Comagine Health

State of Nebraska
Department of Health and Human Services

Technical Proposal

RFP 6303 Z1
External Quality Reviews

Proposal Submitted by

Comagine Health
10700 Meridian Ave N, Suite 100
Seattle, Washington 98133-9008

Proposal Recipient

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RFP Closing Date and Time
October 30, 2020
2:00PM CST

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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:	Comagine Health
COMPLETE ADDRESS:	10700 Meridian Avenue N., Suite 100 Seattle, WA 98133
TELEPHONE NUMBER:	800-949-7536
FAX NUMBER:	N/A
DATE:	10/28/2020
SIGNATURE:	Marie Dunn
TYPED NAME & TITLE OF SIGNER:	Marie Dunn

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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:	Comagine Health
Contractor Address:	10700 Meridian Avenue N., Suite 100 Seattle, WA 98133
Contact Person & Title:	Lori Barrett, Senior Development Director
E-mail Address:	LBarrett@comagine.org
Telephone Number (Office):	(913) 484-5421
Telephone Number (Cellular):	(913) 484-5421
Fax Number:	N/A

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:	Comagine Health
Contractor Address:	10700 Meridian Avenue N., Suite 100 Seattle, WA 98133
Contact Person & Title:	Lori Barrett, Senior Development Director
E-mail Address:	LBarrett@comagine.org
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Section 1 – Executive Summary

Comagine Health (contractor) welcomes the opportunity to respond to the Nebraska Department of Health and Human Services (DHHS) Request for Proposal (RFP) 6303 Z1 – External Quality Reviews (EQR). Our mission is to improve health and create a better healthcare system where communities will flourish. As a trusted, neutral party, we work with our partners to fix intractable healthcare delivery problems. In all our engagements and initiatives, we draw upon our deep expertise in quality improvement (QI), care management, health information technology (HIT), data analytics, and innovative research.

Our organization takes great pride in our efforts to work directly with providers, nursing homes, health systems, states, and the federal government on a wide array of QI efforts. Strong data and analytics, paired with extensive, on-the-ground expertise as healthcare improvement advisors, are at the foundation of our approach. Our team of 25 analysts supports a broad range of data efforts related to healthcare transformation and our robust data and analytic capabilities allow us to parse through big data sets with an eye for the populations, interventions, and quality measures. Our know-how in improvement science and clinical practice allows us to pair these findings with real-time perspective of how to develop and implement QI strategies. Our goal is to combine QI knowledge with data expertise to produce actionable insights.

Comagine Health, under our previous name of Qualis Health, served as a Nebraska Medicaid quality and utilization management program contractor for seven years, from November 1, 2007 through October 31, 2014. For the first six years of this contract (up through October 31, 2013), we also provided prime contractor oversight and monitoring of a subcontracted partner that we used for EQR activities. The EQR activities included reviewing contract services between the Nebraska Medicaid Agency and the State's managed care organizations (MCOs). In addition to leading the quality and utilization management program, Comagine Health assumed all responsibility for work quality, delivery, and supporting services provided by our external quality review organization (EQRO) subcontractor.

While we served as a Nebraska Medicaid contractor, Comagine Health's comprehensive utilization management program created value for DHHS through the principled application of medical necessity and appropriately provisioning targeted and fiscally responsible utilization reviews. We worked collaboratively with DHHS and the provider community to introduce web-based utilization reviews. This approach increased efficiencies, reduced review turnaround time, and lowered the administrative burden for Nebraska providers. We also worked with DHHS and eligible providers to introduce a "Gold Card" program to recognize home health agencies that were meeting strict conditions for review quality. Qualifying agencies, with the submission of minimal information, were then granted authorization for service payment requests, thus reducing their administrative burden.

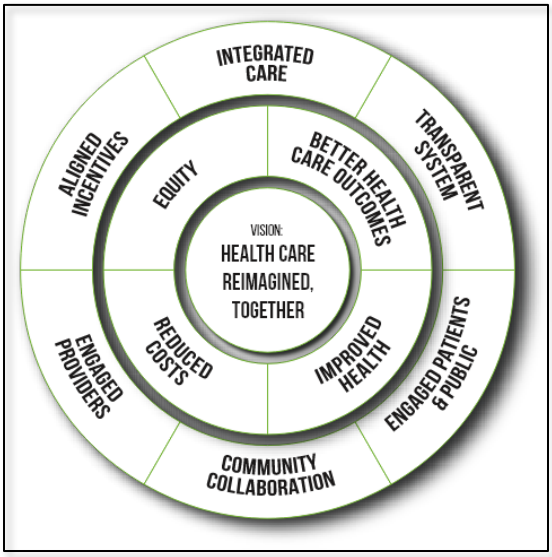
Comagine Health values the partnerships we developed with Nebraska providers as a State Medicaid contractor and we are proud of our work in meeting the providers' needs for administrative simplification in the review process so that their patients could get quality care as efficiently as possible.

We are committed and excited to partner with DHHS on this EQR project. Our approach involves collaboration with a skilled subcontractor, MetaStar, Inc. (MetaStar), who maintains our same commitment to creating healthier communities.

1.1 Comagine Health Corporate Overview

Comagine Health, a Washington-based 501(c)(3) nonprofit organization, was formed upon the merger of Comagine Health and HealthInsight in 2018. For more than 40 years, HealthInsight and Qualis Health independently engaged in healthcare quality consulting and provided QI services to state Medicaid agencies. Comagine Health also possesses substantial experience coordinating healthcare services for state and federal health and human services programs.

Figure 1 - Comagine Health Levers, Outcomes, & Vision



Comagine Health works to improve health and create a better healthcare system so people and their communities will flourish. We approach this mission by working to strengthen healthcare communities by locking arms with community partners to ensure that the key components required for healthcare transformation are strong. For example, as the EQRO in Washington State, we have supported the state on extensive reporting of quality outcomes to foster greater transparency. This work underpins the state's efforts to leverage data to assess managed care performance and payment, and allows greater alignment of incentives. Broadly, it is important to us to meet our partners and communities where they are and bolster their efforts to advance health transformation through the range of services that we provide. In our efforts, we're proud to work with our partners to achieve tangible outcomes, including improved clinical outcomes, patient satisfaction, self-management skills, and provider satisfaction through applicable healthcare analytics, system research, health service utilization, and cost management efforts.

Our organization's three distinguished service lines deliver quality services across the healthcare domain:

- **Research and Innovation** – We assist government agencies, primary care providers, universities, and community organizations turn data into best practices

and optimize their use of HIT for improved quality, efficiency, and outcomes. Our expertise includes, but is not limited to, extensive claims-based analytics, cross-payer quality reporting and analysis, linking all-payer claims to community datasets designed to support research, as well as public reporting, electronic health records (EHR), Medicaid Enterprise Systems (MES), health information exchange (HIE), and Health Insurance Portability and Accountability Act (HIPAA) compliance and training. Additionally, we have HIT project experience managing the certification and implementation of systems for Medicaid agencies. This service line boasts national subject matter expertise in topics ranging from cost transparency to research design and implementation.

- **Systemwide Quality Improvement** – We collaborate with providers, payers, and stakeholders across the healthcare spectrum - as well as community organizations and consumers - on systemic initiatives to improve care delivery and patient outcomes. By combining boots-on-the-ground experience with big picture views, we develop solutions in the best interests of all parties. These subject matter experts (SMEs) center on coalition building and QI activities in provider communities, nursing homes and hospitals, and health systems.
- **Care Management** – Our Care Management services result in better clinical outcomes, higher patient satisfaction, and increased cost savings through services such as utilization review, utilization management, and more proactive population-based approaches. We customize our approach for each client and patient using evidence-based criteria and medicine, data analysis, and deep clinical and technical proficiency gained through serving state Medicaid agencies, workers' compensation commissions, and private insurers. We possess full Utilization Review Accreditation Commission (URAC) accreditation in Case Management and Health Utilization Management.

Comagine Health shares our clients' commitment to helping individuals receive the care they need. Our clients include federal, state, and local government agencies, health plans and providers, and foundations and other privately funded groups. Organizations we work with include the Centers for Medicare & Medicaid Services (CMS), the Agency for Healthcare Research and Quality (AHRQ), the Centers for Disease Control and Prevention (CDC), the U.S. Bureau of Justice Assistance, the National Institute on Drug Abuse, the Pew Charitable Trusts, and Medicaid agencies throughout the United States.

1.2 MetaStar Corporate Overview

At Comagine Health, we form partnerships with other innovative organizations within the healthcare industry to bring our clients better healthcare outcomes. For this EQR project, we have partnered with MetaStar.

Figure 2 - MetaStar Logo

MetaStar is a Madison, Wisconsin-based, independent, nonprofit organization founded in 1973 to provide healthcare quality assurance (QA) and QI services for federal,

state, and private healthcare programs. Their corporate mission is, “To effect positive change in health and healthcare.” MetaStar has served the Wisconsin Department of Health Services (DHS) in supporting its goals and objectives by conducting utilization review, QA, and EQR activities for over 40 years. The scope of work under their Wisconsin contract has grown over the past five years due to MetaStar’s experience and skill at developing and implementing review methodologies that meet federal and state requirements, production of comparable data, and standardization of reporting. Additional programs incorporated in the contract include home and community-based waiver services programs and the Birth to 3 Program for the State of Wisconsin.

MetaStar’s Information Technologies (IT) Department’s ability to create applications with customized, on-demand reporting provide Wisconsin with necessary data in a format that supports the DHS with providing usable, easy to interpret data for reporting to CMS and other oversight bodies. MetaStar’s partnerships and relationships at federal, regional, and state levels will bring significant value as a partner for the DHHS’s EQR scope of work. The MetaStar review team utilizes a consistent approach for conducting reviews of program recipient records and would replicate the process under this contract customizing to incorporate expectations held by the State of Nebraska.

1.3 Existing Partnership Overview

Under our Washington Healthcare Authority (HCA) contract, Comagine Health is currently partnering with MetaStar on a focused study on the Children’s Mental Health system redesign including program compliance of the Wraparound with Intensive Services (WISe) implementation. WISe is designed for Medicaid-eligible children with complex behavioral health needs including providing services to youth in their homes and communities rather than institutions. MetaStar performs behavioral health clinical chart reviews utilizing the Quality Improvement Review Tool (QIRT) to assess WISe services and assist in identifying needed system changes, educational opportunities for providers and other quality improvement strategies. MetaStar produces a report for each behavioral health agency as well as a quarterly summary report for the MCOs and HCA.

Comagine Health has a strong collaborative working relationship with MetaStar and has built a strong and trusting relationship. We will hold a kick-off meeting with MetaStar shortly after contract award notification to review the scope of work and develop a detailed work plan. The work plan will contain a description of all key activities, associated timelines, and responsible parties. Comagine Health and MetaStar will have weekly status meetings and MetaStar will provide a monthly written report. The EQO program manager, Ms. Johnson, will be DHHS’s main contact and will provide oversight of the work conducted by MetaStar and Comagine Health and will keep DHHS apprised of any issues should they arise. Ms. Johnson will advise DHHS of status and expected timeframe for issue resolution, schedule any necessary follow-up meetings and consult with DHHS regarding outcomes and ensure full resolution. Together, Comagine Health and MetaStar have produced all contractual deliverables on time and with a high quality.

1.3 Project Understanding

Comagine Health understands DHHS is seeking a contractor to provide EQR services, including conducting annual, external, and independent quality reviews and produce the required, corresponding reports of Nebraska's MCOs and Dental Benefits Manager (DBM), as well as monitor the Internal Quality Assurance and Performance Improvement programs (QAPI) and standards of the MCOs and DBM. These EQR services are expected to follow the protocols outlined in 42 Code of Federal Regulations (CFR) § 438, subpart E.

Along with performing EQR activities, as the EQRO contractor, Comagine Health will be responsible for the following tasks:

- Providing technical assistance and guidance to the MCOs and DBM to help them complete activities related to providing information for the EQR and help them address issues, or create corrective action plans, for problems as they arise.
- Providing complete and accurate reports, assessments, and recommendations to DHHS, as well as to the MCOs, DBM, other beneficiary advocacy groups, or the public upon request.
- Conducting monthly technical assistance meeting with the DHHS and quarterly operational meetings with the MCOs and DBM.
- Perform quality reviews of collected data.

Comagine Health also understands it is expected to meet the competence and independence requirements as specified in 42 CFR §438.354(b) and 42 CFR §438.354(c). Comagine Health and its subcontractor, MetaStar, are independent from the State Medicaid agency, MCOs, and DBMs entities to be reviewed under the contract resulting from RFP 6303 Z1. We will also ensure mandatory activities with Medicare or accreditation review are not duplicated.

1.4 Comagine Health EQR Experience

From our years of service as an EQRO, Comagine Health (formerly known as Qualis Health, Acumentra Health, QCorp, HealthInsight, and HealthInsight Assure) is experienced at preparing annual technical reports as well as individual MCO reports, synthesizing data from all managed care quality oversight activities, which includes conclusions regarding quality, timeliness, and access to care. In addition, we produce annual performance measure comparative analysis reports with plan-to-plan comparisons, plan-to-state averages, regional assessments, and national benchmarks. Our experience with member-level outcomes data has enabled us to provide a deeper understanding of trends and their drivers.

1.4.1 Recent EQR Contracts

The following table is a sampling of recent EQR contracts very similar in size and scope to Nebraska's EQR work:

Table 1 - Comagine Health Recent EQR Contracts

Washington EQRO – Physical Health, 1993–present
EQRO for Washington physical health managed Medicaid programs. Services including Enrollee Quality Report (Star Rating Report), Performance Measure Comparative Analysis, Value-Based Purchasing (VBP) Performance Measure Recommendation and evaluation of performance measure validation (PMV), compliance with standards, performance improvement project (PIP) validation, administration and reporting Consumer Assessment of Healthcare Providers and Systems (CAHPS)® surveys (adult and child, special populations), focused studies, and quality strategy review.
Washington EQRO – Mental Health (Behavioral Health/SUD integrated under the MCO contracts in 2019), 2008–2019
EQRO for Washington mental health managed Medicaid programs. Services included compliance review, PIP validation, PMV, encounter data validation (EDV), focused studies, Information Systems Capability Assessment (ISCA), and quality strategy review. *Note: This work concluded with the integration of behavioral and physical health management in Washington State*.
Oregon EQRO, 2012–2018
EQRO for mental, physical, and dental health managed Medicaid programs. Services include compliance review, conducting and validation PIPs, validation and calculation of performance measures, ISCA, member surveys, focused studies, validation of network adequacy.
New Mexico EQRO, 2005–2018
EQRO for New Mexico physical and behavioral health, long-term supports and services and Children's Health Insurance Program (CHIP) for the Medicaid programs. Services include PMV, compliance review, PIP validation, EDV, calculation of performance measures, and focused studies.
Idaho EQRO, 2005–2018
The EQR activities included compliance review, validation of PIPs, PMV, and ISCA. In addition, we provided educational sessions, training and technical assistance to the state and the managed care plan on EQR and the applicable CFRs and CMS protocols.
Nebraska Medicaid Quality and Utilization Management Program, 2007–2014
The EQR activities included reviewing contract services between the Nebraska Medicaid Agency and the State's MCOs. In addition to leading the quality and utilization management program, Comagine Health assumed all responsibility for work quality, delivery, and supporting services provided by our EQRO subcontractor.

1.4.2 EQR Expertise and Demonstrated Experience

In this section we provide the Comagine Health and MetaStar descriptions of our combined experience in each of the required expertise areas:

- Comparative Analysis and Reporting
- Improving Healthcare Services
- Compliance Reviews
- PMV
- PIPs
- Network Adequacy
- ISCA
- Surveys
- EDV
- Quality of Care Studies
- Technical Assistance to MCOs

Comparative Analysis and Reporting

Comagine Health has extensive experience aggregating and analyzing diverse data sets, and expertise with performance measure comparative analysis for Healthcare Effectiveness Data and Information Set (HEDIS)®, non-HEDIS® and CAHPS® measures.

Beginning in 2015 as part of our Washington EQRO work for HCA, Comagine Health has designed and created a comparative analysis report and an Enrollee Quality "Star Rating" Report comparing MCO performance. The purpose of the Enrollee Quality Report is to provide MCO applicants and enrollees with simple, straightforward, comparative health plan performance information that can assist them in selecting a plan that best meets their needs.

In 2020 (for Calendar Year 2019 measures) the MCOs were required to report on 54 HEDIS® measure items representing 244 sub-measures, reflecting the levels of quality, timeliness, and accessibility of healthcare services furnished to the state's Medicaid enrollees. Comagine Health receives this data in two forms. The first form included MCO aggregate performance by measure and sub-measure, and the second form is patient-level information for all HEDIS® quality measures to assist in the validation process. We use Microsoft SQL Server to house and process our full data sets.

Improving Healthcare Services

Comagine Health has played a critical role over the last five-year period in Washington State as a part of state's transition to integrated managed care. The organization's work has evolved rapidly in response to the changing landscape of Regional Support Networks (RSNs), Behavioral Health Organizations (BHOs), Administrative Service Organizations (ASOs) and MCOs. Our deep data analysis has informed the state's vision of transformation, most critically in 2019 in response to legislative requirements

related to measurement and payment adjustment for the MCOs. In this work, we developed and provided an in-depth quantitative and qualitative analysis of a synthesized measure set representing the state's current footprint in value-based payment with the goal of identifying opportunities for greatest need and impact. In addition, Comagine Health successfully served as the Healthier Washington Practice Transformation Support Hub from 2016 through early 2019 as the state transitioned to accountable communities of health to foster community-clinical linkages. Comagine Health served on the front line across the state to help primary care and behavioral health providers implement changes in alignment with the state's vision for health system transformation with a team of practice coaches.

In Oregon, Comagine Health is actively engaged with the state's coordinated care organizations (CCOs) serving as a convener and thought partner around healthcare quality. In this capacity, Comagine Health hosts a voluntary all-payer all-claims database, serves as a convening body for Comprehensive Primary Care Plus (CPC+), and organizes and supports a multi-stakeholder group to measure and improve maternity care via the Oregon Maternal Data Center and Oregon Perinatal Collaborative. This expertise in multi-stakeholder convening, data aggregation, and impact analysis is a focal point of the work that the organization does to catalyze transformation across the region.

For an example of the 2019 EQR Comparative and Regional Report, please refer to Appendix B.

Compliance Reviews

MetaStar's experience with compliance reviews for Medicaid managed care programs in the state of Wisconsin spans more than twenty years for a variety of programs. The review team's experience includes transitioning the requirements from 42 CFR Part 438 and state contracts to standards for review and evaluation to ensure compliance. The organization has successfully adapted the review criteria to include the unique aspects of the programs while aligning with requirements in the CMS EQR Protocols, Code of Federal Regulation, and state contracts. MetaStar's evaluation of compliance includes MCOs, Pre-paid In-patient Health Plans (PIHPs), and Special Managed Care Plans (wraparound service for children). Currently MetaStar's reviews include a completion of full reviews for non-accredited organizations as well as abbreviated reviews for organizations that are accredited by the National Committee for Quality Assurance (NCQA). MetaStar currently conducts compliance reviews for six programs in the state of Wisconsin and twelve MCOs and special managed care plans.

For an example of the MetaStar Annual Quality Review Report, please refer to Appendix C.

Performance Measure Validation (PMV)

The Comagine Health EQR team has extensive experience in conducting PMV including, HEDIS®, non-HEDIS® and dental performance measures for multiple state EQR contracts. For our EQR contract work in Washington, we validate performance

measures, including HEDIS® and CAHPS® data. HEDIS® measure validation and reporting include the full Medicaid HEDIS® measure set for children and adults, and it focuses on State priority measures including those related to diabetes, maternal and child health, antidepressant medication management, and medication management for people with asthma. Comagine Health also evaluates MCO performance trends in comparison to statewide and national benchmarks. Once the validation is complete, we work with the State to understand fully the meaning of the performance measure results and how they may be used to achieve meaningful quality improvement, such as to identify and address specific disparities and gaps.

In 2016, Comagine Health identified key concerns related to children's access to services. The State heard those concerns and quickly issued requirements that the MCOs implement performance improvement efforts to ensure better access to care.

In New Mexico, Comagine Health developed a HEDIS®-like methodology that enabled the Human Services Department to better assess early performance of the MCOs under a new waiver. In Oregon, Comagine Health EQR staff validated 17 CCO incentive measures, developed by the Oregon Health Authority (OHA), to evaluate performance on healthcare quality and access, and to hold CCOs accountable for improved outcomes.

Performance Improvement Projects (PIPs)

Comagine Health's EQR team has, since the late 1990s, both participated in the validation of performance improvement projects for many MCOs as well as collaborated with state agencies in developing and implementing several PIPs that focus on high-risk or high-cost areas. The team has validated PIPs for CCOs, BHOs, and dental organizations as well.

In Oregon, Comagine Health facilitated two statewide collaborative PIPs for the OHA. The first PIP (2013–2015) focused on diabetes monitoring in people with schizophrenia or bipolar disorder; the second (2016–2018) targeted opioid safety. We supported the participating CCOs via presentations at monthly meetings of the state Quality and Health Outcomes Committee and through individual meetings and calls. CCOs were required to conduct two additional PIPs and one focused study. Our staff reviewed the CCOs' progress reports to OHA and evaluate their completeness, clarity, and adherence to QI methods, and reported the results to the state.

New Mexico Medicaid required each of its four MCOs to create and maintain a PIP for children and the long-term support and services population. Comagine Health reviewed the progress reports and results of each PIP for each MCO regarding completeness, clarity, and adherence to QI methods, and provided individual technical assistance for MCOs that needed or requested it. In addition, the state directed two statewide PIPs for diabetes management and behavioral health. Our staff reviewed those PIPs for the effectiveness of the QI interventions and for real improvement in the target populations. We provided technical assistance to MCOs that requested help with creating or

maintaining a PIP, and at the State's direction when an MCO's PIP performance did not meet minimum standards.

In Washington, Comagine Health validated three required PIPs for the nine BHOs: two focused on clinical and non-clinical mental health areas, one of those two centered on children, and one targeting substance use disorder and participated in the initial state-level PIP approval process of those PIPs.

In Idaho, Comagine Health validated two required PIPs, one clinical and one nonclinical, for managed care and long-term support and services including reducing readmissions in the dual eligible Medicaid population and reducing the voluntary dis-enrollment rate in the True Blue Special Needs Plan (HMO SNP) dual eligible Medicaid population.

Network Adequacy

The Comagine Health EQR team's experience also includes assessing network and monitoring requirements for the MCO, including direct access to women's health specialists for female beneficiaries, appropriate access to second opinions, coordination with out-of-network providers for payment, and provision of sufficient family planning providers.

In 2016 and 2017, under the OHA Comagine Health EQR team conducted a review of the CCOs' mandatory Delivery System Network (Network Adequacy) reports and provided feedback and recommendations using an integrated care lens. We looked at responses that covered all services delivered by the CCOs (urban, rural and frontier) including, but not limited to, physical and mental health, substance use disorder services, dental care, non-emergency medical transportation, acute care, and specialty care. Our review addressed all state and federal network adequacy and validation requirements and included reviewing the CCOs' plans to meet state-specific time and distance standards for access to various provider types and assessing compliance with standards such as wait times for appointments. Our report to OHA summarized and validated the results of the CCO reviews, including recommendations related to the need for technical assistance or clarification of OHA expectations. In April 2016, in preparation for network adequacy reviews, OHA collaborated with our EQR team to provide technical training for all 16 CCOs in Oregon regarding the expectations for reporting to the state.

In addition, Comagine Health's EQR team also has experience with validating network adequacy through techniques such as member surveys, EDV, and secret shopper calls. In performing secret shopper telephone calls, our EQR team did indeed discover one MCO dental agency was not meeting the state's availability of services standard and reported back the results to the MCO for further investigation.

Information Systems Capabilities Assessment (ISCA)

It should be noted per CFRs §438.50 and §438.52, EQROs can use information obtained from a Medicare review or a private accreditation review to provide information otherwise obtained from the mandatory activities. The RFP indicates for all three MCOs

and the DBM, the NCQA is the accrediting authority. When appropriate and following CFR §438.360, Comagine Health and MetaStar will use reports, findings, and other information from the NCQA accreditation reviews when completing the EQR activities.

Comagine Health has conducted ISCA reviews of MCOs/CCOs, BHOs, selected dental care organizations and third-party data managers using tools and procedures aligned with the CMS EQR protocol for this activity.

With extensive work under the Washington State EQRO and the OHA contracts, the organization's history in this domain includes conducting an ISCA for CCOs and BHOs as well as at the state level, to determine the timeliness, accuracy, and completeness of the claims data that were feeding into encounter data and performance measure calculations.

The Washington HCA in preparation for future EQR of the contracted Dental Managed Care Entities (MCEs) that will be administering the dental program, requested the State's EQRO, Comagine Health, assess and report on the Health Information System section of the HCA Dental Readiness Tool (DRT) to ensure it fully addresses the CFR requirements and protocols for future compliance review and monitoring.

The EQRO team, including technical consultants experienced in the EQR ISCA at the statewide and agency levels, managed care dental programs, and dental information systems implementation, examined the DRT to ensure all CFR required elements were included. The report included additional suggestions regarding integration of data from different source systems and processes to ensure availability of accurate and clean data extracts for the calculation of core performance measures

Consumer or Provider Surveys

The Comagine Health EQR team has nearly 20 years' experience in eliciting feedback on consumer satisfaction with health plans and providers, on consumer and provider perspectives on healthcare policy, and on the health behaviors of populations. Our team assists in the development of a survey tools, develops the methodology for the implementation of the surveys, analyzes the survey responses, and produces a report that include results and recommendations.

Comagine Health has successfully managed the implementation of the CAHPS® survey work for the Washington EQR contract for the past six years. The Comagine Health Program Manager has provided oversight of the work conducted by our internal team members as well as the work of the NCQA-certified CAHPS® vendor. Given our long-standing contractual relationship with our CAHPS® vendor we are confident in ensuring a rapid and smooth implementation process.

For over 10 years Comagine Health has administered a patient experience of care survey annually to roughly 28,000 individuals or their caregivers who received mental health services paid by Medicaid in Oregon. The questions in this survey include a combination of validated items from the mental health statistics improvement plan

(MHSIP) and “homegrown” items, developed collaboratively between the OHA and Comagine Health. Survey recipients are invited to respond on a secure electronic platform (REDCap) or on a paper survey through the mail. Results are weighted and presented at a statewide level as well as by CCO and Certified Community Behavioral Health Clinic, including stratifications according to respondent characteristics.

Through numerous federally funded research grants, Comagine Health has also built an expertise in surveying providers about their experience providing care. Most recently, we surveyed physicians and providers of complementary and alternative medicine (e.g. massage therapists, acupuncturists, physical therapists) about their experience treating patients with back pain under a novel Medicaid policy in Oregon. Responses were collected in REDCap, analyzed, and summarized in a manuscript for submission to a peer reviewed journal.

For an example of the 2019 Apple Health CAHPS® Child Report, please refer to Appendix D.

Encounter Data Validation (EDV)

The Comagine Health EQR team has many years of experience and expertise in the validation of encounter data through both clinical record reviews, claims data analysis, and encounter data reviews.

We have successfully completed EDVs for physical health, behavioral health, vision, transportation, hospital, and pharmacy encounter data in New Mexico, Oregon, and Washington. Our team made important, timely, and actionable recommendations to the State Medicaid agencies, their information systems staff, and key stakeholders for improving the reliability, accuracy, and completeness of encounter data.

Due to the knowledge and expertise of the EQR team, we were asked to provide training to a contracted Medicaid state agency and its health plans on performing encounter data validation, documentation standards, the Golden Thread of treatment plans, and identifying encounterable and medically necessary visits. Additionally, our EQR team has discovered through our reviews, possible cases of fraud, waste, and abuse, and has reported these cases to the State. Finally, during the onsite review of clinical records, the team meets with health plan staff and provides one-on-one training on identified documentation and coding areas.

Quality of Care Studies

Comagine Health has designed and conducted many focused quality of care studies over the past years for use in the QI and program/policy evaluation efforts of public agencies and private health systems. Past topics have included perinatal care, childhood immunizations, asthma, and well-childcare, including Medicaid-mandated Early and Periodic Screening, Diagnosis and Treatment. More recently, there has been a focus on quality issues involved in the delivery of mental healthcare including a focused study of implementation of the Children’s WISe program, which provides

comprehensive behavioral health services and supports for children, as well as oral health.

Examples of quality studies include:

- Since 2017, under a contract with OHA, Comagine Health has conducted a focused quality of care study of members with serious and persistent mental illness (SPMI) who are discharged from acute psychiatric facilities — part of the Oregon Performance Plan for the U.S. Department of Justice to ensure that this vulnerable population is connected with outpatient and other follow-up behavioral healthcare and with immediate housing plans.

In 2015, OHA and the Department of Human Services contracted with Comagine Health to survey consumers and providers of home and community-based services on behalf of the divisions of Addictions and Mental Health, Aging and People with Disabilities, and Oregon Developmental Disabilities Services.

In 2014, the Washington HCA asked our EQR team to study local progress made by Regional Support Networks in implementing the state's standards for serving children, adolescents, and young adults with behavioral health challenges.

In addition, Comagine Health is a leader in oral health integration innovation and quality improvement, below are a few samples of this work:

- 2015: The National Interdisciplinary Initiative on Oral Health (NIIOH) and Comagine Health published a white paper titled "Oral Health: An Essential Component of Primary Care" 2015, http://www.safetynetmedicalhome.org/sites/default/files/White-Paper-Oral-Health-Primary-Care.pdf, describing the case for change and a step-by-step approach for including oral health in primary care practice called the Oral Health Delivery Framework (OHDF)
- 2015 – 2017: Comagine Health tested the OHDF in 19 settings across 5 States including urban, rural, public and private delivery systems and published the Oral Health Integration Implementation Guide and Took Kit, http://www.safetynetmedicalhome.org/sites/default/files/Guide-Oral-Health-Integration.pdf
- 2017: Comagine Health developed and successfully tested a method to measure caries disease severity in a population using dental diagnostic codes. This project was funded by the Seattle-based Arcora Foundation and continues to produce monthly clinical outcome reports.
- 2019: Comagine Health serves as a consultant to the Arcora Foundation, providing Technical Assistance to the Yakima Valley Farmworkers Clinic system where dental hygienists are working in the primary care pediatrics setting to help provide oral health services.

Technical Assistance to MCOs

The Comagine Health EQR team has a broad range of presentation and technical guidance/assistance experience. Technical assistance has been provided in partnership with our state clients and through collaboration with the MCOs and other stakeholders.

