidential Information and the limited purposes for which the Contractor may create, receive, maintain, use, disclose or have access to Confidential Information. This DUA includes, but is not limited to, taking any Confidential Information outside of any DHHS systems provided for data use, as well as the creation of any new data being used outside those systems. This DUA also describes DHHS's remedies in the event of Contractor's noncompliance with its obligations under this DUA. This DUA applies to both DHHS business associates, with "business associate" defined in the Health Insurance Portability and Accountability Act (HIPAA) (see Business Associate Provisions, Request for Proposal – Attachment A), as well as Contractors who are not business associates, who create, receive, maintain, use, disclose or have access to Confidential Information on behalf of DHHS, its programs or clients as described in the Contract. As a best practice, DHHS requires its contractors to comply with the terms of this DUA to safeguard all types of Confidential Information.

1.2. If any provision of the Contract conflicts with this DUA, this DUA controls.

2. DEFINITIONS

For the purposes of this DUA, capitalized terms have the following meanings:

2.1. "Authorized Purpose" means the specific purpose or purposes described in the Contract for Contractor to fulfill its obligations under the Contract, or any other purpose expressly authorized by DHHS, in writing, in advance.

2.2. "Authorized User" means a person:

2.2.1. Who is authorized to create, receive, maintain, access, process, view, handle, examine, interpret, or analyze Confidential Information pursuant to this DUA;

2.2.2. Who has a demonstrable need to create, receive, maintain, use, disclose or have access to the Confidential Information; and

2.2.3. Who has agreed in writing to be bound by the disclosure and use limitations pertaining to the Confidential Information as required by this DUA.

2.3. "Breach" means an impermissible use or disclosure of electronic or non-electronic sensitive personal information by an unauthorized person or for an unauthorized purpose that compromises the security or privacy of Confidential Information such that the use or disclosure poses a risk of reputational harm, theft of financial information, identity theft, or medical identity theft. Any acquisition, access, use, disclosure or loss of Confidential Information other than as permitted by this DUA shall be presumed to be a Breach unless Contractor demonstrates, based on a risk assessment, that there is a low probability that the Confidential Information has been compromised.

2.4. "Confidential Information" means any communication or record (whether oral, written, electronically stored or transmitted, or in any other form) provided to or made available to Contractor or that Contractor may create, receive, maintain, use, disclose or have access to on behalf of DHHS in connection with the Contract, which consists of or includes any or all of the following:

2.4.1. Education records as defined in the Family Educational Rights and Privacy Act, 20 U.S.C. §1232g; 34 C.F.R. Part 99

2.4.2. Federal Tax Information as defined in Internal Revenue Code § 6103 and Internal Revenue Service Publication 1075;

2.4.3. Protected Health Information (PHI) in any form including without limitation, Electronic Protected Health Information or Unsecured Protected Health Information as defined in 45 C.F.R. §160.103;

2.4.4. Personally Identifiable Information (PII) means information that can be used to distinguish or trace an individual's identity, either alone or when combined with other personal or identifying information that is linked or linkable to a specific individual.

2.4.5. Social Security Administration Data, including, without limitation, Medicaid information means disclosures of information made by the Social Security Administration or the Centers for Medicare and Medicaid Services from a federal system of records for administration of federally funded benefit programs under the Social Security Act, 42 U.S.C., Chapter 7;

2.4.6. Medicaid Client refers to:

- A Medicaid applicant;
- A Medicaid member;
- A person who is conditionally eligible for Medicaid; or
- A person whose income or assets are considered in determining eligibility for an applicant or member

2.4.7. Personal Information as defined by Neb. Rev. Stat. § 87-802;

2.4.8. Information or records contained in Neb. Rev. Stat. § 84-712.05;

2.4.9. All privileged work product;

2.4.10. All other information designated as confidential under the constitution and laws of the State of Nebraska and of the United States

2.5. "Contract" includes, collectively, the Request for Proposal (or Request for Qualifications, as applicable), the Contractor's proposal, as well as any addenda, appendices, and attachments;

2.6. "Destroy" or "Destruction", for Confidential Information, means:

2.6.1. Paper, film, or other hard copy media have been shredded or destroyed such that the Confidential Information cannot be read or otherwise reconstructed. Redaction is specifically excluded as a means of data destruction.

2.6.2. Electronic media have been cleared, purged, or destroyed consistent with National Institute of Standards and Technology (NIST) Special Publication 800-88, "Guidelines for Media Sanitization," such that the Confidential Information cannot be retrieved.

2.7. "Discover" or "Discovery" means the first day on which a Breach becomes known to Contractor, or, by exercising reasonable diligence would have been known to Contractor.

2.8. "Legally Authorized Representative" of an individual means any individual as defined in 42 CFR 435.923 (authorized representative), or any individual legally authorized to act on behalf of another individual under Nebraska law;

2.9. "Required by Law" means a mandate contained in law that compels an entity to use or disclose Confidential Information that is enforceable in a court of law and is consistent with 42 CFR Part 431, Subpart F, including court orders, warrants, subpoenas or investigative demands.

2.10. "Subcontractor" means a person who contracts with a prime contractor to work, to supply commodities, or to contribute toward completing work for a governmental entity.

2.11. "Workforce" means employees, volunteers, trainees or other persons whose performance of work is under the direct control of a party, whether they are paid by that party.

3. CONTRACTOR'S DUTIES REGARDING CONFIDENTIAL INFORMATION

3.1. *With respect to **PHI**, Contractor shall*:

3.1.1. Make PHI available if requested by DHHS, if Contractor maintains PHI, as defined in HIPAA.

3.1.2. Provide to DHHS data aggregation services related to the healthcare operations Contractor performs for DHHS pursuant to the Contract, if requested by DHHS, if Contractor provides data aggregation services as defined in HIPAA.

3.1.3. Provide access to PHI to an individual who is requesting his or her own PHI, or such individual's Legally Authorized Representative, in compliance with the requirements of HIPAA.

3.1.4. Make PHI available to DHHS for amendment, and incorporate any amendments to PHI that DHHS directs, in compliance with HIPAA.

3.1.5. Document and make available to DHHS, an accounting of use and disclosures in compliance with the requirements of HIPAA.

3.1.6. If Contractor receives a request for access, amendment or accounting of PHI by any individual, promptly forward the request to DHHS or, if forwarding the request would violate HIPAA, promptly notify DHHS of the request and of Contractor's response. DHHS will respond to all such requests, unless Contractor is Required by Law to respond or DHHS has given prior written consent for Contractor to respond to and account for all such requests.

3.2. *With respect to **ALL Confidential Information**, Contractor shall*:

3.2.1. Exercise reasonable care and no less than the same degree of care Contractor uses to protect its own confidential, proprietary and trade secret information to prevent Confidential Information from being used in a manner that is not expressly an Authorized Purpose or as Required by Law. Contractor must access, create, maintain, receive, use, disclose, transmit or Destroy Confidential Information in a secure fashion that protects against any reasonably anticipated threats or hazards to the security or integrity of such information or unauthorized uses.

3.2.2. Establish, implement and maintain appropriate procedural, administrative, physical and technical safeguards (for the purpose of this paragraph, "Safeguards") to preserve and maintain the confidentiality, integrity, and availability of the Confidential Information, in accordance with applicable laws or regulations relating to Confidential Information, to prevent any unauthorized use or disclosure of Confidential Information as long as Contractor has such Confidential Information in its actual or constructive possession. DHHS must review and approve said Safeguards before actual or constructive possession of any Confidential Information. Contractor must also allow DHHS, or a third party designated by DHHS, to review the Safeguards, in the sole discretion of DHHS.

