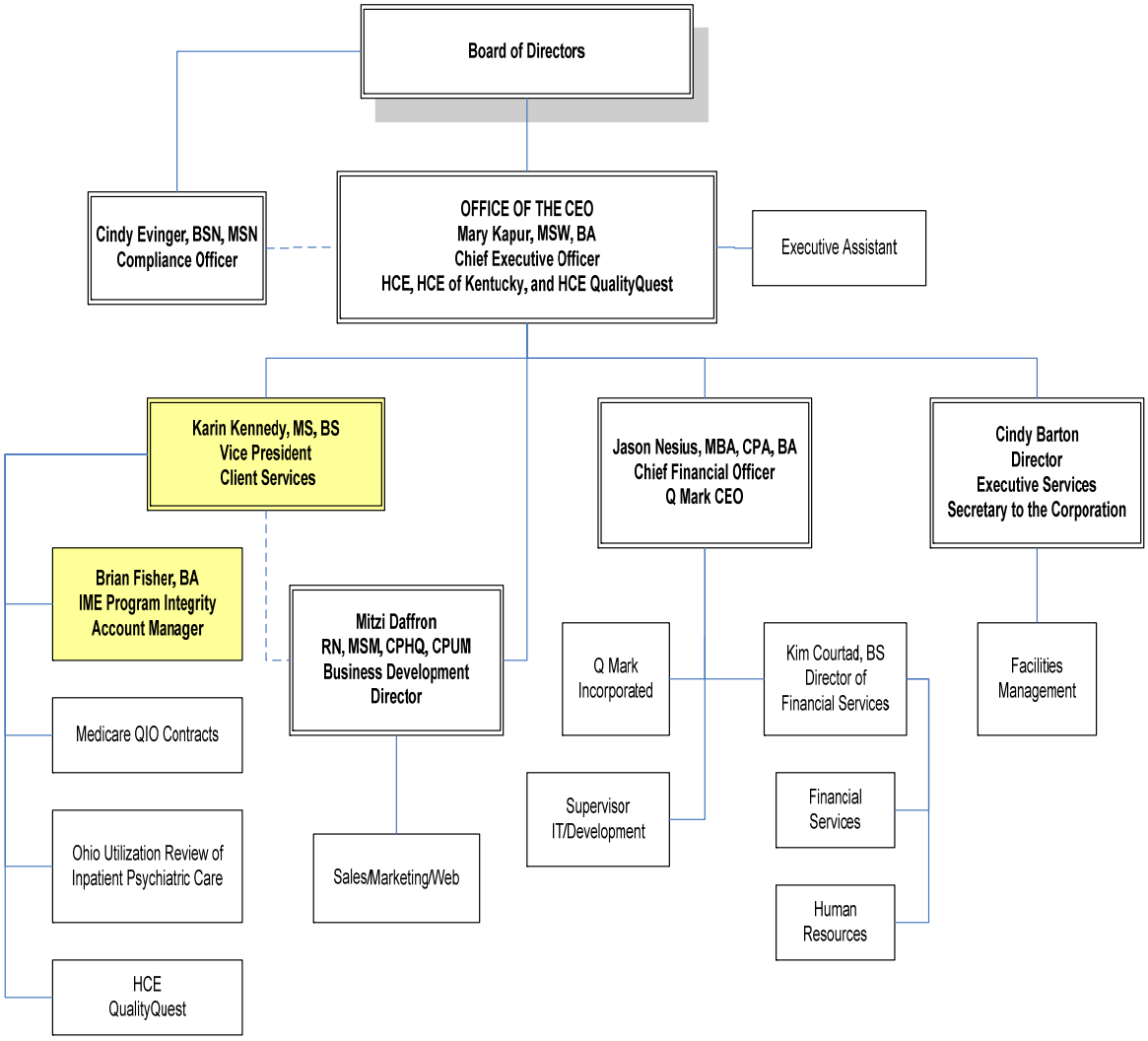
7.2.9 Corporate Qualifications

7.2.9.1 Corporate Organization

The Chief Executive Officer for Health Care Excel is Mary Kapur. She is the individual that is authorized to sign the IME Program Integrity contract. A corporate organizational chart has been provided below displaying the corporate structure and highlighting the organizational oversight of the IME project.

Figure 1: Corporate Organizational Chart



a. History of the organization

Health Care Excel (HCE) is a private, not-for-profit corporation dedicated to assisting health care professionals and organizations deliver high quality, cost-effective care. For more than 35 years, HCE has been providing evidence-based, objective, and independent monitoring of the quality, appropriateness, and medical necessity of health care services.

The corporation has a long history of demonstrated stability in successive renewal of Medicare and Medicaid contracts. Its long-standing contracts in the core business functions of health care cost containment, health care improvement, utilization, DRG/coding review, and quality of care review are strong indicators of customer satisfaction.

HCE holds contracts with several government agencies, including Medicaid contracts in Ohio, Kentucky, Iowa, and Missouri, as well as Medicare contracts in Indiana and Kentucky. HCE has held medical review and quality improvement grants and contracts since the 1970s, initially as one of seven Professional Standards Review Organizations (PSRO) in Indiana. The PSROs were predecessors to the current Medicare Quality Improvement Organizations (QIOs).

HCE has been designated as a Medicare Peer Review and Quality Control Organization (now known as QIOs) by the Centers for Medicare & Medicaid Services. It has served as the statewide Medicare QIO in Indiana and in Kentucky since 1988. Current contracts will be up for renewal in August 2011.

HCE has successfully implemented and functioned as the IME SURS contractor since the inception of the IME contract, meeting contract goals as established by the IME. SUR staff have developed strong working relationships with partners in Iowa, including the Medicaid Fraud Control Unit (MFCU), the Office of Inspector General (OIG), the Attorney General's office (AG), and its peer IME contractors.

b. Health Care Excel Management Staff Summaries

- **Mary Kapur, MSW, BA—Chief Executive Officer**
  Ms. Kapur, as the CEO of Health Care Excel, has ultimate responsibility for the Iowa Medicaid Program Integrity contract. Ms. Kapur was formerly the Chief Operating Officer for Health Care Excel and joined the organization in 1998. She has extensive experience in contract implementation and over 25 years of experience with state and county governments.