We have provided extensive hands-on technical assistance and training to staff members at state agencies and managed care plans to enhance their internal and external QI capabilities and equip them to respond to the findings and recommendations of each annual EQR cycle. Our technical assistance has covered a wide range of subjects:

- The Nuts and Bolts of QI
- Advancing Health Equity through Culturally and Linguistically Appropriate Service
- PIPs: Standards and Lifecycle
- Quarterly PIP Technical Assistance: Using the PDSA Approach, Documentation of Standards
- De-stressing Your PIP
- Analytics 101 and Beyond
- The 2015 Comparative Analysis and Technical Report: Results, Recommendations, and QI
- Hospital Readmissions and Community Health
- Panel Presentation: Confidentiality and Privacy: 42 CFR Part 2, HIPAA, and Goals of Interoperability
- Roundtable Discussion Among MCOs: Using CAHPS® Results for QI
- EDV Training
- Understanding the EDV Review Process: An Interactive Training Session
- Providing and Documenting Medically Necessary Behavioral Health Services
- Maintaining Compliance
- Program Integrity; Fraud, Waste, and Abuse
- Delivery System Network (Network Adequacy) Training
- Supportive Housing Benefit in the 1115 Medicaid Transformation Waiver Mechanism

In previous EQR work, Comagine Health EQR team identified that the majority of MCOs in a state were not providing adequate and/or accurate encounter data documentation that met guidelines for medical necessity to qualify as a billable service. The State requested that the team, with its expertise in coding and documentation, work one-on-one with the organizations to educate and train them on coding and documentation guidelines. We also offered recommendations to the organizations to develop corrective action plans to improve this process. Separately, the Comagine Health team, in collaboration with the state has developed several training webinars, for provider agencies on the correct coding and documentation of encounter services.

Comagine Health served as the EQRO for the Idaho Department of Health and Welfare (IDHW) and provided educational sessions, training and technical assistance to the state and to the managed care plan on EQR and the applicable CFRs and CMS protocols.

Under our EQR contracts with both Oregon and New Mexico, we provided specialized training and assistance to help managed care plan staff develop PIPs that produce meaningful improvements in clinical outcomes and service.

MetaStar's experience with technical assistance for both the state and MCOs includes support, guidance, and training for mandatory and optional activities including hosting and presenting at best practice seminars or facilitating individual discussions between MCOs and the DHS. Technical assistance specific to compliance with standards includes support with topics including utilization, quality management programs, and provider network requirements. Several years ago, MetaStar provided education and monitoring for an MCO under corrective action regarding provider network requirements until which time the issue was remediated.

1.5 Features of Approach and Methodology

Comagine Health is fundamentally committed to assuring that our work is credible and supports taking action to improve the healthcare system in the communities that we serve. That commitment to engaging stakeholders in the results of our work is built into our mission statement: "Together with our partners, we work to improve health and create a better healthcare system so that people and communities will flourish." That commitment is reflected in our approach to presenting data and other information in a way that supports proactive response.

1.5.1 Comparative Analysis and Reporting

Our Comagine Health EQR team routinely performs comparative analyses off performance measurement data and annually produces an Enrollee Quality "Star Rating" Report, in which enrollees can browse the measure performance of MCOs as they select their plan; a Comparative Analysis Report, which compares MCO performance on a set of quality metrics; and a Regional Analysis Report, which compares MCO performance on a set of quality metrics within each region of the state.

We are well versed in calculating performance measures and reviewing results and outcomes in a comparative analysis. We validate outcomes of performance measures to review for completeness and correctness as well as compare results of subgroups (including individual MCOs) against each other, over time, and against national benchmarks. We also have quality improvement and clinical staff on our team who provide a further layer of depth into understanding the performance measure results. Once the validation is complete, we work with the State to fully understand the meaning of the performance measure results and how they may be used to achieve meaningful quality improvement, such as to identify and address specific disparities and gaps in care. We will identify areas where data reporting from certain MCOs seemed to be invalid and quickly elevated the concern to the State.

Our team will compare results of MCOs and DBM and any relevant demographic subgroups against performance from previous years and against each other to find any issues in MCO or DBM reporting processes and results. This detailed analysis is completed using the member-level data set provided by the state each year, ensuring that reported results are correct and enable numerous drill downs and statistical tests of performance by MCO, program, and patient demographics. The goal is to identify areas

of significant variations in quality of care and understand the drivers of patient outcomes. The Comagine Health team builds both interactive dashboards and statistical reports for distribution. Our approach is to show data visualizations with relevant marks like confidence intervals, p-values, and benchmarks alongside descriptions and discussions on what to take away from each finding. We use Tableau to build our data visualizations and work with our experienced communications team to construct informative and actionable reports with clear findings and recommendations. We also make interactive content available for drill downs and quality improvement discussions with clients.

For an example of the 2020 AHMC Plan Report Card, please refer to Appendix E.

1.5.2 Improving the Quality of Healthcare Services

Comagine Health will look for highly-data driven approaches to health system transformation with the goal of using EQRO resources and capacity efficiently and to maximum impact. Similar efforts with other clients to date have laid the groundwork for further work focused on both creating transparency around performance and accelerating the effectiveness of value-based payment efforts by articulating points for maximum clinical and quality impact, with a particular focus on bringing the right pieces of information to the right stakeholders to drive transformation.

As an example, Comagine Health's recommendations for both the State of Washington and its MCOs have resulted in actionable interventions. In early 2017, the state adopted Comagine Health's recommendations in our annual technical report and required all MCOs to make improvements in identified areas, specifically low scoring measures of care for children HEDIS®: child/adolescent access, well-child visits; CAHPS®: Getting Needed Care/Getting Care Quickly). Each MCO was given specific requirements for improvement depending on the plan's performance at the time.

Another time, one MCO experienced significant decreases in multiple performance measures in the previous review year, which negatively affected the state's overall Medicaid performance results. The state leveraged Comagine Health's EQR findings to demand immediate and responsive improvement actions by the MCO, leading to substantial improvement in the next review year.

Similarly, Comagine Health's EDV work has uncovered many issues and problems with encounters received by the state from the health plans. The state increased its focus on Comagine Health's EDV review results, expanding the contract so Comagine Health could provide technical assistance and forums to the BHOs around EDV requirements, clinical record documentation requirements of providers, and guidance on identifying and evaluating suspected fraud, waste and abuse.

Under our contract with OHA, we reviewed the CCOs' mandatory Delivery System Network reports and provide feedback and recommendations using an integrated care lens. Assure looked at responses that covered all services delivered by the CCOs (both

urban and rural), including but not limited to physical and mental health, substance use disorder services, dental care, non-emergency medical transportation, acute care, and specialty care. Our review addressed network adequacy validation requirements, such as reviewing the CCOs' plans to meet state specific time and distance standards for access to various provider types and assessing compliance with standards such as wait times for appointments. Our reports to OHA summarized and validated the results of the CCO reviews, including recommendations related to the need for technical assistance or clarification of OHA expectations. In November of 2016, OHA collaborated with the Comagine Health team to provide technical training for all 16 CCOs in Oregon regarding the expectations for reporting to the State.

1.5.3 Compliance Reviews

Our EQR Team will conduct compliance reviews of the MCOs and DBM following 42 CFR §438.358 and the CMS protocols. Our EQR approaches are grounded in thorough understanding of protocols and extensive review of state requirements, including managed care contracts and subsequent directions from the Medicaid agency and state laws. We use that information to guide the development of our review tools and criteria, in consultation with the Medicaid agency and the organizations. Our compliance reviews are intended to answer the following questions.

- Does the MCO being reviewed meet CMS regulatory requirements?
- Does the MCO meet the requirements of its contract with the Medicaid agency?
- Does the MCO meet and comply with the State's Quality Management Strategy?

We will collect, assess, and analyze the data and information we garner and report our findings and recommendations to the state agency and to the MCOs. In these reports, we present our methodologies and specifications for each protocol and area of review, to demonstrate adherence to the Medicaid agency's requirements and CMS protocols.

1.5.4 Performance Measure Validation (PMV)

Our approach to PMV is informed by our strong internal data structures and systems as well as skilled analytics team members who can efficiently processes and analyze large datasets.

First, we deploy our robust data pipeline that pulls and processes data quickly and is flexible enough to handle numerous data streams. We ingest data and information derived from PIP findings, CAHPS® results, HEDIS® data, and other sources into our data processing system.

Next, the raw data must pass a series of quality gates to ensure the high degree of accuracy. Data is validated by comparing counts, rates, and outcomes against peers and previous data submissions. We then overlay results with confidence intervals to signify statistical difference, noting relevant benchmarks.

Then we validate the performance measure results themselves. This process can vary depending on the level of data granularity provided but can range from running code to create numerator and denominator files, to reviewing code in isolation, to validating another entity's validation procedures.

Finally, we build comprehensive reports that clearly present observed findings, trends, and outcomes combined with recommendations for targeted action and improvement. Our EQRO team boasts a powerful combination of analytics and editorial expertise, clinical leadership, and program knowledge experts to assure the content of our reports is accurate and targeted to be useful to state program leadership, staff, and other readers.

1.5.5 Performance Improvement Projects (PIPs)

Comagine Health will work with the state to positively affect the quality of care of enrollees as we encourage health plans to use rapid cycle process improvement for PIPs. This process expedites results and allows for early course correction. Following a rapid cycle with shorter measurement time frames allows the plan to initiate a series of interventions to improve gaps/barriers identified within each measurement period early, which lends to the ability to demonstrate real, sustained improvements that impact enrollee health, functional status, and/or satisfaction. Further, it allows the health plan the ability to more comprehensively address a broad spectrum of key aspects of enrollee care and services (e.g., access, timeliness, preventative, chronic, acute, coordination of care, inpatient, high-need, high-risk, etc.). We understand that different health plans may have different resources and capacity to develop and implement a PIP, and we are experienced in working with health plans of all types to provide the appropriate level of guidance and support to each plan.

1.5.6 Network Adequacy

Comagine Health has the expertise and experience to validate whether the MCO/DBM provider network is adequate to ensure effective and efficient delivery of care. The MCOs/DBM must follow set time and distance standards for a variety of provider types including, primary care (adult and pediatric), OB/GYN, behavioral health, specialist (adult and pediatric), hospital, pharmacy, pediatric dental, long-term support services providers, and additional provider types that promote the objectives of the Medicaid program. Our EQR team will assess the provider network for sufficiency in number, mix, and geographic distribution to meet the needs of the number or anticipated number of beneficiaries in the service area. This assessment includes reviewing the number and types of providers within the provider network as well as the proximity of the beneficiaries to the providers. Our work includes reviewing both rural and urban areas and whether the provider network meets time and distance standards set by the state for member access to healthcare providers, including specialty providers.

Additionally, Comagine Health conducts telephonic and onsite provider interviews to verify the results of the provider adequacy review.

1.5.7 Information Systems Capabilities Assessment (ISCA)

Our experienced ISCA specialists examine state, MCO, and provider information systems and data processing and reporting procedures to determine the extent to which they support the production of valid and reliable data. Additionally, they will conduct appropriate annual ISCA reviews by interviewing MCO and provider staff and performing onsite reviews at both the MCO as well as a sampling of provider agencies to ensure both meet the requirements for the following areas:

- Information systems.
- Staffing.
- Configuration management – hardware systems.
- HIPAA security.
- Administrative data (claims and encounters).
- Enrollment system (Medicaid eligibility).
- Ancillary systems.
- Vendor data integration.
- Report production.
- Provider data.

We understand that each required activity intersects in meaningful ways with other activities, and have systems and processes in place to ensure the ISCA team communicates early observations with the encounter data validation and PMV teams, as issues with the accuracy, timeliness, and completeness of data submissions may also affect results in other areas.

1.5.8 Consumer or Provider Surveys

State Medicaid departments are beginning to play a larger role in healthcare delivery transformation through payment reform. Payment reform initiatives, such as value-based reimbursement programs, are often driven by data, with one key component being the patient experience of care that is captured through survey data. Consumer response to surveys, such as CAHPS®, is integral to healthcare transformation.

If requested, Comagine Health will administer or validate consumer or provider surveys. Comagine Health's scope of services would be informed and guided by our deep experience administering surveys in multiple formats to multiple healthcare audiences. Comagine Health will follow the CMS protocols and requirements when validating consumer and/or provider perception surveys.

For the consumer surveys, Comagine Health will subcontract with a NCQA-certified CAHPS® vendor to administer enrollee/consumer surveys. We currently have contractual relationships with two very experienced NCQA-certified CAHPS® vendors.

For the provider surveys, our approach will be to administer a CAHPS®-like survey to providers that are affiliated with the MCOs and/or DBM to better understand their experience serving the enrollees.

Our proposed approach includes drafting survey questions, administering the survey including multiple reminders to providers who have not yet responded, securely collecting responses, analyzing results, and presenting results to DHHS in an agreed upon format.

Both CAHPS® vendors and Comagine Health employ statistical and research experts who will provide support to EQR teams and DHHS on advanced qualitative and quantitative research designs. Analyses can be produced in the aggregate at the system or state level, as well as at any level of stratification, such as statewide, program, condition specific, and geographical. Depending on the intended audience for the analyses we may apply suppression criteria for cells with small numbers. Analyses are based on bivariate analysis at the case level or the question level, according to client preference. Achievement scores are calculated at the overall level (i.e., aggregate, national or “system” level), and for designated strata (i.e., regional or state level).

For an example of the 2019 Apple Health CAHPS® Child Report, please refer to Appendix D.

1.5.9 Encounter Data Validation (EDV)

The EQR Team follows CMS Protocol 5 - Validation of Encounter Data as the standard process when validating encounter data and will perform an independent validation of the procedures used by the MCOs and DBM.

Additionally, the Comagine Health EQR team obtains and reviews the MCO/DBM encounter data validation report submitted to the State as a contract deliverable for the calendar year. The encounter data validation methodology, encounter and enrollee sample size(s), selected encounter dates and fields as well as data collection tools are reviewed for conformance with State contract requirements. The encounter and/or enrollee sampling procedures are reviewed for conformance with accepted statistical methods for random selection.

The Comagine Health team’s EDV process consists of electronic data checks—state-level validation of all encounter data received by the State during the review period. The Comagine Health Team analyzes encounter data submitted to the State to determine the magnitude of missing encounter data by field, consistency of potentially missing encounter data, overall data quality issues, and any issues with the processes for compiling encounter data and submitting the data files to the State. The error rates are then compared to error rates reported to the State for encounters for which dates of service fell within the same time period. We also report out on documentation concerns and issues, non-encounter services, and non-compliance with medical necessity

1.5.10 Quality of Care Studies

As a Quality Innovation Network-Quality Improvement Organization (QIN-QIO), Comagine Health has many years of experience in conducting studies on quality. Comagine Health's EQR services contribute to advancing the quality, efficiency, and value of healthcare and is prepared to conduct ad hoc studies, if requested by DHHS. The focus may be on QI, administrative, legislative, or other areas of interest. Focus studies may examine and report on clinical or nonclinical aspects of care provided by the MCOs and/or DBM.

Comagine Health can implement quality of care studies using a data driven QI methodology, providing technical assistance, and may include practice facilitation for workflow modification. The approach will include:

- Clinical leadership, in partnership with DHHS, MCOs, and DBM, will select appropriate quality of care topics, define scope of the project, develop data definitions for reporting, and messaging to staff, aligning with their strategic priorities.
- Data definitions will be translated into metrics for monitoring progress and driving innovation. Metrics will include clinical outcome measures to health status and process measures to reflect improvement in care delivery.
- Design improved care processes, in collaboration with the MCOs and DBM, and test them on a small scale in rapid process improvement cycles until they are ready for spread to the organization.

Our approach will be a collaborative effort between Comagine Health and DHHS. Comagine Health will conduct a planning meeting with DHHS to determine the focus of the study. We will develop a project plan and collaborate with DHHS on an agreed upon timeline. Comagine Health will provide regular updates on the study and/or report during monthly meetings with DHHS. Our expert clinicians, researchers, and analysts will design studies to "drill down" for root causes behind performance and patient satisfaction scores, to help identify high-leverage opportunities for improvement. An appropriate mix of data analysts and research and field staff will assist the project team.

Comagine Health will follow a standard process to implementing an ad-hoc study, CMS Protocol 9 - Conducting Focus Studies of Healthcare Quality.

1.5.11 Technical Assistance to MCOs

Comagine Health goes beyond the typical checklist approach to EQR. We provide extensive hands-on technical assistance and training to staff members at state agencies and managed care plans to enhance their internal and external QI capabilities and equip them to respond to the findings and recommendations of each annual EQR cycle. We offer detailed consultation to help our agency clients and their contracted health plans meet Medicaid program requirements related to ensuring access to timely, high-quality healthcare. Our technical assistance includes a wide range of subjects. Some of the trainings we have provided have focused on quality assurance and performance

improvement; disaster recovery/business continuity planning; delegation of services; clinical documentation; program integrity; fraud, waste, and abuse; risk assessment; and EDV.

While EQR approaches and tools are founded on CMS mandated protocols and industry-standard best practices, our EQR team will customize services to meet the Nebraska Medicaid program's specific goals, requirements, and budget constraints. We have extensive experience in adapting our processes and tools to clients' changing needs, thus allowing us to negotiate customized approaches to deliver the best results at the most efficient cost. All our EQRO contracts have spanned periods of substantial change in the Medicaid programs we serve, and we have adapted as necessary to ensure the MCOs are continuing to provide high-value services for children and adults.

1.6 Timeline

The table below outlines the EQR deliverables for this project. A detailed version of the work plan draft is located in Section 7 – Draft Work Plan.

Table 2 - Tentative Project Milestone Timeline

Reports	Due Dates
Submit the draft EQR report for each MCO/DBM to DHHS	Within 90 days of the onsite review
Submit the draft Annual Technical report to DHHS	August 15
Submit Final Annual Technical report to DHHS	October 15
Submit final Annual Validation of Performance Measures Report	December 31
Submit final Annual Validation of Network Adequacy Report	December 31
Develop and submit a progress report	Monthly
Ad-hoc reporting	To be determined

1.7 Value Proposition

By partnering with the Comagine Health team, DHHS and their affiliated MCOs should benefit from the following:

- 30 years of QI and process improvement methods such as Lean and Continuous Quality Improvement (CQI) to improve operational and administrative efficiencies.
- Enable DHHS to identify and address specific disparities and gaps in care.
- Enable DHHS to identify areas of significant variations in quality of care and

understand the drivers of patient outcomes.
- Create transparency around performance and accelerating the effectiveness of value-based payment efforts by articulating points for maximum clinical and quality impact.
- Build comprehensive reports that clearly present observed findings, trends, and outcomes combined with recommendations for targeted action and improvement.
- Enable the health plans to comprehensively address a broad spectrum of key aspects of enrollee care and services (e.g., access, timeliness, preventative, chronic, acute, coordination of care, inpatient, high-need, high-risk, etc.).

1.8 Commitment to Success

Comagine Health is committed to providing DHHS with quality EQR services so DHHS may complete its contractual agreement between DHHS, the MCOs, and DBM to provide competitive and reasonable healthcare costs to DHHS consumers enrolled in managed care. To assist in this goal, Comagine Health will provide EQR services, technical assistance, reporting services, quality reviews, as well as distribution services for the EQR reports, assessments, and recommendations and conduct monthly and quarterly meeting with DHHS and appropriate stakeholders.

The team at Comagine Health has actively partnered with the Washington HCA in EQRO work for the past five years, using this opportunity to enhance our analytic, reporting, and engagement skills to help improve quality, access, and timeliness of care for Apple Health enrollees. As presented in our proposal, the team that we offer DHHS includes deeply experienced professionals committed to the success of Nebraska's EQR services program, including our EQRO Program Manager, Kristin Johnson, PMP®, and multiple Comagine Health senior leaders well-versed in EQRO programs.

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Section 2 – Corporate Overview

Section VI.A.1 Corporate Overview

The following sections outline Comagine Health's organization, past performances, and structure for our EQR Team.

2.1 Contractor Identification and Information

Section VI.A.1.a Contractor Identification and Information

Table 3 - Corporate Overview

Comagine Health Corporate Information	
Full Company Name	Comagine Health
Address of Headquarters	10700 Meridian Avenue N., Suite 300, Seattle, WA 98133
Entity Organization	501(c)(3) nonprofit organization
State of Incorporation	Washington State
Founding Year	1974
Corporate Changes Since Founding	**Qualis Health** ▪ 1974 – Established - Washington State Professional Standards Review Organization - Washington State private, 501(c) (3) non-profit organization (this has not changed through any of our iterations). ▪ 1979 – Name change - Washington PRO/W. ▪ 1993 – Name change - PRO-West, A Professional Review Organization. ▪ 2001 – Name change - PRO-West, Quality Health Care Solutions. ▪ 2002 – Name Change – Qualis Health. ▪ 2005 – Qualis Health acquired Outlook Associates. **HealthInsight** ▪ 1984 – Established - Acumentra Health. ▪ 1999 – Name change - HealthInsight Assure. ▪ 2016 - Acumentra Health announced corporate affiliation with HealthInsight. ▪ 2017 –HealthInsight Management Corporation, HealthInsight Oregon and Oregon Health Care Quality Corporation (Q Corp) merge. **Comagine Health** ▪ 2018 – Qualis Health merged with HealthInsight to become Comagine Health.

2.2 Financial Statements

Section VI.A.1.b Financial Statements

Comagine Health Financial statements for 2019 are considered confidential and can be found in the separate Proprietary Information file under Appendix A – Financial Statements.

2.3 Change of Ownership

Section VI.A.1.c Change of Ownership

Comagine Health does not anticipate any change in ownership or control of the company during the 12 months following the proposal due date. Comagine Health understands that any change of ownership to an awarded contractor will require notification to the State.

2.4 Office Location

Section VI.A.1.d Office Location

Comagine Health main headquarters in 10700 Meridian Avenue N., Suite 300, Seattle, WA 98133 will be responsible for performance pursuant to an award of a contract with the State of Nebraska for this EQR project.

2.5 Relationships with the State

Section VI.A.1.e Relationships with the State

Comagine Health was a Nebraska Medicaid contractor from 2007 – 2014. In 2007, the State of Nebraska, Department of Administrative Services, Materiel Division, Purchasing Bureau issued RFP #1961Z1 for the purpose of selecting a qualified contractor to provide both quality and utilization management programs for medical services provided to clients not enrolled in a health maintenance organization. This RFP also asked contractors to provide the Nebraska Medicaid Agency 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 Nebraska Medicaid Agency and the MCO providing healthcare to Nebraska Medicaid consumers enrolled in Medicaid managed care.

Comagine Health secured this QIO and EQRO Services contract under our previous name, Qualis Health, vendor number 1321185. The Contract Number for the scope of work was 27625-O4. The following list highlights the services we provided under Contract 27625-O4:

- Retrospective reviews for ambulatory surgery centers and critical access hospitals, including DRG validation and discharge review.
- Cost-outlier reviews.
- Prior authorization reviews of hospital admission, rehabilitation, out-of-state services, home health, private duty nursing, and select surgical procedures.
- Concurrent reviews.
- Retrospective eligibility reviews.
- Quality of care reviews.
- Focused reviews of specific providers.

- Reconsiderations, Appeals, and support for Fair Hearings.
- Special projects (one annually).
- EQRO activities that included:
  - Validation of performance improvement required by the State.
  - Validation of MCO performance measures reported or MCO performance measures calculated by the State.
  - A review of the MCO's compliance with standards established by the State to comply with the requirements of 42 CFR Section 438.204(g).

From November 2007 – October 2013, EQRO activities for the contract were provided through a subcontractor, with Comagine Health providing prime contractor oversight and monitoring. We were responsible for all required EQRO deliverables. Under Comagine Health's direction, our EQRO subcontractor developed review tools and EQR report deliverables including Compliance Review Tools for regulated Federal requirements and State contract requirements, Annual EQR Reports for each Nebraska MCO, and Final Technical Reports.

Contract 27625-O4 was originally issued for a base period of three years—effective November 1, 2007 through October 31, 2010—with the option to renew for additional option year periods as mutually agreed upon by all parties. Amendment One to the contract, issued on 10/30/07—just prior to contract start—added the EQR project as was bid.

Amendment Two issued in in January 2010, increased our Contractor responsibilities to also include the establishment and management of a statewide utilization and quality control program for home health and private-duty nursing services provided to Nebraska Medicaid clients in Fee-For-Service (FFS) systems. It also modified compensation amounts. Later in 2010, the first renewal of the contract was issued.

Then in February 2012, Amendment Four was issued to adjust upward the quantity of reviews and number of EQRO projects. Amendment Five in that same month involved another contract renewal, and added administrative and post-payment reviews and costs to Contract 27625-O4

In 2013, the State decided to separate the QIO and EQRO scopes of work. Amendment Six, which was issued in November 2013, deleted in its entirety the EQRO scope of work from Contract 27625-O4, and updated the contract period for the quality and utilization program to run from November 1, 2013 to April 30, 2014. Comagine Health successfully completed the term of the contract.

2.6 Contractor's Employee Relations to State

Section VI.A.1.f Contractor's Employee Relations to State

None of Comagine Health's or MetaStar's proposed staff for RFP 6303 Z1: External Quality Reviews are currently employed by the State of Nebraska nor have been employed by the State of Nebraska in the past 60 months.

2.7 Contract Performance

Section VI.A.1.g Contract Performance

Neither Comagine Health nor its subcontractor, MetaStar, has had a contract terminated for default during the past 10 years. 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.

2.8 Summary of Contractor's Corporate Experience

Section VI.A.1.h Summary of Contractor's Corporate Experience

2.8.1 State of Washington, Healthcare Authority (HCA) – EQR Services – Comagine Health

Reference #1 – EQR Services			
Comagine Health: Prime or Sub	Prime		
Planned Budget	$4,190,565		
Actual Budget	$4,190,565		
Client Organization	State of Washington, Healthcare Authority (HCA)		
Planned Start Date	01/01/2015	Planned End Date	12/31/2019
Actual Start Date	01/01/2015	Actual End Date	12/31/2019
Contact Person's Name	Telephone Number	Facsimile Number	Email
Colette Jones	(360) 725-1782	--	Colette.jones@hca.wa.gov
Scope of Work			
Conduct EQR activities as described in 42 CFR §438.358 and to perform specific QI activities of nine BHOs and their contracted agencies and five MCOs. The activities for the BHOS included conducting compliance reviews, PMVs of PIHP contracts, core PMV of the PIHP contract Core Performance Measures, ISCA at the BHO and state level, and Focused Study on the Children's Mental Health system and the statewide implementation of WISe including conducting a review of clinical records for 15 behavioral health agencies using the Quality Implementation Review Tool (QIRT) and reporting.			

The activities for the MCOs included creating an Enrollee Quality Report (Star Rating Report), Validation of Performance Measures (HEDIS® Audits), Performance Measure Comparative Analysis, administration and reporting CAHPS® Surveys, and VBP and Performance Measure Recommendation and Evaluation.

2.8.2 State of Washington, Healthcare Authority (HCA) - Medicaid Compliance Review and Analytics – Comagine Health

Reference #2 – Medicaid Compliance Review and Analytics			
Comagine Health: Prime or Sub	Prime		
Planned Budget	$2,151,964 (first 18 months of the contract)		
Actual Budget	$2,151,964 (first 18 months of the contract)		
Client Organization	State of Washington, Healthcare Authority (HCA)		
Planned Start Date	01/01/2020	Planned End Date	12/31/2023
Actual Start Date	01/01/2020	Actual End Date	Ongoing
Contact Person's Name	Telephone Number	Facsimile Number	Email
Colette Jones	(360) 725-1782	--	Colette.jones@hca.wa.gov
Scope of Work			
Conduct EQR and QIO activities to meet 42 C.F.R § Part 462 and 42, C.F.R. § Part 438, Managed Care, Subpart E, EQR including Enrollee Quality Report (Star Rating Report), Validation of Performance Measures (HEDIS® Audits), Performance Measure Comparative Analysis, administration and reporting CAHPS® Surveys, VBP Performance Measure Recommendation and Evaluation, and WISe QIRT Reviews (clinical chart reviews).			

In 2019, a new law took effect requiring the state of Washington EQRO to annually analyze performance of MCOs. Specifically, MCOs are to be assessed on a set of seven performance measures, including four shared measures reported by all plans and three specific to each of the five MCOs. In preparation for this annual review, the state asked Comagine Health to analyze HEDIS® data for the MCOs and to recommend a set of priority measures that meets the legislations specific criteria and best reflects the state's quality and value priorities—balancing cost and utilization—while ensuring quality care to clients. The state selected final measure sets from these recommendations.

2.8.3 Wisconsin Department of Health Services (DHS) – External Quality Review – MetaStar

Reference #3 – EQR	
MetaStar: Prime or Sub	Prime
Planned Budget	$22,140,000
Actual Budget	$22,140,000
Client Organization	Wisconsin Department of Health Services (DHS), Bureau of Adult Programs and Policy/Bureau of Children's Services

Planned Start Date	2002	Planned End Date	06/30/2020
Current Start Date	07/01/2017	Actual End Date	06/30/2022 (currently in the 1st year of 2, 1-year extensions)
Contact Person's Name	Telephone Number	Facsimile Number	Email
Rosa Plasencia	(608) 266-3840	--	Rosa.Plasencia@dhs.wisconsin.gov
Scope of Work			
MetaStar is contracted as the EQRO for the state of Wisconsin for programs under this contract. MetaStar conducts both mandatory (as identified in the CMS EQRO Protocols) and optional review activities for Medicaid Managed Care programs and Home and Community Based Waiver Services (HCBS) programs. Optional activities include record reviews and review of state-level appeals and grievances.			

2.9 Summary of Contractor's Proposed Personnel/Management Approach

Section VI.A.1.i Summary of Contractor's Proposed Personnel/Management Approach

Our EQRO staff have proven expertise in both project management and implementation management. Our team members have the necessary experience with the planning, oversight, and challenges involved with implementing a new EQRO contract. Comagine Health understands the establishment of task dependencies, milestones, and deliverable schedules, which allow for the continuous monitoring of progress and the ability to identify risks and threats to the project so that mitigating strategies can be deployed and we can meet the schedules for which the project team has committed. Specifically, Comagine Health's project management methodology includes:

- Keeping the overall goals and objectives for the project "front and center" throughout the project's duration so that resources stay focused on what is most important.
- Developing a comprehensive project work plan and timeline.
- Establishing deliverables, milestones, tasks, schedule, resources, and dependencies.
- Establishing roles associated with tasks.
- Providing direct subcontractor oversight.
- Conducting a project kick-off meeting and participating in ongoing status meetings; delivering reports; reporting on progress, issues, and risks; and coordinating upcoming activities.