3.2.3. Implement, update as necessary, and document privacy, security and Breach notice policies and procedures and an incident response plan to address a Breach, to comply with the privacy, security and breach notice requirements of this DUA prior to conducting work under the Contract. Contractor shall produce, within three business days of a request by DHHS, copies of its policies and procedures and records relating to the use or disclosure of Confidential Information.

3.2.4. Obtain DHHS's prior written consent to disclose or allow access to any portion of the Confidential Information to any person, other than Authorized Users, Workforce or Subcontractors of Contractor, provided said Authorized Users, Workforce or Subcontractors have completed DHHS-specified training in confidentiality, privacy, security, and on the importance of promptly reporting any Breach to Contractor's management and as permitted in Section 3.1.3, above. All Authorized Users, Workforce or Subcontractors must execute, individually, an acknowledgement noting their obligations as regards Confidential Information, and referencing this DUA. Additional requirements set forth below pertaining to Subcontractors dictate further requirements before disclosure.

3.2.5. Establish, implement and maintain appropriate sanctions against any member of its Workforce or Subcontractor who fails to comply with this DUA, the Contract or applicable law. Contractor must maintain evidence of sanctions and produce it to DHHS upon request.

3.2.6. Obtain prior written approval of DHHS, to disclose or provide access to any Confidential Information on the basis that such act is Required by Law, so that DHHS may have the opportunity to object to the disclosure or access and seek appropriate relief.

3.2.7. Certify that its Authorized Users each have a demonstrated need to know and have access to Confidential Information solely to the minimum extent necessary to accomplish the Authorized Purpose and that each has agreed in writing to be bound by the disclosure and use limitations pertaining to the Confidential Information contained in this DUA. Contractor and any previously authorized Subcontractors shall maintain at all times an updated, complete, accurate list of Authorized Users and supply it to DHHS upon request.

3.2.8. Provide, and require Subcontractors and agents to provide, to DHHS periodic written confirmation of compliance with controls and the terms of this DUA.

3.2.9. Return to DHHS or Destroy, at DHHS's election and at Contractor's expense, all Confidential Information received from DHHS or created or maintained by Contractor or any of Contractor's agents or Subcontractors on DHHS's behalf upon the termination or expiration of this DUA, if reasonably feasible and permitted by law. Contractor shall certify in writing to DHHS that all such Confidential Information has been Destroyed or returned to DHHS, and that Contractor and its agents and Subcontractors have retained no copies thereof. Notwithstanding the foregoing, Contractor acknowledges and agrees that it may not Destroy any Confidential Information if federal or state law, or DHHS record retention policy or a litigation hold notice prohibits such Destruction. If such return or Destruction is not reasonably feasible, or is impermissible by law, Contractor shall immediately notify DHHS of the reasons such return or Destruction is not feasible, and agree to extend the protections of this DUA to the Confidential Information for as long as Contractor maintains such Confidential Information.

3.2.10. Comply with the current DHHS Acceptable Use Policy (AUP), and require each Subcontractor and Workforce member who has direct access to DHHS Information Resources, as defined in the AUP, to execute a DHHS Acceptable Use Agreement. See Section 3.2.14 bullet point labeled "DHHS Information Security Policies."

3.2.11. Only conduct secure transmissions of Confidential Information whether in paper, oral or electronic form. DHHS must approve the method of secure transmission before any Confidential Information is transmitted by Contractor. A secure transmission of electronic Confidential Information in motion includes secure File Transfer Protocol (SFTP) or encryption at an appropriate level as required by rule, regulation or law. Confidential Information at rest requires encryption unless there is adequate administrative, technical, and physical security as required by rule, regulation or law. All electronic data transfer and communications of Confidential Information shall be through secure systems. Contractor shall provide proof of system, media or device security and/or encryption to DHHS no later than 48 hours after DHHS's written request in response to a compliance investigation, audit, or the Discovery of a Breach. DHHS may also request production of proof of security at other times as necessary to satisfy state and federal monitoring requirements. De-identification of Confidential Information in accordance with HIPAA de-identification standards is deemed secure.

3.2.12. Designate and identify a person or persons, as Privacy Official and Information Security Official, each of whom is authorized to act on behalf of Contractor and is responsible for the development and implementation of the privacy and security requirements in this DUA. Contractor shall provide name and current address, phone number and e-mail address for such designated officials to DHHS upon execution of this DUA and prior to any change. Upon written notice from DHHS, Contractor shall promptly remove and replace such official(s) if such official(s) is/are not performing the required functions.

3.2.13. Make available to DHHS any information DHHS requires to fulfill DHHS's obligations to provide access to, or copies of, Confidential Information in accordance with applicable laws, regulations or demands of a regulatory authority relating to Confidential Information. Contractor shall provide such information in a time and manner reasonably agreed upon or as designated by the applicable law or regulatory authority.

3.2.14. Comply with the following laws and standards if applicable to the type of Confidential Information and Contractor's Authorized Purpose:

- The Privacy Act of 1974 (USC 552a);
- OMB Memorandum 17-12;
- 42 CFR Part 431, Subpart F;
- The Federal Information Security Management Act of 2002 (FISMA);
- The Health Insurance Portability and Accountability Act of 1996 (HIPAA);
- Internal Revenue Publication 1075 – Tax Information Security Guidelines for Federal, State and Local Agencies;
- NIST Special Publication 800-66 Revision 1 - An Introductory Resource Guide for Implementing the Health Insurance Portability and Accountability Act (HIPAA) Security Rule;
- NIST Special Publications 800-53 and 800-53A – Recommended Security Controls for Federal Information Systems and Organizations, as currently revised;
- NIST Special Publication 800-47 – Security Guide for Interconnecting Information Technology Systems;
- NIST Special Publication 800-88, Guidelines for Media Sanitization;
- NIST Special Publication 800-111, Guide to Storage of Encryption Technologies for End User Devices containing PHI;
- Nebraska Information Technology Commission, Chapter 8 – Information Security Policy, available at: https://nitc.nebraska.gov/standards/index.html;
- DHHS IT Policies available at the following link: http://dhhs.ne.gov/Documents/Information%20Technology%20(IT)%20Security%20Policies%20and%20Standards.pdf
- Family Educational Rights and Privacy Act; and
- Any other state or federal law, regulation, or administrative rule relating to the specific DHHS program area that Contractor supports on behalf of DHHS.

3.2.15. Be permitted to use or disclose Confidential Information, except Confidential Information about Medicaid Clients, for the proper management and administration of Contractor roles and responsibilities or to carry out Contractor's legal responsibilities, except as otherwise limited by this DUA, the Contract, or law applicable to the Confidential Information, if: (1) Disclosure is Required by Law; or (2) Contractor obtains reasonable assurances from the person to whom the information is disclose that the person shall:

- Maintain the confidentiality of the Confidential Information in accordance with this DUA;
- Use or further disclose the information only as Required by Law or for the Authorized Purpose for which it was disclosed to the person; and
- Notify Contractor in accordance with Section 4 of a Breach of Confidential Information that the person Discovers or should have Discovered with the exercise of reasonable diligence.