- **Jason Nesius, MBA, CPA, BS—Chief Financial Officer**
  Mr. Nesius serves as the CFO for Health Care Excel, and is responsible for oversight of human resource and financial operations for the corporation, as well as overseeing the information technology infrastructure. He has been with Health Care Excel since 2008.

- **Kim Courtad, BS—Director of Financial Services and Human Resources**
  Ms. Courtad directly oversees financial operations and human resource management for Health Care Excel. She has been with the corporation since 1990, serving in various capacities within the accounting and financial operations.

- **Karin Kennedy, MS, BS—Vice President, Client Services**
  Ms. Kennedy oversees all contract operations for Health Care Excel, including the Iowa Medicaid Enterprise SURS contract at the current time. She will continue to provide corporate oversight of the Program Integrity contract, with the Program Integrity Account Manager reporting directly to her. Ms. Kennedy has a strong background in contract management, having successfully managed and retained Medicare QIO contracts in Indiana and Kentucky.

- **Cindy Barton—Director of Executive Services**
  Ms. Barton has been with Health Care Excel for more than 23 years, serving in various capacities of support to the CEO and COO. Her current responsibilities include oversight of Board of Directors activities, including communication with the Board, scheduling of Board events, and development of Board meeting agendas.

- **Cindy Evinger, MS, BS—Compliance Officer**
  Ms. Evinger has served in various capacities within Health Care Excel, including having contract oversight of the Kentucky Medicare QIO contract and serving in an internal quality control capacity for the corporation. She has been with Health Care Excel since 1999 and currently serves as the corporation's Compliance Officer, reporting directly to HCE's Board of Directors.

c. Legal structure of the organization

Health Care Excel, Incorporated, was incorporated in 1974 in Indiana as a not-for-profit corporation. It is currently a 501(c)3 corporation managed through a Board of Directors, none of whom are owners or partners. Summary biographies of each HCE board member have been provided below.

Biographies of the Health Care Excel, Board of Directors

The maximum membership on the Health Care Excel (HCE) Board of Directors is 15. During 2007, the Board of Directors established that the election of its membership should be limited to six consecutive years. HCE complies with all standards for appropriate governance structure and functions.

Forrest Wayne Calico, MD, MPH, was elected to the Board of Directors in February 2008. Dr. Calico received his medical degree from the University Of Kentucky College Of Medicine and his Master of Public Health from the Harvard School of Public Health. During his 12-year tenure in the military, he served in various capacities both in the United States and abroad. Dr. Calico's

civilian experience ranges from various positions in senior management and includes serving as Senior Advisor on Quality, National Rural Health Association. Academically, he has been appointed Assistant and Associate Clinical Professorships. He is the recipient of numerous awards and honors, has published many papers, individually and as a coauthor, and is a popular lecturer in his area of expertise: rural health.

Jerry W. Chapman was elected to the Board of Directors in March, 2009. Mr. Chapman devoted more than forty-four years to providing public accounting and consulting services as the quality assurance partner on client engagements, primarily with the firms of Ernst & Young and Arthur Andersen & Co. During the last half of his career, his emphasis was on providing strategic, economic, financial, and managerial-oriented consulting services to health care industry clients. Although Mr. Chapman retired from active full-time public practice at the end of 1999, he continues to serve as a consultant to a select number of public, private, and not-for-profit organizations.

Mr. Ray J. Gans began his term on the Board of Directors in November 2007. Mr. Gans is a graduate of the University of Notre Dame with a Bachelor of Science in Electrical Engineering. He is currently a volunteer senior health insurance counselor for Indiana's State Health Insurance Assistance Program (SHIP). His expertise covers Medicare and Medicaid benefit needs and issues. He assists low-income individuals in obtaining free prescription drugs from pharmaceutical companies as well. During 2001, Mr. Gans retired as founder, chairman, and chief executive officer of Great Lakes Technology Corporation, a computer manufacturing company in South Bend, Indiana. In prior years, Mr. Gans was chairman and chief executive officer of the Commodore Corporation, manufacturer of modular homes and recreational vehicles doing business in the United States and Canada. He served as president of the Fort Wayne, Indiana division of International Telephone and Telegraph Corporation.

Michael Bowen Hoover, MD, was elected to the Board of Directors in May 2008. He earned his Bachelor of Pre-Medical degree at Vanderbilt University, and his medical degree from the Emory University School of Medicine. He has maintained certification from the American Board of Surgery since 1979. Dr. Hoover has served as a Clinical Instructor at the Indiana University School of Medicine, Evansville, for the past 22 years. He also is on the Active Staff at St. Mary's Medical Center and Deaconess Hospital, both in Evansville. Dr. Hoover has held numerous directorships and honoraria, including Chairman of the Board of Deaconess Hospital and Deaconess Health System, Vice Speaker and Speaker of the House of Delegates of the Indiana State Medical Association, President of the Indiana State Medical Association, and Member of the Vanderburgh County Medical Society's Board of Directors.

Carol Ireson, RN, PhD, began her term on the Board of Directors in November 2007 and is the current Chair of the Board of Directors of Health Care Excel, as well as Health Care Excel of Kentucky. She received her bachelors, masters, and doctorate degrees in nursing from the University Of Kentucky College Of Nursing. Dr. Ireson is a research consultant for the Center for Health Services Management and Research of the University of Kentucky. She has served as an associate professor in the College of Public Health at the University of Kentucky, and is an active international speaker.

Thomas E. Kaercher was elected to the Board of Directors in February 2008. His early advanced education focused on mechanical and civil engineering; special education in later years covered executive and purchasing management, accounting and financial management and human resources. Mr. Kaercher was executive vice president and general manager of Quality Mill Supply Company from which he retired. He retains a seat on their board of directors. Mr. Kaercher has served as the general manager of Strong Tool Company based in Cleveland, Ohio; president and CEO of Vonnegut Industrial Products in Indianapolis (later W. W. Grainger); and Union/Butterfield Division of Litton Industries where he rose from sales representative to Midwest regional manager.