Kristin Johnson, PMP®, our EQR program manager, will coordinate with the DHHS contract manager on the initial implementation project planning and will obtain final DHHS approval of the project work plans developed for carrying out the EQR tasks. The approved project work plans allow us to understand what tasks are on the horizon so that Comagine Health and DHHS can discuss issues and conduct pre-planning before the due dates arrives. The work plans provide an avenue of communications across all parties—Comagine Health, MetaStar, DHHS, the MCOs, and the DBM—about the

timeframe for activities. If timeframes shift for any task, we can discuss the ramifications to later activities, adjusting timeframes or expediting other tasks to meet deliverable due dates.

The work plans also function in conjunction with the project status reports that Comagine Health will submit to DHHS. We will use these work plans as “anchors” for the activities and program updates that will be provided in the project status reports and meetings. The tasks and subtasks identified in the work plans will also form the basis for identification of risks, and any remediation plans.

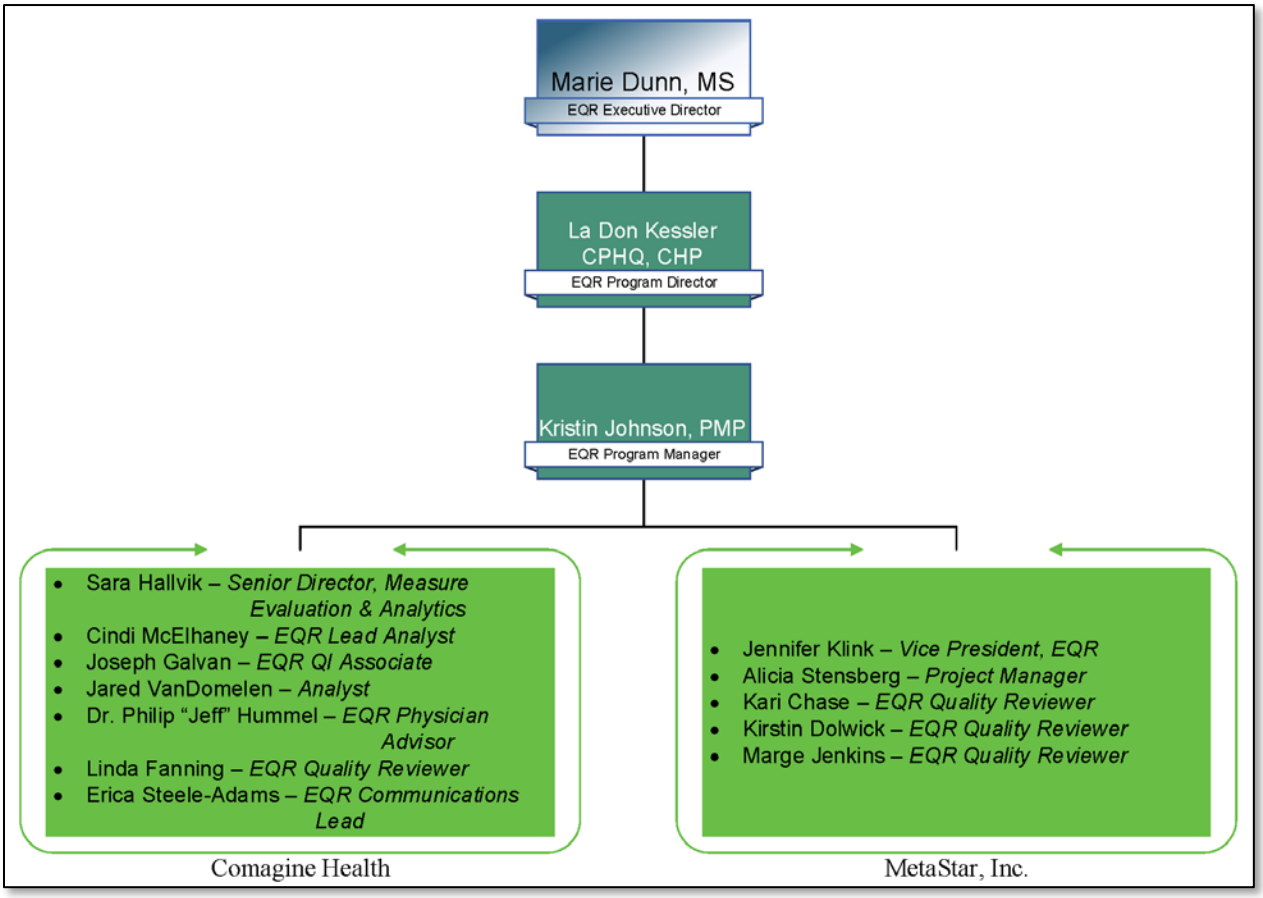
Comagine Health’s project management approach has proven successful over many years of providing EQR services. Our management strategy incorporates quality checks by Ms. Johnson at each process step, including weekly internal team reviews of the written work plan to determine whether projects are on task and meeting deadlines. We track risks and issues that arise throughout each EQR activity while identifying and implementing solutions. We expect our staff to complete all work at the highest level of quality and to produce error-free final deliverables, and we have several layers of quality control checks in place. In addition, our team is tasked to continually assess and identify ways to improve on the current tools, processes, and reports to meet the clients’ needs more efficiently and effectively. We are a quality improvement organization and take that to heart as we apply quality improvement strategies to our own processes and work.

Our approach involves a partnership with a skilled subcontractor, MetaStar, in which we have an already established relationship. Comagine Health and MetaStar’s team approach to the scope of work involves a specific division of tasks between the two organizations that is designed to take advantage of the organizational strengths and experience of each EQRO partner, such as MetaStar’s long history of conducting annual EQR compliance reviews and reporting and Comagine Health’s extensive experience with validation of performance measures, PIPs, network adequacy, and reporting. While our EQR approaches and tools are founded on industry standard best practices, we tailor our services to meet each Medicaid program’s specific goals. We have deep experience in adapting our processes and tools to clients’ changing needs, enabling us to negotiate customized approaches to deliver the best results cost-efficiently.

The EQR team will replicate the successful current processes utilized for planning and conducting mandatory review activities of the three MCOs and one DBM on behalf of DHHS. The team will collaborate with DHHS to confirm the timing and scope of the reviews and commit to conducting the onsite review of each MCO and DBM in the second calendar quarter of each year.

The EQR Program Manager and QI Associate have knowledge of the compliance review protocols and process and will oversee the work conducted by MetaStar.

Figure 3 - EQR Project Team Organization Chart



2.9.1 Resumes

In this section, Comagine Health is supplying resumes for all personnel proposed to work on this project. We have also included a skills matrix which demonstrates the expertise of our proposed staff in the following table:

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Table 4 - Summary of the Project Team's Qualifications, Knowledge, and Experience

	Physical (medical), behavioral healthcare, and dental services	Managed care regulations, program, and data systems	EQR Compliance reviews	Validation of performance measures and HEDIS® audit experience	Technical guidance/assistance and quality improvement education related to mandatory and additional activities related to EQR and development of PIPs	Validation of PIPs	Writing, publication skills, and/or experience with EQR technical reports including recommendations for improving quality of healthcare services delivered	Validation of network adequacy	Research design and methods, including data collection and statistical analysis	Quality assessment and performance improvement methods	Managed care delivery systems, organizations, and financing	Medicaid beneficiaries, policies, data systems, and processes
Comagine Health Staff												
Marie Dunn	▪	▪	▪	▪		▪	▪	▪			▪	
La Don Kessler	▪	▪	▪			▪		▪	▪		▪	
Kristin Johnson	▪	▪	▪		▪	▪	▪	▪	▪	▪	▪	▪
Sara Hallvik	▪	▪	▪	▪		▪	▪	▪			▪	▪
Cindi McElhaney	▪	▪	▪	▪	▪	▪	▪		▪		▪	▪
Joseph Galvan	▪	▪	▪			▪		▪		▪	▪	
Jared VanDomelen	▪			▪								
Philip “Jeff” Hummel	▪	▪	▪	▪		▪	▪	▪		▪	▪	▪
Linda Fanning	▪	▪			▪	▪		▪		▪	▪	▪
Erica Steele Adams	▪					▪				▪		
MetaStar Staff												
Jennifer Klink	▪	▪	▪		▪	▪	▪	▪	▪	▪	▪	
Alicia Stensberg	▪	▪	▪		▪	▪		▪	▪	▪	▪	
Kari Chase	▪	▪	▪		▪	▪		▪		▪	▪	
Kirstin Dolwick	▪	▪	▪		▪	▪	▪	▪		▪	▪	
Marge Jenkins	▪	▪	▪			▪	▪	▪		▪	▪	

Table 5 - Summary of the Project Team's Qualifications, Knowledge, and Experience for Additional/Ad-Hoc Activities

	Assist with the quality ratings of MCOs	Conduct studies on quality	Administration and/or validation of consumer or provider surveys	Conduct PIPs	Calculation of additional performance measures	Validation of encounter data
Comagine Health Staff						
Marie Dunn				▪		▪
La Don Kessler			▪	▪	▪	
Kristin Johnson			▪	▪	▪	▪
Sara Hallvik	▪	▪		▪	▪	
Cindi McElhaney	▪	▪	▪	▪	▪	▪
Joseph Galvan	▪					
Jared VanDomelen	▪	▪		▪	▪	
Philip “Jeff” Hummel			▪		▪	
Linda Fanning					▪	
Erica Steele Adams			▪	▪	▪	
MetaStar Staff						
Jennifer Klink				▪	▪	
Alicia Stensberg					▪	
Marge Jenkins					▪	
Kirstin Dolwick				▪	▪	
Kari Chase					▪	

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2.9.1.1 Marie Dunn, MS

EQR Executive Director
(Chief Growth Officer, Comagine Health)

Summary

Ms. Dunn is currently the Chief Growth Officer for Comagine Health. In this position she is responsible for organizational growth, strategy and oversight of several product lines including analytics, health IT consulting, research and evaluation, contracts, and staff. Her team takes a data-driven approach to problem solving and has expertise in both Medicaid and state-based transformation efforts, as well as national initiatives. In her role as External Quality Review Organization (EQRO) Executive director, Ms. Dunn will provide executive leadership on all matters regarding operations, client relationship, and contractual aspects of the EQR program.

Ms. Dunn is an experienced healthcare leader with formal training in public health and a passion for leveraging data and systematic interventions to improve outcomes, reduce harm and reduce costs in our healthcare system. Her experience includes work in strategy, management, operations, business and program development. Previously, Ms. Dunn worked as Vice President of Population Health Strategy and Operations for the Health Catalyst, advising leading health systems on how to deploy analytic systems in support of value-based payment efforts to improve outcomes and reduce costs. She served as a senior consultant for the Advisory Board Company, conducting best-practice research studies on a variety of topics related to delivery system improvement, in addition to launching the firm's Meaningful Use consulting program. She received her master's degree in health policy and management from Harvard School of Public Health, where she served as a teaching assistant to Dr. Lucian Leape and did her graduate work with Partners HealthCare and InterSystems in efforts focused on leveraging digital innovations to improve health outcomes.

References

Name	Address	Phone	Email
Marci Scott-Weis ▪ Former COO - Qualis Health ▪ Senior Pastor, Magnolia United Church of Christ	3555 W McGraw St, Seattle, WA 98199	425-681-0909	marci@magnoliaucc.org
Mike Doyle ▪ General Manager, Professional Services - Health Catalyst	3165 Millrock Dr #400 Salt Lake City, UT 84121	855-309-6800	Michael.doyle@healthcatalyst.com
Colette Jones, RN, MN ▪ Section Manager - Medicaid Compliance Review and Analytics,	626 8th Ave SE PO Box 45530 Olympia, WA 98504-5530	360-725-1782	collette.jones@hca.wa.gov

Name	Address	Phone	Email
Washington State Healthcare Authority			

Education

Master of Science, Health Policy and Management	Harvard University, Harvard School of Public Health	Boston, MA
Bachelor of Arts, Economics and Comparative Literature	University of Virginia	Charlottesville, VA

Relevant Work Experience

2017-present. Chief Growth Officer, Comagine Health (formerly Qualis Health), Seattle, WA

- Provides executive leadership on all matters regarding operations and customer oversight for all contracts and programs within Research and Innovation; in previous role as VP for Quality and Safety Initiatives, oversaw work for all quality-based contracts in Washington and Idaho.
- Defines, develops and directs goals and programs; monitors regulatory standards and implements policies; engages senior leaders and stakeholders in the communities served.
- Plans, organizes and directs all contracts, operations, budgets, customer relations, contract administration and other activities within the department(s) to ensure that contract deliverables are met in a high-quality, timely and cost-effective manner.
- Serves as executive lead for the Washington EQR Contract with specific focus in developing a framework for selection of VBP clinical quality metrics recommended to be used by the Washington HCA to annually analyze the performance of MCOs providing services to clients.
- Guides the development of leaders within the team and facilitates strategic planning and initiatives for all contracts, products and the department, including leading change initiatives within the department using Lean principles.

2014-2017. Health Catalyst

- Launched and accelerated new ventures centered on leveraging analytics to drive outcomes improvement—reducing costs and improving quality—in healthcare.

2017. Vice President, Population Health Strategy and Operations, Professional Services

- Led a marketing and strategy effort to unify product and service offerings across the company in support of a cohesive, overarching population health approach.
- Chaired a workgroup of subject matter experts to the end of articulating a series of best practices for using data to drive outcomes improvement.
- Authored, Population Health Management: Leveraging Analytics for Care and Payment Transformation summarizing the findings of the workgroup and based on

on-the-ground experience with leading health systems.

2014-2015. Accountable Care Analytics
- Launched the product line for analytic tools to support population health, growing the business from 3 to 10 clients in 2015 (representing ~about 25% of the firm's client base).
- Oversaw sales, client operations and product strategy for the product line; also responsible for setting strategic direction and priorities for the technical team.

2012-2014. Harvard School of Public Health
- Pursued training in public health, with particular focus on digital innovation.

2014. Teaching Assistant
- Teaching assistant to Drs. Lucian Leape and Ashish Jha's Healthcare Quality course.

2013-2014. Partners HealthCare, Population Health Management, Graduate Work
- Worked with population health management leaders to evaluate analytic needs in support of their overall strategic aims, craft a rubric to evaluate vendors and conduct a market analysis.

2013. InterSystems, HealthShare (HIE), Graduate Work
- Worked with leaders on efforts to strategically position the company's HIE platform to serve healthcare system's needs related to data aggregation and analytics.

2007-2012. The Advisory Board Company
- Advised healthcare executives on strategy and operations through best practice research and legislative guidance.

2012. Senior Consultant, Research and Insights

2010-2012. Consultant, Research and Insights

2009-2010. Senior Analyst, Research and Insights

2008-2009. Research Manager, Original Inquiry

2007-2008. Research Manager, Original Inquiry

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2.9.1.2 La Don Kessler, CPHQ, CHP

EQR Program Director
(Director, R&I Administration, Comagine Health)

Summary

Ms. Kessler has more than 30 years of applicable experience working in healthcare in a range of positions that include healthcare quality assessment and improvement, project management, and team leadership of operations and administration. She is currently Comagine Health's Director of Administration for the Research and Innovation (R&I) department. In this role, she leads contract management, budgeting, proposal development, financial reporting, and subcontract/consultant procurement and monitoring, and ensures compliance with all aspects of Medicare, Medicaid, state, and private contracts. In her role as EQR Program Director, Ms. Kessler will provide direction on the operations and implementation of the EQR contract, provide direct oversight of the EQR Program manager, negotiate and execute all contracts and subcontracts, and monitor all fiscal aspects and contract performance.

References

Name	Address	Phone	Email
Peggy Evans, PhD ▪ CTO - Neighborcare Health	1200 12th Ave S, Suite #901 Seattle, WA 98144	206-715-7193	peggy@chin-evans.com
Jan Cunningham, CHC, MSSW, LICSW, ACSW ▪ Retired Compliance Officer & Director of Corporate Risk Management - Comagine Health	14315 103rd Ave. NE Kirkland, WA	425-499-6795	jcgam_wa@yahoo.com
Colette Jones, RN, MN ▪ Section Manager - Medicaid Compliance Review & Analytics, Washington State Healthcare Authority	626 8th Ave SE PO Box 45530 Olympia, WA 98504-5530	360-725-1782	collette.jones@hca.wa.gov

Education

Bachelor of Science (BS), Medical Record Administration	Southwestern Oklahoma State University	Weatherford, OK
Courses in Healthcare Statistics	University of Denver	Denver, CO

Certification/Training

2006-present Certified Professional in Healthcare Quality

Relevant Work Experience

2008-present. Director of Contracts and Administration, Research and Innovation, Comagine Health (formerly Qualis Health), Seattle, WA

- Ensures compliance with Medicare, Medicaid and private contractual requirements as well as compliance with corporate policies.
- Provides management oversight of the Washington EQR Contract including management of program managers.
- Works with risk manager and other contract administrators to revise contract administration policies and processes.
- Develops proposals and budgets that include sufficient staffing and other resources to meet contractual requirements and organizational goals.
- Develops financial monitor reports to ensure contracts are meeting corporate financial targets.
- Works closely with the contracting and procurement department to identify potential partners and subcontractors/consultants, develops RFPs/RFQs, evaluates responses, selection, implementation and monitoring of subcontractors/consultants.
- Participates on the management team to provide leadership and strategic direction for the QSI department.

2005-2008. Director, Quality Improvement – Home Health, Qualis Health, Seattle, WA

- Designed and led plans to successfully accomplish the goals of the home health project.
- Ensured the integrity and high quality of the home health subtask project work.
- Was responsible for the operational management of clinical and non-clinical staff who work with home health agencies.
- Ensured compliance with Medicare contractual requirements as well as compliance with corporate policies.
- Participated on the management team to provide leadership and strategic direction for the Medicare contract.

1999-2005. Associate, Manager of Project Operations, Qualis Health (formerly PRO-West), Seattle, WA

- Managed project staff working on the CMS Medicare QIO contract and CMS special studies.
- Ensured timely development of project plans and interventions, allocation of staff resources for project teams, and coordination of appropriate team members.
- Participated on the management team to provide leadership and strategic direction for the Medicare contract, including budget development and monitoring.
- Developed special study proposals and responded to RFPs, including developing overall project approach, project plans, and determining staffing and budget.
- Served as co-director for Washington State Diabetes Collaboratives I and II and the National Surgical Infection Prevention Collaborative; provided day-to-day

management and planned, coordinated, and executed Learning Sessions and Action Period activities.

1997-1999. Senior Analyst for Special Projects

1995-1997 Manager, Information Systems, The Colorado Healthcare Purchasing Alliance (The Alliance)

1990-1995 Managed Care Analyst

Other Experience and Professional Memberships

- Washington State Association for Healthcare Quality, 2003–2007
- NCQA Audit Methodology Panel (AMP), 1998–2001, 2005
- NCQA-certified HEDIS® Compliance Auditor, 1999–2001

Project Experience

Active Projects

Washington State EQRO
01/2015 to present
Washington HCA
Division of Healthcare Services
As Washington's Medicaid EQRO, Comagine Health provides external quality review and supports quality improvement for enrollees of Washington Apple Health managed care programs and the BHO network. Comagine Health reviews services provided by Apple Health MCOs through the following annual activities including evaluating CAHPS® customer satisfaction surveys distributed among MCO enrollees, validating MCO performance measures on important dimensions of care and service through audits of the MCOs' HEDIS® measures, conducting a comparative analysis of MCO performance measure performance, developing a framework for selection of clinical quality metrics recommended to be used by HCA to annually analyze the performance of MCOs providing services to Clients and producing annual quality and technical reports.

Washington HCA
Division of Behavioral Health and Recovery
As Washington's Medicaid EQRO, Comagine Health provides external quality review and supports quality improvement for enrollees of Washington Apple Health managed care programs and the BHO network. Activities include conducting compliance audits of enrollee rights, grievance systems, program integrity, quality assessment and performance improvement, and provider network adequacy. Validate required PIPs for managed mental health plans, validate mental health performance measures, and perform external data validation.

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2.9.1.3 Kristin Johnson, PMP®

EQR Program Manager
(Program Manager for Comagine Health)

Summary

Ms. Johnson possesses more than 20 years of healthcare experience in a variety of capacities, including project management, program development and oversight, quality improvement, communications and stakeholder relations. In her role as EQR Program Manager, Ms. Johnson leads the EQR team in all facets of the contract and serves as the main project contact for HCA. She manages timelines and deliverables for all contract activities, leads the VBP measure work, oversees all work conducted by subcontractors, and provides technical assistance to state agencies and health plans.

Ms. Johnson has served as program manager for our Patient-Centered Medical Home (PCMH) division, overseeing a variety of efforts including performance measurement and reporting for provider organizations seeking to transform healthcare delivery, and our HIT consulting team.

References

Name	Address	Phone	Email
Peggy Evans, PhD ▪ CTO - Neighborcare Health	1200 12th Ave S, Suite #901 Seattle, WA 98144	206-715-7193	peggy@chin-evans.com
Jan Cunningham, CHC, MSSW, LICSW, ACSW ▪ Retired Compliance Officer & Director of Corporate Risk Management - Comagine Health	14315 103rd Ave. NE Kirkland, WA	425-499-6795	jcgam_wa@yahoo.com
Colette Jones, RN, MN ▪ Section Manager - Medicaid Compliance Review & Analytics, Washington State Healthcare Authority	626 8th Ave SE PO Box 45530 Olympia, WA 98504-5530	360-725-1782	collette.jones@hca.wa.gov

Education

Bachelor of Arts, English	Pacific Lutheran University	Seattle, WA

Certification/Training

2014	Project Management Professional (PMP)®	Project Management Institute

Relevant Work Experience

2014-present. Program Manager – EQRO, Comagine Health (formerly Qualis Health), Seattle, WA

- Oversees EQRO activities for Washington Apple Health (Medicaid).

- Serves as liaison to state Medicaid agency; provides technical support and quality improvement guidance.
- Manages performance measurement activities; oversees subcontractors hired to complete HEDIS® audits and CAHPS® reporting work.
- Evaluates MCO compliance with state and federal regulations, assessing MCO performance as it relates to access, quality and timeliness of care provided to Medicaid enrollees.
- Contributes to the development of the enrollee, regional, comparative and annual technical reports which identify state and MCO achievements, recommendations and opportunities for improvement.
- Develops and monitors project plans and risk mitigation strategies; ensures timely submission of contract deliverables; addresses stakeholder concerns.
- Collaborates with internal team, community stakeholders, and state agencies to coordinate MCO education and training events.
- Monitors state and federal legislative action, regulatory changes, stakeholder activities, and statewide collaborations.
- Oversees contract and program budgets.

2010-2014 Program Manager – PCMH, Comagine Health (formerly Qualis Health), Seattle, WA

- Provided division oversight, ensuring team deliverables were completed accurately, on time and within budget. Advised leadership and staff of potential risks and worked collaboratively with team members to resolve issues. Served as liaison to clients and stakeholders.
- Served as Project Manager on various consulting efforts, notably those relating to performance measurement and reporting, quality improvement and practice transformation. Projects included:
  - A three (3) year federal demonstration to help over four hundred (400) Federally Qualified Health Centers (FQHC) across the country achieve NCQA Recognition,
  - Practice transformation assessment efforts in the states of Washington, Kentucky and California, and
  - A Centers for Disease Control (CDC) and Washington Department of Health (DOH) initiative to award and support providers working to enhance the interoperability of their EHR system with the state's immunization registry.
- Managed the PCMH division budget; worked with finance teams to ensure invoices were issued and payment received; collaborated with leadership on budget planning.
- Contributed to business development efforts, including proposal development and follow up. Created dashboards for tracking contracts, anticipated revenue, and department goals. Collaborated with internal teams to develop performance metrics.

2008-2009 Development Coordinator (Temporary), Foundation and Corporate Relations Seattle Children's Foundation and Guild Association

- Responsible for obtaining conference sponsorships and corporate donations from the organization's vendors. Utilized project management strategies to achieve target goal. Met with hospital leadership to present program concepts and identify project opportunities.

2000-2008 Program Coordinator - Pastoral and Spiritual Care, Children's Hospital and Regional Medical Center

- Responsible for department's administrative, fund development, and communications functions. Served as department contact for internal and external constituents.
- Strategized with multi-disciplinary teams to develop and implement client programs and services. Evaluated programs through metrics and satisfaction surveys. Led quality improvement efforts and oversaw special projects.
- Secured financial and in-kind support. Wrote and edited effective grant proposals, donor materials, and stewardship reports. Maintained relationships with key contributors and community partners.
- Managed operating budgets and gift accounts, ensuring funds were utilized appropriately and within designated timeframes.
- Created and oversaw implementation of department's internal and external communications plans. Developed patient communications, webpages, and community resources.

Project Experience

Active Projects

Washington State EQRO
01/2015 to present
Washington HCA
Division of Healthcare Services
As Washington's Medicaid EQRO, Comagine Health provides external quality review and supports quality improvement for Washington Apple Health. Comagine Health reviews services provided by Apple Health MCOs through the following annual activities including evaluating enrollee experience through CAHPS® surveys, validating MCO performance measures on important dimensions of care and service through audits of the MCOs' HEDIS® measures, conducting comparative analyses of MCO performance measures, developing a framework for selection of clinical quality metrics recommended to be used by HCA to analyze the performance of Medicaid MCOs and producing annual quality and technical reports.

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2.9.1.4 Sara Hallvik, MPH

Senior Director
(Senior Director, Analytic Services, Comagine Health)

Summary

Sara Hallvik is dedicated to improving the affordability and quality of healthcare in our communities, thereby improving the community's health. She started by leading community health assessment projects in frontier and rural public health jurisdictions, then moved to an urban setting to implement quality improvement strategies across large systems of care. Sara currently leads a highly skilled team of analysts working on research grants and healthcare cost, quality, and utilization projects under federal and local contracts and grants.

References

Name	Address	Phone	Email
Scott Wiener, MD MPH, ▪ Brigham and Women's Hospital,	75 Francis St, Boston, MA 02115	617-732-5500	sweiner@bhw.harvard.edu
Rebecca Gould, MS, ▪ Survey Research Analyst, Health Analytics - Oregon Health Authority (OHA), Survey Research Analyst, Health Analytics, ,	Five Oak Building 421 SW Oak Street, Suite 850 Portland, OR 97204	503-339-6613	rebekah.gould@dhsoha.state.or.us
Valerie Stewart, ▪ Metrics and Evaluation Manager - Oregon Health Authority (OHA),	Five Oak Building 421 SW Oak Street, Suite 850 Portland, OR 97204	971-673-2937	valerie.t.stewart@dhsoha.state.or.us

Education

2005	Bachelor of Arts, History and Spanish	University of Puget Sound	Tacoma, WA
2010	MPH, Biostatistics and Epidemiology	Oregon Health & Science University	Portland, OR

Relevant Work Experience

2020-present. Senior Director – Analytic Services, Comagine Health, Portland, OR

- Oversight of a dynamic and growing portfolio of analytic-based service offerings. including external quality review, research, and cost and quality analytic services
- Lead business development and proposal efforts.
- Lead strategic planning efforts for analytic services in collaboration with a broader leadership team.

2019-2020. Director - Health Economics and Research Analytics, Comagine Health (formerly HealthInsight), Portland, OR

- Oversee survey administration to diverse populations, following the CMS External Quality Review Protocol 5.
- Orchestrate analytic work on Total Cost of Care reporting in Oregon.
- Consult on special cost, quality, and utilization projects.
- Participate in multi-stakeholder steering committees for Oregon Data Collaborative and Cost of Care.
- Oversee strategic planning and Oregon and Utah analytics on AHRQ grant with the National Bureau of Economic Research (NBER) at Harvard University.
- Oversee analytics on other related contracts, including the Oregon Maternal Data Center, and CPC+.
- Research Support:
  - Using a Novel Comprehensive Linked Dataset to Determine Early Predictors of Opioid Overdose, Weiner, S (PI), NIDA 1 R01 DA044167-01A1, 10/1/2018 – 9/30/2022.
  - Back Pain Opioid Policies to Influence Outcomes Through Nonpharmacologic Services, Choo E (PI), NIDA 1 R01 DA044284-01A1, 10/1/2018 – 9/30/2021.

2015-2018. Analytic Services Manager, HealthInsight (formerly Acumentra Health), Portland, OR

- Oversee survey administration to diverse populations, following the CMS External Quality Review Protocol 5.
- Lead PMV, Performance Measure Calculation, and Encounter Data Validation tasks following applicable EQR Protocol.
- Oversee program evaluation and analytics on an academic detailing project in Utah and a diabetes referral program in Oregon.
- Lead analyst on two CMS Special Innovation Projects (SIPs) on the topics of Expanding Participation in Self-Management Education Programs and Preventing Opioid Harms in Older Adults.
- Research Support:
  - Using High-Quality Data to Evaluate and Improve Prescribing Practices, Fondario (PI), BJA, 10/01/2016–09/30/2019.
  - Opioid Prescribing Patterns, Policies and Heroin Outcomes in a State Medicaid Population, Hartung, D (PI), CDC U01CE002786, 09/01/2016-08/31/2018.
  - A Pharmacy Prescription Drug Monitoring Program Toolkit to Improve Opioid Safety, Hartung, D (PI), AHRQ 1R18 HS024227-01, 09/30/2015-07/31/2018.

2013-2014. Senior Healthcare Data Analyst, Acumentra Health, Portland, OR

- External Quality Review:
  - Oversee External Quality Review (EQR) work under contract with the Healthcare Authority in Washington State.
  - Lead PMV, Performance Measure Calculation, and Encounter Data Validation tasks following applicable External Quality Review Protocol under previous EQR contract in Oregon.

  - Oversee survey administration to diverse populations, following the CMS EQR Protocol 5. Tasks include paper and web survey development, data collection and management, analysis and reporting.
  - Analyze and report on HEDIS® data and performance measures for Washington and New Mexico.
- Advanced Analytic Services:
  - Lead and oversee a portfolio of analytic services contracts including the Florida Claims Analytic Services, Oregon Maternal Data Center, Oregon Data Collaborative and associated projects (e.g. CPC+, total cost of care reporting), and COVID analytics
  - Consult on special cost, quality, and utilization projects.
  - Lead new analytic services business development and consult on analytics in wide-ranging proposals.
  - Oversee strategic planning and Oregon and Utah analytics on AHRQ grant with the National Bureau of Economic Research (NBER) at Harvard University.
  - Oversee program evaluation and analytics on an academic detailing project in Utah and a diabetes referral program in Oregon.
  - Lead analyst on two CMS Special Innovation Projects (SIPs) on the topics of Expanding Participation in Self-Management Education Programs and Preventing Opioid Harms in Older Adults.
  - Internal content expert in data collection, governance, analysis, and visualization and reporting.
- Research Support:
  - Using a Novel Comprehensive Linked Dataset to Determine Early Predictors of Opioid Overdose, Weiner, S (PI), NIDA 1 R01 DA044167-01A1, 10/1/2018 – 9/30/2022.
  - Engaging Clinicians to Improve Opioid Safety and Reduce Overdose Risk will evaluate the impact of a provider-focused opioid intervention in Oregon, Fischer, M (PI, CDC 1 R01 CE003153-01, 9/1/2019 - 8/30/2022.
  - Back Pain Opioid Policies to Influence Outcomes Through Nonpharmacologic Services, Choo E (PI), NIDA 1 R01 DA044284-01A1, 10/1/2018 – 9/30/2021.
  - Using High-Quality Data to Evaluate and Improve Prescribing Practices, Fondario (PI), BJA, 10/01/2016–09/30/2019.
  - Opioid Prescribing Patterns, Policies and Heroin Outcomes in a State Medicaid Population, Hartung, D (PI), CDC U01CE002786, 09/01/2016-08/31/2018.
  - A Pharmacy Prescription Drug Monitoring Program Toolkit to Improve Opioid Safety, Hartung, D (PI), AHRQ 1R18 HS024227-01, 09/30/2015-07/31/2018.