3.2.16. For Confidential Information about Medicaid Clients, DHHS must provide prior written approval to the Contractor before Contractor is permitted to use such information for the uses described immediately above.

3.3. *With respect to **ALL Confidential Information**, Contractor shall **NOT**:*

3.3.1. Attempt to re-identify or further identify Confidential Information that has been de-identified, or attempt to contact any persons whose records are contained in the Confidential Information, except for an Authorized Purpose, without express written authorization from DHHS.

3.3.2. Engage in marketing or sale of Confidential Information.

3.3.3. Permit, or enter into any agreement with a Subcontractor to, create, receive, maintain, use, disclose, have access to or transmit Confidential Information, on behalf of DHHS without requiring that Subcontractor first gain approval from DHHS and execute the Form Subcontractor Agreement, Appendix 1. Contractor is directly responsible for its Subcontractors' compliance with, and enforcement of, this DUA. If Subcontractor requires Medicaid Client information access, the Contractor shall specifically identify as such in its request to DHHS.

4. BREACH NOTICE, REPORTING AND CORRECTION REQUIREMENTS

4.1. *Cooperation and Financial Responsibility*

4.1.1. Contractor shall, at Contractor's expense, cooperate fully with DHHS in investigating, mitigating to the extent practicable, and issuing notifications as directed by DHHS, for any Breach of Confidential Information.

4.1.2. Contractor shall make Confidential Information in Contractor's possession available pursuant to the requirements of HIPAA or other applicable law upon a determination of a Breach.

4.1.3. Contractor's obligation begins at the Discovery of a Breach and continues as long as related activity continues, until all effects of the Breach are mitigated to DHHS's satisfaction (the "incident response period").

4.2. *Initial Breach Notice*

4.2.1. For federal information obtained from a federal system of records, including Federal Tax Information and Social Security Administration Data (which includes Medicaid and other governmental benefit program Confidential Information), Contractor shall notify DHHS of the Breach within the first hour of Discovery. The Contract shall specify whether Confidential Information is obtained from a federal system of records. For all other types of Confidential Information, Contractor shall also notify DHHS of the Breach within the first hour of Discovery, or in a timeframe otherwise approved by DHHS in writing. Contractor shall initially report to DHHS's Privacy and Security Officers via email at:

- DHHS.InformationSecurityOffice@nebraska.gov; and
- DHHS.PrivacyOfficer@nebraska.gov.

Notification shall also be provided via email to the DHHS Contract Manager.

4.2.2. Contractor shall report all information reasonably available to Contractor about the Breach. This shall include, but not necessarily be limited to:

- Date and time of the incident;
- Date and time the incident was discovered;
- Description of the incident and the data involved, including specific data elements, if known;
- Potential number of records involved; if unknown, provide an estimated range;
- Address where the incident occurred;
- Information technology involved (e.g., laptop, server, mainframe etc.)

4.2.3. Contractor shall provide contact information to DHHS for Contractor's single point of contact who will communicate with DHHS both on and off business hours during the incident response period.

4.3. *Third Business Day*. No later than 5 p.m. on the third business day after Discovery, or a time within which Discovery reasonably should have been made by Contractor of a Breach of Confidential Information, Contractor shall provide written notification to DHHS of all reasonably available information about the Breach, and Contractor's investigation, including, to the extent known to Contractor:

4.3.1. The date the Breach occurred;

4.3.2. The date of Contractor's and, if applicable, Subcontractor's Discovery;

4.3.3. A brief description of the Breach, including how it occurred and who is responsible (or hypotheses, if not yet determined);

4.3.4. A brief description of Contractor's investigation and the status of the investigation;

4.3.5. A description of the types and amount of Confidential Information involved;

4.3.6. Identification of and number of all individuals reasonably believed to be affected, including first and last name of the individual(s) and if applicable, the Legally Authorized Representative, last known address, age, telephone number, and email address if it is a preferred contact method;

4.3.7. Contractor's initial risk assessment of the Breach, demonstrating whether individual or other notices are required by applicable law or this DUA for DHHS approval, including an analysis of whether there is a low probability of compromise of the Confidential Information or whether any legal exceptions to notification apply;

4.3.8. Contractor's recommendation for DHHS's approval as to the steps individuals and/or Contractor on behalf of individuals, should take to protect the individuals from potential harm, including Contractor's provision of notifications, credit protection, claims monitoring, and any specific protections for a Legally Authorized Representative to take on behalf of an individual with special capacity or circumstances;

4.3.9. The steps Contractor has taken to mitigate the harm or potential harm caused (including without limitation the provision of sufficient resources to mitigate);

4.3.10. The steps Contractor has taken, or will take, to prevent or reduce the likelihood of recurrence of a similar Breach;

4.3.11. Identify, describe or estimate of the persons, Workforce, Subcontractor, or individuals and any law enforcement that may be involved in the Breach;

4.3.12. A reasonable schedule for Contractor to provide regular updates regarding response to the Breach, but no less than every three (3) business days, or as otherwise directed by DHHS in writing, including information about risk estimations, reporting, notification, if any, mitigation, corrective action, root cause analysis and when such activities are expected to be completed; and

4.3.13. Any reasonably available, pertinent information, documents or reports related to a Breach that DHHS requests following Discovery.

4.4. *Breach Notification to Individuals and Reporting to Authorities*.

4.4.1. DHHS may direct Contractor to provide Breach notification to individuals, regulators or third-parties, as specified by DHHS following a Breach.

4.4.2. Contractor must comply with all applicable legal and regulatory requirements, including but not limited to those contained in the Financial Data Protection and Consumer Notification of Data Security Breach Act of 2006, Neb. Rev. Stat. §§ 87-801 et seq., in the time, manner and content of any notification to individuals, regulators or third-parties, or any notice required by other state or federal authorities. Notice letters will be in Contractor's name and on Contractor's letterhead, unless otherwise directed by DHHS, and will contain contact information, including the name and title of Contractor's representative, an email address and a toll-free telephone number, for the individual to obtain additional information.

4.4.3. Contractor shall provide DHHS with draft notifications for DHHS approval prior to distribution and copies of distributed and approved communications.

4.4.4. Contractor shall have the burden of demonstrating to the satisfaction of DHHS that any required notification was timely made. If there are delays outside of Contractor's control, Contractor shall provide written documentation to DHHS of the reasons for the delay.

4.4.5. If DHHS directs Contractor to provide notifications, DHHS shall, in the time and manner reasonably requested by Contractor, cooperate and assist with Contractor's information requests in order to make such notifications.

5. GENERAL PROVISIONS

5.1. Ownership of Confidential Information

5.1.1. Notwithstanding any other provision in the Contract, all data collected as a result of this project (including but not limited to all Confidential Information) shall be the property of DHHS.

5.2. DHHS Commitment and Obligations

5.2.1. DHHS will not request Contractor to create, maintain, transmit, use or disclose PII/PHI in any manner that would not be permissible under applicable law if done by DHHS.

5.3. DHHS Right to Inspection

5.3.1. At any time, upon reasonable notice to Contractor, or if DHHS determines that Contractor has violated this DUA, DHHS, directly or through its agent, will have the right to inspect the facilities, systems, books and records of Contractor to monitor compliance with this DUA. For purposes of this subsection, DHHS's agent(s) include, without limitation, the Office of Public Counsel, the Nebraska Attorney General's Office, the Nebraska Auditor of Public Accounts, outside consultants, legal counsel, or other designee.