Mr. William Keeney, JD, was elected to the Board of Directors in September 2004. He graduated from Indiana University with a Bachelor of Science, Business Administration degree, and received his Juris Doctorate from the University of Louisville Law School. He has been employed by JPMorgan Chase & Co. for more than 34 years and is currently vice president/city executive for Southern Indiana Business Banking. Mr. Keeney is certified in Civil Mediation and is admitted to practice law in the State of Indiana, the Southern Federal District of Indiana, and the Northern Federal District of Indiana. Mr. Keeney devotes time to his community by serving as a disaster response volunteer for the Clark County Chapter for the American Red Cross; is a board member (chairman emeritus) of LifeSpring, Inc., provider of community mental health services for six Southern Indiana counties; and is a board member for One Southern Indiana, an economic development and business services group dedicated to Clark and Floyd Counties, Indiana. Mr. Keeney also is a member of the Tau Kappa Epsilon Fraternity Board of Advisors at Indiana University Southeast.

Elizabeth McNamee, MPH, FACHE, began her term on the Board of Directors in November 2007. Ms. McNamee was recently elected Chair of the Board of Directors for Health Care Excel's nonprofit subsidiary, HCE QualityQuest. She graduated from Trinity University in San Antonio, Texas with a Bachelor of Arts degree in Biology and Chemistry. She received her Master of Public Health degree from the University of Texas. She is also a Fellow of the American College of Healthcare Executives. Ms. McNamee is the Associate Director, Community Innovation and Development, St. Luke's Health Initiatives in Phoenix, Arizona.

Wade Mountz, President Emeritus of Norton Healthcare was elected to the Board of Directors in May 2008. With a Master in Hospital Administration degree from the University of Minnesota, his extensive experience centered on the position of president of Norton Hospital, and its successor corporations. He retired in 1989 as President Emeritus. Other extensive activities included the Chairmanships of the Kentucky Hospital Association and American Hospital Association. He was the Kentucky Regent of the American College of Healthcare Executives (ACHE). He also served on the Boards of the Joint Commission, Blue Cross and Blue Shield of Kentucky, the Kentucky Board of Education (K-12), among many others. Mr. Mountz has received numerous awards including an honorary Doctor of Humane Letters from Kentucky Wesleyan College, the Gold Medal Award for Excellence in Hospital from ACHE, and was inducted into the 2008 Modern Healthcare—Health Care Hall of Fame.

d. Evidence of an Iowa business license

A copy of the Iowa Business Registration is provided below.

IOWA

No. W00433684
Date: 08/18/2005

SECRETARY OF STATE

504RFN-000315634
HEALTH CARE EXCEL, INCORPORATED

ACKNOWLEDGEMENT OF DOCUMENT FILED

The Secretary of State acknowledges receipt of the following document:

Certificate of Authority

The document was filed on August 15, 2005, at 10:40 AM, to be effective as of August 15, 2005, at 10:40 AM.

The amount of $25.00 was received in full payment of the filing fee.

STATE OF IOWA SEAL SECRETARY OF STATE

CHESTER J. CULVER SECRETARY OF STATE

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e. Established partnership relationships with the community

Health Care Excel has established partnerships within the Iowa Medicaid community through its current role as the IME SURS contractor. SURS staff members have strong working relationships with the MFCU, OIG, AG, and other IME contractors in performing the work of the SURS contract.

f. Current projects with similar services to the Program Integrity RFP

Iowa Medicaid Enterprise Surveillance and Utilization Review Services
Patricia Ernst-Becker, Program Integrity Director
Iowa Medicaid Enterprise
100 Army Post Road
Des Moines, Iowa 50315
(515) 725-1347
pernstb@dhs.state.ia.us

g. Other Current Projects

Project Title	**Medicare Quality Improvement Organization for Indiana and Kentucky**
Organization	Centers for Medicare & Medicaid Services Federal Office Building
Address	601 East 12th Street, Room 235 Kansas City, MO 64106
Telephone Number:	(816) 426-5746
Client Name:	Maribeth Fonner
Client Title	Project Officer
Client Telephone Number:	(816) 426-6349
Client Facsimile Number:	(816) 426-5525
Client E-mail Address	Maribeth.Fonner@cms.hhs.gov

7.2.9.2 Corporate Experience

Client Organization	**Iowa Department of Human Services** **Iowa Medicaid Enterprise**
Project Title	**Iowa Medicaid Enterprise Surveillance and Utilization Review Services (SURS)**
Telephone Number	(515) 725-1347
Client Reference Name	Patricia Ernst-Becker
Client Title	Executive Officer Program Integrity Director
Client Telephone Number	(515) 725-1347
Client Facsimile Number	(515) 725-1010
Client E-mail Address	pernstb@dhs.state.ia.us
Original Contract Start Date	July 1, 2004
Original Contract End Date	June 30, 2010
Average Staff Hours in FTEs	12 FTEs
Total Contract Value to the Bidder's Organization	07/01/2004—06/30/2010 $8,937,517
Workload Statistics for SFY 2009	Cases Reviewed—413 Overpayment Recovered on Cases—190 Appeal cases—25 Referrals for Fraud and Abuse—42

Description of Work—Health Care Excel is the current IME SURS contractor. Within this contract, HCE analyzes claims data to identify aberrant patterns and trends, and initiates provider reviews to determine if payment was made appropriately for the services provided. Claims reviews are also initiated to determine if there are aberrancies in claims submission, such that a claims edit would sufficiently eliminate a payment error. Referrals are received from Medicaid recipients, providers, other IME contractors, and state agencies (MFCU, OIG) and investigations are initiated to determine the appropriate course of action. Cases in which there is suspected fraud and/or abuse are referred to the appropriate agency, such as the Medicaid Fraud Control Unit.

HCE is the prime contractor and has no subcontractor for the current work.

Client Organization	**Missouri Department of Social Services** **MO HealthNet Division**
Project Title	**Medicaid Prior Authorization and Utilization Review Services**
Telephone Number	(573) 751-3277
Client Reference Name	Lynn Hebenheimer
Client Title	MO HealthNet Supervisor
Client Telephone Number	(573) 751-3277
Client Facsimile Number	(573) 526-4651
Client E-mail Address	Lynn.R.Hebenheimer@dss.mo.gov
Original Contract Start Date	July 1, 2001
Original Contract End Date	December 31, 2009
Average Staff Hours in FTEs	17 FTEs
Total Contract Value to the Bidder's Organization	• 07/01/2005—09/30/2009, Unit Price contract, up to $2.1 million per year • 10/01/2009—12/31/2009, Fixed Price contract value $927,421
Workload Statistics	Have processed 582,253 utilization reviews since July 1, 2005, averaging nearly 140,000 reviews per year.