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2.9.1.5 Cindi Jean McElhaney

EQR Lead Analyst
(Senior Healthcare Analyst, Comagine Health)

Summary

Ms. McElhaney is a healthcare analyst with more than 20 years of experience analyzing healthcare data. She is experienced at developing project plans, collecting data, and publishing metrics and other reports related to healthcare quality and resource use. As a senior analyst, Ms. McElhaney is in a leadership role within a team of analysts. She works with fellow analysts to ensure measurement and reporting is both accurate and relevant to various stakeholder audiences. In her role as EQR Lead Analyst, Ms. McElhaney will serve as the lead analyst in developing a multitude of analytic reports, oversee the collection of EQR data, design analytic methods and outputs, interpret findings, manage analytic timelines., and help develop the selection tool used for the VBP Performance Measure Recommendations.

References

Name	Address	Phone	Email
Colette Jones, RN, MN ▪ Section Manager - Medicaid Compliance Review and Analytics, Washington State Healthcare Authority	626 8th Ave SE PO Box 45530 Olympia, WA 98504-5530	360-725-1782	collette.jones@hca.wa.gov
Jon C Collins, PhD ▪ Deputy Director Health Systems Division, Operations - Oregon Health Authority (OHA), Health Systems Division	Five Oak Building 421 SW Oak Street, Suite 850 Portland, OR 97204	503-569-0044	jon.c.collins@dhsoha.state.or.us
Betsy Boyd-Flynn, CAE ▪ Executive Director - Oregon Academy of Family Physicians	1717 NE 42nd Ave #2103, Portland, OR 97213	503-528-0961 503-956-3308	bbf@oafp.org

Education

1988	Bachelor of Science, Mathematical Sciences	Oregon State University	Corvallis, OR

Certification/Training

1998	Project Management	Systemation
1999	Designing Effective Program Evaluations	American Institutes for Research

Relevant Work Experience

2011-present. Sr. Healthcare Analyst, Comagine Health (formerly HealthInsight), Seattle, WA

- Provide analytical support in for a wide variety of quality and cost reporting initiatives. Develop projects plans and publish metrics and other reports related to healthcare quality and resource use.
- Work in a leadership role with other analysts to ensure Q Corp (formerly HealthInsight) measurement and reporting is both accurate and relevant to various stakeholder audiences.
- Major projects include the following:
  - Metrics consultant for Q Corp – Considerable expertise with industry metrics standards, particularly HEDIS®; is often consulted when Q Corp projects require the calculation of standardized metrics.
  - Provider Reporting Portal Measures – Provide measurement expertise to support the reporting of measure results to primary care providers through Comagine Health's online Provider Reporting Portal.
  - CCO Metrics – Worked closely with the OHA) to validate incentive measures used for performance payments for the CCO's that manage care for members under the Oregon Medicaid demonstration project. Validated other performance measures and model calculations that Oregon is required to report to CMS as part of the demonstration project. Provided other measure related consulting to the OHA as needed.
  - Cover Oregon Quality Ratings – Produced the quality measures and star ratings that appeared on the Oregon healthcare exchange website.
  - Low Back Pain Initiative – Produced baseline and post-implementation reporting to monitor the effectiveness of an initiative to reduce unnecessary utilization of services related to low back pain.

2002-2011. Sr. Healthcare Analyst, Health Net, Los Angeles, CA

- Performed strategic analyses to enable decision support within the organization.
- Majority of projects were related to healthcare cost/utilization and reimbursement modeling. Other analyses were performed as needed.
- As the senior member of the team, also provided mentoring and direction for the other analysts.

1997-2000. Corporate Management Analyst, SAIF Corporation, Salem, Oregon

1995-1997 Statistical Analyst, PACC Health Plans, Clackamas, OR

1993-1995 Sr. Programmer Analyst, PACC Health Plans, Clackamas, OR

Project Experience

Active Projects

Washington HCA EQRO
2/2019 to current

Washington HCA
Division of Healthcare Services
As part of Comagine Health's contract with the HCA as the EQRO with Washington State, serving as lead analyst in developing a framework for selection of clinical quality metrics recommended to be used by HCA to annually analyze the performance of MCOs providing services to Clients.

Completed Projects

Hospital Improvement Innovation Network (HIIN) Special Improvement Project for Oncology
10/2018 to 3/2019
Developed a rating methodology to identify top performing hospitals in terms of oncology treatment using a set of cancer specific measures. Once the top hospitals were identified, site visits were conducted to identify best practices to share with other HIINs.

Measure Testing and Development
9/2017 to 6/2018
Centers for Medicare and Medicaid Services (CMS)
As a subcontractor for CMS, tested the feasibility of using standard Medicare measures to assess the quality of care being delivered to commercial members enrolled in qualified health plans under the Affordable Care Act. This analysis involved calculating the measures using standard specifications, and then assessing the impact of modifying the measures for a younger population. It also included identifying statistical differences using different stratifications of the data, including age, gender, and commercial product type.

CCO Metrics
2/2013 to 4/2017
OHA
Worked closely with the OHA to validate incentive measures used for performance payments for the CCO's that manage care for members under the Oregon Medicaid demonstration project. Validated other performance measures and model calculations that Oregon is required to report to CMS as part of the demonstration project. Provided other measure related consulting to the OHA as needed.

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2.9.1.6 Joseph L. Galvan

EQR Quality Improvement (QI) Associate
(Quality Improvement Associate, Comagine Health)

Summary

Mr. Galvan possesses over 20 years of experience in the healthcare field. He offers an extensive set of administrative and resource management skills, including tool development and maintenance, project planning, and event coordination. As a Quality Improvement Associate at Comagine Health for the EQR team, he provides a variety of logistical and administrative support, including scheduling, document preparation, and task monitoring. As a former Project Coordinator, Mr. Galvan designed, created, and maintained Microsoft Access databases to track HIT and patient-centered medical home (PCMH) contracts as well as supported HIT consultant work using the Salesforce customer relationship management tool. In his role as the EQRO QI Associate, Mr. Galvan will provide EQR project support, be responsible for secure data storage, assist teams members with planning and scheduling, serve as the WISe clinical review coordinator, support the analytic and communication teams, and serve as the event coordinator for the Quality Forum.

Skills

- Knowledge of CMS protocols for external quality review—Code of Federal Regulations 42, Part 438.
- Experience in the healthcare industry, specifically, with HIPAA standards, Meaningful Use, EHR, and medical terminology.
- Proficient in Microsoft Office Products: Outlook, Word, Excel, PowerPoint, Access and Visio.
- Proficient in Microsoft SharePoint platform.
- Experience with C#, SQL, PHP, XHTML, XML and Visual Basic for Applications.
- Bilingual: English and Spanish.

References

Name	Address	Phone	Email
Colette Jones, RN, MN ▪ Section Manager - Medicaid Compliance Review and Analytics, Washington State Healthcare Authority	626 8th Ave SE PO Box 45530 Olympia, WA 98504-5530	360-725-1782	collette.jones@hca.wa.gov
Peggy Evans, PhD ▪ CTO - Neighborcare Health	1200 12th Ave S, Suite #901 Seattle, WA 98144	206-715-7193	peggy@chin-evans.com

Name	Address	Phone	Email
Marc Bollinger, LICSW ▪ CEO – Community Integrated Health Services, LLC	57 West Main Street, Suite 260 Chehalis, WA 98532	360-795-5959	mbollinger@greatriversbho.org

Education

1996	Bachelor of Arts, Drama	University of Washington	Seattle, WA
1995	Bachelor of Science, Business Administration	University of Arizona	Tucson, AZ

Certification/Training

2013	Database Administration and Development	Seattle Central College, Seattle, WA
Currently Enrolled	Project Management	Seattle Central College, Seattle, WA

Relevant Work Experience

2013-present. Quality Improvement Associate, Comagine Health (formerly Qualis Health), Seattle, WA

- Provides overall project coordination in support of the Washington External Quality Review (EQR) Contract including develops, implements and maintains project plans/timelines, including tracking subtask status and other project activities.
- Develops, implements, and maintains project plans/timelines, including tracking subtask status and other project activities.
- Supports external conferences and other events, including logistics, participant registration, preparation and distribution of presenters' materials, and travel.
- Schedules all external quality review and WISe activity with agencies and providers.
- Prepares and distributes detailed agendas and documentation requests to agencies and providers.
- Serves as key contact to external organizations throughout the review process.
- Schedules and monitor production of external quality review and WISe reports, ensuring timely delivery to the State.
- Develops and maintains recurring (weekly/monthly) and ad hoc reports, as needed.
- Contributes to reports and serves as the report proofreader.
- Responsible for secure storage of database information.
- Supports internal meetings, including logistics, agenda, and distribution of materials.
- Works with team to create external quality review and ISCA tools based on CMS protocols and guidelines.
- Participates in external quality reviews and Information Systems Capabilities Assessments.
- Designed, created, and maintained Microsoft Access databases to track HIT and

PCMH contracts.
- Supported HIT consultant work using a highly customized customer relationship management (CRM) tool, Salesforce.
- Provides high-level administrative support to the Systemwide Quality Improvement (SQI) department and others, as requested.

1998-2013. Customer Service Specialist/Assistant to Resource Manager, SHPS

Project Experience

Active Projects

Washington State EQRO
2013 to present
Washington HCA
Division of Healthcare Services
As Washington's Medicaid EQRO, Comagine Health provides external quality review and supports quality improvement for enrollees of Washington Apple Health managed care programs and the BHO network. Comagine Health reviews services provided by Apple Health MCOs through the following annual activities including evaluating CAHPS® customer satisfaction surveys distributed among MCO enrollees, validating MCO performance measures on important dimensions of care and service through audits of the MCOs' HEDIS® measures, conducting a comparative analysis of MCO performance measure performance, developing a framework for selection of clinical quality metrics recommended to be used by HCA to annually analyze the performance of MCOs providing services to Clients and producing annual quality and technical reports.

Washington HCA
Division of Behavioral Health and Recovery
As Washington's Medicaid EQRO, Comagine Health provided external quality review and supported quality improvement for enrollees of Washington Apple Health managed care programs and the BHO network. Activities included conducting compliance audits of enrollee rights, grievance systems, program integrity, quality assessment and performance improvement, and provider network adequacy. Validated required PIPs for managed mental health plans, validated mental health performance measures, and performed external data validation.

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2.9.1.7 Jared VanDomelen

Analyst
(Associate Healthcare Data Analyst, Comagine Health)

Summary

Mr. VanDomelen designs and builds survey forms and data collection processes, including data entry quality control and inter-rater reliability checks. He performs accurate and rapid data entry and often works with sensitive information, including protected health information (PHI) and personally identifiable information (PII) of Medicare and Medicaid recipients with diabetes, hypertension, mental illness or other targeted diagnoses. He has expertise in SAS and Excel automation, used in survey projects to manage follow-up with survey respondents, refining mailing lists for subsequent survey distributions and monitoring response rates. His eye for detail and ability to learn new programs and processes quickly has supported project teams on a variety of topics.

References

Name	Address	Phone	Email
Rebecca Gould, MS, ▪ Survey Research Analyst, Health Analytics - Oregon Health Authority (OHA),, Survey Research Analyst, Health Analytics	Five Oak Building 421 SW Oak Street, Suite 850 Portland, OR 97204	503-339-6613	rebekah.gould@dhsoha.state.or.us
Valerie Stewart, ▪ Metrics and Evaluation Manager - Oregon Health Authority (OHA),	Five Oak Building 421 SW Oak Street, Suite 850 Portland, OR 97204	971-673-2937	valerie.t.stewart@dhsoha.state.or.us
Meghan Donohue ▪ Senior Manager, Quality Data and Analytics - Seattle Cancer Care Alliance	1354 Aloha St, Seattle, WA 98109	206-779-2945	meghan.tiahrt.donohue@gmail.com

Education

2010 Associate in General Studies Portland Community College Portland, OR

Relevant Work Experience

2015-present. Associate Healthcare Data Analyst, Comagine Health (formally HealthInsight), Portland, OR

- Performs data analysis using SAS and Excel.
- Supports analytic and project teams on External Quality Review (EQR) analytics projects.

- Develops and maintains automation procedures to quickly and accurately process large quantities of data on a regular basis.
- Performs quality control processes with a high degree of accuracy.
- Extracts survey data with SAS and Excel using REDCap API to update response rates and mailing lists.
- Designs and formats surveys using REDCap and StatPac.
- Works with PHI and PII and apply appropriate safeguards.
- Collaborates with project teams to set up and maintain data management systems.
- Enters survey data into Access, Excel, REDCap, and StatPac with high accuracy.

2015 Data Entry Specialist, Comagine Health (formerly Aerotek/Acumentra Health), Portland, OR

- Organized surveys returned via mail for data entry and storage.
- Entered survey data into Access with high accuracy.
- Searched online and entered personal/business information into Excel.

2014 Data Equipment Specialist, Agile1/PacifiCorp, Portland, OR

- Responsible for the timely processing of customer payments, including payment processing; mail sorting and extraction; data entry and completion of payment transactions; and opening and processing customer payments.

2012-2013 Data Entry Specialist, Adecco/Epiq Systems, Portland, OR

- Keyed class action and bankruptcy claim information.
- Transcribed voicemails and processed invoices.
- Used VDE Viking, OCR AnyDoc, Excel, Word and other applications.
- Trained co-workers on system fields and entry details.
- Tested/quality checked new systems prior to implementation.
- Developed scripts that increased input speed by an additional 50% to 100%. Scripts included shortcuts and automation to maximize the use of keying efficiencies and to minimize errors and repetitive input. Implemented and trained co-workers on the scripts.

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2.9.1.8 Phillip Jeffrey (Jeff) Hummel, MD, MPH

EQR Physician Advisor
(Medical Director, Informatics, Comagine Health)

Summary

Dr. Hummel is a general internist with 35 years of medical experience and advanced training in Health Services. He is currently Comagine Health's Medical Director for Healthcare Informatics, a position in which he provides leadership for practice coaches working with practices engaged in practice transformation, population health consulting, clinical outcomes reporting and integration of behavioral health and oral health into primary care settings. He is also the author of five white papers on the use of IT in quality improvement, as well as Oral Health: An Essential Component of Primary Care and the forthcoming Oral Health Integration Implementation Guide. In his role as Medical Director, Dr. Hummel will serve as clinical co-lead in developing a framework for selection of VBP clinical quality metrics recommended to HCA, assist in developing the VBP measures evaluation report, and provide clinical leadership and expertise as needed.

References

Name	Address	Phone	Email
Colette Jones, RN, MN ▪ Section Manager - Medicaid Compliance Review and Analytics, Washington State Healthcare Authority	626 8th Ave SE PO Box 45530 Olympia, WA 98504-5530	360-725-1782	collette.jones@hca.wa.gov
Michael Parchman, MD, MPH ▪ Kaiser Washington Research Center, Seattle, WA	1730 Minor Ave., Suite 1600 Seattle, WA 98101	206-287-2395	parchman.m@ghc.org
Evan Oakes, MD, MPH ▪ HealthPoint FQHC, Seatte, WA	4424 S 188TH St., #900 Seatac, WA 98188	206-898-0958	eoakes@healthpointchc.org

Education

Master of Public Health	University of Washington	Seattle, WA
Internal Medicine Residency	University of Massachusetts Medical Center	Worcester, MA
Doctor of Medicine	University of Washington, School of Medicine	Seattle, WA
Bachelor of Science	University of Washington	Seattle, WA

Relevant Work Experience

2005-present. Medical Director, Healthcare Informatics, Comagine Health (formerly Qualis Health) Seattle, WA

- Clinical lead for Practice Transformation consulting team at Comagine Health, working with practices across the country on multiple aspects of practice transformation including workflow optimization, using health IT for population management of common chronic conditions, outcomes reporting for process and clinical outcome measures and integration of oral health and behavioral health into to the primary care setting.
- Served as clinical co-lead in developing a framework for selection of VBP clinical quality metrics recommended to be used by the Washington HCA to annually analyze the performance of MCOs providing services to Clients.
- Served as clinical lead on five consecutive contracted scopes of work for CMS pertaining to EHR implementation and reporting EHR data for quality improvement. Focus on improving immunization rates as part of the Cardiac Learning and Action Network.
- Participated in the Office of the National Coordinator (ONC) Health Information Security and Privacy Collaborative (HISPC).
- Served on the Washington State Health Information Infrastructure Advisory Board (HIIAB), which addressed many of the policy issues involved in the secure exchange of health information.
- Served as Medical Director for the Washington and Idaho Regional Extension Center since its foundation in 2010.
- Was a member of the ONC Meaningful Use Community of Practice Advisory Board, including chairing the Workflow and Policy workgroups.
- Served as a member of the International Society for Disease Surveillance Meaningful Use Workgroup, tasked with developing syndromic surveillance guidelines for Stage 3 Meaningful Use.
- Served as a member of the BioSense 2.0 Governance Group charged by the Centers for Disease Control with overseeing the management of the national syndromic surveillance database.
- Contributed to the Commonwealth Fund-sponsored Safety Net Medical Homes Initiative, providing expertise in the area of optimization of health information technology to support medical homes workflows.
- Participated in electronic health records readiness assessment of the Seattle King County Health Department clinic system performed by Comagine Health in 2008.
- Participated in Washington and Idaho Regional Extension Centers (WIREC) work with providers in Washington and Idaho to prepare providers across both states to qualify for Medicaid meaningful use incentives.

2005-2014. Founder and Chief Medical Officer, Deep Domain, Inc.

2004-2007. Director for Medical Informatics, UW Medicine Neighborhood Clinics, Seattle, WA

2003-2005. Medical Director, NexCura, Inc.

2002-2009. Chair, Pharmacy and Therapeutics Committee, Premera Blue Cross

Project Experience

Active Projects

VBP Performance Measures Recommendation Team
04/2019 to present
Washington HCA
Division of Healthcare Services
As part of Comagine Health's contract with the HCA as the EQRO with Washington State, participating in developing a framework for selection of clinical quality metrics recommended to be used by HCA to annually analyze the performance of MCOs providing services to Clients.

Washington Population Oral Health Project
07/2017 to present
Arcora Foundation
Developed a method for dentists to document disease severity for caries and periodontal disease using ICD-10 diagnosis codes and successfully implemented a reporting system in two Seattle area Federally Qualified Health Center (FQHC) systems. Currently engaged in efforts to use similar reporting techniques to monitor impact of interventions designed to improve the periodontal health of patients with diabetes in a third FQHC.

Completed Projects

EvidenceNow – Healthy Hearts Collaborative
08/2015 to 04/2019
AHRQ
Healthy Hearts Northwest was part of the EvidenceNOW: Advancing Heart Health initiative, to help smaller primary care practices effectively integrate evidence-based approaches to improving cardiovascular care outcomes. The study team tested combinations of strategies and support to learn which improve clinical quality measures in 200 primary care clinics across Washington, Oregon, and Idaho.

Oral Health Integration Project
09/2014 to 01/2018
Funder: National Interdisciplinary Initiative on Oral Health (NIIOH)
NIIOH contracted with Comagine Health to publish a white paper outlining a framework for integrating oral health content into primary care practice. The paper titled, "Oral Health: An Essential Component of Primary Care" which outlined the "oral health delivery framework" was published in June 2015. This was followed by a contract to implement the Oral Health Delivery Framework in 19 primary care systems in 5 states and write an implementation guide. The project was completed successfully with publication of the implementation guide and tool kit in January 2018.

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2.9.1.9 Linda Fanning, MSW, LCSW, CHC

EQR Quality Reviewer
(Program Manager, Comagine Health)

Summary

Linda Fanning has more than 36 years of experience connecting communities through social service and healthcare activities in both public and private sector organizations. As a Program Manager for Comagine Health, she is responsible for management of multiple contracts with the State of Oregon, including the utilization review program of Oregon's fee-for-service psychiatric residential treatment facilities and state hospital levels of care. Additional responsibilities include managing the Qualified Residential Treatment Program Independent Assessment process, a focused study measuring improvements in the "Warm Handoff" process for adults leaving acute psychiatric care and the MHSIP survey of youth, families and adults receiving Medicaid mental health services. Recent experience has included External Quality Review compliance and network adequacy reviews of Oregon MCOs. During 2013–2015, she was the OHA's Medicaid policy analyst for all federally qualified health centers (FQHCs), rural health clinics (RHCs), Indian Health Services (IHS) and Tribal 638 clinics. In that role, she coordinated and communicated state and federal policy, billing and reimbursement, rate development, active participation in alternative payment methodology pilot project, advocating for and supporting tribal communities and participating in government-to-government meetings. Before joining OHA, she worked for a children's mental health agency, ChristieCare/Youth Villages, for 21 years in clinical, contracting, compliance, and program development roles. She is a licensed clinical social worker in Oregon and is certified in Healthcare Compliance (CHC) through the Healthcare Compliance Association.

References

Name	Address	Phone	Email
Nancy Allen ▪ Placement Services Manager - Oregon Department of Human Services	2446 SE Ladd Portland, Oregon 97214	503-473-1859 503-269-3041	nancy.allen@dhsoha.state.or.us
Trevor Douglass ▪ Pharmacy Director - Oregon Health Authority (OHA)	500 Summer St. NE Salem, Oregon 97301	206-287-2395	trevor.douglass@state.or.us
Alex Palm ▪ Policy Advisory, Child Welfare Director's Office - Oregon Department of Human Services	500 Summer St. NE Salem, Oregon 97301	503-884-3292	alex.palm@dhsoha.state.or.us

Education

1982	Bachelor of Arts, Social Work	Boise State University	Boise, ID
1987	Masters, Social Work	Eastern Washington University	Cheney, WA

Certification/Training

1992	Licensed Clinical Social Worker #1807
1992	Academy of Certified Social Workers, National Association of Social Workers
2016	Certified in Healthcare Compliance (CHC)

Relevant Work Experience

2016-present. Program Manager, Comagine Health, Portland, OR

February 2020 - July 2020. Director of Operations for Implementation of Oregon Independent and Qualified Agent (IQA) program

- Directed overall operations for implementation of the Oregon 1915(i) Home and Community Based Services, IQA program for adults with severe and persistent mental illness. This work includes concurrent reviews at the Oregon State Hospital, work with Secure Residential Treatment Facilities, State Plan Personal Care services for those with behavioral health needs, and work with non-Medicaid individuals who may reside in residential treatment programs.

July 2020–present. Qualified Residential Treatment Program (QRTP) Independent Assessments

- Oversee the contract of State and Federal mandates under the Family First legislation, providing independent assessments of youth referred to traditionally Behavioral Residential Services (BRS) residential levels of care.

2019–present. Warm Handoff Focus Study

- Manage review of medical records of adults receiving care through Medicaid in 10 acute care psychiatric hospitals in Oregon to ensure a “Warm Handoff” to the community has occurred. This work was part of the Oregon Performance Plan from the US DOJ.

2018–present. Mental Health Statistics Improvement Program

- Manage survey of Medicaid recipients who have received mental health services. This includes a sample of individuals who have received outpatient and residential services. Adults, youth ages 14-17 and families of youth who have received mental health services are surveyed. Our sample between 30,000 and 35,000 individuals.

2017–present. Utilization Review

- Manage utilization review program of Oregon’s fee-for-service psychiatric residential treatment facilities and state hospital levels of care.
- Assess, analyze, and define operational processes and related policies, organization structure, personnel, supporting systems; identify areas for needed improvement and communicate written recommendations to various stakeholders.
- Interpret and apply federal regulations and state Medicaid regulations.
- Provide clinical support and inter-rater reliability to ensure consistency of application of the utilization review processes.

2016-2018. Program Manager, HealthInsight Assure, Portland, OR

- Manage planning, coordination, review, assessment, and evaluation of EQR activities of 16 Oregon Medicaid MCOs for compliance with federal standards.
- Assess, analyze, and define operational processes and related policies, organization structure, personnel, supporting systems; identify areas for needed improvement and communicate written recommendations to various stakeholders.
- Develop, implement, and monitor project plans and timelines.
- Interpret and apply federal regulations and state Medicaid regulations.
- Design and oversee the EQR review of MCOs and document findings based on application of designated criteria.
- Conduct various related projects, including Network Adequacy reviews of MCOs.

2015-2016. Clinical Quality Improvement Specialist, Acumentra Health, Portland, OR

- Participate in the planning, coordination, review, assessment and evaluation of EQR activities of Oregon Medicaid MCOs for compliance with federal standards; Assist with utilization review for children and adults receiving mental health services in psychiatric residential treatment facilities and at the state hospitals. Perform clinical record review and treatment staff interviews for quality studies.

2013-2015. Operations & Policy Analyst 3, OHA, Medical Assistance Programs (MAP), Salem, OR

2008-2013. Contract Compliance Manager, Youth Villages, Inc., Marylhurst, OR

2006-2008. Program Development Manager, ChristieCare, Marylhurst, OR

2002-2006. Program Development Manager, ChristieCare, Marylhurst, OR

1998-2002. Program Manager, ChristieCare, Marylhurst, OR

1997–1998 Program Services Coordinator, ChristieCare, Marylhurst, OR

1996–1997 Clinical Supervisor, ChristieCare, Marylhurst, OR

1992–1996 Child and Family Therapist, ChristieCare, Marylhurst, OR

1989–1992 Director of Social Services, Emerald Terrace Nursing Center, Vancouver, WA

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2.9.1.10 Erica Steele Adams

EQR Communications Lead
(Senior Communications Strategist, Comagine Health)

Summary

Erica Steele Adams has 15 years of experience in healthcare-related communications, including two years as the communications lead for the Washington EQR contract and nearly 10 years as the communications lead for the previous Oregon EQR contract. She is well versed in EQR terminology, protocols and reporting requirements.

Erica is a precise editor and writer with a knack for clarity and consistency. She is adept at translating technical language into plain English. She works closely with subject matter experts to craft consistent messages throughout publications, ensuring they meet standards for accuracy and readability.

Programs and Skills

- Microsoft Office Suite
- Adobe Creative Suite
- Constant Contact
- Expertise in major style guides: Associated Press, Chicago and American Medical Association

References

Name	Address	Phone	Email
Colette Jones, RN, MN ▪ Section Manager - Medicaid Compliance Review and Analytics, Washington State Healthcare Authority	626 8th Ave SE PO Box 45530 Olympia, WA 98504-5530	360-725-1782	collette.jones@hca.wa.gov
Adam Tollinger ▪ Proposal Coordinator – Cambia Health Solutions,	100 SW Market St, Portland OR 97201	503-809-9532	adam.tollinger@gmail.com
Karen Sutherland ▪ Freeland Editor	95883 Cape Drive Brookings, OR 97415	503-957-7840	sutherlandcommunications1@gmail.com

Education

2001 Bachelor of Journalism University of Texas Austin, TX

Relevant Work Experience

2007-present. Senior Communications Strategist, Comagine Health, Portland, OR

- As the communications lead for the Washington EQR contract, Erica ensures accuracy, quality, and consistency of all reports, including the annual EQR technical report.

- Previously managed production of 25 multi-author reports per year for contracts with the State of Oregon, including EQR and Oregon mental health services consumer surveys.
- Manages editorial production of data-rich reports, from template development to final proofreading, working with subject matter experts to ensure accuracy and readability.
- Writes and edits external and internal communications, including newsletter articles, web posts and board updates.
- Key responsibilities include:
  - Editing and formatting reports according to in-house style and client specifications
  - Writing executive summaries and other narrative content
  - Creating graphs and tables
  - Ensuring accuracy and consistency in content, tone and style throughout publications
  - Guiding reports through review process to meet timelines

2004-2007. Contract/Freelance Editor and Writer, Multiple Locations

- Key clients included:
  - American Airlines Custom Publishing, Dallas, TX – wrote and edited articles for regional and specialty magazines, including for a major hospital system.
  - *CURE* magazine, Dallas, TX – wrote and edited feature articles for this national magazine focused on providing the latest cancer information for those undergoing treatment.
  - Center for Biomedical Continuing Education, Irving, TX – edited continuing medical education materials including newsletters, slides and journal articles.
  - Big Think Media, remote – wrote and conducted research for white papers and newsletter articles for this communications consulting firm specializing in healthcare.

2002-2004. Cancer Information Group, Dallas, TX

2004. Copyediting Manager

- Supervised copyediting team and coordinated editing and production of six peer-reviewed oncology journals, including *Clinical Breast Cancer* and *Clinical Lung Cancer.*

2002-2003. Copyeditor and Acquisitions Editor

  - Copyedited and proofread articles for journals according to company and industry standards.
  - Tracked submissions and corresponded with authors regarding their manuscripts.

2.9.1.11 Jennifer Klink, MA, BS

Vice President of External Quality Review, MetaStar, Inc.
(Vice President of External Quality Review, MetaStar, Inc.)

Summary

Ms. Klink is a certified Social Worker in the state of Wisconsin. She has six years' experience working in residential settings for individuals with disabilities ensuring compliance with state requirements under DHS 83. Ms. Klink worked for a contracted care management unit for a pilot managed care program supporting the transition from pilot to entitlement for almost ten years in a variety of roles including care manager and supervisor. Her experience includes working with individuals with disabilities and behavioral health issues. Ms. Klink has worked for an EQRO for nine years in a variety of roles including quality reviewer and project manager. In her roles, she has coordinated and participated in all review activities and has supported development of new review activities. She is currently the administrator of the EQRO Contract for the state of Wisconsin including mandatory and optional review activities as well as Fee-for-Service Utilization Reviews.