5.4. Term; Termination of DUA; Survival

5.4.1. This DUA will be effective on the date on which it was signed, and will terminate upon termination of the Contract and as set forth herein. If the Contract is extended, this DUA is extended to run concurrent with the Contract.

5.4.2. If DHHS determines that Contractor has violated a material term of this DUA, DHHS may, in its sole discretion:

- Exercise any of its rights, including but not limited to reports, access and inspection under this DUA and/or the Contract; or
- Require Contractor to submit to a corrective action plan, including a plan for monitoring and plan for reporting as DHHS may determine necessary to maintain compliance with this DUA; or
- Provide Contractor with a reasonable period to cure the violation as determined by DHHS; or
- Terminate the DUA and Contract immediately, and, if DHHS further determines, seek relief in a court of competent jurisdiction.
- Before exercising any of these options, DHHS will provide written notice to Contractor describing the violation and the action it intends to take.

5.4.3. If neither termination nor cure is feasible, DHHS shall report the violation to the applicable regulatory authorities.

5.4.4. The duties of Contractor or its Subcontractor under this DUA survive the expiration or termination of this DUA until all the Confidential Information is Destroyed or returned to DHHS, as required by this DUA.

5.5. Injunctive Relief

5.5.1. Contractor acknowledges and agrees that DHHS may suffer irreparable injury if Contractor or its Subcontractor fails to comply with any of the terms of this DUA with respect to the Confidential Information or a provision of HIPAA or other laws or regulations applicable to Confidential Information.

5.5.2. Contractor further agrees that monetary damages may be inadequate to compensate DHHS for Contractor's or its Subcontractor's failure to comply. Accordingly, Contractor agrees that DHHS will, in addition to any other remedies available to it at law or in equity, be entitled to seek injunctive relief without posting a bond and without the necessity of demonstrating actual damages, to enforce the terms of this DUA.

5.6. Indemnification

5.6.1. All of Contractor's duties and obligations regarding indemnification otherwise contained herein apply to the provisions contained in this DUA.

5.7. Automatic Amendment and Interpretation

5.7.1. Upon the effective date of any amendment or issuance of additional regulations to any law applicable to Confidential Information, this DUA will automatically be amended so that the obligations imposed on DHHS and/or Contractor remain in compliance with such requirements. Any ambiguity in this DUA will be resolved in favor of a meaning that permits DHHS and Contractor to comply with laws applicable to Confidential Information.

5.8. Notices; Requests for Approval

5.8.1. All notices and requests for approval related to this DUA must be directed to the DHHS Contract Manager.

APPENDIX 1. SUBCONTRACTOR AGREEMENT FORM

RFP XXXX Z1

The DUA between DHHS and Contractor establishes the permitted and required uses and disclosures of Confidential Information by Contractor. Contractor has received permissions by DHHS for operations purposes for Authorized Use, and has subcontracted with _____(Subcontractor name) for performance of duties on behalf of Contractor, which are subject to the DUA. Subcontractor acknowledges, understands and agrees to be bound by the same terms and conditions applicable to Contractor under the DUA, incorporated by reference in this Agreement, with respect to DHHS Confidential Information. Contractor and Subcontractor agree that DHHS is a third-party beneficiary to applicable provisions of the subcontract.

DHHS has the right, but not the obligation, to review or approve the terms and conditions of the subcontract by virtue of this Subcontractor Agreement Form.

Contractor and Subcontractor assure DHHS that any Breach as defined by the DUA that Subcontractor Discovers shall be reported to DHHS by Contractor in the time, manner and content required by the DUA.

If Contractor knows or should have known in the exercise of reasonable diligence of a pattern of activity or practice by Subcontractor that constitutes a material breach or violation of the DUA or the Subcontractor's obligations, Contractor shall:

1. Take reasonable steps to cure the violation or end the violation, as applicable;
2. If the steps are unsuccessful, terminate the contract or arrangement with Subcontractor, if feasible;
3. Notify DHHS immediately upon Discovery of the pattern of activity or practice of Subcontractor that constitutes a material breach or violation of the DUA and keep DHHS reasonably and regularly informed about steps Contractor is taking to cure or end the violation or terminate Subcontractor's contract or arrangement.

This Subcontractor Agreement Form is executed by the parties in their capacities indicated below.

FOR CONTRACTOR:	FOR SUBCONTRACTOR:
_____	_____
Name Title Contractor Name	Name Title Subcontractor name
DATE: _____	DATE: _____

ATTACHMENT 1

TECHNICAL APPROACH NARRATIVE

Instructions: *Please complete all sections titled "Bidder Response" in the Technical Approach Narrative below. File should retain a minimum of 12 point Arial-type font with 1" margins. This form does not replace the Corporate Overview Narrative, which must be submitted as a separate narrative.*

V.C. Business Requirements	
Section	Description
V.C.1.	Describe how Bidder meets or exceeds the independence requirements of this section.
Bidder Response:	
V.C.2.	Describe how Bidder meets or exceeds the non-duplication requirements of this section and ensures mandatory activities with Medicare or accreditation review are not duplicated.
Bidder Response:	
V.D. Project Requirements	
V.D.1.	Describe the Bidder's use of the required protocols of this section and Bidder's approach to ensure current protocols are utilized in performance of duties under this contract.
Bidder Response:	

V.D.2.a.	Describe the Bidder's approach to conducting an annual external quality review of the MCOs and PAHP in Nebraska, and how the approach meets or exceeds the requirements of this RFP.
Bidder Response:	
V.D.2.b.	Describe the Bidder's approach to performing validation of PIPs, and how the approach meets or exceeds the requirements of this RFP.
Bidder Response:	
V.D.2.c.	Describe the Bidder's approach to providing validation of MCO and PAP performance measures, and how the approach meets or exceeds the requirements of this RFP.
Bidder Response:	
V.D.2.d.	Describe the Bidder's approach to performing a review to determine the MCOs and PAHPs compliance with the standards set forth in 42 CFR 438, subpart D and the quality assessment and performance improvement requirements described in 42 CFR § 438.330, and how the approach meets or exceeds the requirements of this RFP.
Bidder Response:	
V.D.2.e.	Describe the Bidder's approach to performing validation of MCO and PAHP network adequacy, and how the approach meets or exceeds the requirements of this RFP.
Bidder Response:	

V.D.3.	Describe the Bidder's approach to providing technical assistance as identified in this section, and how the approach meets or exceeds the requirements of this RFP.
Bidder Response:	
V.D.4.a.	Describe the Bidder's approach to providing an annual detailed technical report for each MCO and PAHP, and how the approach meets or exceeds the requirements of this RFP.
Bidder Response:	
V.D.4.b.	Describe the Bidder's approach to providing an annual assessment of each MCO's or PAHP's strengths and weaknesses for the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries, and how the approach meets or exceeds the requirements of this RFP.
Bidder Response:	
V.D.4.c.	Describe the Bidder's approach to providing recommendations for improving the quality of health care services furnished by each MCO or PAHP, and how the approach meets or exceeds the requirements of this RFP.
Bidder Response:	
V.D.4.d.	Describe the Bidder's approach to providing methodologically appropriate, comparative information about all MCOs and PAHPs, upon request, and how the approach meets or exceeds the requirements of this RFP.
Bidder Response:	