Description of Work—Health Care Excel has provided Medicaid Utilization Review services to the State of Missouri since November 2001, primarily performing prior authorization reviews and medical necessity validation reviews. HCE conducts prior authorization of requests for hospital admission and continued stay; reviews a sample of post-payment review certified cases (validation of medical necessity); conducts review of augmentative communication devices; conducts the review of certificate of need for psychiatric facilities; and conducts provider education.

HCE is the prime contractor for the Missouri contract with no subcontractor.

Client Organization	**Kentucky Cabinet for Health and Human Services**
Project Title	**Kentucky Medicaid Surveillance & Utilization Review**
Telephone Number	(502) 562-5472
Client Reference Name	Angie Lawrence
Client Title	Program Integrity Director
Client Telephone Number	(502) 562-5472
Client Facsimile Number	(502) 564-3232
Client E-mail Address	Angie.Lawrence@ky.gov
Original Contract Start Date	April 1, 2008
Original Contract End Date	December 31, 2009
Average Staff Hours in FTEs	11 FTEs
Total Contract Value to the Bidder's Organization	04/01/2008—12/31/2009, $4,937,597
Workload Statistics	Conducted 10 SURS projects from April 1, 2009 through December 31, 2009, resulting in 1,252 demand letters to providers. Conducted 24 on-site audits and 64 medical record audits. Total dollars recouped through SURS activities during this time period was $1,257,360; total in outstanding overpayments was $4,552,075; and total cost savings identified was $1,571,529.

Description of Work—Health Care Excel has performed as the Surveillance and Utilization Review contractor for Kentucky Medicaid since 2008. Contractual responsibilities include data mining and trending, identification of aberrancies, post-payment reviews, on-site audits, and appropriate referrals to state agencies in cases of suspected fraud and/or abuse. Responsibilities also include recoupment of overpayment as appropriate.

HCE is the prime contractor and subcontracts with Thomson Reuters for this current work.

Client Organization	**Centers for Medicare & Medicaid Services**
Project Title	**Medicare Quality Improvement Organization for Indiana and Kentucky**
Telephone Number	(816) 426-5746
Client Reference Name	Maribeth Fonner
Client Title	Project Officer
Client Telephone Number	(816) 426-6349
Client Facsimile Number	(816) 426-5525
Client E-mail Address	Maribeth.Fonner@cms.hhs.gov
Original Contract Start Date	August 1, 2008
Original Contract End Date	July 31, 2011
Average Staff Hours in FTEs	35 FTEs
Total Contract Value to the Bidder's Organization	Indiana QIO, 08/01/2008—07/31/2011, $10,982,881 Kentucky QIO, 08/01/2008—07/31/2011, $ 7,142,106
Workload Statistics	1,285 utilization reviews completed since August 1, 2008.

Description of Work—Health Care Excel has held the Indiana and Kentucky Medicare QIO contracts since 1988 with successful, non-competitive renewals for the past six years. Through the QIO contracts, HCE works with health care providers in Indiana and Kentucky to implement quality improvement efforts in the hospital, nursing home, and physician office settings. These efforts include implementation of electronic health records in the physician offices, reducing the use of restraints in nursing facilities, and reducing hospital-acquired infections in the hospital setting, to name a few. Also included in the QIO contracts is a beneficiary protection component which involves case reviews initiated from beneficiary complaints, hospital-issued notices of non-coverage, EMTALA violations, and requests for higher-weighted DRGs. Under the Indiana QIO contract, a special study was awarded to implement a Care Transitions project in a defined area within the State. HCE is currently working with various health care providers and community organizations to improve the transition of care within the Evansville, Indiana area.

HCE serves as the prime contractor for both the Indiana and Kentucky QIO contracts and has no subcontracts.

Client Organization	**Ohio Department of Mental Health**
Project Title	30 East Broad Street, 7th Floor Columbus, OH 43215
Telephone Number	(614) 466-9982
Client Reference Name	Terry R. Jones, LISW
Client Title	Manager of Program Compliance
Client Telephone Number	(614) 466-9982
Client Facsimile Number	(614) 644-1503
Client E-mail Address	jonestr@mh.state.oh.us
Original Contract Start Date	July 1, 1996
Original Contract End Date	June 30, 2010
Average Staff Hours in FTEs	6 FTEs
Total Contract Value to the Bidder's Organization	07/01/2006—06/30/2010, $4,577,773
Workload Statistics	96,591 utilization reviews over the period of 2003 to 2008. Average 16,099 reviews per year.

Description of Work—In 1996, HCE was awarded the first contract procured by the Ohio Department of Mental Health to evaluate inpatient psychiatric hospital admissions, conduct on-site post-payment reviews, maintain criteria, distribute a provider manual, and conduct provider education. HCE continues this work and provides an annual report to the ODMH regarding reviews processed and savings identified for the State.

For this contract, HCE serves as the prime contractor and has no subcontractor.

THOMSON REUTERS (HEALTHCARE), INC.

Company Overview

Thomson Reuters produces insights, information, benchmarks, and analysis that enable organizations to manage costs, improve performance, and enhance the quality of healthcare. Thomson Reuters is the world's leading source of intelligent information for businesses and professionals. The company combines industry expertise with innovative technology to deliver critical information to leading decision makers in the healthcare, financial, legal, tax, and accounting, scientific, and media markets, powered by the world's most trusted news organization. With healthcare headquarters in Ann Arbor, Michigan and major operations in New York and Eagan, Minnesota, Thomson Reuters employs more than 50,000 people in over 100 countries.

Independent and Objective

Thomson Reuters is not owned or controlled by any health plan, pharmaceutical company, or healthcare provider. It is therefore able to provide consulting and support using an objective assessment of the best solution for its customers.