References

Name	Address	Phone	Email
Ann Lamberg ▪ Deputy Bureau Director - State of Wisconsin Department of Health Services	1W Wilson Street Madison, WI 53703	262-521-5385	ann.lamberg@wisconsin.gov
Erika Rupnow ▪ Quality Oversight Manager - State of Wisconsin Department of Health Services	1W Wilson Street Madison, WI 53703	262-521-5090	erika.rupnow@dhs.wisconsin.gov
Makalah Wagner ▪ Quality & Special Initiatives Section Manager Department of Health Services	1W Wilson Street Madison, WI 53703	608-261-8871	mitzi.melendezprodoehl@wi.gov

Education

1995	Bachelor of Science, Social Welfare	University of Wisconsin	Milwaukee, WI
2005	Master of Arts, Public Service	Marquette University	Milwaukee, WI

Certification/Training

1997	Certified Social Worker, Wisconsin	
2001	Certificate in Gerontology	University of Wisconsin

Relevant Work Experience

2016-present. Vice President of External Quality Review, MetaStar, Inc., Madison, WI
2012-2016. Project Manager
2011-2012. Quality Reviewer

- Serves as the primary liaison to Wisconsin DHS for EQRO contract.
- Ensures EQRO activities comply with federal and state Medicaid managed care quality standards and protocols.
- Confirms that deliverables are met in a timely manner.
- Facilitates contract amendments, as needed.
- Secures feedback from DHS, MCOs, HMOs, and SMCPs.
- Helps staff with Family Care, Partnership, PACE, and CLTS policy application/process improvements.
- Extensive knowledge and experience working with target groups of developmental disabilities, frail elders, dementias, and severe and persistent mental illness.
- Project managed day-to-day operations related to performing EQR activities for Family Care MCOs.
- Served as care management review/quality of care review lead for Family Care, Family Care Partnership, and PACE programs.

2008-2011. Supervisor-Family Care-Liaison to Milwaukee County Department of Family Care, Milwaukee Center for Independence, Milwaukee, WI

- Supervised a care management unit contracted to coordinate services for individuals eligible for Medicaid managed care program.
- Active member of the following committees facilitated by the MCO:
  - Clinical Advisory Committee.
  - Quality Management Committee.
  - Self-Directed Support Committee.
  - Integrated Employment Workgroup.

2007-2008. Acting Lead Supervisor- Liaison to Milwaukee County Department on Aging, Milwaukee Center for Independence, Milwaukee, WI

- Responsibilities of the supervisor while maintaining a caseload.
- Managed a caseload of individuals with developmental disabilities.

2006-2008. Lead Family Care Case Manager-Liaison to Milwaukee County Department on Aging, Milwaukee Center for Independence, Milwaukee, WI

- Provided case consultation for crisis cases and unexpected situations.
- Assisted in dispute resolution between care managers, program recipients, and providers.

2002-2006. Family Care Case Manager-Liaison to Milwaukee County Department on Aging, Milwaukee Center for Independence, Milwaukee, WI

- Provided comprehensive assessment, service planning, oversight of service provisions, and service evaluation to a caseload of older adults with disabilities.

1997-2002. Individual Service Coordinator, St. Coletta of Wisconsin, Jefferson, WI

- Provided case management oversight for developmentally disabled adults in a residential setting (community-based residential facility and independent apartments).
- Managed a community-based residential facility regulated by Wisconsin DHS 83.

1995-1997. Residential Living Staff/Individual Support Staff, St. Coletta of Wisconsin, Jefferson, WI

- Provided direct care for adults with developmental disabilities residing in a behavioral health CBRF.

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2.9.1.12 Alicia Stensberg, MA

Project Manager
(Long-Term Care Project Manager, Managed Health and Long-Term Care Services, MetaStar, Inc)

Summary

Ms. Alicia Stensberg possess 12 years of experience in long-term care, supporting adults with disabilities in community settings. She has served as the liaison between counties, MCOs, the State of Wisconsin, and other entities. Ms. Stensberg also served as the administrator for multiple state licenses under Wisconsin DHS 88 and various waiver programs. She has conducted mock surveys in facilities licensed under Wisconsin DHS 88 and 83 to ensure quality, compliance, and make recommendations for improvement. In her position as project manager at MetaStar, her responsibilities include the planning, coordination, implementation, and reporting for a variety of mandatory and optional review activities including Compliance Reviews, Information Systems Capabilities Assessment, Record Review, Appeal and Grievance Reviews, and PMV. She works closely with the teams including training, mentoring, and participating in the reviews.

References

Name	Address	Phone	Email
Ann Lamberg ▪ Deputy Bureau Director - State of Wisconsin Department of Health Services	1W Wilson Street Madison, WI 53703	262-521-5385	ann.lamberg@wisconsin.gov
Erika Rupnow ▪ Quality Oversight Manager - State of Wisconsin Department of Health Services	1W Wilson Street Madison, WI 53703	262-521-5090	erika.rupnow@dhs.wisconsin.gov
Jenny Froemming ▪ Member Care Quality Specialist - State of Wisconsin Department of Health Services	1W Wilson Street Madison, WI 53703	262-521-5162	jennifer.froemming@dhs.wisconsin.gov

Education

2016	MA, Servant Leadership	Viterbo University	LaCrosse, WI
1996	Bachelor of Science	University of Wisconsin	LaCrosse, WI

Certification/Training

Certified Screener — Wisconsin Long-Term Care Adult Functional Screen

Relevant Work Experience

2016-present. Project Manager, MetaStar, Inc., Madison, WI

- Supervise Quality Reviewer staff.
- Serve as quality of care review lead for Family Care, Family Care Partnership, and PACE programs.
- Develop reviewer tools and guidelines for quality of care review.
- Provide consultation for quality of care reviews for MCOs.
- Manage day-to-day operations related to performing EQRO activities for Family Care MCOs.
- Extensive knowledge and experience supporting and coordinating care in community-based setting for adults with physical disabilities, intellectual and developmental disabilities, severe and persistent mental illness, and frail elders.
- Experience reading, interpreting, and applying various state administrative codes related to Medicaid services and long-term care.
- Support and guide investigators in working with Family Care program members and IRIS participants to resolve appeal and grievance issues.
- Gather, analyze, and interpret data used to monitor compliance and drive improvement in MCOs.

2003-2016. Area Director, North Western, Black River Falls, WI

- Served as the administrator for Wisconsin DHS 83.
- Served as the liaison between counties, MCOs, the State of Wisconsin, and other entities.

2010-2012. Lead Program Director, North Western, Black River Falls, WI

- Oversaw the operations of 11 group homes supporting adults with disabilities, approximately 50 employees, and 30 clients.
- Assessed clients for needed services and appropriate placement and coordinated client services within each program.

2006-2010. Program Director, North Western, LaCrosse, WI

- Responsible for the overall management of assigned programs and ensured that the health, well-being, and safety of each client is held to the highest standard.

2005-2006. Program Manager, North Western, LaCrosse, WI

- Supervisory position that also performed the duties of a Residential Coordinator.

2003-2005. Residential Coordinator, North Western, LaCrosse, WI

- Promoted client choices and independence, based on needs and desires.

2001-2003. • Surround Care Staff, YMCA Surround Care Program, LaCrosse, WI

2.9.1.13 Kari L. Chase, MSW, APSW

EQR Quality Reviewer
(Quality Reviewer, Managed Health and Long-Term Care Services, MetaStar, Inc.)

Summary

Ms. Chase is a master's level licensed Social Worker in the state of Wisconsin. Her experience includes working in skilled nursing facilities as well as licensed adult day care centers. Ms. Chase worked as a care manager in a managed care program in the state of Wisconsin for two years. In her current role as a quality reviewer, she participates in record review, appeal and grievance reviews, and is part of the compliance with standards team, conducting reviews for five MCOs annually. Ms. Chase is a subject matter expert in the areas of provider network and care management. She is responsible for conducting provider file reviews as part of the verification activities that occur during the compliance reviews.

References

Name	Address	Phone	Email
Ann Lamberg ▪ Deputy Bureau Director - State of Wisconsin Department of Health Services	1W Wilson Street Madison, WI 53703	262-521-5385	ann.lamberg@wisconsin.gov
Erika Rupnow ▪ Quality Oversight Manager - State of Wisconsin Department of Health Services	1W Wilson Street Madison, WI 53703	262-521-5090	erika.rupnow@dhs.wisconsin.gov
Jenny Froemming ▪ Member Care Quality Specialist - State of Wisconsin Department of Health Services	1W Wilson Street Madison, WI 53703	262-521-5162	jennifer.froemming@dhs.wisconsin.gov

Education

2002	Bachelor of Social Work (BSW)	University of Wisconsin	River Falls, WI
2016	Master of Social Work (MSW), Mental Health Concentration	University of Wisconsin	Madison, WI

Certification/Training

2002 Advanced Practice Social Worker (APSW), Wisconsin

Relevant Work Experience

2016-present. Quality Reviewer, MetaStar, Inc., Madison, WI

- Conducts external quality review activities for Family Care, Family Care-Partnership, and PACE programs based on federal and state Medicaid managed care quality standards.
- Works collaboratively with Family Care, Family Care-Partnership and PACE program members and MCOs to resolve appeal and grievance issues.
- Assists in preparing review findings including summarizing data and narrative accompaniment as well as validation of PIPs.
- Provided diagnosis and developed treatment plans of mental health disorders under the supervision of the Director of Therapeutic Services.
- Administered in-service education related to vulnerable adults, abuse prevention, and behavior recognition programs.
- Provided case management to children and adults with intellectual disabilities.
- Planned daily activities and maintained a safe environment while providing daily living care for children and adults with intellectual and physical disabilities.

2016. Medical Social Worker, Home Health United, Madison, WI
- Conducted in-home assessments and referrals to community supports as needed.

2015-2016. Clinician Intern, Collaborations (State Certified Mental Health Clinic), Madison, WI
- Conducted individual psychotherapy under the supervision of the Director of Therapeutic Services.
- Diagnosis and treatment plans for individuals with mental health disorders.

2013-2015. Support Broker, United Cerebral Palsy of Greater Dane County, Madison, WI
- Performed ongoing assessments of functional limitations for clients.
- Developed and supported individualized support plans.

2012-2013. Adult Day Care Human Service Specialist, Catholic Charities Adult Day Center, Madison, WI
- Scheduled and facilitated care plan reviews for members.
- Facilitated annual member satisfaction surveys.

2011-2012. Adult Day Care Human Service Specialist, Care Wisconsin Adult Day Center, Madison, WI
- Scheduled and facilitated care plan reviews for members.
- Facilitated annual member satisfaction surveys.

2009-2011. Family Care Manager, Care Wisconsin, Portage, WI
- Provided care management to members receiving Medicaid managed care services.
- Performed ongoing assessments of functional limitations and safety of members.
- Worked collaboratively with care team members to meet needs of members.

2008-2009. Director of Social Services, Karmenta Center, Madison, WI

- Oversight of social services department at a skilled nursing facility.
- Assessed new patient assessments.
- Managed care conferences, collaborated with nursing, dietary, therapies, activities, and family members.

2005-2007, 2008. Director of Social Services, Park Health and Rehabilitation Center, St. Louis Park, MN

- Oversight of social services department at a skilled nursing facility.
- Supervised discharge planning for residents and discussed medical and financial options for those needing long-term care.

2007-2008. Medicaid Service Coordinator, Cantalician Center for Learning, Buffalo, NY

- Provided necessary services to individuals with intellectual disabilities.
- Facilitated meetings with appropriate professionals to discuss plan of care for consumers.
- Assisted with completing necessary paperwork to obtain appropriate financial resources.

2000-2002, 2004-2006. Respite Care Provider, Have-A-Heart, Inc., River Falls, WI

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2.9.1.14 Kristin Dolwick, MS, BS

EQR Quality Reviewer
(Quality Reviewer, Managed Health and Long Term Care Services, MetaStar, Inc.)

Summary

Ms. Dolwick has eight years' experience working in sheltered workshop/day program settings for individuals with disabilities In her current role, Ms. Dolwick participates in the validation of PIPs, PMV, record review, appeals and grievance reviews, and compliance with standards reviews. She was part of the team to create the deeming crosswalk for DHS for MCOs that are NCQA accredited to avoid duplication. Ms. Dolwick serves as an editor for reports ensuring they meet corporate style guidelines. In her role for compliance reviews, she has reviewed all focus areas and is familiar with the requirements in their entirety.

References

Name	Address	Phone	Email
Makalah Wagner ▪ Quality & Special Initiatives Section Manager Department of Health Services	1W Wilson Street Madison, WI 53703	608-261-8871	mitzi.melendezprodoehl@wi.gov
Becky Granger ▪ Policy and Initiatives Section Manager Department of Health Services	1W Wilson Street Madison, WI 53703	608-733-8889	rebecca.granger@wisconsin.gov
Judith Stych, DNP, RN, CDDN ▪ Nurse Consultant - Wisconsin Department of Health Services	1W Wilson Street Madison, WI 53703	608-266-8783	judith.stych@dhs.wisconsin.gov

Education

1989	Bachelor of Science, Psychology	University of Wisconsin	LaCrosse, WI
1997	Master of Science, Healthcare Management	University of Wisconsin	Milwaukee, WI

Certification/Training

Certified Screener	Wisconsin Long-Term Care Adult Functional Screen
Mental Health and the Older Adult Certificate Series training (43 CEUs)	University of Wisconsin Madison, Department of Professional Development and Applied Studies
Certified Nursing Assistant	Waukesha County Technical College

Relevant Work Experience

2002-present. Quality Reviewer, MetaStar, Inc., Madison, WI

- Conducts external quality review activities for managed care programs based on federal and state quality standards.
- Develops/edits reports regarding the results of external quality review activities.
- Applies EQRO protocol to determine the MCOs' compliance with Medicaid Managed Care Quality Standards.
- Applies EQRO protocol to review MCO PIP proposals and validate PIPs according to state and federal standards and regulations.
- Works collaboratively with Family Care, Family Care-Partnership, PACE, IRIS program members, and MCOs to resolve appeals and grievances.
- Participates in contract certification document review for BadgerCare Plus MCOs.
- Develops review tools and leads onsite discussions with MCO staff.
- Participated in Department of Health Services Mental Health/AODA Redesign Workgroup developing outcome measures.
- Led the Family Care Member Outcome Interview Assessment project, a personal outcome-based performance review system.
- Extensive knowledge and experience working with individuals with intellectual/ developmental disabilities, many of whom also have physical disabilities.
- Assisted with developing and supervising a medically fragile day services program for adults with developmental disabilities.

2000-2002. Family Care Member Outcome Interview Assessment Project Lead, Wisconsin DHS, Office of Strategic Finance, Center for Delivery Systems Development, Madison, WI

- Project lead on the Family Care member Outcome Interview Assessment project.
- Assisted with the design of the information and information collection methodology.
- Developed policy and procedure manuals for interviewers and schedulers.
- Assisted with ongoing quality monitoring and quality assurance efforts for managed care programs.

1999-2000. Site Supervisor, Goodwill Industries – Adult Center, Waukesha, WI

- Responsible for the administration, monitoring, and ongoing functioning of a community program site.
- Assisted with the development of a medically fragile program serving developmentally disabled population.

1992-1999. Site Supervisor, Goodwill Industries – Adult Center, Genesee, WI

- Responsible for the complex program administration for individuals with developmental disabilities.

2.9.1.15 Marge Jenkins, MSW, LCSW, BA

EQR Quality Reviewer
(Quality Reviewer, Managed Health and Long-Term Care Services, MetaStar, Inc.)

Summary

Ms. Jenkins is a master level licensed Social Worker in the state of Wisconsin. She has thirteen years' experience working in residential settings for frail elders. During her time at MetaStar, Ms. Jenkins, has served as a quality reviewer and project manager. In her current role, she participates in record review, validation of PIPs, appeals and grievance review, and compliance reviews. Ms. Jenkins is a subject matter expert in the enrollee rights and grievance systems for compliance reviews.

References

Name	Address	Phone	Email
Ann Lamberg ▪ Deputy Bureau Director - State of Wisconsin Department of Health Services	1W Wilson Street Madison, WI 53703	262-521-5385	ann.lamberg@wisconsin.gov
Erika Rupnow ▪ Quality Oversight Manager - State of Wisconsin Department of Health Services	1W Wilson Street Madison, WI 53703	262-521-5090	erika.rupnow@dhs.wisconsin.gov
Jenny Froemming ▪ Member Care Quality Specialist - State of Wisconsin Department of Health Services	1W Wilson Street Madison, WI 53703	262-521-5162	jennifer.froemming@dhs.wisconsin.gov

Education

1987	Bachelor of Science, Social Work	University of Wisconsin	Madison, WI
1988	Master of Science, Social Work	University of Wisconsin	Madison, WI

Certification/Training

Certified Screener	Wisconsin Long-Term Care Adult Functional Screen
1994-present	Licensed Clinical Social Worker (LCSW), Wisconsin Social Work License

Relevant Work Experience

2009-2011, 2012-present. Quality Reviewer, MetaStar, Inc., Madison, WI
2011-2012. Project Manager, MetaStar, Inc. Madison, WI

- Conducts external quality review activities for Family Care, Family care-Partnership and PACE programs based on federal and state Medicaid managed care quality

standards.
- Develops/edits reports regarding the results of external quality review activities.
- Works collaboratively with Family Care, Family Care-Partnership, PACE, IRIS enrollees, and MCOs/IRIS Consultant Agencies to resolve appeal and grievance issues.
- Extensive knowledge and experience working with target groups of frail elders, dementia, and severe/persistent mental illness.
- Ability to accurately assess individuals and develop care plans with them.
- Facilitated various quality improvement projects in SNF and CBRF settings to improve systems and processes to increase the quality of life to residents.
- Provided Resident Rights and dementia training to staff in SNF and CBRF.
- Ability to work effectively as an interdisciplinary team.
- Ability to assess member's strengths and risks.
- Knowledge of community resources to support an individual's ability to reside in a community-based setting.

1998-2009. Social Service Manager, Meriter Retirement Services/Capital Lakes (2008–2009), Madison, WI
- Responsible for supervision of staff in Social Service/Admissions Department in a skilled nursing facility.
- Maintained compliance with codes including DHS 132 and DHS 83.
- Maintained a clinical caseload of residents.

1996-1998. Social Worker/Lead Social Worker, Meriter Retirement Services, Madison, WI
- Responsible for supervision of social work staff in Retirement Services
- Maintained a clinical caseload of residents with a focus on:
  - Care planning.
  - Assessment of cognitive abilities, mood status, and quality of life.
  - Resident rights.

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2.10 Subcontractors

Section VI.A.1.j Subcontractors

Table 6 - Subcontractor Information

MetaStar Corporate Information	
Full Company Name	MetaStar, Inc.
Address of Headquarters	2909 Landmark Place, Madison, WI 53713
Telephone Number	(608) 274-1940

MetaStar's experience with compliance reviews for Medicaid managed care programs in the state of Wisconsin spans more than twenty years for a variety of programs. The review team's experience includes transitioning the requirements from 42 CFR 438 and state contracts to standards for review and evaluation to ensure compliance. Currently MetaStar's reviews include a completion of full reviews for non-accredited organizations as well as abbreviated reviews for organizations that are accredited by the NCQA. MetaStar currently conducts compliance reviews for six programs in the state of Wisconsin and twelve MCOs and special managed care plans.

MetaStar's contributions will include the following:

- Conduct the compliance portion of the review to determine the MCO's and DBM compliance with the standards set forth in 42 CFR subpart D and the quality assessment requirements described in §438.330.
- Write and compile the compliance review portion and collaborate with Comagine Health on the individual MCO and DBM reports as well as the annual technical report.
- Participate in required monthly technical assistance meetings with DHHS staff, quarterly operational meetings with the MCOs and DBM, and will be available to meet on an ad hoc basis as needed.

The total percentage of MetaStar's performance hours across the initial term (3 years) plus the three option years is 20%.

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Section 3 – Terms and Conditions

Section II. Terms and Conditions

The following section reflects Comagine Health's compliance with RFP Section II. Terms and Conditions. We understand that by signing we are agreeing to be legally bound by all the accepted terms.

3.1 General

Section II.A General

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

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.

3.2 Notification

Section II.B Notification

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

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.

3.3 Change Orders of Substitutions

Section II.G Change Orders or Substitutions

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

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

3.4 Vendor Performance Report(s)

Section II.H Vendor Performance Report(s)

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

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.

3.5 Notice of Potential Contractor Breach

Section II.I Notice of Potential Contractor Breach

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

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.

3.6 Breach

Section II.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.

3.7 Non-Waiver of Breach

Section II.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.

3.8 Severability

Section II.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.

3.9 Indemnification

Section II.M Indemnification

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

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.

3.10 Attorney's Fees

Section II.N Attorney's Fees

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

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.

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3.11 Assignment, Sale, or Merger

Section II.O Assignment, Sale, or Merger

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

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.

3.12 Contracting with Other Nebraska Political Sub-Divisions of the State or Another State

Section II.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:
MD			

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.

3.13 Force Majeure

Section II.Q Force Majeure

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

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.

3.14 Confidentiality

Section II.R Confidentiality

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

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.

3.15 Early Termination

Section II.U Early Termination

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

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.

3.16 Contract Closeout

Section II.V Contract Closeout

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

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.

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Section 4 – Contractor Duties

Section III. Contractor Duties

The following section reflects Comagine Health's compliance with RFP Section III. Contractor Duties. We understand that by signing we are agreeing to be legally bound by all the accepted terms.

4.1 Independent Contractor/Obligations

Section III.A Independent Contractor/Obligations

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

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.

4.2 Employee Work Eligibility Status

Section III.B Employee Work Eligibility Status

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

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.

4.3 Cooperation with Other Contractors

Section III.D Cooperation with Other Contractors

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

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.

4.4 Ownership of Information and Data/Deliverables

Section III.I Ownership of Information and Data/Deliverables

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

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.

4.5 Insurance Requirements

Section III.J Insurance Requirements

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

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.

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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."	

3. 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.

4. 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.

4.6 Antitrust

Section III.K Antitrust

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

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.

4.7 Conflict of Interest

Section III.L Conflict of Interest

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

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.

4.8 State Property

Section III.M State Property

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

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.

4.9 Site Rules and Regulations

Section III.N Site Rules and Regulations

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

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 onsite 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.

4.10 Advertising

Section III.O Advertising

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

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.

4.11 Disaster Recovery/Back Up Plan

Section III.Q Disaster Recovery/Back Up Plan

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

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.

4.12 Drug Policy

Section III.R Drug Policy

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

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.

4.13 Warranty

Section III.S Warranty

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

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.

Section 5 – Payment

Section IV. Payment

The following section reflects Comagine Health's compliance with RFP Section IV. Payment. We understand that by signing we are agreeing to be legally bound by all the accepted terms

5.1 Invoices

Section IV.C Invoices

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

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.

5.2 Inspection and Approval

Section IV.D Inspection and Approval

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

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.

5.3 Payment (Statutory)

Section IV. E Payment (Statutory)

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

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.

5.4 Right to Audit (First Paragraph is Statutory)

Section IV.H Right to Audit (First Paragraph is Statutory)

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

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.

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.

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Section 6 – Attachment 1 – Technical Approach Narrative

Attachment 1 – Technical Approach Narrative

The form for Attachment 1 – Technical Approach Narrative will start on the next page.

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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:

Regarding 42 CFR §438.358, Comagine Health is not a State agency, department, university, or other a State entity; nor is our subcontractor, MetaStar. Comagine Health and MetaStar are qualified as an External Quality Review Organization (EQRO) as designated by the Centers for Medicare & Medicaid Services (CMS) and defined in 42 CFR §438.354. In addition, both organizations are registered as a Quality Innovation Network-Quality Improvement Organization (QIN-QIO). Comagine Health and MetaStar are independent, non-stock 501(c)(3) corporations with no common ownership.

Comagine Health and MetaStar are independent from the State of Nebraska Department of Health and Human Services (DHHS), the Medicaid agency for the State of Nebraska, and from the MCOs, DBM, PIHPs, and PAHPs operating in the State and over which we will exert control or which exert control over us. Comagine Health and MetaStar attest to meeting all requirements to qualify as "independent" as specified in §438.354(c) and do not now, and will not in the future, review any MCO, PIHP, PAHP, or PCCM entity, or a competitor operating in Nebraska over which we exert control or which exerts control over us where control means having:

- Stock ownership.
- Stock options and convertible debentures.
- Voting trusts.

- Common management, including interlocking management.
- Contractual relationships.

We further attest that Comagine Health and MetaStar do not now, and will not in the future do the following:

- Deliver healthcare services to Medicaid beneficiaries in Nebraska.
- Conduct, on the State's behalf, ongoing Medicaid managed care program operations related to oversight of the quality of MCO entity services, except for the related EQR activities specified in §438.358.
- Review any MCO entity for which it is conducting or has conducted an accreditation review within the previous three years.
- Have a present, or known future, direct or indirect financial relationship with an MCO entity that it will review as an EQRO.

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:

Per CFRs §438.50 and §438.52, EQROs can use information obtained from a Medicare review or a private accreditation review to provide information otherwise obtained from the mandatory activities. The RFP indicates for all three

MCOs and the DBM, the NCQA is the accrediting authority. When appropriate and following CFR §438.360, Comagine Health and MetaStar will use reports, findings, and other information from the NCQA accreditation reviews when completing the EQR activities.

Comagine Health is well versed in ensuring our activities are non-duplicative when reviewing PMV. For example, when we perform measure validation for the state of Washington, we closely track the steps and tasks in the process that have been audited and/or have been included in the accreditation review. By carefully mapping the process and flow, our team can determine which pieces still need review and detailed inspection. The goal is to ensure the work has been completely validated and reliable for public reporting.

MetaStar also has experience ensuring the non-duplication of mandatory review activities specific to compliance with standards through its current work with the Wisconsin Department of Health Services (DHS). An example of this is MetaStar's creation of a deeming crosswalk that was submitted to CMS. Health plans that are accredited by the NCQA do not require a full compliance with standards review in the state as many of the requirements are evaluated during accreditation reviews. The crosswalk demonstrates how the state can assure that organizations which provide managed

care meet the requirements identified in 42 CFR Part 438 through the NCQA standards and MCO certification application.

The development of the crosswalk began with comparing the following requirements and identifying areas that require evaluation:

- CFR.
- NCQA Accreditation Standards.
- DHS-MCO Contract.
- DHS-MCO Certification Application.

Following the documentation of the requirements, the review team identified gaps in the NCQA accreditation standards. MetaStar supported DHS with review of the current certification application, identifying areas that could be revised to support evidence of compliance where current gaps existed between the NQCA standards and the CFRs. Historically, MetaStar has developed and completed gap reviews to ensure the requirements not included in the NCQA requirements or certification submission were evaluated. The process included a review of policies, procedures, and other written guidance submitted by the MCO to MetaStar. Short discussions were held with the MCO staff to clarify questions which arose as a result of the document review. Results were scored and submitted to the MCOs and DHS.

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:

Decades of experience working with federal EQR protocols and with diverse Medicaid programs has given our staff wide-ranging expertise in Medicaid operations and regulatory requirements. Our EQR approaches are grounded in thorough understanding of protocols and extensive review of state requirements, including managed care contracts and subsequent directions from the Medicaid agency and state laws. We use that information to guide the development of our review tools and criteria, in consultation with the Medicaid agency and the organizations. Our review tools cite the guidance we use to determine compliance with the review elements and include:

- data to be reviewed,
- sources of the data,
- activities and steps to be followed in collecting the data to promote its accuracy, validity, and reliability,

- method(s) for analyzing and interpreting data, and
- instructions, guidelines, worksheets, and other documents or tools necessary for implementing the protocol.

The EQR team has documented methodologies that are easily modifiable to reflect the latest CFR protocols and Nebraska MCO/DBM contracts. Along with the methodologies, the MCOs/DBM will be provided instructions, worksheets, and other documents detailing the requirements of the specific protocols involved in the current review period. These documents guide not only the team through the evaluation process but allow the MCOs/DBM the ability to know how gathered and submitted data will be analyzed and interpreted.

With the release of the revised protocols for EQR in March 2020, the team updated our evaluation methods (further details given in V.C.2). Our updates align with the recommended order and format identified in the protocol. It includes the CFR requirements and will include any supplemental details from relevant MCO and DBM contracts, including the citations for the CFR, contract, and applicable state requirements. The requirements are incorporated into the review tool utilized by the team to support a consistent process of evaluation for each requirement.

A database will be developed to maintain the documents submitted by the organization as well as to store reviewer notes capturing the findings of the document review and interviews as well as scoring for each requirement. Customizing reporting will be created to pull results to incorporate into narrative report.

To assure consistency among reviewers and determinations of compliance, the team will develop reviewer guidance to ensure all reviewers evaluate with the same thresholds. Prior to the review cycle, the guidance will incorporate direction from 42 CFR Part 438 and the Nebraska contracts. Thresholds for compliance are identified and agreement will be secured from DHHS prior to the reviews beginning.

In preparation for the interviews with organization staff, the team will request documentation from the organization including policies, procedures, data regarding quality improvement initiatives which demonstrate compliance with the requirements identified in 42 CFR §438 and the MCO and DBM contracts.

A standardized document request form and submission process will be shared with the organization. Upon receipt of the requested documents, the review team will review the documents, identifying missing items, and request additional submission from the organization. At this time, preliminary scoring will occur comparing the documents to the requirements identifying gaps to address during the interviews with organizational staff. The organization specific questions are combined with standard questions as identified in the protocol to ensure the policies and procedures are

fully implemented and practices align as documented. Interviews are conducted by the review team with employees throughout the organization.

Upon completion of the interviews, the review team includes information gathered during the interviews in the database to support the determination of the compliance or non-compliance with each requirement.

Throughout the review process, both CFR protocols and contractual requirements are considered and any issues or problems with the administration of the MCO/DBM contract will be reported to DHHS and corresponding corrective action plans proposed and included within the individual MCO and DBM report as well as the Annual Report.
The EQR team will provide frequent follow-up in the form of weekly meetings or conference calls, as well as daily interactions by phone and/or email, if necessary, to ensure that DHHS's expectations are met. We welcome regular conversations to maintain a smooth communication channel and collaborate to resolve issues or barriers to achieving successful outcomes.

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:

Comagine Health and MetaStar's approach to conducting EQR activities are grounded in a thorough understanding of protocols and extensive review of state requirements, including managed care contracts and subsequent directions from the Medicaid agency, state laws, and any relevant information. Both organizations have deep experience in conducting the mandatory activities related to external quality review including such as those listed below:

- Validation of PIPs required in accordance with §438.330(b)(1) that were underway during the preceding 12 months.
- Validation of MCO, PIHP, or PAHP performance measures required in accordance with §438.330(b)(2) or MCO, PIHP, or PAHP performance measures calculated by the State during the preceding 12 months.
- A review, conducted within the previous 3-year period, to determine the MCO's, PIHP's, or PAHP's compliance with the standards set forth in subpart D of this part and the quality assessment and performance improvement requirements described in §438.330.
- Validation of MCO, PIHP, or PAHP network adequacy during the preceding 12 months to comply with requirements set forth in §438.68 and, if the State enrolls Indians in the MCO, PIHP, or PAHP, §438.14(b)(1).