V.D.4.e.	Describe the Bidder's approach to providing an annual assessment of the degree to which each MCO or PAHP has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR, and how the approach meets or exceeds the requirements of this RFP.
Bidder Response:	
V.D.4.f.	Describe the Bidder's approach to providing ad hoc studies and reports, how the proposed hourly rate is competitive, and how the approach meets or exceeds the requirements of this RFP.
Bidder Response:	
V.D.5	Describe the Bidder's approach to distributing the EQR reports, assessments, and recommendations of section V.D.5., and how the approach meets or exceeds the requirements of this section.
Bidder Response:	
V.D.6.	Describe the Bidder's approach to meetings, and how the approach meets or exceeds the requirements of this section.
Bidder Response:	
V.D.7.	Describe the Bidder's approach to performing quality review, and how the approach meets or exceeds the requirements of this section.
Bidder Response:	

V.G. Work Plan	
V.G.	Describe the Bidder's approach to successfully completing all EQR-related services and how the approach meets or exceeds the requirements of this RFP. Bidder must include a Draft Work Plan that includes a timeline of deliverable submission for review.
Bidder Response:	
V.H. Project Planning and Management	
V.H.	Describe the Bidder's approach to communication planning and how the approach meets or exceeds the requirements of this section. Bidder must include a Draft Communications Plan for review.
Bidder Response:	

ADDENDUM ONE - REVISED SCHEDULE OF EVENTS

Date: June 26, 2020

To: All Bidders

From: Keith Roland, Buyer
Nebraska Department of Health and Human Services

RE: Addendum for Request for Proposal Number 6303 Z1 to be opened July 31, 2020 at 2:00:00 p.m. Central Time

Schedule of Events

The State expects to adhere to the tentative procurement schedule shown below. It should be noted, however, that some dates are approximate and subject to change. It is the Bidder's responsibility to check the State Purchasing Bureau website for all addenda or amendments.

ACTIVITY		DATE/TIME
1.	Release Solicitation	June 1, 2020
2.	Last day to submit written questions	June 15, 2020
3.	State responds to written questions through Solicitation "Addendum" and/or "Amendment" to be posted to the Internet at: http://das.nebraska.gov/materiel/purchase_bureau/vendor/agency-rfp.html	~~June 30, 2020~~ July 7, 2020
4.	Last day to submit "Notification of Intent to Submit a Proposal"	July 15, 2020
5.	Proposal Opening Location for mailed/hand delivered submissions: Department of Health and Human Services 301 Centennial Mall S., 3rd floor Lincoln, NE 68509 Electronic submissions: https://nebraskastategov.sharefile.com/r-r4058b5be7e64e798	July 31, 2020 2:00 PM Central Time
6.	Review for conformance to solicitation requirements	August 1, 2020
7.	Evaluation period	August 1, 2020 – August 31, 2020
8.	"Oral Interviews/Presentations and/or Demonstrations" (if required)	To be announced if required
9.	Post "Notification of Intent to Award" to Internet at: and/or http://das.nebraska.gov/materiel/purchasing.html	September 1, 2020
10.	Contract finalization period	September 1, 2020 - September 15, 2020
11.	Contract award	September 30, 2020
12.	Contractor start date	October 1, 2020

This addendum will become part of the proposal and should be acknowledged with the Request for Proposal response.

ADDENDUM TWO
QUESTIONS and ANSWERS

Date: July 7, 2020

To: All Bidders

From: Keith Roland, Buyer
Department of Health and Human Services

RE: Addendum for External Quality Reviews Request for Proposals

Questions and Answers

Following are the questions submitted and answers provided for the above mentioned Request for Qualifications. The questions and answers are to be considered as part of the Request for Qualifications. It is the Bidder's responsibility to check the project information page for all addenda or amendments.

Question Number	Section Number	Question	State Response
1.	D.2 EQRO Activities	Please clarify the frequency of the compliance review. Section 2.a describes an annual review, whereas, section 2.d describes a 3-year cycle.	Both are accurate, the 3-year cycle is a full audit whereas the annual covers those items non-compliant for the prior year.
2.	D.4 Reporting	For the annual technical report, does DHHS require individual MCO/DBM reports or an aggregate statewide report, or both?	Both
3.	D.6 Meetings	Is the EQRO expected to attend the quarterly operational meetings in-person or is virtual attendance acceptable?	Virtual, however there may be times the State will request in person.
4.	Cost proposal	Please confirm that the unit of measure for each deliverable (with the exception of Ad-hoc Technical Assistance and Consultation) is one MCO or DBM.	Yes, the Unit of Measure is per MCO (3 in total) or DBM.
5.	Cost Proposal	The instructions stated that Forms A, B, and C must be complete and submitted with the proposal. Would those forms be provided? The	A Revised Cost Proposal with reference to Forms A, B, and C removed has been posted.

		current cost proposal document doesn't have forms or sections A, B, and C.	
6.	V.D.2.a.i	RFP states, "The Contractor will provide a review, conducted annually, to determine the MCO's/DBM's compliance with standards (except with respect to standards under 42 CFR §438.240(b)(1) and (2), for conducting performance improvement projects and calculations of performance measures, respectively) established by the State to comply with the requirements of 42 CFR § 438.204(g)." • 42 CFR §438.240 was deleted in new regulations, and §438.330 and §438.340 are now the relevant sections regarding quality. Will the RFP and contract be updated with the new references? 42 CFR § 438.204(g), Managed care State quality strategy is now contained in §438.340(b). which does not contain the language referenced in §438.204(g). Will the RFP and contract be updated with the new reference, §438.340(b)?	Section V.D.2.a.i is hereby revised to read: The Contractor will provide a review, conducted annually, to determine the MCO's/DBM's compliance with standards for conducting performance improvement projects and calculations of performance measures, respectively, established by the State to comply with the requirements of 42 CFR § 438.340(b).
7.	D(2)(d) Project Requirements	RFP states, "The Contractor will perform a review, conducted within the previous 3-year period, to determine the MCOs and DBMs compliance with the standards set forth in 42 CFR 438, subpart D and the quality assessment and performance improvement requirements described in 42 CFR § 438.330." When was the last review performed to determine the MCOs and DBMs compliance with the standards set forth in 42 CFR 438, subpart D and the quality assessment and performance improvement requirements described in 42 CFR § 438.330 by the current EQRO?	The last 3 year audit was completed in April 2018, with a review of 2017 data.
8.	D(2)(e)	RFP states, "The Contractor will perform validation of MCO and DBM network adequacy	The protocols can be found in the current Heritage Health contracts located at the following webpage:

	Project Requirements	during the preceding calendar year to comply with requirements set forth in 42 CFR § 438.68." Does the state have review protocols for network adequacy? If yes, can those protocols be provided as part of the RFP?	https://das.nebraska.gov/materiel/purchasing/contracts/pdfs/71163(o4)awd.pdf
9.	H. SUBMISSION OF PROPOSALS	Should the Technical, Cost and Proprietary information proposal files each be submitted in separate emails?	Proposals will not be accepted via email. Bidders can submit proposals electronically via ShareFile. Bidders can also mail or hand deliver a paper/hard copy. If submitting electronically via ShareFile, the Technical, Cost, and Proprietary files should be uploaded as separate and distinct files.
10.	N. REQUEST FOR PROPOSAL REQUIREMENTS	Should the Contractor Proposal Point of Contact form, Technical Approach Narrative, Corporate Overview Narrative, draft Work Plan and draft Communications Plan all be submitted in one "Technical" file to meet the submission directions of 'The Technical, Cost Proposal and Proprietary information should be uploaded as separate and distinct files? If not, please clarify how these should be packaged for electronic submission.	The Contractor Proposal Point of Contact form, Technical Approach Narrative, Corporate Overview Narrative, draft Work Plan and draft Communications Plan can be submitted as a single file or as separate files if the proposal is being submitted electronically via ShareFile. The Cost Proposal and any Proprietary information must be submitted as separate files if the proposal is being submitted electronically via ShareFile.
11.	D. PROJECT REQUIREMENTS, 2. EQRO Activities	a. Conduct an annual external quality review of the Managed Care Organizations (MCO) and the Dental Benefits Mangers (DBM) in Nebraska and produce the required report(s). The quality review must use information from mandatory activities as set forth in 42 CFR § 438.358(b). ii. The Contractor will conduct the on-site review of each MCO and DBM in the second calendar quarter of each year. The Contractor will establish and provide a schedule for documentation requests of the MCOs and DBMs ahead of reviews. Does the state intend for this to begin in the second quarter of calendar year 2021?	Yes

12.	D. PROJECT REQUIREMENTS, 2. EQRO Activities	b. The Contractor will perform validation of Performance Improvement Projects (PIPs) required by the State to comply with requirements set forth in 42 CFR § 438.330(b)(1), that were underway during the preceding calendar year. How many PIPs are conducted by the MCOs and how many PIPs are conducted by the DBM?	MCOs: Two (2) clinical and one (1) non-clinical DBM: One (1) clinical and one (1) non-clinical
13.	D. PROJECT REQUIREMENTS, 2. EQRO Activities	c. The Contractor will provide validation of MCO and DBM performance measures reported (as required by the State) or MCO and DBM performance measures calculated by the State during the precedingcalendar year to comply with requirements set forth in 42 CFR § 438.330(b)(2). Some performance measures may be required by the State to be continued, based on specific outcomes for a specifiedperiod of time.Will the state allow the contractor to accept audited results for performance measures validated under NCQA accreditation?	Yes, the State will allow the Contractor to accept audited results for performance measures validated under NCQA accreditation.
14.	D. PROJECT REQUIREMENTS, 6. Meetings.	a. The Contractor will establish monthly technical assistance meetings or conference calls with DHHS staff. Are the meetings required to be in-person?	No, the meetings are not required to be in-person.
15.	E. SCOPE OF WORK, 2. Other EQR-related activities	At the request of DHHS, the Contractor shall perform the following EQR-related activities, using the most recent federally approved EQR protocol: How many optional activities does the state anticipate?	Up to two (2) optional activities.
16.	J. INSURANCE REQUIREMENTS	Is any evidence of coverage, insurance information, &/or certificate of insurance required with proposal submission?	A Certificate of Insurance is not required to be submitted with the proposal. However, the Contractor shall not commence work on the contract until the insurance is in place.

17.	d. OFFICE LOCATION	Is the contractor required to have an office in the State of Nebraska?	No
18.	Attachment 1: Technical Approach Narrative	Is this Technical Approach Narrative form required, or may the bidder use the same headers, but in a separate file which includes the Corporate Overview Narrative?	Bidders must use the Technical Approach Narrative form.
19.	COST PROPOSAL FORM	The instructions at the top of this form say "Forms A, B, and C must be complete and submitted with the proposal". Will the State please clarify what forms A, B and C are and where they are located?	See answer to question #5.
20.	Pricing	Will the state be providing estimated hours and the overall pricing structure to be used to propose overall costs?	No
21.	General	Does the contract begin October 1, 2020?	The anticipated Contractor start date is April 1, 2021. See Addendum Three, Revised Schedule of Events. DHHS expects to adhere to this schedule, but it is subject to change.
22.	General	Does the contract overlap with the current contractor's contract term?	No. See question 21.
23.	H. Submission of Proposals and W. Email Submissions	The State identifies acceptance of electronically submitted responses on page 3 of the solicitation, and then on page 8 states, "SPB will not accept proposals by email, electronic, voice, or telephone proposal except for one-time purchases under $50,000.00." Should the Contractor follow guidance on page 3 or page 8?	Section I.W is amended to read: DHHS will not accept proposals by email, voice, or telephone proposals except for one-time purchases under $50,000. Bidders may submit proposals electronically via ShareFile.
24.	N. Request for Proposal/Proposal Requirements	The State requires: "Original Request for Proposal for Contractual Services form signed using an indelible method". With offices closed in many states, will the State allow for a scanned signature applied to the form?	Yes, Bidders may sign and scan the Request for Proposal for Contractual Services form.
25.	V. Project Description and Scope of Work; D.2.d EQRO Activities	RFP reads (D.2.d), "The Contractor will perform a review, conducted within the previous 3-year period, to determine the MCOs and DBMs compliance with standards…" How is this different from the review detailed in D.2.a.? Is this referencing a comprehensive review?	Section V.D.2.a. is one annual external quality review of each of the Managed Care Organizations (MCO) and the Dental Benefits Mangers (DBM) in Nebraska.

			Section V.D.2.d is a review, conducted within the previous 3-year period, summarizing all MCEs. See answer to question #7.
26.	V. Project Description and Scope of Work; D.4.a., Reporting	RFP reads, "For each MCO and DBM, the Contractor will provide an annual detailed technical report…" Please confirm that this is one annual technical report summarizing each MCO and DBM's activities, not four separate reports. Or if four separate reports are required, is the State requiring one additional annual technical report (summarizing each MCO and DBM's activities) which will be submitted to CMS?	See answer to question #25.
27.	V. Project Description and Scope of Work; D.2.a	Please confirm accuracy of CFR references: "42 CFR §438.240(b)(1) and (2), for conducting performance improvement projects and calculations of performance measures, respectively, established by the State to comply with the requirements of 42 CFR § 438.204(g)."	This is accurate.
28.	V. Project Description and Scope of Work; D.2.a	Specifically, due to Question 5, what EQR activities should be included in the annual review conducted in Nebraska in D.2.a. besides the Compliance Review (compliance with standards set forth in 42 CFR 438, subpart D and the quality assessment and performance improvement requirements described in 42 CFR § 438.330)?	EQR reviews should include all requirements set forth in this RFP, as well as the CFR.
29.	V. Project Description and Scope of Work; D.4.a	Since this is an October 1, 2020 start, we are confirming the incumbent EQRO is responsible for completing the annual technical report due to the State by October 15, 2020. Is this an accurate assumption?	The start date of this contract has been revised to April 1, 2021. See Addendum Three – Revised Schedule of Events. The incumbent EQRO will complete the annual technical report.
30.	V. Project Description and Scope of Work; D.4.a.i	Is the draft or final annual detailed technical report due to the State by October 15th?	The final annual detailed technical report is due by October 15.