A Focus on Healthcare Results

The healthcare business of Thomson Reuters was founded in 1981 to help Fortune 500 corporations obtain better information with which to control employee health benefit costs. In the mid-1980s, its systems were enhanced to meet the needs of managed care plans and insurers. In the early 1990s, Thomson Reuters augmented its solution to include advanced analytic reporting, data warehousing, and decision support to meet the emerging needs of state Medicaid agencies. The company has built its leadership reputation by seamlessly integrating databases, software, and people to help its customers achieve measurable improvements in business operations and clinical performance.

a. Relevant governmental experience with the functional areas and RFP requirements

State Medicaid Expertise

Thomson Reuters has vast expertise in clinical analysis and the business of healthcare, as well as healthcare technology. Its reputation and staff expertise are just two reasons why state and federal agencies around the country choose Thomson Reuters for important and highly visible projects. The project summaries below demonstrate the company's experience with:

- Data analytics, research, and consulting services to state and federal clients;
- SURS and program integrity functionality in conformance with expanding and ongoing Medicaid programs;
- Medicaid Managed Information Systems, including certification activity experience.

Medicaid experience is one of the core strengths of Thomson Reuters. The company has in-depth expertise providing large-scale data warehouses, decision support systems, and analytic services to state Medicaid programs and other state and federal agencies. They understand the particular challenges of integrating both traditional and non-traditional Medicaid data types. Thomson Reuters has integrated managed care and fee-for-service data for many Medicaid agencies. They also link the Decision Support System (DSS) to patient assessment data, vital statistics, and other types of data that are not commonly stored in Medicaid databases. Identifying strategies for integrating these types of data in an analytically effective manner requires more than just technical experience – it requires expertise in how to make correct analytic interpretations of the data. Thomson Reuters acquired that expertise over the years in many complex integration projects for the federal government, state government, and private customers as well.

Thomson Reuters currently provides systems and services 26 state Medicaid agencies representing over 30 million covered lives. The array of services provided in each state varies and may include:

- Data warehouses
- Surveillance and Utilization Reporting Systems (SURS)
- Fraud and abuse detection services
- Management and Reporting Systems (MARS)
- Decision support systems
- Encounter data management
- Quality of care/provider profiling services
- Various research and consulting services

Table 1 lists the state Medicaid agencies that use one or more of the Thomson Reuters offerings. In addition, the list includes a notation as to Thomson Reuters' role as a prime or subcontractor.

Table 1—Thomson Reuter Contract List by State Medicaid Agency

State Medicaid Agency	Thomson Reuters Prime or Subcontractor
Alaska Department of Health Services	Subcontractor
Alabama Public Health Department (SCHIP Program)	Prime
District of Columbia Department of Health	Subcontractor
Georgia Community Department of Community Health	Prime
Idaho Department of Health and Welfare	Prime
Illinois Department of Healthcare and Family Services	Prime
Kansas Health Policy Authority	Prime
Kentucky Cabinet for Health and Family Services, Department of Medical Services (KY Office of Inspector General)	Subcontractor
Louisiana Department of Health and Hospitals	Subcontractor
Maine Department of Health and Human Services	Subcontractor
Maryland Department of Health and Mental Hygiene	Prime
Michigan Department of Community Health	Subcontractor
Minnesota Human Services Department	Prime
Mississippi Division of Medicaid	Subcontractor
Missouri Department of Social Services MO HealthNet Division (Missouri Medicaid)	Prime
Nebraska Department of Health and Human Services	Prime
Nevada Division of Health Care Financing	Subcontractor
New Hampshire Department of Health and Human Services	Prime
New Jersey Department of Human Services	Subcontractor
New York State Department of Health	Subcontractor
North Dakota Department of Human Services	Prime
Ohio Department of Job and Family Services	Prime
Pennsylvania Department of Public Welfare	Prime
Rhode Island Department of Human Services/ Medicaid	Prime
South Carolina Department of Health and Human Services	Prime
West Virginia Department of Health and Human Services, Bureau for Medical Services	Subcontractor

Below are relevant summaries showing how Thomson Reuters has worked with some of these state customers in the past five years.

- **GEORGIA—**The Georgia Department of Community Health (DCH) Program Integrity unit and OIG use Advantage Suite and DataProbe as a comprehensive fraud detection solution. Thomson Reuters has provided analytic support for DCH since 1998 and continue to provide data analysis and algorithm development, which the DCH Program Integrity unit uses for prioritizing follow-up desk and field audits. As just one example of the value of these algorithms, DCH used the "policy code pair violations" algorithm on just a few clearly defined policy coding violations and identified approximately $750,000 in overpayments, which was initiated without extensive audits or investigation.

- **IDAHO—**Thomson Reuters is designing, developing, and implementing a comprehensive healthcare decision support system and data warehouse (DSS/DW) for the Idaho Department of Health and Welfare (DHW) as part of the State's efforts to modernize its MMIS. The DSS/DW system will improve DHW's ability to manage and mine data from 9 million healthcare claims submitted to the state Medicaid program each year.

  The contract was awarded in late 2007 and the implementation process is well underway. DHW will use the analytic and reporting capabilities of the DSS/DW to strengthen management of Medicaid programs, measure cost effectiveness and quality of care, forecast budgets, and fulfill federal Management and Administrative Reporting (MAR) requirements. The system will generate information that supports program planning and evaluation, financial reporting, healthcare utilization management, Medicaid eligibility analysis, actuarial rate setting, and other functions. It will also serve as the Department's Surveillance and Utilization Review System (SURS).

- **KENTUCKY—**The Kentucky Cabinet for Health and Family Services is responsible for the administration of the Commonwealth's Medicaid program, which serves more than 700,000 beneficiaries. The Cabinet's Inspector General, who has the responsibility for Medicaid Program Integrity, operates independently from the Medicaid program. The Inspector General's Division of Fraud, Waste, and Abuse Identification and Prevention (DFWAIP) focuses on Medicaid oversight, examining both provider and member issues. The Medicaid Surveillance and Utilization Review (SUR) function is performed by DFWAIP.

  In April 2008, DFWAIP contracted with Health Care Excel and its subcontractor, Thomson Reuters, to make Kentucky's SUR function state of the art, and prepare Kentucky to meet future federal standards for Program Integrity best practices. Thomson Reuters' role is to provide data analysis and fraud detection algorithms to support Health Care Excel's and the Commonwealth's audit and review activities. Thomson Reuters and HCE work together to provide technical and educational support to Kentucky to fully identify fraud, rule out potential erroneous/fraudulent billing

through clinical reviews and audits, identify opportunities for system payment edits and audits, and generally take a more comprehensive approach to provider and recipient utilization review and control. The goal of the services is to enhance/expand Kentucky's existing Program Integrity practices to align with all current and upcoming federal initiatives, and to equip Kentucky staff with state-of-the-art SURS methodologies.