The Comagine Health and MetaStar's team approach to the scope of work involves a specific division of tasks between the two organizations that is designed to take advantage of the organizational strengths and experience of each EQRO partner, such as MetaStar's long history of conducting annual EQR compliance reviews and Comagine Health's extensive experience with validation of performance measures, PIPs, and network adequacy. While our EQR

approaches and tools are founded on industry standard best practices, we tailor our services to meet each Medicaid program's specific goals. We have deep experience in adapting our processes and tools to clients' changing needs, enabling us to negotiate customized approaches to deliver the best results cost-efficiently.

The EQR team will replicate the successful current processes utilized for planning and conducting mandatory review activities of the three MCOs and one DBM on behalf of DHHS. The team will collaborate with DHHS to confirm the timing and scope of the reviews and commit to conducting the onsite review of each MCO and DBM in the second calendar quarter of each year. Once the details of the review are finalized, the designated project managers will create a tentative schedule of reviews before reaching out to the MCOs and DBM to confirm the review dates. The final review schedule will be shared with DHHS should staff wish to participate in the role of an observer during the interviews with the organizations.

No later than two weeks after the contract start date, the assigned project manager will create and submit to DHHS a detailed work plan, including all deliverables, tasks and subtasks, and activities including milestones and timeline. In an effort to ensure consistency and standardization when conducting review activities, the team creates, reviews, and updates internal documentation and tools as needed to support this review activity which include:

- Standard operating procedures (SOPs)
- Process maps
- Internal reviewer guidance (including thresholds for compliance)
- Document request lists
- Report template (includes reviewer guidance for writing to ensure consistency)

For the compliance reviews, MetaStar's internal review team and Information Technology (IT) department develop and test databases to store review information. The databases are standardized data collection systems which store the following information:

- Requirements (standards under review)
- Documentation of findings from organizational document review
- Customized discussion questions (organization specific)
- Rating of compliance by standard
- Rationale for compliance/non-compliance
- Recommendations for the organization
- Documentation from interviews with the organization

The EQR review team will schedule a planning call with the MCOs and DBM to walk through the specifics of the review including:

- Overall review expectations
- Deliverable dates
- Onsite review dates, if applicable
- Interview dates
- Data and information submission requirements
- Reporting
- Questions regarding the review process

MetaStar staff will finalize interview questions in advance of the discussion. MetaStar uses a team approach for interview sessions in order to effectively facilitate interviews and document responses. Our review team is assigned a primary facilitator and note taker for each session. Additional review staff serve as back-up notetakers. All members of the team support the facilitator by asking follow-up questions as needed. MetaStar staff identify the purpose for the discussion on a standardized agenda and encourage all participants to provide input into the discussion. Discussion tools are tailored for the organization and the type of personnel being interviewed.

Interviews are conducted over one-to-three days depending on the scope of the review, number of requirements being reviewed, and the number of onsite discussions needed. MetaStar uses an appreciative inquiry approach to gather information before and during the onsite visits. It focuses on strengths and supports immediate identification of potential recommendations when full compliance is not achieved

The onsite review of each MCO and DBM will occur in the second calendar quarter of each year. A schedule for documentation requests will be established and provided to the MCOs and DBM. With the current COVID-19 pandemic in process, Comagine Health realizes that situations may change. The team is also prepared to conduct remote reviews if preferred by DHHS at a future time. Historically in MetaStar's work with Wisconsin, interviews had been conducted onsite at the location of the MCO's main office. As MCOs expanded service areas to cover much of the state of Wisconsin, an identified burden was having MCO staff travel to interview, often spending more time on the road than in the session. To increase efficiency, MetaStar has chosen to hold interviews utilizing Zoom or another video platform. This method reduces the time spent traveling, the burden on the MCO needing to allocate space for the review team and will provide for social distancing. MetaStar has been conducting reviews through this method over the past several years which has enabled the review team to become comfortable using this method of communication.

A draft of the reports will be provided to DHHS within 90 days of the onsite review, in electronic format and will deliver a final report to DHHS within 30 days of the draft report delivery. All annual EQR reports will be provided to DHHS annually by October 15th.

We welcome regular conversations to maintain a smooth communication channel, to discuss current and future work, and collaborate to resolve issues or barriers to achieving successful outcomes. The EQR team will provide regular updates to DHHS throughout the compliance review process via weekly or monthly meetings and a monthly written report. The team will be available via phone and email to ensure that DHHS expectations are met.

For an example of the MetaStar Annual Quality Review Report, please refer to Appendix C.

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:

Validation of State Approved PIPs

The Comagine Health EQR Team, including an Analytics member, evaluates PIP design and implementation based on documents the MCOs and DBM provide and information received through interviews with the respective staff using the 9-step process outlined in "EQR Protocol 1 - Validating Performance Improvement Projects" developed by CMS.

Prior to the PIP evaluation process, Comagine Health's EQR leaders will meet with DHHS to discuss any specifications for the PIPs that may be outlined in the MCO and DBM contracts or the Medicaid waiver special terms and conditions, or any corrective action plans issued to the MCOs and DBM in past reviews. At this time, our EQR reviewers also submit the team's scoring tool for State approval.

The Comagine Health EQR Team hosts an overview/kickoff meeting at the beginning of the EQR cycle where EQR reviewers are available to answer the MCOs' and DBM's questions and discuss audit details, timelines, and expectations. During the first cycle, the PIP reviewers will review ongoing PIPs, along with any previous recommendations from the previous year and assist with identifying new PIP topics, when appropriate. In addition to the required quarterly calls with the MCOs and DBM, the reviewers will be available throughout the cycle to assist with any questions and provide guidance which allows for a stream-lined discussion and current status of the PIPs under evaluation to the organization during the onsite portion. (See Section V.D.3 for additional information.)

Scoring

To facilitate scoring, the Comagine Health Team provides each MCO and DBM with a PIP methodology form containing the questions used to assess the components in each step of the evaluation process.

The MCOs and DBM will receive a form on which they can describe their PIPs. During the desktop audit and onsite review, the PIPs will be reviewed according to the protocols stated above. The EQR Team assigns a score of "Met," "Partially Met," or "Not Met" to each of the nine evaluation components applicable to the PIP being evaluated. Components may be "Not Applicable" if the PIP is at an early stage of implementation. Components determined to be "Not Applicable" are not reviewed and are not included in the final scoring. Scoring is based on the answers to the questions listed under each evaluation component as determined by EQR reviewers, following a review of written documentation and staff interviews. The scoring key for the PIP standards follows:

- Fully Met (pass)
- Partially Met (pass)
- Not Met (fail)
- N/A (not applicable)

The Comagine Health EQR Team assigns a final score to the PIP and makes an assessment to determine the validity and reliability of the reported results for projects that progressed to at least a first re-measurement of the study indicator. For PIPs that did not progress to at least a first re-measurement period, the assessment will conclude that "Not enough time has elapsed to assess meaningful change." Because determining potential issues with the validity and reliability of the study design is sometimes a judgment call, we report one of the following levels of confidence in the study findings based on a global assessment of study design, development, and implementation:

- High confidence in reported results - The study results are based on high-quality study design and data collection and analysis procedures. The study results are clearly valid and reliable.
- Moderate confidence in reported results - The study design and data collection and analysis procedures are not of sufficient quality to warrant a higher level of confidence. Study weaknesses (e.g., threats to internal or external validity, barriers to implementation, questionable study methodology) are identified that may impact the validity and reliability of reported results.
- Low confidence in reported results - The study design and/or data collection and analysis procedures are unlikely to result in valid and reliable study results.
- No confidence - The study design and/or data collection and analysis procedures did not result in valid and reliable study results. (i.e., study design did not include key outcomes, data collection will not reliably monitor results).
- Not enough time has elapsed to assess meaningful change - A PIP has not progressed to at least the first re-measurement of the study indicator.

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:

Comagine Health's EQR team has over 15 years of experience with PMV and exceed RFP requirements by routinely conducting additional comparative analyses of performance measurement data. This approach is buoyed by our skill and experience in calculating performance measures and reviewing results and outcomes in a comparative analysis. (For example, through our current Washington State EQRO contract, the HEDIS® measure validation and reporting we provide includes the full Medicaid HEDIS® measure set for children and adults, and focuses on state priority measures including those related to diabetes, maternal and child health, antidepressant medication management, and medication management for people with asthma.) We also validate outcomes of performance measures to review for completeness and correctness as well as compare results of subgroups (including individual MCOs) against each other, over time, and against national benchmarks. We have identified areas where data reporting from certain MCOs seemed to be invalid and quickly elevated the concern to the state. Once the validation is complete, we work with the state to fully understand the meaning of the performance measure results and how they may be used to achieve meaningful quality improvement, such as to identify and address specific disparities and gaps.

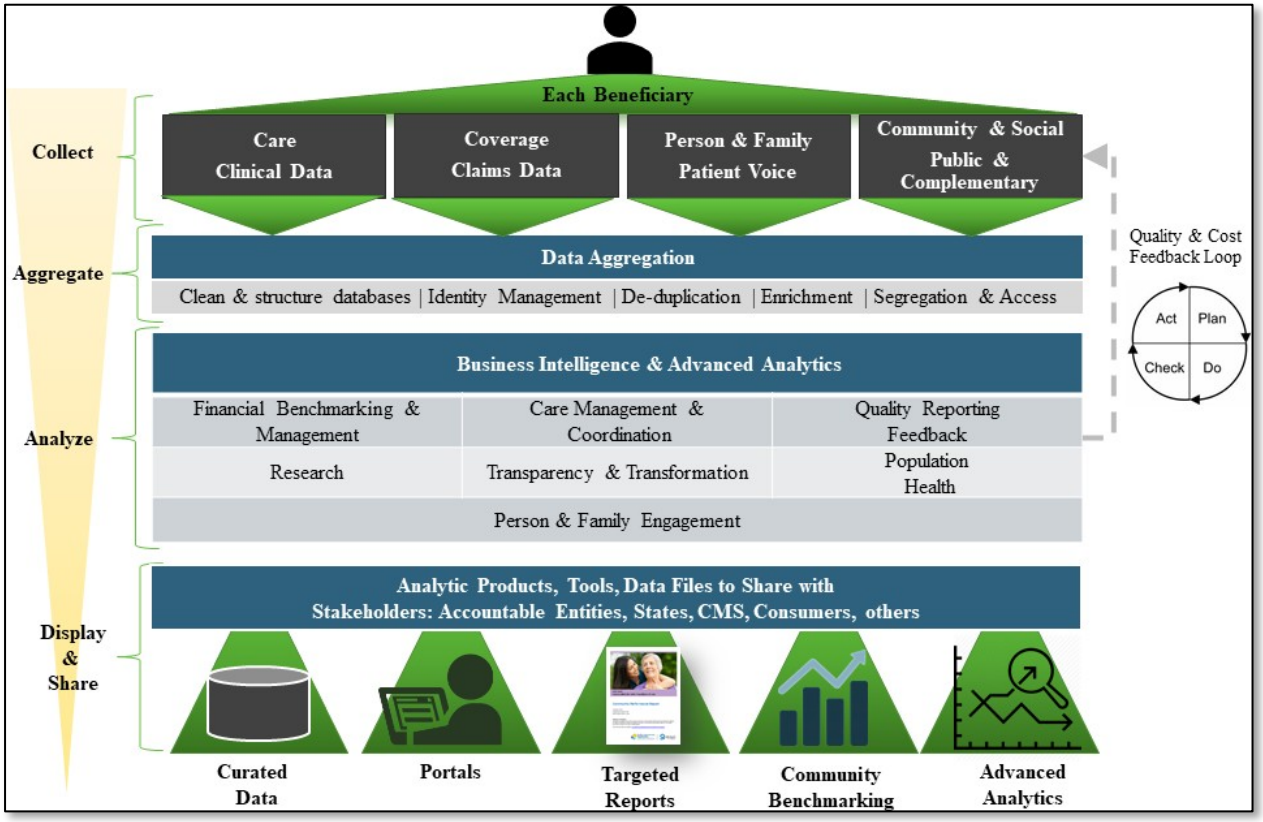
Strong data analytics are at the foundation of Comagine Health, and this foundation guides our approach to PMV. We actively seek out opportunities to help guide and teach stakeholders on how to use and interpret data and analytics. We regularly participate in deep dive data meetings with state agencies (as requested by the state) to share findings. In these sessions, we use interactive Tableau workbooks to visualize data and results and to explore questions from the group. For example, a Disparity workgroup in the state of Washington asked us to examine medication management among Spanish-speaking women enrollees. We then led a detailed discussion on the findings. Using, our interactive dashboards the workgroup was able to explore new questions and examine the population further. Across our portfolio of contracts and programs, Comagine Health's deep bench of analysts is highly experienced in effectively collecting and analyzing a wide range of data sources, ultimately helping state agencies find valuable insights in their data.

Performance measure data must be properly analyzed and effectively shared to be valuable. Our Comagine Health analytics team is ready and experienced in analyzing and sharing data and results in a way that best suits the customer. For example, we frequently produce detailed reports for complex and targeted qualitative and quantitative data analysis, as well as curate data files and tables for direct data transfers. We can mass produce uniform and routine user-friendly reports for hundreds of recipients using our data model, or release data through our interactive data portal enabling a client to explore the data as needed. We use data to inform and motivate by including context in our reports, such as

national benchmarking, to enable clients to clearly see areas for improvement. Our teams have also produced peer-reviewed manuscripts to disseminate findings and methodology related to our quality improvement and research work.

Our approach to PMV is informed by our strong internal data structures and systems. Comagine Health has built a robust data pipeline that pulls and processes data quickly and is flexible enough to handle numerous data streams.

Figure 1 - Comagine Health's Use of Data to Inform and Motivate



Before we share any data, it must pass a series of quality gates to ensure the high degree of accuracy. Data is validated by comparing counts, rates, and outcomes against peers and previous data submissions. We then overlay results with confidence intervals to signify statistical difference, noting relevant benchmarks. Our audiences for data

reports and analyses include outpatient clinicians, inpatient facilities, and community partners. Outpatient clinicians look for trends and peer comparisons in the ambulatory setting for metrics such as opioid prescribing patterns, wellness visits, transitional and chronic care management services, and post-acute encounters. Inpatient facilities may find interest in hospital readmission patterns, admissions for ambulatory-sensitive conditions, hospital acquired infection rates, and ER usage by vulnerable populations. Community partner users can see regional trends in screening rates or preventive care visits to understand access barriers, with results segmented by vulnerable populations.

For EQRO contracts, elements of our overall robust analytic and reporting structure described above are targeted to synthesize data and information derived from PIP findings, CAHPS® results, HEDIS® data, and other sources to build comprehensive reports that clearly present observed findings, trends, and outcomes combined with recommendations for targeted action and improvement. Our EQRO team boasts a powerful combination of analytics and editorial expertise, clinical leadership, and program knowledge experts assures the content of our reports is accurate and targeted to be useful to program leadership, staff, and other readers.

Analyzing Equity

Our team regularly compares results of MCO and any relevant demographic subgroups against performance from previous years and against each other to find any issues in reporting. This detailed analysis has been completed under other contracts using data provided by the state, ensuring that reported results are correct and enable numerous drill downs and statistical tests of performance by MCO, program, and demographics. The goal is to identify areas of statistically significant variations and understand the drivers of outcomes. The Comagine Health team builds both interactive dashboards and statistical reports for distribution. Our approach is to show data visualizations with relevant marks like confidence intervals and benchmarks alongside descriptions and discussions on what to take away from each finding.

Upon beginning any clinical outcome analysis, we gather relevant demographic indicators such as matching the patient's ZIP code to the US Census Economic survey to clearly show how patients' neighborhoods differ. Comagine Health tests the significance of these indicators against outcomes. For example, when reviewing the outcome of a readmission within 30 days, we conduct a simple univariate regression to check if the readmission rates for patients of varying race differs significantly. This method is replicated for all socio-demographic data. When displaying this information to community partners, we display any rates with confidence intervals to enable a reader to clearly see if differences are significant. To further enhance a better understanding of the patients' circumstances, we employ county attributes from Behavioral Risk Factor Surveillance Surveys (BRFSS), Area Deprivation Index, Social Vulnerability Index, and Medical Shortage Area data. Ultimately, the goal is to create a full picture of a patient and to clearly articulate

potential barriers to care or health inequities. By examining patients of similar complexity but varying social demographic circumstances we can better understand where to target efforts and how to effectively intervene.

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:

As part of our overall EQR team strategy, MetaStar will be conducting the reviews to determine the MCOs' and DBM's compliance with the standards set forth in 42 CFR Part 438, subpart D. MetaStar has standard processes for conducting compliance reviews based on the requirements and review schedule set forth in 42 CFR Part 438 and the needs of DHHS. The MetaStar review team will utilize a review of all requirements once every three years. Follow-up to ensure remediation of requirements not fully met will be conducted during the next full review. During the first year of the cycle, the team will also review the prior year MCO, DBM, and annual technical reports with a close focus on the recommendations and/or corrective action plans.

MetaStar utilizes a collaborative approach with organizational personnel to gather documentation that demonstrates compliance with requirements prior to the onsite review. Approximately six weeks prior to the interviews, a document request list will be sent to the organization identifying each specific requirement as well as examples of documents. The request includes documentation that demonstrates compliance for each requirement for the look-back period as identified. Submission of documents will be required three weeks prior to the interviews. Upon receipt and review of the documentation, the review team will document findings in the database, noting areas of follow up and identifying onsite discussion questions. In instances when documentation is lacking or identified by the organization but not submitted, MetaStar will make an additional document request prior to the discussion.

Additionally, MetaStar conducts verification activities that support the determination of compliance in specific areas of Subpart D including:

- Grievance and appeals systems
- Provider selection (provider file/credentialing review).
- Coordination and Continuity of care/Care management (record review).

The verification items are completed prior to the onsite review, which allows clarification or questions to be discussed during the interviews.

For additional information of the onsite review process, please see V.D.2.a

MetaStar staff will finalize interview questions in advance of the discussion. MetaStar uses a team approach for interview sessions in order to effectively facilitate interviews and document responses. The review team is assigned a primary facilitator and note taker for each session with additional review staff serving as back-up notetakers. All members of the team support the facilitator by asking follow-up questions as needed. MetaStar staff identify the purpose for the discussion on a standardized agenda and encourage all participants to provide input into the discussion. Discussion tools are tailored for the organization and the type of personnel being interviewed.

Interviews are conducted over one-to-three days depending on the scope of the review, number of requirements being reviewed, and the number of onsite discussions needed. MetaStar uses an appreciative inquiry approach to gather information before and during the onsite visits. It focuses on strengths and supports immediate identification of potential recommendations when full compliance is not achieved.

Following the completion of the interviews and any final document submissions, the review team will score the standards utilizing a three-point scale with a recommended scoring approach from the CMS EQR Protocols. Results will be documented in the MetaStar compliance with standards database. The team will work collaboratively to write a draft report which will go through a standardized editing process, prior to sending to DHHS. A draft review report will be delivered to DHHS within 90 days of the onsite review, in electronic format and a final report within 30 days of the draft report delivery, in electronic form.

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:
Comagine Health will partner with DHHS to outline the process and validate the network adequacy of the MCOs/DBM, including the applicable portion of the "Quality Strategy for Heritage Health and the Dental Benefit Program for MCOs and DBPMs" for the previous year. Comagine Health will utilize existing contract and regulatory requirements (42 CFR §438.68) to outline, request, review, and validate access standards. Comagine Health will partner with DHHS to develop evaluation criteria and provide training for the MCOs and DBM regarding the requirements, timeframes, and documentation necessary for submission.

Comagine Health is prepared to assess and validate each MCO or DBM to determine that they have a provider network adequate to ensure effective and efficient delivery of care. The provider network will be assessed for sufficiency in number, mix, and geographic distribution to meet the needs of the number or anticipated number of beneficiaries in the service area. Among multiple requirements, this assessment will include reviewing the number and types of providers within each provider network as well as the proximity of the beneficiaries to the providers, which includes reviewing urban, rural and frontier areas, and whether the proposed provider network meets time and distance standards for member access to healthcare providers including specialty providers.

With the goal of validation of network adequacy being to ensure that each MCO/DBM contracts with a network of providers sufficient in size and specialized services to meet the medical necessity needs of their Medicaid enrollees, Comagine Health recommends the following general processes be used to implement network adequacy validation:

- Develop an annual validation plan that includes reporting requirements, rationale for selecting validation methods, and specifications for calculating network adequacy. The plan will include, at a minimum:
  - Population and measure definitions (numerator, denominator, and exclusions),
  - Data collection and sources (primary and secondary) information, which may include member-level files, EDI 274 Healthcare Provider Information files, contract deliverables, Provider Capacity Report spreadsheets, geo-mapping, encounter data (utilization data), grievance and appeals information, secret shopper data, narrative responses and other information supplied by the MCO/DBMs and DHHS. The data will be used to determine the network capacity based on ratios of required provider types to member location, availability of all contracted services, and geographic distribution requirements (requirements for enrollees' proximity to provider types),
  - Sampling and data collection methodology,
  - Audit findings and recommendations for quality improvement (QI),
  - Data completeness assessment, and
  - Reporting bias assessment identifying outliers to prevent skewing or bias of provider-to-enrollee ratio, time/distance results, or grievance/utilization data.
- Develop network validation tools and resources to assesses the provider network for sufficiency in number, mix, and geographic distribution to meet the needs of the number of anticipated enrollees in the service area.
- Collaborate with DHHS to identify the appropriate provider specialty types to include in the network adequacy analysis.
- Create a data requirements and submission manual to guide the MCO/DBMs on the specific data Comagine Health will need for the analysis (e.g., member demographic information, provider information on specialty and practice location, process for data submission, etc.) and a data dictionary for categorizing provider specialties.
- Conduct the assessments reviewing the number and types of providers within the provider network as well as the

proximity of the beneficiaries to the providers, which includes reviewing urban, rural and frontier areas and whether the provider network meets time and distance standards set by the state for member access to healthcare providers including specialty providers.
- Validate network capacity and time/distance standards.
- Report on results as directed by DHHS.

Comagine Health's review tools and evaluation will address the access standards which are designed to ensure the networks ensure the following:
- Are of adequate size, meet geographic access requirements, and include sufficient numbers of primary care providers (PCPs), specialists, and other providers,
- Maintain adequate and timely coverage of services not available in network and require out-of-network providers coordinate with the MCO/DBM with respect to payment,
- Ensure services included in the contract are available seven days a week and 24 hours each day, and
- Safeguard enrollee privacy and ensure that it is protected when coordinating care.

Evaluation criteria will include:
- Detailed information related to requirements, specifically regarding delivery network adequacy and access to meet enrollee needs,
- Provide a standardized tool for measurement of the quality and completeness of narrative reports,
- Include Provider type, capacity, and geo-mapping criteria, and
- Include indicator categories and a pilot score to measure the MCOs' and DBM's response to each question within each indicator.

Scoring & Criteria/Requirements

For narrative responses, potential scores for each question within the indicator categories could range from 0 to 3, as follows:
- 0 = discussion not provided (Not Met)
- 1 = discussion minimally addresses topic (Partially Met)
- 2 = discussion addresses topic adequately (Substantially Met)
- 3 = discussion addresses topic comprehensively (Fully Met)

Reporting

Comagine Health will review and analyze the above information as well as the results of any secret shopper and additional validation techniques to assess and validate the MCO/DBMs' network adequacy. Additionally, if approved by

DHHS, the MCO/DBM's will be given an opportunity to review the draft report, meet with DHHS and Comagine Health, and provide additional information to support their documentation of network adequacy. Results for each MCO/DBM and DHHS report will include strengths, as well as recommendations for focus and improvement.

How the approach meets or exceeds the requirements of this RFP

To build commitment and understanding, Comagine Health will partner with DHHS and the MCOs and DBM for the following purposes:

- Design the evaluation tool, provide opportunities for the MCOs/DDBM to review a draft network adequacy report, and
- Provide opportunity for the MCOs/DBM to review a draft adequacy report, ask questions, and provide additional documentation to support an accurate picture of the adequacy of their network
- Provide technical assistance in the form of training and support.

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:

Technical Assistance

The Comagine Health and MetaStar Team is committed to providing technical guidance related to required EQR activities throughout its process, including reporting any problems in writing and proposing a correction action plan, as well as providing technical guidance in the development of PIPs. We will work with the state to understand the types of technical guidance that have been available historically, what's worked well, and what merits improvement from past experiences, bringing to bear lessons learned from the field. We are prepared to offer technical guidance in a wide array of formats, whether in one-on-one or group settings, in-person or remote, depending on the state's needs. In performing all EQR activities, we follow CMS protocols, sometimes modifying the protocols as negotiated with and approved by the state Medicaid agency to incorporate state-specific policies and procedures. Trainings can be provided through in-person or remote mechanisms such as webinars.

MetaStar is prepared to provide technical assistance about the requirements included in the compliance with standards review. The review team has experience providing technical assistance at either the individual organization level or to a larger group. The topic that MetaStar has most recently provided technical assistance to both MCOs and DHS are the provider network standards including requirements related monitoring to ensure the MCO has a qualified network of providers.

Problem Identification and Corrective Action Planning

The Comagine Health and MetaStar teams have significant experience with issue identification and corrective action planning. Our team is prepared to utilize our experience, when needed, to report in writing any problems with the MCO or the DBM contracts to DHHS and will propose a corrective action plan for any problems directly related to the performance of this contract.

When an issue is recognized, we will inform the MCO or DBM and the State. A preliminary review will consist of identifying where the organization was meeting state, contractual, and federal guidelines, and what the organization needed to do to implement needed policies, programs, trainings, and provider monitoring tools to comply with the CFRs and state administrative rules. We will work with the organization to develop a comprehensive corrective action plan that may include one-on-one trainings with the organization trainings on how to correct the issue. These trainings may include education on EQR work activities, applicable Code of Federal Regulations (CFRs), and CMS protocols

The Comagine Health Team is also able to provide technical assistance to help resolve deficiencies in the areas of program integrity and fraud, waste, and abuse. For example, our reviewers discovered that many managed care plans in one of our EQR states were unaware of the need or the methodology for performing organization-wide risk assessments to identify real or potential quality and integrity risks. The Comagine Health Team developed training and tools to assist the plans in the development of their own policies and procedures, as well as evaluation and monitoring tools for conducting risks assessments, identifying and prioritizing potential and real risks, and implementing interventions to mitigate the risks.

Performance Improvement Projects (PIPs)

Comagine Health has provided technical assistance to MCOs, as well as state agencies, in the development of PIPs. The EQR team have experience in providing specialized training to help health plan staff ensure that their PIPs produce meaningful improvements in clinical outcomes and service. Our training sessions address understanding the purpose of PIPs, defining study indicators and population, creating a plan for data collection and analysis, documenting interventions, interpreting and discussing results, and developing or modifying interventions to sustain quality improvement.

The EQR Team examines the proposed PIPs and offers insight to ensure they accomplish the following:

- Designed to achieve, through ongoing measurements and intervention, significant improvement sustained over time that is expected to have a favorable effect on health outcomes and enrollee satisfaction.
- Meet state and federal guidelines.

- Designed, conducted, and reported in a methodologically sound manner.

As part of the PIP development process, the EQR Team will work closely with the MCO/DBM with technical assistance, including video conference or phone calls in developing and preparation of the submission of the PIP to the EQRO.

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:

Annually by the deadline of October 15th, Comagine Health will produce an annual technical report that complies with CMS EQR protocols and 42 CFR §438.364 and describes how data from all activities conducted in accordance with §438.358 were collected, aggregated, and analyzed. Comagine Health and MetaStar have many years' experience in writing EQR technical reports for plans and state clients and working closely with our state clients to develop content that meets the changing information needs of all stakeholders. Comagine Health and MetaStar will collaborate on the individual MCO and DBM reports as well as the annual technical report. MetaStar will provide the compliance review and Comagine Health will integrate their findings into the overall report.

Prior to writing and compiling the report, the EQR team will create a template ensuring all requirements are captured in the report. The template includes guidance, suggestions, and examples of what should be included for each section to ensure all areas are covered. The template will be reviewed with DHHS to ensure that the report design and layout will meet their expectations.

The reporting effort will be led by our Senior Communications Strategist who has vast experience in writing EQR technical reports. The strategist will be responsible for leading the development of all EQR technical reports and ensuring they include EQRO-contracted findings and all EQR activities. As required by the CMS EQR protocols, the annual report will include an assessment of each MCO's and DBM's strengths and weaknesses with respect to the quality, timeliness, and access to healthcare services furnished to recipients; recommendations for improving the quality of healthcare services furnished by each MCO and DBM; methodologically appropriate, comparative information about all MCOs and DBM; an assessment of the degree to which each MCO and DBM has effectively addressed the recommendations for quality improvement during the previous year's EQR; and an assessment of the quality of data collected and recommendations regarding improving data collection and usability to improve performance improvement for the State, MCOs, and DBM.

An executive summary will be included at the beginning of the Annual Technical Report to provide readers with ready access to strengths and recommendations, and an introduction that will provide an overview of the State's healthcare landscape as context for the report. Additionally, we include MCO and DBM profiles in the report Appendix, summarizing the results of all monitoring activity in easily accessible form. Our approach to organizing the report is to present one chapter for each EQR activity.

Each chapter will include an introduction detailing the objectives of the EQR activity and associated methodology, how we gathered, validated, and analyzed the data for the assessment (e.g., review of documentation, desktop audits, onsite MCO interviews, onsite provider interviews, phone interviews), the type of data and documentation we received (e.g., policies and procedures, program descriptions, survey results, monitoring tools, monitoring results, protocols, workflow documentation), and conclusions drawn from the data.

In scoring and presenting the results of EQR monitoring activities, we use the categorical scoring of "Met" (pass), "Partially Met" (pass), or "Not Met" (fail) for the evaluation components. Categorical scores allow both the state and the MCOs or DBM to clearly understand what assessment components passed the review and what components require a corrective action plan. For each report section, we will note strengths and weaknesses for the quality, timeliness, and access to healthcare services furnished to Medicaid beneficiaries, both generally observed and specific to the individual MCO or DBM, as well as improvement opportunities and recommendations requiring a corrective action plan. The reports will also follow up on any corrective action plans issued during the previous year's EQR.

Our goal is to produce reports that are readable, understandable, and usable. We provide results in ways that maximize reader comprehension using editorial tactics such as:

- Presenting strengths and weaknesses in bulleted form organized by timeliness, access, and quality,
- Highlighting recommendations requiring corrective action plans, and
- Showing year-to-year comparisons in table format.

Each section of the annual technical report undergoes repeated peer-review among the EQR program staff, analytics staff, and leadership teams, as well as a tiered editing process designed to ensure our writing is clear, concise, and straightforward. Once we produce a draft of the report, we submit this version to the state for feedback and comment. This process ensures we produce easy-to-read, informative reports with actionable recommendations for the MCOs, DBM, and state.