31.	V. Project Description and Scope of Work; D.6	Please confirm monthly technical assistance meetings can be conducted via conference calls or webinars.	Yes they can be conducted via conference calls or webinars.
32.	V. Project Description and Scope of Work; D.7	Please confirm activities outlined in D.7.a-g (and activities outlined in E.2.a-e) will only be conducted at the request of the State and will be completed based on an hourly rate. It does not appear these activities are captured in the cost proposal template and therefore should not be included in the cost of the proposal.	Activities outlined in Sections V.D.7.a-g (and activities outlined in E.2.a-e) will only be conducted at the request of the State and will be completed based on an hourly rate.
33.	V. Project Description and Scope of Work; F	Is the intent of Deliverables 1 and 2 (Annual EQR Reports) to capture and report results of all EQR activities—as in the report that is submitted to CMS? If so, does this deliverable capture the results of the Compliance Review (D.2.d, pg 29)? There does not appear to be a separate deliverable for the compliance review activity (deliverable section and cost proposal template).	Yes, the intent of Deliverables 1 and 2 (Annual EQR Reports) is to capture and report results of all EQR activities. Yes, the deliverable captures the results of Section V.D.2.d.
34.	Cost Proposal Template	Where should the EQRO capture the cost of the compliance review (D.2.a and D.2.d)?	Annual EQR Report- MCO/DBM
35.	Cost Proposal Template	Please clarify what is meant by “unit of measure”? Is it a per MCO/DBM cost? Therefore the State multiplies the unit of measure by the number of participating MCOs.	See answer to question #4.
36.	V. Project Description and Scope of Work; H.1.b	Clarify what is meant by draft reports to DHHS require a minimum of two months lead time for review? Should the EQRO just follow deliverable deadlines outlined in D.2.a.iii and D.4.a.i?	The EQRO must provide a draft to DHHS for review two months in advance of the deliverable due date.
37.	Cost Proposal Template	It appears reports for Performance Improvement Project Validation and Performance Measure Validation are due by 12/31 annually. Is the incumbent EQRO completing these 2020 reports (for the previous 2019 calendar year) or does the State anticipate having the successful bidder complete the reports (requiring transition of validation findings) so reporting can be complete per the due date?	The incumbent will complete the 2020 reports.

38.	Cost Proposal Template	It appears reports for Performance Improvement Project Validation and Performance Measure Validation are due by 12/31 annually. Is this 12/31 date for draft or final reports?	Final Reports are due 12/31.
39.	V. Project Description D.2.c	What are the performance measures required for measurement year 2020?	The performance measures can be found in the current Heritage Health contracts located at the following webpage: https://das.nebraska.gov/materiel/purchasing/contracts/pdfs/71163(o4)awd.pdf
40.	V. Project Description D.2.c	Are on-site visits required for Performance Measure Validation?	Yes
41.	V. Project Description D.2.b	How many performance improvement projects will the EQRO validate per MCO/DBM on an annual basis?	One per MCO (three in total) and DBM (one).

ADDENDUM THREE - REVISED SCHEDULE OF EVENTS

Date: July 7, 2020

To: All Bidders

From: Keith Roland, Buyer
Nebraska Department of Health and Human Services

RE: Addendum for Request for Proposal Number 6303 Z1 to be opened ~~July 31, 2020~~ October 30, 2020 at 2:00:00 p.m. Central Time

Schedule of Events

The State expects to adhere to the tentative procurement schedule shown below. It should be noted, however, that some dates are approximate and subject to change. It is the Bidder's responsibility to check the State Purchasing Bureau website for all addenda or amendments.

ACTIVITY		DATE/TIME
1.	Release Solicitation	June 1, 2020
2.	Last day to submit written questions	June 15, 2020
3.	State responds to written questions through Solicitation "Addendum" and/or "Amendment" to be posted to the Internet at: http://das.nebraska.gov/materiel/purchase_bureau/vendor/agency-rfp.html	~~June 30, 2020~~ July 7, 2020
4.	Last day to submit "Notification of Intent to Submit a Proposal"	July 15, 2020
5.	Proposal Opening Location for mailed/hand delivered submissions: Department of Health and Human Services 301 Centennial Mall S., 3rd floor Lincoln, NE 68509 Electronic submissions: https://nebraskastategov.sharefile.com/r-r4058b5be7e64e798	~~July 31, 2020~~ October 30, 2020 2:00 PM Central Time
6.	Review for conformance to solicitation requirements	~~August 1, 2020~~ November 2, 2020
7.	Evaluation period	~~August 1, 2020 – August 31, 2020~~ November 3, 2020 – December 17, 2020
8.	"Oral Interviews/Presentations and/or Demonstrations" (if required)	To be announced if required
9.	Post "Notification of Intent to Award" to Internet at: and/or http://das.nebraska.gov/materiel/purchasing.html	~~September 1, 2020~~ December 18, 2020
10.	Contract finalization period	~~September 1, 2020 - September 15, 2020~~ December 21, 2020 – February 14, 2021
11.	Contract award	~~September 30, 2020~~ February 15, 2021
12.	Contractor start date	~~October 1, 2020~~ April 1, 2021

This addendum will become part of the proposal and should be acknowledged with the Request for Proposal response.

ADDENDUM FOUR
QUESTIONS and ANSWERS

Date: September 17, 2020

To: All Bidders

From: Keith Roland, Buyer
Department of Health and Human Services

RE: Addendum for External Quality Reviews Request for Proposals

Questions and Answers

Following are the questions submitted and answers provided for the above mentioned Request for Qualifications. The questions and answers are to be considered as part of the Request for Qualifications. It is the Bidder's responsibility to check the project information page for all addenda or amendments.

Question Number	Section Number	Question	State Response
1.	V. Project Description and Scope of Work D.4.a.i. H.1.b.i.	As per Addendum Three – Revised Schedule of Events, the Contractor start date is now April 1, 2021. Per the RFP, the annual detailed technical report is due to DHHS by October 15th (pg. 29), with the draft being due to DHHS with a minimum of two months lead time for review (p.32). Will the incumbent and/or DHHS provide the selected contractor with summaries of EQRO activities the incumbent performed after the 2020 annual detailed technical report was submitted (i.e. from October 16, 2020 through March 31, 2021) to be included in the October 15, 2021 annual detailed technical report submission? Or is it the expectation of DHHS that the selected contractor will complete all identified EQRO tasks	Yes, summaries will be provided.

		and deliverables between April 1, 2021 and August 15, 2021 to be included in the annual detailed technical report due October 15, 2021?	
2.	NA	Will DHHS require the managed care plans to report the retired HEDIS measures, Medication Management for People With Asthma and Well-Child Visits in the First 15 Months of Life? Or will they be replaced?	This has yet to be determined by DHHS.

This addendum will become part of the proposal and should be acknowledged with the Request for Proposal response.