Thomson Reuters supports the Kentucky contract with our DataProbe system for in-depth data investigation, as well as Medstat Auto-Audit code editing software, and our Payment Integrity Algorithm Library. Thomson Reuters is building a 5-year database containing all of the Kentucky Medicaid claims and eligibility data, and will use DataProbe to mine the data to detect patterns of behavior that would indicate the need for possible provider or member education and/or sanction, as well as opportunities for payment recovery. A full-time Thomson Reuters analyst will be stationed in Frankfort to provide daily ongoing assistance to the Commonwealth and to HCE.

- **MISSOURI—**The Missouri Department of Social Services, MO HealthNet Division (MHD), is the Medicaid agency for Missouri. Since 1997, Thomson Reuters has provided Advantage Suite as a comprehensive decision support system, and then as a fraud and abuse detection system. The system supports the agency's overall program monitoring and investigation needs and is used to manage health costs, quality, and access to care. Missouri also uses DataProbe as a data mining tool to enhance fraud detection, and uses our services to develop fraud algorithms in DataProbe. Approximately 40 MHD users access our systems.

  In addition to delivering approximately 45 fraud algorithms to date, Thomson Reuters has conducted a comprehensive PI review and gap analysis for MHD. As a result, MHD gave Thomson Reuters the primary responsibility for claims-based investigations, with the goal of streamlining the investigative process. The MHD PI unit had a target of $25 million in recoveries in SFY 2008. With support from the Thomson Reuters account team, they exceeded their goal.

- **NORTH DAKOTA—**The Department of Human Services (DHS) is the Medicaid agency for North Dakota. In 1996, the North Dakota Department of Health retained Thomson Reuters' services to build and implement a data warehouse and DSS, using DataProbe, which integrated data from all of the state's healthcare payers (private and public, including Medicare).

  In November 1999, DHS assumed responsibility for the Thomson Reuters contract from the Department of Health. The database was converted for DHS' use for monitoring the Medicaid program and the Medicaid database was expanded, enhanced, and extended. Thomson Reuters was responsible for designing the database, providing comprehensive implementation services, updating the database, and maintaining the software. Thomson Reuters also provides ongoing analytic consultation. North Dakota's Medicaid program covers approximately 60,000 individuals and contains 11 years of data. DHS uses the system to project the cost of proposed benefit changes for

this population; track the impact of previous plan and program changes; detect waste, fraud and abuse; monitor prescription drug utilization and costs; and design disease management initiatives, among other applications

- **SOUTH CAROLINA—** The South Carolina Department of Health and Human Services (DHHS) uses Advantage Suite and DataProbe as its comprehensive SURS and fraud detection solution. The systems are used collaboratively by DHHS' users and by the Thomson Reuters account team. Over a two-year period, DHHS recovered more than $9.2 million from Medicaid providers and beneficiaries by using the fraud and abuse algorithms and methodologies that were developed by Thomson Reuters. Support is provided to DHHS by conducting proactive analysis and making recommendations for audit and investigation. Thomson Reuters algorithms have assisted DHHS in developing cases for prosecution and changing reimbursement policy to prevent future overpayment.

Federal Healthcare Expertise

Thomson Reuters provides services to the Centers for Medicare and Medicaid Services (CMS) for numerous projects to combat fraud, waste, and abuse:

- **Medicare Program Safeguard Contractor—**Thomson Reuters serves as the fraud detection software and data analysis subcontractor to CSC AdvanceMed, a Medicare Program Safeguard Contractor (PSC) in 14 states. As a part of this team, Thomson Reuters has provided the analytic data warehouse development, analytic systems, reporting, and healthcare fraud domain expertise on several PSC task orders encompassing millions of Medicare beneficiaries. Thomson Reuters integrates data from Medicare Part A, Part B, Home Health, Durable Medical Equipment, and provider data from multiple source systems, as well as beneficiary enrollment data. Thomson Reuters designed, developed, implemented, maintains and operates a multi-state database to facilitate rapid fraud detection and analysis and provides DataProbe for rules-based data mining. Through this contract, the AdvanceMed Team has identified tens of millions of dollars in Medicare program fraud, waste, abuse, overpayments, and vulnerabilities. The Thomson Reuters data warehouse environment is updated monthly and currently includes 5+ Terabytes of data for over 12 million Medicare beneficiaries.

- **OnePI and IDR—** One PI is a CMS initiative to link Medicaid and Medicare data analytically in support of cross-program fraud detection analytics ("Medi-Medi") at the national level. Thomson Reuters is part of a team to deliver the Medicaid integrated data repository for CMS, linking the Medicaid data to Medicare data in support of Medi-Medi program integrity analytics. The architecture for this project uses the Teradata relational database management system as the back-end database and Business Objects and the Thomson Reuters Advantage Suite decision support tools as the initial front-end analytic applications. The overall solution enables advanced analytics of Medicare and Medicaid data via a modernized portal infrastructure. The solution includes advanced methods such as episodes of care, hospital admissions, and

other analytic constructs from Thomson Reuters that will provide enhanced fraud and abuse detection capabilities. The solution integrates data across the Medicare and Medicaid programs and will integrate all claim types (Part A, Part B, DME, Home Health and Hospice, and potentially Part D) into a single repository that will provide proven views to help detect fraud, waste, and abuse.

The initial data sets included in the implementation of this data warehouse are the Ohio and Pennsylvania Medicaid claims and enrollment data. Separate data are received per state as well as per data type (professional, facility, drug, eligibility and provider), making the data loading process complex. The project focus has shifted to Medicare data this year with the goal of incorporating all 45 million beneficiaries into the data warehouse. Thomson Reuters' experience in healthcare, data integration, and data quality has played a key role in the success of building the One PI system. The company has developed over 30 in-depth fraud scenarios and has demonstrated their effectiveness to CMS. Recent studies have focused on provider profiling and providers with suspect activity.