A draft of the MCO and DBM reports will be provided to DHHS within 90 days of the onsite review, in electronic format and will deliver a final report to DHHS within 30 days of the draft report delivery. All annual EQR reports will be provided to DHHS annually, by October 15th.

For an example of the 2019 EQR Annual Technical Report, please refer to Appendix F.

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:

As part of our EQR collaboration, MetaStar will be performing annual assessments of each MCO and the DBM. When conducting compliance reviews on behalf of DHHS, MetaStar will identify strengths and weaknesses based on evidence submitted by the organization to demonstrate quality services for their members. This will include an evaluation of the organization's quality management program and data from internal monitoring and improvement efforts. Additionally, interviews with staff members from the organization will support determination of timeliness and access to services for members.

MetaStar has identified definitions for both strengths and promising practices to support the team with a consistent approach to identification of both for organizations.

MetaStar has delineated a standardized definition of a strength utilized by the review team to ensure consistency when identifying a strength. The definition for a strength is: organizational capabilities beyond basic compliance (e.g., human competencies, process capabilities, technological factors, quality of service, and member-centeredness).

MetaStar has also delineated promising practices based on the following definition. A promising practice is an innovative product, practice, activity, or approach within an organization that improves upon existing practice and has the potential to positively impact the quality of program operations. The practice must be working successfully and demonstrating the intended outcome within the organization and have the potential for replication in other organizations.

All requirements not fully met during the compliance with standards review are identified as opportunities for improvement or weaknesses.

Further details of the review process are outlined in section V.D.2.d.

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:

The EQR team will provide DHHS with recommendations for improving the quality of healthcare services furnished by each MCO or DBM including how the State can target goals and objectives in the quality strategy on a quarterly basis or more frequently as identified. The process for determining recommendations is firmly grounded in the goals of the "Quality Strategy for Heritage Health and the Dental Benefit Program 2020" and driven by data. For the MCO, DBM, and annual technical report, our EQRO team will assemble analytic findings from the comparative analysis and regional quality report, HEDIS®/PMV results, and relevant data sources.

Our program manager will facilitate an iterative review process with an interdisciplinary team that comprises experts from the analytics team, our clinical leaders, quality improvement advisors, our Medicaid EQRO program leadership, and senior program communications staff to review the observed findings associated within each protocol area to formulate recommendations. As part of that process, the recommendations from each protocol area are compiled and reviewed to develop overarching recommendations to the state. In developing those recommendations, the team considers factors such as the scale and impact (i.e., size of population impacted), comparison of Nebraska's performance to national benchmarks, and the seriousness of the observed findings vis-à-vis quality, access, and timeliness.

Support for the Quality Strategy including identification of access quality and timeliness for each MCO and DBM will include:

- Identification of quality measures and performance outcomes each year.
- Identifying, supporting, and conducting PIPs. These projects will include supporting and suggesting any interventions to improve access, quality, or timeliness of care for members.
- Conducting annual compliance reviews and report on the quality outcomes, timeliness of, and access to services covered in the contract with DHHS.
- Reviewing the MCO and DBM transition of care policies for compliance and outcomes, as appropriate, to ensure access, quality, and timeliness.
- As directed by DHHS, review of MCOs' and DBM's compliance with identifying, evaluating, and reducing health disparities based on age, race, ethnicity, sex, primary language, and disability status.

To ensure quality improvement recommendations are aligned with the State's quality strategy and healthcare transformation efforts, our EQRO team will ensure that we thoroughly understand the historical context of and current healthcare landscape in Nebraska. As appropriate, the recommendations will identify potential opportunities to leverage transformation efforts and initiatives that the State is currently undergoing. Additionally, the team will research evidence-based practices and nationally recognized innovative approaches to include in the recommendations to address identified gaps in quality, timeliness, and access to care.

Our EQRO team will also utilize a health equity lens during the recommendation process. We will analyze the data by desired sub-populations (e.g., primary language, ethnicity) to identify potential disparities in healthcare delivery and access and make recommendations accordingly.

Our EQRO team's approach exceeds the expectations of this RFP as we will work with DHHS, the MCOs, and DBM to address and suggest improvements regarding all requirements of the Quality Strategy.

Further details of the review process are outlined in section V.D.2.d.

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:

From our years of service as an EQRO, Comagine Health is experienced at preparing annual performance measure comparative analysis reports with plan-to-plan comparisons, plan-to-state averages, regional assessments and national benchmarks, and routinely performs comparative analyses using performance measurement data and annually produces an Enrollee Quality "Star Rating" Report, Comparative Analysis Report, and Regional Analysis Report. Comagine Health will coordinate closely with DHHS to assure that the performance measure comparative reports are useful for the State and other key stakeholders. Our goal for presenting results is to provide information to DHHS, MCOs, DBM, and stakeholders that will allow them to understand how member experience and health outcomes are related to patient population groups as defined by race, socioeconomic status, geographic location, and other determining factors. Results will be valuable in efforts to identify specific groups that may experience higher gaps in care and design or fine-tune improvement efforts.

Our reports will be tailored to the various target audiences, which requires a thorough understanding of internal and external audiences, the types of information and data to make available to each one, and their planned uses of this

data. We will collaborate with DHHS on the comparative analysis reports and our project plans and timelines will include multiple rounds of input from DHHS to assure that the reports we produce meet DHHS goals. We provide opportunities for DHHS to confirm reports structure, templates, and visual displays, and to provide for review and comment on draft reports prior to finalization.

Comagine Health will assemble a multidisciplinary team of experts representing multiple disciplines—data analytics, clinical expertise, editorial communications, visual display and design, and Medicaid program knowledge—to synthesize findings and recommendations for presentation to DHHS and other stakeholders. This as an ongoing process where data presentations are refined and re-developed as new results became available (e.g. trending) and as new information and stakeholder needs arise. As the State of Nebraska's healthcare environment evolves, Comagine Health will work with DHHS to refine data presentations and reports that best serve its needs.

Our team will compare results of MCOs and DBM and any relevant demographic subgroups against performance from previous years and against each other to find any issues in reporting. This detailed analysis is completed using the member-level data set provided by the state each year, ensuring that reported results are correct and enable numerous drill downs and statistical tests of performance by MCO/DBM, program, and demographics. The goal is to identify areas of statistically significant variations and understand the drivers of outcomes.

First the data is compared against the previous year to validate that the data received is accurate and reliable enough for analysis. Our method for collecting and processing data is to use Microsoft SQL Server to house our full data sets. This data is cleaned and prepped in SQL where we process the data so it can be analyzed running a series of statistical test to calculated statistically significant variation among sub-groups (e.g., plan, program, gender, etc.). We use SAS (a statistical software package) to analyze the data and deliver the output files (with flags and Key Performance Indicators (KPIs)) back to SQL for data visualization through Tableau (a data visualization software). Once the data is ready for data visualization, we check the data against previous run tests to be sure nothing is changed or lost. In Tableau, we build interactive dashboards and work with our internal communications staff to be sure the data presentation is clear and easy to understand. We use key visuals from our dashboards to build static reports with clear findings and recommendations. We also make interactive content available for real-time drill downs and quality improvement discussions with clients. Our approach is to show data visualizations with relevant marks such as confidence intervals and benchmarks alongside descriptions and discussions on what to take away from each finding.

The comparative report will provide estimates of the average performance among the three MCOs for the three most recent reporting years, when available. The state average for a given measure is calculated as the weighted average

among the MCOs that report the measure with the MCOs' shares of the total eligible population used as the weighting factors. In addition, the comparative reports will include comparisons to national benchmarks derived from the Quality Compass, published annually by NCQA, and are used with the permission of NCQA. These benchmarks represent performance of NCQA-accredited Medicaid plans and Medicaid plans that opt to publicly reported their HEDIS® rates. These plans also represent states with and without Medicaid expansion.

Plan performance rates must be interpreted carefully. HEDIS® measures are not risk adjusted. Risk adjustment is a method of using characteristics of a patient population to estimate the population's illness burden. Diagnoses, age, and gender are characteristics that are often used. Because HEDIS® measures are not risk adjusted, the variation between MCOs is partially due to factors that are out of a plan's control, such as enrollees' medical acuity, demographic characteristics, and other factors that may impact interaction with healthcare providers and systems.

Where data is available, the analysts will attempt to identify true statistical differences between populations. This is done through the comparison of 95% confidence interval ranges calculated using a Wilson Score Interval. In layman's terms, this indicates the reader can be 95% confident there is a real difference between two numbers, and that the differences are not just due to random chance. The calculation of confidence intervals is dependent on denominator sizes. Confidence interval ranges are narrow when there is a large denominator because we can be more confident in the result with a large sample. When there is a small sample, we are less confident in the result, and the confidence interval range will be much larger. The confidence interval is expressed as a range from the lower confidence interval value to the upper confidence interval value. A statistically significant improvement is identified if the current performance rate is above the upper confidence interval for the previous year.

For example, if a plan had a performance rate in the previous year of 286/432 (66.20%), the Wilson Score Interval would provide a 95% confidence interval of 61.62% (lower confidence interval value) to 70.50% (upper confidence interval value). The plan's current rate for the measure is then compared to the confidence interval to determine if there is a statistically significant change. If the plan is currently performing at a 72% rate, the new rate is above the upper confidence interval value and would represent a statistically significant improvement. However, if the plan is currently performing at a 63% rate, the new rate is within the confidence interval range and is statistically the same as the previous rate. If the current performance rate is 55%, the new rate is below the lower confidence interval value and would represent a statistically significant decrease in performance.

Some measures may have very large denominators (populations of sample sizes), making it more likely to detect significant differences even when the apparent difference between two numbers is very small. Conversely, many

HEDIS® measures are focused on a small segment of the patient population, which means there may be situations where it appears there are large differences between two numbers, but the confidence interval is too wide to be 95% confident that there is a true difference between two numbers. In such instances, we will look at patterns among associated measures to interpret overall performance.

For an example of the 2019 EQR Comparative and Regional Report, please refer to Appendix B.

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:

As described in V.D.2.e., During the first year of the contract, the team will review the prior year MCO, DBM, and annual technical reports with a close focus on the recommendations and/or corrective action plans.to initiate the Comagine Health EQR cycle.

For each of the MCOs and DBM that Comagine Health will review as the Nebraska EQRO, we will produce an organization-specific report which will include an assessment of the organization's strengths and weaknesses with respect to quality, timeliness, and access to care and services. Each organization-specific report will also provide recommendations to the DHHS for assigning Corrective Action Plans (CAPs), as well as include a section describing the organization's progress toward addressing CAPs assigned during the prior review year.

If an MCO and/or DBM receives an "unmet" or "partially met" finding on any review element, they are asked to submit a Corrective Action Plan. The MCO/DBM will need to implement their Corrective Action Plans in the year they receive the quality recommendations. During the EQR review in the subsequent year, the MCO/DBM submits documentation addressing actions taken. The EQR team will review the submitted documentation and will either accept the CAP as complete, still pending, or not acceptable. When CAPs are still pending, the EQR team will follow up on the action plan at a later designated date to ensure the completion of the plan. When the CAP is not acceptable, the review team will define why the action plan is not acceptable, suggest other actions that may be incorporated, and then require resubmission of the CAP. The process repeats until all recommendations have been resolved. The CAPs results are then included as part of the MCO's/DBM's specific report, provided to the DHHS and the MCO/DBM, after the formal review activities have been completed for the year.

This project solution will utilize MetaStar's database for holding the results of the compliance reviews, as well as customized reports, the review team has on-demand easy access to the results from the prior review. The prior results are reviewed as part of the review preparation in order to ensure the team evaluates progress for those requirements not fully met during the last review to ensure progress is evaluated.

Finally, we will include an executive summary at the beginning of the Annual Technical Report, to provide readers with ready access to strengths and recommendations, and an introduction that will provide an overview of the State's healthcare landscape as context for the report.

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:

Comagine Health is prepared to conduct ad hoc studies and/or reports, if requested by DHHS. The focus may be on QI, administrative, legislative, or other areas of interest. Focus studies may examine and report on clinical or nonclinical aspects of care provided by the MCOs and/or DBM. Comagine Health will follow a standard process to implementing an ad-hoc study and/or report. This process is modeled after CMS EQR Protocol 9 - Conducting Focus Studies of Healthcare Quality. Comagine Health will meet with DHHS to determine the focus of the study and/or report. We will develop a project plan and collaborate with DHHs on an agreed upon timeline. Comagine Health will provide regular updates on the study and/or report during monthly meetings with DHHS.

To ensure efficiency and achieve competitive hourly rates, Comagine Health will designate the most appropriate subject matter expert (SME) within the EQR team to lead the requested ad hoc study and/or report while engaging other team members throughout the development and execution process. The EQR team includes SMEs in data analytics, clinical quality improvement and practice transformation, and communications staff to ensure conciseness of the ad hoc studies and/or reports. Given our experience conducting ad hoc studies and reports for current EQR contracts, the team is proficient in identifying the appropriate staff who will be engaged at certain points in the study and/or report process. Additionally, as delineated in the project plan that will be collaboratively developed with DHHS, we will implement and adhere closely to internal milestones to ensure deliverable timelines are met.

Comagine Health utilizes several techniques to determine our hourly rates to ensure that the rates are competitive. When DHHS requests an ad hoc study and/or report, Human Resources regularly participates in, and collects salary data from, relevant local, regional and national labor market surveys. To the extent possible, surveys are selected that represent organizations within Comagine Health's industry and of a similar size (revenue and/or headcount) and in the

geographic locations where the company has offices. This analysis helps to ensure that salary grades remain competitive and reasonable within their relevant labor markets. Skills and experience detailed in position descriptions are used to support alignment with appropriate survey data. 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.

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:
The reporting effort will be led by our Senior Communications Strategist. The strategist will be responsible for leading the development of all EQR technical reports and ensuring they include EQRO-contracted findings and all EQR activities. The reports will be readable, actionable, understandable, and usable. We provide results in ways that maximize reader comprehension using editorial tactics such as presenting strengths and weaknesses in bulleted form organized by timeliness, access, and quality; highlighting recommendations requiring corrective action plans; and showing year-to-year comparisons in table format. Each section of the Annual Report undergoes repeated peer-review among the EQR program staff, analytics staff, and leadership teams, as well as a tiered editing process designed to ensure our writing is clear, concise, and straightforward.

On an annual basis the Comagine Health will work with DHHS to update the following:

- Distribution list of report recipients.
- Schedule for report distribution.
- Number of report copies.
- Media for reports.

Comagine Health will not share or deliver reports and any data utilized for reporting purposes to any other individual or entity without prior written approval of DHHS. The schedule, number of copies, and media for reports shall be specified by DHHS.

Comagine Health agrees to provide copies of the EQR reports through print or electronic media to interested parties, such as:

- Participating healthcare providers.
- Enrollees and potential enrollees of the MCO or DBM.
- Beneficiary advocacy groups.
- Members of the general public.

Comagine Health will follow PDF web usability guidelines as published by Adobe. As a CMS contractor, we agree to provide reports in alternative formats for persons with disabilities, when requested. Comagine Health currently does this for our other EQR clients.	
V.D.6.	Describe the Bidder's approach to meetings, and how the approach meets or exceeds the requirements of this section.

Bidder Response:

We welcome regular conversations to maintain a smooth communication channel, plan current and future work, and collaborate to resolve issues or barriers to achieving successful outcomes. Staff will provide frequent follow-up in the form of weekly meetings or conference calls, as well as daily interactions by telephone and email, to ensure that DHHS's expectations are met.

Comagine Health will conduct regular, monthly technical assistance meetings with DHHS staff in order to actively oversee and monitor the progress of EQR services. We will also participate in quarterly operational meetings with the MCOs and DBM. By default, meetings will be held remotely by using online conferencing tools, such as Zoom. If an email, phone call, or other form of communication will suffice in place of a remote or in-person meeting, that form of communication will be used instead.

Comagine Health strives to ensure meetings are productive and efficient. Meeting agendas will be distributed no more than five days before a meeting and will consist of - but are not limited to - the meeting date, times, location (if in-person), video/conference line (if remote), a list of attendees, facilitator's name, designated note taker, meeting topics, desired outcomes, and a notes section. Meeting agendas will also clearly highlight when a meeting requires the presence of a decision marker and/or if a decision needs to be made by a proper authority before a meeting's conclusion. Furthermore, Comagine Health will establish rules and protocols for recurring meetings so they can operate smoothly.

Cognizant of staff time, each meeting will have a designated meeting timekeeper to ensure meetings start and stop at their specified times. Before each meeting conclusion, time will be set aside for the meeting facilitator to summarize all topics, plans, decisions, expectations, and other relevant items discussed in the meeting.

After each meeting, meeting minutes will be supplied to all attendees. Meeting minutes will be published no more than five business days of the meeting's conclusion and will recapitulate topics, plans, decisions, expectations, and other

relevant items covered during the meeting. Copies of meeting agendas and minutes will be stored in a location agreed upon by DHHS and Comagine Health.

The EQRO team will also be available to meet on an ad hoc basis as needed.

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:

Validation of encounter data

The purpose of validation of encounter data is to determine whether the data used to calculate performance measures are complete and accurate and whether the calculation adheres to CMS specifications. Comagine Health EQR Team has many years of experience and expertise in the validation of encounter data through both clinical record reviews, claims data analysis, and encounter data reviews. Because of the knowledge and expertise of the EQR Team, we have previously provided training to a contracted Medicaid state agency and its health plans on performing encounter data validation, documentation standards, and identifying encounterable and medically necessary visits. Additionally, our EQR Team has discovered through our reviews possible cases of fraud, waste, and abuse, and has reported these cases to the State. Finally, during the onsite review of clinical records, the team met with health plan staff and provided one-on-one training on identified documentation and coding areas.

The EQR Team follows CMS Protocol 5 - Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan as the standard process when validating encounter data and will perform an independent validation of the procedures used by the MCOs and DBM. The EDV requirements included in the contracts with the State are the standards for validation.

The Comagine Health EQR Team obtains and reviews the encounter data validation report submitted to the State as a contract deliverable for the calendar year. The encounter data validation methodology, encounter and enrollee sample size(s), selected encounter dates, and fields are reviewed for conformance with State contract requirements. The encounter and/or enrollee sampling procedures are reviewed for conformance with accepted statistical methods for random selection.

A copy of the tool (spreadsheet, database, or other application) used to conduct encounter data validation will be requested, along with any supporting documentation, policies, procedures, or user guides, by the Comagine Health EQR Team for review. The Comagine Health Team's analytics staff then evaluates the tool to determine whether its functionality was adequate for the intended program. For example, we will review if the data collected is tracking the

essential information needed to fully monitor care and at the correct level of granularity. We will also evaluate the process for data entry to observe that the tool has been used correctly and captures the critical information needed.

Additionally, the MCO/DBM submits the actual statistical programming code or documentation describing the data analysis methods that were used to calculate the encounter data validation summary statistics. The code or description of data analysis methods are then reviewed by the Comagine Health Team analytics staff to determine validity. We audit code with sample data to ensure any calculations and manipulations of the data is performed correctly.

The Comagine Health Team's EDV process consists of electronic data checks—State-level validation of all encounter data received by the State from the MCO/DBM during the review period.

The Comagine Health Team analyzes encounter data submitted to the State to determine the magnitude of missing encounter data by field, consistency of potentially missing encounter data, overall data quality issues, and any issues with the MCO's processes for compiling encounter data and submitting the data files to the State. Specific tasks include:

- A review of standard edit checks performed by the State on encounter data received by the MCO/DBM and how the DHHS treats data that fail an edit check.
- A basic integrity check on the encounter data files to determine whether expected data exist, whether the encounter data element values fit within expectations, and whether the data are of sufficient quality to proceed with more complex analysis.
- Application of consistency checks, including verification that critical fields contain values in the correct format and that the values are consistent across fields.
- Inspection of data fields for general validity.
- Analysis and interpretation of data for submitted fields, the volume and consistency of encounter data and utilization rates, in aggregate and by time dimensions, including service date and encounter processing data, provider type, service type, and diagnostic codes.

The error rates are then compared to error rates reported to the State for encounters for which dates of service fell within the same time period. We also report out on documentation concerns and issues, non-encounterable services, and non-compliance with medical necessity requirements.
With our background and experience, Comagine Health is fully prepared to perform encounter data validation, if requested.

Administration or Validation of Consumer or Provider Surveys of Quality of Care

Comagine Health has successfully managed the implementation and evaluation of consumer and provider survey work for many years. We have very strong relationships with two NCQA-certified CAHPS® vendors and can activate a contract with one of these vendors on a very short timeframe. Both vendors have been NCQA certified to conduct CAHPS® surveys for over 15 years and can implement the Medicaid NCQA CAHPS® 5.0H Adult (Commercial and Medicaid) and Child (Commercial, Medicaid, and Medicaid with Chronic Care Conditions) Surveys.

The EQR program manager will provide the oversight for this work and has deep experience working with both CAHPS® survey vendors. The survey implementation team will include a project director who will work closely with Comagine Health's EQR program manager and will handle development of specifications for each project, all administrative tasks, and serve as liaison between across all stakeholders including DHHS and the MCOs and DBM. An appropriate mix of data analysts and field staff at will assist the project team.

If DHHS requests this optional activity, Comagine Health will organize and participate in a kick-off meeting with the survey vendor and DHHS to discuss the scope of work and timelines related to the survey activities. Comagine Health will provide regular updates on the study and/or report during monthly meetings with DHHS. We commit that the survey process and activities will:

- Adhere to AHRQ, NCQA and CMS' guidelines for sampling, printing, mailing, processing returned questionnaires, and submission of data.
- Ensure that survey research design is deployed precisely.
- Monitor quality and progress of the research.
- Ensure timely data submission to NCQA and CMS, as well as accommodating various data submission formats for numerous state and regional organizations.
- Provide analysis, reporting, and interpretation of results.
- Incorporate preparation of client specific customized reporting, including comparison and consolidation reporting based on state, region, plan type, and physician group, where applicable.

The CAHPS® survey administration will follow the standard Mixed Mode Methodology of survey administration, consisting of a minimum of two questionnaire mailings, two reminder postcards, and up to six phone attempts. The vendor will administer the survey in English with the option to complete the survey in Spanish either in written format or orally over a toll-free phone call.

Both CAHPS® vendors and Comagine Health employ statistical and research experts who will provide support to EQR teams and DHHS on advanced qualitative and quantitative research designs. Analyses can be produced in the

aggregate at the system or state level, as well as at any level of stratification, such as statewide, program, condition specific, and geographical. Analyses are based on bivariate analysis at the case level or the question level, according to client preference. Achievement scores are calculated at the overall level (i.e., aggregate, national or “system” level), and for designated strata (i.e., regional or state level).

The CAHPS® survey results will produce the following:

- Identify strengths and weaknesses in plans' quality of care and services.
- Demonstrate where resources are needed to improve weaknesses.
- Show the effects of plan efforts to improve over time.

Through numerous federally funded research grants, Comagine Health has also built an expertise in surveying providers about their experience providing care and serving the Medicaid population. If requested to conduct a provider survey, we will conduct a project kick-off meeting to discuss overall approach to survey (inclusions and exclusions) and review draft work plan. The survey activities will include:

- DHHS will provide Comagine Health with a list of eligible providers to receive the survey, data elements would include the providers’ name, credential, specialty, MCO affiliation(s), address and zip code, email address, and phone number and other variables of interest and available to DHHS. If all eligible providers will receive a survey, then no sampling methodologies will be deployed. If a sample is needed, Comagine Health can recommend a sampling methodology to DHHS and deploy the selected methodology.
- Comagine Health will develop, in collaboration with DHHS, a new survey or adopt or adapt an existing survey. Comagine Health has extensive experience surveying providers about and could borrow existing questions from our previous work and other external sources if desired by DHHS
- Comagine Health will email the identified eligible providers an introductory letter with a link to the survey, including a request to complete the survey by a specified date.
- Weekly, Comagine Health will follow up via email with providers who have not yet completed the survey with a reminder and the link to complete the survey.
- At the end of the survey administration period, Comagine Health analysts will close download all collected data onto encrypted and secure servers, accessible only by analysts working on the project.
- Comagine Health analysts will analyze the data, assembling aggregate results in a series of tables that communicate provider experience according to MCO affiliation, region, provider type, and other stratification variables as available and appropriate.

Comagine Health also has extensive survey evaluation experience, including the validation of surveys conducted by Medicaid MCOs as well as other entities. Comagine Health will utilize their survey evaluation experts and statisticians to conduct this work. To guide the proposed work, the Comagine Health survey validation team will use the most recent version of CMS EQR Protocol 6 - Administration or Validation of Quality of Care Surveys specifying the eight activities required to assess the methodological soundness of a survey.

Per CFRs §438.50 and §438.52, EQROs can use information obtained from a Medicare review or a private accreditation review to provide information otherwise obtained from the mandatory activities. The RFP indicates for all three MCOs and the DBM, the NCQA is the accrediting authority. When appropriate and following CFR §438.360, Comagine Health will use reports, findings, and other information from the NCQA HEDIS® Compliance Audits which includes a validation of the CAHPS® survey sample frame. An NCQA HEDIS® Compliance auditor will verify the integrity of all applicable sample frames prior to survey administration. For each survey measure, auditors validate the survey sample frame to ensure that it was compliant with respective survey technical specifications and verify that the organization utilized certified measure software to produce the sample frame. If the organization utilized non-certified measure software to produce the survey sample, auditors will review the source code that was used to produce the sample to ensure compliance with survey technical specifications.

With our background and experience, Comagine Health is fully prepared to perform CAHPS® survey administration, analysis, reporting duties, and/or validation, if requested.

Calculate performance measures

Comagine Health is well versed in calculating performance measures. We have built, validated, and shared results for performance measures under several contracts, including EQR in Washington and our APCD in Oregon. Our team will follow the direction of DHHS to transparently build our measure and share both our programming methodology and visualizations for DHHS to use as needed.

Comagine Health will, at the State's direction, calculate additional specified performance measures. Comagine Health will conduct a planning meeting with DHHS to discuss the performance measures to be calculated and reported. We will develop a project plan and collaborate with DHHS on an agreed upon timeline. Comagine Health will provide regular updates on the progress of the tasks during monthly meetings with DHHS. The EQR Senior Analyst will lead this effort. An appropriate mix of data analysts and research staff at will assist the project team.

Comagine Health will follow the CMS Protocol 7 - Calculation of Additional Performance Measures. The team will collect the relevant data needed to analyze and prepare data to ensure there are no gaps or data quality issues, code and calculate measures for reporting, verify the data is reliable for public reporting, and display data in a format that is universally understood is our expertise. We deliver clear outcomes and narrative to explain and data visualizations.

Conduct Performance Improvement Projects (PIPs)

Comagine Health partners with healthcare providers, community organizations, and consumers on data-driven systemic initiatives to improve outcomes, reduce harm, eliminate disparities, and engage patients and caregivers. Implementation and evaluation of PIPs is at the core of Comagine Health's work across services lines, not just in EQR work.

Comagine Health staff design and conduct focused quality-of-care studies for use in the QI and program/policy evaluation efforts of public agencies and private health systems. The EQR Team follows CMS Protocol 8 - Implementation of Additional PIPs as the standard process when implementing PIPs. Our expert clinicians, researchers, and analysts can design studies to "drill down" for root causes behind performance and patient satisfaction scores, to help identify high-leverage opportunities for improvement.

Comagine Health utilizes the use of rapid cycle process improvement for PIPs. This expedites the findings and allows for early course correction. Following a rapid cycle with shorter measurement time frames allows the plan to initiate a series of interventions to improve gaps/barriers identified within each measurement period early, which lends to the ability to demonstrate real, sustained improvements that impact enrollee health, functional status, and/or satisfaction. Further, it allows the health plan the ability to more comprehensively address a broad spectrum of key aspects of enrollee care and services (e.g., access, timeliness, preventative, chronic, acute, coordination of care, inpatient, high-need, high-risk, etc.).

Comagine Health has the knowledge and skills in developing and implementing PIPs and with our background and experience, we are fully prepared to implement PIPs, if requested.

Conduct Studies on Quality

As a QIN-QIO, Comagine Health has many years of experience in conducting studies on quality. Comagine Health's EQR services contribute to advancing the quality, efficiency, and value of healthcare and is prepared to conduct ad hoc studies, if requested by DHHS. The focus may be on QI, administrative, legislative, or other areas of interest. Focus studies may examine and report on clinical or nonclinical aspects of care provided by the MCOs and/or DBM.

Comagine Health 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. Comagine Health will conduct a planning meeting with DHHS to determine the focus of the study. We will develop a project plan and collaborate with DHHs on an agreed upon timeline. Comagine Health will provide regular updates on the study and/or report during monthly meetings with DHHS. The EQR program manager will provide the oversight for this work. Our expert clinicians, researchers, and analysts can design studies to "drill down" for root causes behind performance and patient satisfaction scores, to help identify high-leverage opportunities for improvement. An appropriate mix of data analysts and research and field staff at will assist the project team. Comagine Health will follow a standard process to implementing an ad-hoc study, CMS Protocol 9 - Conducting Focus Studies of Healthcare Quality.

With our background and experience, Comagine Health is fully prepared to conduct studies on quality, if requested.

Assistance Quality Rating of MCOs and DBM

Comagine Health will, at the DHHS' direction, create a quality rating of the MCOs and DBM. As part of its work as the EQRO for the Washington State HCA, Comagine Health has produced an Enrollee Quality "Star Rating" Report. Comagine Health has extensive experience aggregating and analyzing diverse data sets, and expertise with performance measure comparative analysis for both HEDIS® and CAHPS® measures. Our EQR program manager will lead this effort to create the quality rating of the MCOs and DBM in close partnership with DHHS. Comagine Health will conduct a planning meeting with DHHS to discuss the performance measures to be calculated and reported. We will develop a project plan and collaborate with DHHs on an agreed upon timeline. Comagine Health will provide regular updates on the progress of the tasks during monthly meetings with DHHS.

The purpose of the Enrollee Quality Report is to provide MCO applicants and enrollees with simple, straightforward comparative health plan performance information that can assist them in selecting a plan that best meets their needs. The purpose of the scoring methodology is to identify variation between plans rather than to compare plan performance to other benchmarks. Data sources for this report include HEDIS® and CAHPS® measures. The primary goal for the EQRO is to conduct a side-by-side fair comparison of plans. Depending on the data available across all plans, our primary data sources may change to remove potential biases in the data.

As part of the initial star rating development process, Comagine Health reviewed multiple rating systems implemented by other state EQROs, as well as NCQA and CMS. Health plan rating systems are usually based on the differences between individual health plan performance measure results and a benchmark, such as a national or state average

score. If enough plan-level score information is available, they may also be based on percentile rankings of performance measure results, whereby stars or ratings are applied based on score quantiles.