Certificate Of Completion

Envelope Id: EE8CA33BEE884B189604550731BA70C3
Status: Completed
Subject: Please DocuSign: 93851-O4 HSAG/DHHS External Quality Review
Division: MLTC
Envelope Type: Contract
Document #: 93851 O4
Source Envelope:
Document Pages: 450
Signatures: 2
Certificate Pages: 5
Initials: 8
AutoNav: Enabled
EnvelopeId Stamping: Enabled
Time Zone: (UTC-06:00) Central Time (US & Canada)

Envelope Originator:
Keith Roland
301 Centennial Mall S
Lincoln, NE 68508-2529
keith.roland@nebraska.gov
IP Address: 164.119.5.16

Record Tracking

Status: Original
3/9/2021 8:01:52 AM
Holder: Keith Roland
keith.roland@nebraska.gov
Location: DocuSign

Signer Events	Signature	Timestamp
Mary Ellen Dalton mdalton@hsag.com Chief Executive Officer Security Level: Email, Account Authentication (None)	DocuSigned by: Mary Ellen Dalton 5A6EBD2BF28E43D... Signature Adoption: Pre-selected Style Using IP Address: 63.158.171.83	Sent: 3/9/2021 8:12:40 AM Viewed: 3/9/2021 8:55:41 AM Signed: 3/11/2021 4:28:22 PM
Electronic Record and Signature Disclosure: Accepted: 3/9/2021 8:55:41 AM ID: 98411578-24fb-445e-bd71-9dab40d3ee77		
Kevin Bagley kevin.bagley@nebraska.gov Director, Division of Medicaid and Long-Term Care Security Level: Email, Account Authentication (None)	DocuSigned by: kevin Bagley EEF89D05BD264A5... Signature Adoption: Pre-selected Style Using IP Address: 164.119.5.74	Sent: 3/11/2021 4:28:30 PM Viewed: 3/15/2021 9:45:28 AM Signed: 3/15/2021 9:46:23 AM
Electronic Record and Signature Disclosure: Accepted: 3/15/2021 9:45:28 AM ID: c452496c-31bd-40da-bd7c-ca46356f9bbf		

In Person Signer Events	Signature	Timestamp

Editor Delivery Events	Status	Timestamp

Agent Delivery Events	Status	Timestamp

Intermediary Delivery Events	Status	Timestamp

Certified Delivery Events	Status	Timestamp

Carbon Copy Events	Status	Timestamp
Gretchen Thompson GThompson@hsag.com Security Level: Email, Account Authentication (None)	COPIED	Sent: 3/9/2021 8:12:40 AM Viewed: 3/9/2021 11:08:25 AM
Electronic Record and Signature Disclosure:		

Carbon Copy Events	Status	Timestamp
Not Offered via DocuSign		
Tracy Walter Contracts@hsag.com HSH, Inc. Security Level: Email, Account Authentication (None) **Electronic Record and Signature Disclosure:** Not Offered via DocuSign	COPIED	Sent: 3/9/2021 8:12:40 AM Viewed: 3/15/2021 10:26:38 AM
Nancy Keller nancy.keller@nebraska.gov Administrative Assistant III MLTC Security Level: Email, Account Authentication (None) **Electronic Record and Signature Disclosure:** Not Offered via DocuSign	COPIED	Sent: 3/11/2021 4:28:30 PM Viewed: 3/12/2021 11:06:39 AM
Roxie Anderson Roxie.Anderson@nebraska.gov Security Level: Email, Account Authentication (None) **Electronic Record and Signature Disclosure:** Not Offered via DocuSign	COPIED	Sent: 3/11/2021 4:28:30 PM

Witness Events	Signature	Timestamp

Notary Events	Signature	Timestamp

Envelope Summary Events	Status	Timestamps
Envelope Sent	Hashed/Encrypted	3/9/2021 8:12:40 AM
Certified Delivered	Security Checked	3/15/2021 9:45:28 AM
Signing Complete	Security Checked	3/15/2021 9:46:23 AM
Completed	Security Checked	3/15/2021 9:46:23 AM

Payment Events	Status	Timestamps

Electronic Record and Signature Disclosure

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From time to time, Nebraska Department of Health & Human Services (we, us or Company) may be required by law to provide to you certain written notices or disclosures. Described below are the terms and conditions for providing to you such notices and disclosures electronically through the DocuSign, Inc. (DocuSign) electronic signing system. Please read the information below carefully and thoroughly, and if you can access this information electronically to your satisfaction and agree to these terms and conditions, please confirm your agreement by clicking the 'I agree' button at the bottom of this document.

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Withdrawing your consent

If you decide to receive notices and disclosures from us electronically, you may at any time change your mind and tell us that thereafter you want to receive required notices and disclosures only in paper format. How you must inform us of your decision to receive future notices and disclosure in paper format and withdraw your consent to receive notices and disclosures electronically is described below.

Consequences of changing your mind

If you elect to receive required notices and disclosures only in paper format, it will slow the speed at which we can complete certain steps in transactions with you and delivering services to you because we will need first to send the required notices or disclosures to you in paper format, and then wait until we receive back from you your acknowledgment of your receipt of such paper notices or disclosures. To indicate to us that you are changing your mind, you must withdraw your consent using the DocuSign 'Withdraw Consent' form on the signing page of a DocuSign envelope instead of signing it. This will indicate to us that you have withdrawn your consent to receive required notices and disclosures electronically from us and you will no longer be able to use the DocuSign system to receive required notices and consents electronically from us or to sign electronically documents from us.

All notices and disclosures will be sent to you electronically

Unless you tell us otherwise in accordance with the procedures described herein, we will provide electronically to you through the DocuSign system all required notices, disclosures, authorizations, acknowledgements, and other documents that are required to be provided or made available to you during the course of our relationship with you. To reduce the chance of you inadvertently not receiving any notice or disclosure, we prefer to provide all of the required notices and disclosures to you by the same method and to the same address that you have given us. Thus, you can receive all the disclosures and notices electronically or in paper format through the paper mail delivery system. If you do not agree with this process, please let us know as described below. Please also see the paragraph immediately above that describes the consequences of your electing not to receive delivery of the notices and disclosures electronically from us.

How to contact Nebraska Department of Health & Human Services:

You may contact us to let us know of your changes as to how we may contact you electronically, to request paper copies of certain information from us, and to withdraw your prior consent to receive notices and disclosures electronically as follows:
To contact us by email send messages to: john.canfield@nebraska.gov

To advise Nebraska Department of Health & Human Services of your new e-mail address

To let us know of a change in your e-mail address where we should send notices and disclosures electronically to you, you must send an email message to us at john.canfield@nebraska.gov and in the body of such request you must state: your previous e-mail address, your new e-mail address. We do not require any other information from you to change your email address..

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To request delivery from us of paper copies of the notices and disclosures previously provided by us to you electronically, you must send us an e-mail to john.canfield@nebraska.gov and in the body of such request you must state your e-mail address, full name, US Postal address, and telephone number. We will bill you for any fees at that time, if any.
To withdraw your consent with Nebraska Department of Health & Human Services

To inform us that you no longer want to receive future notices and disclosures in electronic format you may:

i. decline to sign a document from within your DocuSign session, and on the subsequent page, select the check-box indicating you wish to withdraw your consent, or you may;

ii. send us an e-mail to john.canfield@nebraska.gov and in the body of such request you must state your e-mail, full name, US Postal Address, and telephone number. We do not need any other information from you to withdraw consent.. The consequences of your withdrawing consent for online documents will be that transactions may take a longer time to process..

Required hardware and software

Operating Systems:	Windows® 2000, Windows® XP, Windows Vista®; Mac OS® X
Browsers:	Final release versions of Internet Explorer® 6.0 or above (Windows only); Mozilla Firefox 2.0 or above (Windows and Mac); Safari™ 3.0 or above (Mac only)
PDF Reader:	Acrobat® or similar software may be required to view and print PDF files
Screen Resolution:	800 x 600 minimum

Enabled Security Settings:	Allow per session cookies

** These minimum requirements are subject to change. If these requirements change, you will be asked to re-accept the disclosure. Pre-release (e.g. beta) versions of operating systems and browsers are not supported.

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