The Integrated Data Repository (IDR) is a CMS initiative to create an integrated database of Medicaid and Medicare data for every state in the union. The IDR project exists to support joint program integrity analytics at the national level and is part of the One PI project. As noted above, Thomson Reuters is implementing the Advantage Suite decision support tool, which will access the IDR data. To date, the IDR data includes the nation's Medicare data. The production implementation is scheduled for late 2009, at which time end users will be able to access the system and begin using the Thomson Reuters Advantage Suite system specifically to research and investigate fraud, waste, and abuse.

- **MIC - IDIQ—**In early 2008, The Centers for Medicare & Medicaid Services (CMS) awarded Thomson Reuters an Indefinite Delivery Indefinite Quantity (IDIQ) umbrella contract under CMS' Medicaid Integrity Program's Review of Providers procurement. Under this umbrella award, Thomson Reuters is eligible to compete for the awarding of a task order to assist CMS Medicaid program integrity efforts by reviewing the actions of Medicaid providers to identify potentially fraudulent Medicaid payments. Fraud, waste, and abuse will be detected by analyzing Medicaid claims and forwarding fraud leads to the Medicaid Integrity Program's Audit of Providers contractors, which will be tasked by CMS to conduct audits of the providers.

  Since the IDIQ was awarded in 2008, Thomson Reuters has won three Task Order contracts as described below.

  - **MIC Task Order 1—**Thomson Reuters is assisting CMS in promoting Medicaid program integrity by identifying inappropriate claim payments and reviewing the actions of Medicaid providers to identify potentially fraudulent Medicaid payments for the following states: Alabama, Delaware, District of Columbia, Florida, Georgia, Kentucky, Maryland, Mississippi, North Carolina, Pennsylvania, South Carolina, Tennessee, Virginia, and West Virginia. Fraud,

waste, and abuse is detected by analyzing Medicaid claims and forwarding potential overpayments and fraud leads to CMS Medicaid Integrity Group (MIG), who forward to CMS Division of Field Operations or the Audit MIC for review and action as appropriate.

In seven months, Thomson Reuters delivered 126 algorithms to CMS representing over $525,000,000 in estimated potential overpayments. Of that amount, reports that included approximately $180,000,000 have passed both the Thomson Reuters and CMS quality assurance process and have been passed on to the Division of Field Operations for further vetting prior to being turned over to the Audit MIC. Thomson Reuters anticipates that by the end of the contract year, it will have submitted more than 150 algorithms representing well over $600,000,000 in potential overpayments.

To date, these algorithms have been largely requested by CMS, based on logic at least partially supplied by CMS. Thomson Reuters has begun the process of finding additional algorithms to suggest to CMS for future consideration. This process involves researching known algorithms to determine which of those are likely to produce results using only MSIS data. A narrowly focused data investigation is performed against the MSIS database (possibly followed by a sample algorithm run) to determine the viability of the algorithm. As of the end of February 2009, one algorithm had been submitted to CMS for consideration. Additional brainstorming sessions utilized Thomson Reuters subject matter experts, to look beyond our library of known algorithms and suggest additional algorithms based on current trends in fraud and abuse. Several of these are being reviewed, and we anticipate being able to start submitting at least one or two new suggestions per month to CMS.

- **MIC - Task Order 2**—Thomson Reuters was selected as a subcontractor to AdvanceMed to assist CMS in promoting Medicaid program integrity by identifying inappropriate claim payments and reviewing the actions of Medicaid providers to identify potentially fraudulent Medicaid payments for the following states: Arkansas, Colorado, Louisiana, Montana, New Mexico, North Dakota, Oklahoma, South Dakota, Texas, Utah, and Wyoming. Fraud, waste, and abuse is detected by analyzing Medicaid claims and forwarding fraud leads to the Medicaid Integrity Program's Audit of Providers contractors, who will work with their respective states and CMS field offices for review and action as appropriate. Since the beginning of the project, the Thomson Reuters team has submitted 15 assignments to CMS, for total overpayments of $16,334,924.

- **MIC - Task Order 5**—Thomson Reuters recently won an additional task order under the MIC IDIQ to assist CMS in promoting Medicaid program integrity by identifying inappropriate claim payments and reviewing the actions of Medicaid providers to identify potentially fraudulent Medicaid payments for the following states: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont, New Jersey, New York, Puerto Rico, and the Virgin Islands. Fraud,

waste, and abuse is detected by analyzing Medicaid claims and forwarding potential overpayments and fraud leads to CMS Medicaid Integrity Group (MIG) , who forward to CMS Division of Field Operations or the Audit MIC for review and action as appropriate.

- **Zone Program Integrity Contractor (ZPIC) Zone 4**—Thomson Reuters is part of a team responsible for the detection, deterrence, and prevention of fraud, waste, and abuse across all Medicare types for Task Order 1 and Medicare-Medicaid data matching (Medi-Medi) for Task Order 2 for the following states: Colorado, New Mexico, Oklahoma, and Texas. ZPICs are responsible for ensuring payments are appropriate and consistent with Medicare coverage, coding, and audit policy. Thomson Reuters' tasks include:

  - ✓ Data analysis and mining to support fraud detection and investigation
  - ✓ Fraud pre and post payment medical reviews to support fraud investigations
  - ✓ Fraud case development, complaint processing, and law enforcement support
  - ✓ Cost report audits
  - ✓ Provider education related to fraud activities and post-payment medical review

  Thomson Reuters is specifically responsible for implementing the initial data warehouse for this zone and working with Health Integrity (the prime contractor) to maintain four years of ongoing historical data for Medicare and Medicaid claims for all Medicare beneficiaries and Medicaid recipients in Zone 4.

  Thomson Reuters implemented Texas Medicaid data ahead of schedule in early April 2009. During that same month, Thomson Reuters released Medicare Part B claims data two months ahead of schedule. We have also released DME claims, and will release inpatient, outpatient, and SNF claims by mid-June of 2009. Throughout, Thomson Reuters has met its goals ahead of the promised deadline and with very good quality.