Our approach to producing the quality rating report is based on teamwork. Comagine Health's EQR program staff, data analysts, and communications specialists work in unison to collaboratively plan, draft, and produce final reports. As previously described in Sections V.D.2.c. and V.D.4.a., our reports will undergo repeated peer-review among the EQR program staff, analytics staff, and leadership teams, as well as a tiered editing process designed to ensure our writing is clear, concise, and straightforward. Once we produce a draft of the reports, we will submit this version to the DHHS for feedback and comment. This process ensures we produce an easy-to-read, polished, and informative quality rating report that will meet the needs of DHHS.

The analyst team will create a database that includes both current and historical results, and, as stated previously, runs a series of analyses using R, SAS, and Tableau per the specifications in the contract to inform early findings. The team is also supported by a skilled communications team, with professional writers and key editorial staff that have multiple years of EQRO experience.

We propose following the current process we use to create the Enrollee Quality Report. Comparisons are made at the plan level, using the state unweighted (simple) average as the benchmark for plan performance. Because the Enrollee Quality Report does not include state rates for each measure, we believe that there will be minimal confusion related to aggregate state performance arising from the report. This methodology aligns with those from other states. Rating systems will vary regarding how many "stars" are assigned. The national-level systems, which are based on rankings, assign between one and five stars (or points, for NCQA) based on quantile cut points. The state-level rating systems tend to assign between one and three stars based on significance of the final score in comparison to the benchmark. The Enrollee Quality Report utilizes a rating system based on three stars, primarily because the observed variation for most performance measures at the state level does not support a level of precision that would reliably define five rating levels.

Comagine Health's methodology relies on qualitative judgment to determine the number and composition of rating system domains; statistical methods for establishing domains (such as factor analysis) are not applicable because of the small number of plans included. Generally, the literature on this suggests it is best to limit the number of domains and to compose them in such a way that they are most likely to be relevant and actionable for Medicaid plan consumers. Below are several criteria we considered when selecting domains.

- **Precedent—**It is useful to consider the domains used in other star rating systems, especially in cases in which

domains were determined using empirical analysis and/or consumer focus groups. For example, the fact that access to care was used in all rating systems we reviewed suggests a consensus that this is an important domain.

- **Coverage/Importance—**All potentially important rating areas should be covered by the final selection of domains to the extent possible, based on the availability of measures.
- **Final number of domains—**The number of domains presented to consumers for comparison should be limited to avoid information overload, yet still provide adequate diversity to allow specificity in areas of interest. Most star rating systems include a half dozen or fewer domains.

To define a set of domains, it is necessary to distill a subset of performance measures from the full list of HEDIS® effectiveness of care and CAHPS® measures. Below are several criteria considered when selecting indicators for the rating system.

- **Degree of variation**—There is enough variation in the indicator across plans that it will help differentiate plan performance and add value to the star rating comparison.
- **Population impact—**The indicator reflects a broad population base, or a population of specific or prioritized interest, ensuring its meaningfulness or importance to consumers.
- **Precedent**—The indicator is used in other similar rating systems, suggesting a degree of consensus regarding its importance.
- **Compatibility**—The population represented by the indicator is broadly present across the plans.
- **DHHS priority**—The indicator reflects current DHHS priorities and measures included in the MCO and DBM contracts.

Please see the 2020 AHMC Plan Report Card in Appendix E for more details. Given our background and experience, Comagine Health is fully prepared to produce a quality rating report, if requested.

Provide Technical Guidance to MCOs and/or DBM

The Comagine Health EQR Team has a broad range of presentation and technical guidance/assistance experience. Technical assistance will be offered in partnership with the State and through collaboration with the MCOs and the DBM and based on the needs identified through reviews, discussions, and survey tools. We are prepared to provide hourly technical assistance, either one-on-one or in group settings, according to the State's needs. In performing all EQR activities, we follow CMS protocols, sometimes modifying the protocols as negotiated with and approved by the state Medicaid agency to incorporate state-specific policies and procedures.

Comagine Health is prepared to provide technical guidance to the State and the MCOs/DBM as requested by the State. Our EQR program manager will be the primary contact for DHHS if technical assistance is needed. Comagine Health

will respond to each request from DHHS for technical guidance and consultative services with a detailed cost proposal and a draft work plan covering specific tasks, responsible parties, and dates of finishing deliverables for completing the scope of work. We will collaborate with the state, MCOs, DBM, and other stakeholders as appropriate to finalize the plan and execute the technical guidance.

Comagine Health goes beyond the typical checklist approach to EQR. We provide extensive hands-on technical assistance and training to staff members at state agencies and managed care plans to enhance their internal and external QI capabilities and equip them to respond to the findings and recommendations of each annual EQR cycle. We will offer detailed consultation to help DHHS and the MCOs and DBM meet Medicaid program requirements related to ensuring access to timely, high-quality healthcare. Our technical assistance includes a wide range of subjects. Some of the trainings we have provided have focused on quality assurance and performance improvement; disaster recovery/business continuity planning; delegation of services; clinical documentation; program integrity; fraud, waste, and abuse; risk assessment; and EDV.

While EQR approaches and tools are founded on CMS mandated protocols and industry-standard best practices, the Comagine Health EQR Team will customize services to meet the DHHS Medicaid program's specific goals, requirements, and budget constraints. We have extensive experience in adapting our processes and tools to clients' changing needs, thus allowing us to negotiate customized approaches to deliver the best results at the most efficient cost. All of our EQRO contracts have spanned periods of substantial change in the Medicaid programs we serve, and we have adapted as necessary to ensure the MCOs are continuing to provide high-value services for children and adults.

In designing technical guidance/assistance tools, supports, and training activities, the Comagine Health team researches and incorporates best practices from other states operating Medicaid Managed Care programs, research on topic areas, current CMS guidance, and OHA and MCE input. Trainings can be provided through in-person or remote mechanisms, such as video conferences and/or webinars. Please refer to section V.D.3 for additional information and examples of other EQR technical trainings the Comagine Health Team has provided to MCOs.

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:	The project scope, as defined by the EQRO contract, covers planning and design of mandatory EQR activities, including preparing for and conducting site visits, interviews, analysis, and reporting. The scope also includes evaluation of our work as an EQRO and process improvement. The EQR Program Lead will coordinate with DHHS on project planning and will obtain final DHHS approval of the project plans for carrying out the EQR tasks. As part of the annual planning process and depending on the activity, SMEs will present information to MCO and DBM and OHA for review, revision, and approval. The EQR team develops an annual plan that coordinates all planning, site visits, travel, and communications to ensure efficient completion of all contract deliverables. For each EQR activity, a lead SME is responsible for planning, review, and reporting for that activity. After MCO and DBM reviews are complete, each SME contributes material to the individual MCO and DBM EQR reports and to the Annual EQR Technical Report based on the MCO and DBM reviews and additional QI activities. The annual work plan specifies the timelines and deliverables for all EQR activities. Refer to Section 7 for Draft Work for our proposed timeline for all mandatory EQR activities.
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:	Comagine Health understands the necessity for effective teamwork within the EQRO framework. We will approach EQRO as an opportunity to engage with key stakeholders (i.e., DHHS, MCOs, and DBM) and create a collaborative and productive environment. We will work with DHHS to implement a communications strategy that is consistent and coordinated with the established overall DHHS communication plan. Our communication approach will ensure proper collaboration and coordination with all project stakeholders. A key component of our approach will describe methods and criteria for distributing our work products and deliverables to the appropriate project stakeholders. Our approach to managing our team's communications will also be based on the communication principles and best practice steps found in PMBOK®. These include: ▪ Identifying and documenting project stakeholders,

	▪ Developing a communications plan, ▪ Establishing and deploying a process for distribution information, ▪ Managing project stakeholder expectations, and ▪ Reporting on our team activities and performance. Our communications plan that will outline the dissemination criteria for our artifacts and deliverables. Our Project Manager will develop a communication plan that outlines: ▪ Purpose of the communication, ▪ Anticipated content of our communications, including protocols, deliverables, and reports, ▪ Frequency or timing of the communication, ▪ Escalation procedures, ▪ Communication modality, such as a report, e-mail, meeting, or conference call, ▪ Our team member responsible for the communication, ▪ Intended recipients of the communication, and ▪ A roster of our team and other key project stakeholders including telephone numbers and e-mail addresses. Please refer to our Draft Communications Plan in Section 8 – Draft Communications Plan. Comagine Health will supply DHHS with a Detailed Communications Plan no later than two weeks after signing the EQRO contract with DHHS. We understand DHHS may approve or reject, in writing, the Detailed Communications Plan or any proposed updates to the Detailed Communications Plan.

Section 7 – Draft Work Plan

Comagine Health has prepared the following high level General Work Plan draft with timeframes for completing the scope of work activities described in this RFP, which includes report development, draft report development, and final report production in accordance with the RFP Deliverables. Please note that a detailed work plan providing specific details for each task including due dates will be submitted to DHHS no later than two weeks after contract award.

Table 7 - Draft - General Work Plan

Task	Responsible Party	Timeframe/Due Date
Contract negotiation and execute contract with DHHS	▪ Comagine Health Program Director and Program Manager ▪ DHHS	Within one month of contract award notification
Schedule and conduct contract kick-off meeting with DHHS to introduce team, discuss the various tasks, deliverables, and overall timelines such as ▪ Confirm purpose, target audience(s), scope, ▪ Deliverable requirements, review and approval requirements ▪ Deadlines for individual MCO/DBM reports and Annual Technical report	▪ Comagine Health Program Director and Program Manager ▪ MetaStar Vice President, Project Manager ▪ Applicable Comagine Health and MetaStar staff ▪ DHHS	Within one week of start of contract date
Develop and submit 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. of the proposal.	▪ Comagine Health Program Manager ▪ MetaStar Project Manager	No later than two weeks after the contract start date
Develop and submit Detailed Communications Plan meeting the requirements of Section V.D.	▪ Comagine Health Program Manager and Communications Lead	No later than two weeks after the contract start date

Task	Responsible Party	Timeframe/Due Date
Compliance Reviews Conduct kick-off meeting to discuss scope of reviews and timeline (a detailed workplan and timeline will be provided to DHHS after contract award)	▪ Comagine Health Program Manager and QI Associate ▪ MetaStar Vice President and Project Manager ▪ DHHS	No later than two weeks after the contract start date Final reports will be submitted by October 15, annually (per the RFP)
Annual Validation of PIPs Report Conduct kick-off meeting to discuss the PIPs required by the state and conducted by the MCOs and DBM during the preceding calendar year (a detailed workplan and timeline will be provided to DHHS after contract award)	▪ Comagine Health Program Manager, Quality Reviewer, QI Associate, Communications Lead ▪ DHHS	No later than two weeks after the contract start date Final report will be submitted by December 31, annually (per the RFP Q&A)
Annual Validation of Performance Measures Report Conduct kick-off meeting to discuss validation of the 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 (a detailed workplan and timeline will be provided to DHHS after contract award)	▪ Comagine Health Program Manager, Analytic Lead, Quality Reviewer, QI Associate and Communications Lead ▪ DHHS ▪	No later than two weeks after the contract start date Final report will be submitted by December 31, annually (per the RFP Q&A)
Annual Validation of Network Adequacy Report Conduct kick-off meeting to discuss the overall approach to validation of network adequacy including developing evaluation criteria (a detailed workplan and timeline will	▪ Comagine Health Program Manager, Analytic Lead, Quality Reviewer, QI Associate and Communications Lead ▪ DHHS ▪	No later than two weeks after the contract start date Final report will be submitted by December 31,

Task	Responsible Party	Timeframe/Due Date
be provided to DHHS after contract award)		annually (per the RFP Q&A)
Develop key contacts list including contacts from Comagine Health, MetaStar, DHHS, each MCO and the DBM	▪ Comagine Health Program Manager ▪ MetaStar Project Manager ▪ DHHS ▪ MCOs and DBM	No later than three weeks after the contract start date
Develop and submit a progress report that includes the status of the work completed from the detailed Project Work Plan to DHHS	▪ Comagine Health Program Manager and QI Associate ▪ MetaStar Project Manager	On at least a monthly basis
Conduct monthly project meetings with DHHS staff and other stakeholders	▪ Comagine Health Program Director and Program Manager ▪ MetaStar Vice President, Project Manager ▪ Applicable Comagine Health and MetaStar staff ▪ DHHS	On at least a monthly basis
Submit invoices at the fixed rate for services provided	▪ Comagine Health Program Director and Program Manager ▪	Within 30 calendar days following the date of deliverable completion and no later than 30 calendar days
Develop and submit the report template for the individual MCO/DBM EQR reports to DHHS for review and comment	▪ Comagine Health Program Manager, Analytic Lead, Communications Lead, Quality Reviewer and QI Associate ▪ MetaStar Vice President, Quality Reviewers and Project Manager	Within 90 days prior to the first onsite review
DHHS reviews and provides comments on report template	▪ DHHS	Within 14 days after submission of report template

Task	Responsible Party	Timeframe/Due Date
Revise the individual MCO/DBM EQR report template based on feedback from DHHS	▪ Comagine Health Program Manager and Communications Lead ▪ MetaStar Vice President, Quality Reviewers and Project Manager	Within 30 days after receipt of comment on report template
Submit the draft EQR report for each MCO/DBM to DHHS for review and comment	▪ Comagine Health Program Manager, Analytic Lead, Communications Lead, Quality Reviewer and QI Associate ▪ MetaStar Vice President, Quality Reviewers and Project Manager	Within 90 days of the onsite review
DHHS reviews and provides comments on draft MCO/DBM EQR reports	▪ DHHS	No later than 15 days after draft report delivery
Revise MCO/DBM review reports based on feedback from DHHS and submit Final EQR reports to DHHS	▪ Comagine Health Program Manager, Quality Reviewer and Communications Lead ▪ MetaStar Vice President, Quality Reviewers and Project Manager	Within 30 days of the draft report delivery
Develop and submit the Annual Technical report template to DHHS for review and comment	▪ Comagine Health Program Manager, Analytic Lead, Communications Lead, Quality Reviewer and QI Associate ▪ MetaStar Vice President, Quality Reviewers and Project Manager	Within 120 days prior to the Final report delivery due date
DHHS reviews and provides comments on report template	▪ DHHS	Within 14 days after submission of report template
Revise the Annual Technical report template based on feedback from DHHS	▪ Comagine Health Program Manager and Communications Lead ▪ MetaStar Vice President, Quality Reviewers and Project Manager	Within 30 days after receipt of comment on report template

Task	Responsible Party	Timeframe/Due Date
Submit the draft Annual Technical report to DHHS for review and comment	▪ Comagine Health Program Manager, Analytic Lead, Communications Lead, Quality Reviewer and QI Associate ▪ MetaStar Vice President, Quality Reviewers and Project Manager	No later than August 15
DHHS reviews and provides comments on draft Annual Technical report	▪ DHHS	No later than September 15th
Revise the Annual Technical report based on feedback from DHHS and submit Final Annual Technical report to DHHS	▪ Comagine Health Program Manager, Quality Reviewer, QI Associate and Communications Lead ▪ MetaStar Vice President, Quality Reviewers and Project Manager	No later than October 15th
Ad-hoc Reports	▪ To be determined if ad-hoc report is requested	To be determined if ad-hoc report is requested
Ad-hoc Technical Assistance and Consultation	▪ To be determined if technical assistance and consultation is requested	To be determined if technical assistance and consultation is requested

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Section 8 – Draft Communication Plan

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DRAFT COMMUNICATION MANAGEMENT PLAN

EQRO RFP 6303 Z1

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Introduction

This Communications Management Plan sets the communications framework for this project. It will serve as a guide for communications throughout the life of the project and will be updated as communication needs change. This plan identifies and defines the roles of persons involved in this project. It also includes a communications matrix which maps the communication requirements of this project. An in-depth guide for conducting meetings details both the communications rules and how the meetings will be conducted, ensuring successful meetings. A project team directory is included to provide contact information for all stakeholders directly involved in the project.

Communication Management Approach

The Project Manager will take a proactive role in ensuring effective communications on this project. The communications requirements are documented in the Communications Matrix presented in this document. The Communications Matrix will be used as the guide for what information to communicate, who is to do the communicating, when to communicate it, and to whom to communicate.

As with most project plans, updates or changes may be required as the project progresses or changes are approved. Changes or updates may be required due to changes in personnel, scope, budget, or other reasons. Additionally, updates may be required as the project matures and additional requirements are needed. The project manager is responsible for managing all proposed and approved changes to the communications management plan. Once the change is approved by DHHS, the project manager will update the plan and supporting documentation and will distribute the updates to the project team and all stakeholders. This methodology ensures that all project stakeholders remain aware and informed of any changes.

Communication Management Constraints

All project communication activities will occur within the project's approved budget, schedule, and resource allocations. The project manager is responsible for ensuring that communication activities are performed by the project team and without external resources which will result in exceeding the authorized budget. Communication activities will occur in accordance with

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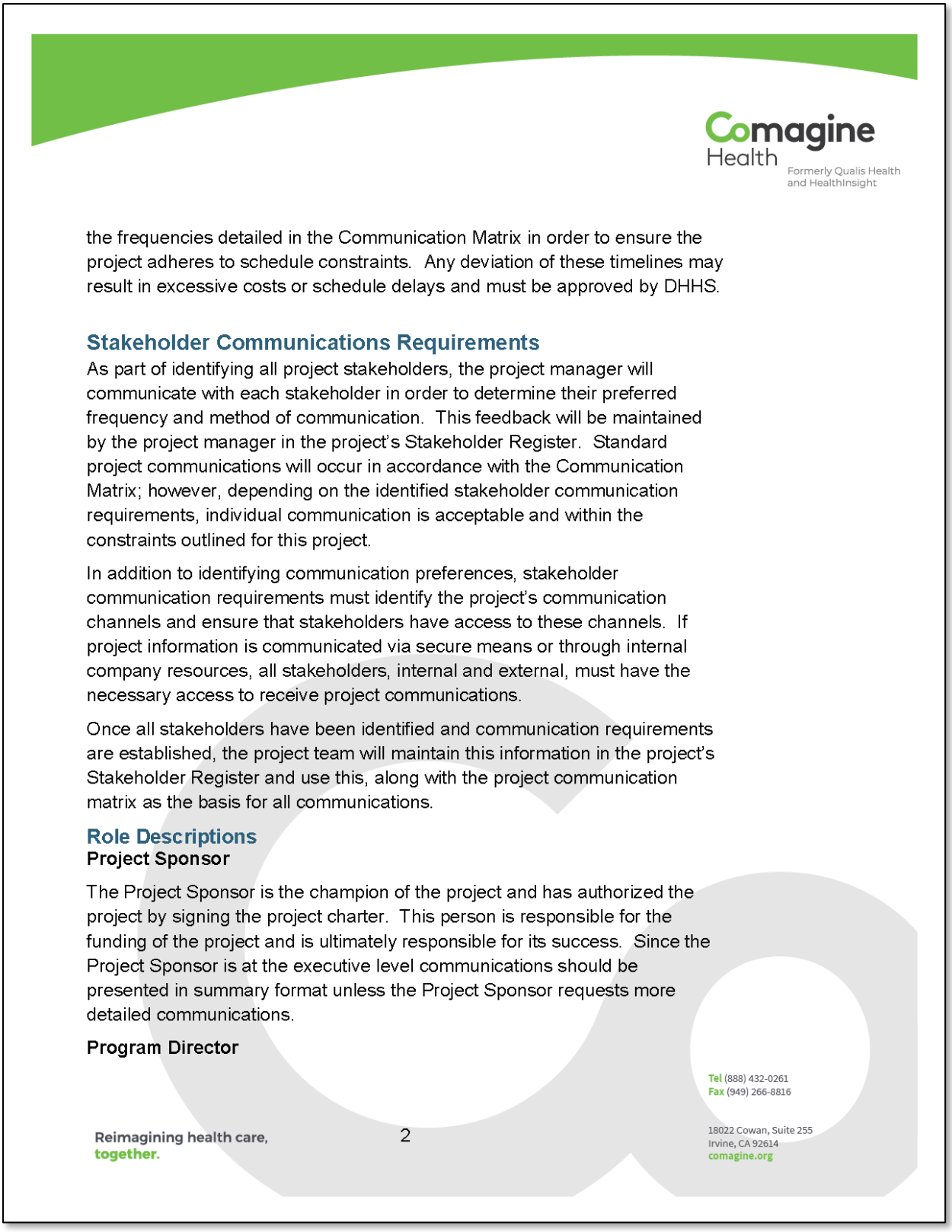

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the frequencies detailed in the Communication Matrix in order to ensure the project adheres to schedule constraints. Any deviation of these timelines may result in excessive costs or schedule delays and must be approved by DHHS.

Stakeholder Communications Requirements

As part of identifying all project stakeholders, the project manager will communicate with each stakeholder in order to determine their preferred frequency and method of communication. This feedback will be maintained by the project manager in the project's Stakeholder Register. Standard project communications will occur in accordance with the Communication Matrix; however, depending on the identified stakeholder communication requirements, individual communication is acceptable and within the constraints outlined for this project.

In addition to identifying communication preferences, stakeholder communication requirements must identify the project's communication channels and ensure that stakeholders have access to these channels. If project information is communicated via secure means or through internal company resources, all stakeholders, internal and external, must have the necessary access to receive project communications.

Once all stakeholders have been identified and communication requirements are established, the project team will maintain this information in the project's Stakeholder Register and use this, along with the project communication matrix as the basis for all communications.

Role Descriptions

Project Sponsor

The Project Sponsor is the champion of the project and has authorized the project by signing the project charter. This person is responsible for the funding of the project and is ultimately responsible for its success. Since the Project Sponsor is at the executive level communications should be presented in summary format unless the Project Sponsor requests more detailed communications.

Program Director

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The Program Director oversees the project at the portfolio level and owns most of the resources assigned to the project. The Program Director is responsible for overall program costs and profitability as such they require more detailed communications than the Project Sponsor.

Program Manager

The Program Manager has overall responsibility for the execution of the project. The Program Manager manages day to day resources, provides project guidance and monitors and reports on the project's metrics. As the person responsible for the execution of the project, the Program Manager is the primary communicator for the project distributing information according to this Communications Management Plan.

Project Team

The Project Team is comprised of all persons who have a role performing work on the project. The project team needs to have a clear understanding of the work to be completed and the framework in which the project is to be executed. Since the Project Team is responsible for completing the work for the project, they play a key role in creating the Project Plan including defining its schedule and work packages. The Project Team requires a detailed level of communications which is achieved through day to day interactions with the Program Manager and other team members along with weekly team meetings.

Key Stakeholders

Normally, Stakeholders includes all individuals and organizations who are impacted by the project. For this project we are defining a subset of the stakeholders as Key Stakeholders. These are the stakeholders with whom we need to communicate with and are not included in the other roles defined in this section. The Key Stakeholders includes executive management with an interest in the project and key users identified for participation in the project.

Customer

The customer for this project is DHHS. As the customer who will be accepting the final deliverable of this EQR project, they will be informed of the

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project status including potential impacts to the schedule for the final deliverable or the product itself.

Project Team Directory

The following table presents contact information for all persons identified in this communications management plan. The email addresses and phone numbers in this table will be used to communicate with these people.

Role	Name	Title	Organization/ Department	Email	Phone
Project Sponsor					
Program Director					
Program Manager					
Project Stakeholders					
DHHS					
Project Team					

Communication Methods and Technologies

The project team will determine, in accordance with DHHS organizational policy, the communications methods and technologies based on several factors to include: stakeholder communication requirements, available technologies (internal and external), and organizational policies and standards.

Communications Matrix

The following table identifies the communications requirements for this project.

Protocol	Medium	Frequency	Audience	Owner	Deliverable	Format
General Communication (formal/ informal)	TBD	As needed	Project Sponsor Program Director	Program Director	TBD	TBD

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Protocol	Medium	Frequency	Audience	Owner	Deliverable	Format
			Program Manager Project Team DHHS Stakeholders			
Staff Changes (hiring, resignations, dismissals)	In writing	1 business day after initial knowledge of change	DHHS Stakeholders	Program Director	Inform DHHS of staffing change and plan to	TBD
Distribution of Reports, Assessments, and Recommendations	Print or electronic, alternative formats for persons with disabilities	As requested	DHHS Stakeholders, as identified on the Report Distribution List	Program Director	Provide copies of the information to interested parties (e.g. participating health care providers, enrollees, and potential enrollees of the MCO or DBM beneficiary advocacy groups and members of the general public)	TBD
Meetings	Conference Calls	Monthly	Project Team DHHS Staff Stakeholders, as necessary	Program Manager	Agendas Meeting Minutes	TBD
Technical Assistance Planning	In writing	As Needed	MCOs DBM	Program Manager	Provide technical guidance to MCOs or DBM at DHHS's request. Report any problems with the administration of	TBD

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Protocol	Medium	Frequency	Audience	Owner	Deliverable	Format
					the MCO or DBM Contracts and will propose a corrective action plan for any problems directly related to the performance of this Contract.	
Draft Report Review	In writing	Submission of draft reports to DHHS with a minimum of 2 months lead time for review and a correction of any noted deficiencies identified by DHHS within 2 weeks.	DHHS	Program Manager	TBD	TBD
Ad-hoc Deliverables	In writing	Response within 1 busines day of request or as agree upon in EQR contract.	DHHS	Program Manager	TBD	TBD
Work Plan Progress Reviews	Conference Call	Monthly	DHHS, or as directed by DHHS	Program Director	Agenda Meeting Minutes	TBD

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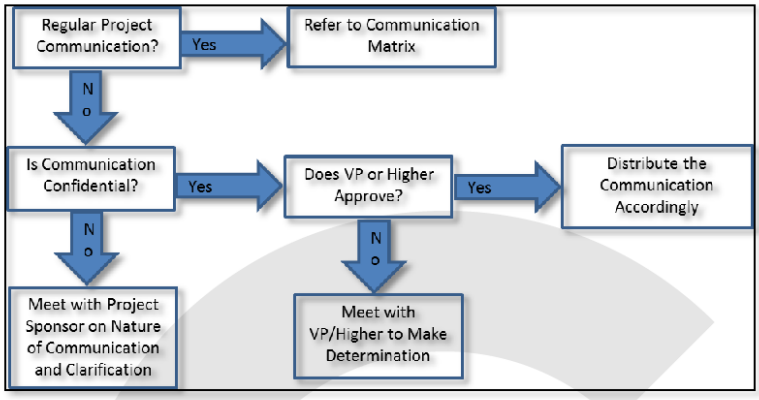
Communication Process

The communication flowchart below was created to aid in project communication. This flowchart provides a framework for the project team to follow for this project. However, there may be occasions or situations which fall outside of the communication flowchart where additional clarification is necessary. In these situations, the Program Manager is responsible for discussing the communication with the Project Sponsor and making a determination on how to proceed.

FIGURE 1 - COMMUNICATIONS PROCESS



Communication Standards

For this project, DHHS will utilize standard organizational formats and templates for all formal project communications. Formal project communications are detailed in the project's communication matrix and include:

Kickoff Meeting – project team will utilize DHHS standard templates for meeting agenda and meeting minutes. Additionally, any slides presented will use the DHHS standard slideshow template.

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Project Team Meetings – project team will utilize DHHS standard templates for meeting agenda and meeting minutes. Additionally, any slides presented will use the DHHS standard slideshow template.

Monthly Project Status Meetings - project team will utilize DHHS standard templates for meeting agenda and meeting minutes. Additionally, any slides presented will use the DHHS standard slideshow template.

Project Status Reports – project team will utilize DHHS standard templates for meeting agenda and meeting minutes. Additionally, the standard project status report document, available on the share drive, will be used to provide project status.

Informal project communications should be professional and effective but there is no standard template or format that must be used.

Guidelines for Meetings

Meeting Agenda

Meeting Agenda will be distributed 5 business days in advance of the meeting. The Agenda should identify the presenter for each topic along with a time limit for that topic. The first item in the agenda should be a review of action items from the previous meeting.

Meeting Minutes

Meeting minutes will be distributed within 2 business days following the meeting. Meeting minutes will include the status of all items from the agenda along with new action items and the Parking Lot list.

Action Items

Action Items are recorded in both the meeting agenda and minutes. Action items will include both the action item along with the owner of the action item. Meetings will start with a review of the status of all action items from previous meetings and end with a review of all new action items resulting from the meeting. The review of the new action items will include identifying the owner for each action item.

Meeting Chairperson

The Chairperson is responsible for distributing the meeting agenda, facilitating the meeting and distributing the meeting minutes. The Chairperson

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will ensure that the meeting starts and ends on time and that all presenters adhere to their allocated time frames.

Note Taker

The Note Taker is responsible for documenting the status of all meeting items, maintaining a Parking Lot item list and taking notes of anything else of importance during the meeting. The Note Taker will give a copy of their notes to the Chairperson at the end of the meeting as the Chairperson will use the notes to create the Meeting Minutes.

Timekeeper

The Timekeeper is responsible for helping the facilitator adhere to the time limits set in the meeting agenda. The Timekeeper will let the presenter know when they are approaching the end of their allocated time. Typically, a quick hand signal to the presenter indicating how many minutes remain for the topic is sufficient.

Parking Lot

The Parking Lot is a tool used by the facilitator to record and defer items which are not on the meeting agenda; however, merit further discussion at a later time or through another forum. A parking lot record should identify an owner for the item as that person will be responsible for ensuring follow-up. The Parking Lot list is to be included in the meeting minutes.

Communication Escalation Process

Efficient and timely communication is the key to successful project completion. As such, it is imperative that any disputes, conflicts, or discrepancies regarding project communications are resolved in a way that is conducive to maintaining the project schedule, ensuring the correct communications are distributed, and preventing any ongoing difficulties. In order to ensure projects stay on schedule and issues are resolved, we will use its standard escalation model to provide a framework for escalating communication issues. The table below defines the priority levels, decision authorities, and timeframes for resolution.

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Priority	Definition	Decision Authority	Timeframe for Resolution
Priority 1	Major impact to project or business operations. If not resolved quickly there will be a significant adverse impact to revenue and/or schedule.	Vice President or higher	Within 4 hours
Priority 2	Medium impact to project or business operations which may result in some adverse impact to revenue and/or schedule.	Project Sponsor	Within one business day
Priority 3	Slight impact which may cause some minor scheduling difficulties with the project but no impact to business operations or revenue.	Program Director	Within two business days
Priority 4	Insignificant impact to project but there may be a better solution.	Program Manager	Work continues and any recommendations are submitted via the project change control process

** NOTE: Any communication including sensitive and/or confidential information will require escalation to VP level or higher for approval prior to external distribution.

Approvals

Role	Name	Signature	Date
Project Sponsor			
Program Director			
Program Manager			

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