- **A/B MAC J3**—Thomson Reuters is part of a team working on Part A and Part B Medicare claims for six states. The prime contractor, Noridian Administrative Services, serves as the first point-of-contact for processing and paying fee-for-service claims from hospitals and other institutional providers, physicians, and other practitioners in Arizona, Montana, North Dakota, South Dakota, Utah, and Wyoming. The primary goal of A/B MAC J3 is to integrate Part A and Part B data to improve claims payment accuracy. MAC J3 was the first A/B MAC awarded by CMS. As part of the team, Thomson Reuters leads the medical review data analysis activities of the A/B MAC J3 workload. To support the data analysis function, Thomson Reuters created and is maintaining a database of J3 claims history through the use of Thomson Reuters' DataProbe. The data is also enhanced with Thomson Reuters' Medical Episode Grouper, which enables more efficient analysis. Thomson Reuters also works to identify applicable comparative benchmarks for analytical use with the database.

  In addition to the database activities, Thomson Reuters provides ongoing data analysis and reporting to support the prime contractor in fulfilling its medical review, policy

development, and education obligations under the Statement of Work. Thomson Reuters is also responsible for recommending topics to the prime contractor for Local Coverage Decisions based on the results of the data analysis. In its three years on the MAC J3 team, Thomson Reuters has repeatedly exceeded expected delivery dates set by CMS.

b. Relevant commercial experience with the functional areas and RFP requirements

Thomson Reuters has more than 200 employer customers and 85 health plan customers. Our customers in Iowa include two of the state's largest insurers: The Principal Financial Group and Wellmark Blue Cross Blue Shield of Iowa.

- The Principal Financial Group—Principal has been a Thomson Reuters customer since 2003. Their Advantage Suite database was originally developed to support 850,000 member lives. Following inception, Principal expanded its database to include another division of its operation, resulting in the addition of approximately 1 million more lives. Principal uses a range of Thomson Reuters analytical applications, including Advantage Suite, Medical Episodes Grouper, DCGs, and Account Group Reporting, to provide improved employer group reporting and medical analytic reporting to their national accounts.

- Wellmark BCBS— Thomson Reuters provides Wellmark BCBS a comprehensive data analytic service package that provides a mix of data management services, reporting applications, consultative expertise, training, and customer networking opportunities.

c. Other experience with governmental healthcare programs

Thomson Reuters' analytic and research expertise underlies our history of many successful, collaborative partnerships. Some of our research and analytic projects for State healthcare programs in the past five years include:

- California Healthcare Foundation—TRH is a subcontractor to the RAND Corporation on this grant to analyze health care costs, utilization, and quality of care for members of high-deductible and consumer-driven health plans.

- Iowa Dept of Elder Affairs—After Iowa received a Real Choice Systems Change grant in 2007 from CMS, Thomson Reuters developed a State Profile Tool to assess the State's long-term care system.

- Maine Quality Forum - Maine Hospital Quality Snapshots—Thomson Reuters designed and developed the Maine Hospital Quality Snapshots Web site for the Maine Quality Forum, part of the State of Maine Governor's Office. The purpose of the Web site is to make information on the quality of care in Maine hospitals easily accessible to users and providers of hospital services in Maine.

- **Minnesota Department of Human Services - National State Profile Tool**—Development of a State Profile Tool to assess the State of Minnesota's long-term care system. The State Profile Tool will describe the long term support delivery systems for seven population groups (older adults, adults with physical disabilities, adults with mental retardation/developmental disabilities, children and adults with mental illness, adults living with HIV/AIDS infections, adults with traumatic brain injuries, and children with special needs).

- **Minnesota Department of Human Services - Participant Experience Survey Instruments**—Thomson Reuters developed and tested a modified version of the Participant Experience Survey (PES) for use with participants in the four HCBS waivers operated by the Disability Services Division.

- **Pennsylvania Bureau of Autism**—Thomson Reuters provided consulting services to assist the State in the redesign of the service delivery system for both children and adults with autism spectrum disorders. Thomson Reuters developed policy recommendations and provided technical assistance to programmatic and operational issues.

- **Pennsylvania Department of Public Welfare – Home and Community-Based Services Reform**—To provide research, analytics, and technical assistance supporting the State's efforts to improve the financing and administration of its home and community-based services and long-term services for adults with disabilities and long-term needs.

- **Rhode Island Department of Human Services**—Thomson Reuters designed the Community Support Management Module for the Rhode Island CHOICES project.

- **Virginia Department of Medical Assistance Services**—Thomson Reuters is developing a State Profile Tool that will serve as an assessment of the Commonwealth's long-term care system by target group. This assessment will analyze trends in service delivery, use, and spending, and will identify strengths and weaknesses of the Commonwealth's LTC system. Also, Thomson Reuters will perform an evaluation of the Commonwealth's home and community-based services systems transformation effort (funded in large part by a 2006 CMS Systems Transformation Grant).

Some Thomson Reuters projects in the last five years for other Federal healthcare programs (in addition to 30 research and analytic projects for CMS) include:

- **Army MEDCOM**—Thomson Reuters provides comprehensive evidence-based drug, disease, toxicology, and patient education reference information to Army healthcare providers.

- **Centers for Disease Control and Prevention—**The CDC contracted with Thomson Reuters to conduct a Landscape Assessment of employer efforts in the area of Workforce Health Promotion and Safety (WHPS). This initiative reflects the CDC's strategic objective to understand the state of the WHPS field – focusing on the integration between Health Promotion and Occupation and Environmental Safety, and to identify the gaps in the field.

- **Department of Defense - Consortium on Complex Chronic Illness—** Thomson Reuters provided the DoD with essential data needed to identify and prioritize opportunities for quality improvement in caring for those Military Health System (MHS) beneficiaries with complex chronic illness.

- **Department of Defense - Development of Appropriate Health Data Benchmarks for Retired Military Members—** For this project, Thomson Reuters will: 1) Assist in the development of plan participation assumptions, based upon demographic information provided by OACT, in addition to TRICARE benefit plan information. Using the MarketScan Database containing information from enrolled retirees with employer-sponsored benefits, Thomson Reuters will produce recommended benchmark statistics for utilization and cost measures. 2) Assist in the development of valuation trend rate assumptions, by analyzing the cumulative and separate effects of changes in retiree participation and pure health care trends – contemporaneous health care trends from normal increases in use and cost for retirees. 3) Satisfy special, ad-hoc reporting and analysis needs of the OACT. These may relate to changes in cost-sharing provisions, or changes to the Medicare and/or TRICARE health benefits.

- **Department of Defense TEAMS Indefinite Delivery Indefinite Quantity Contract (IDIQ) - TRICARE Evaluation Analysis and Management Support—**The Military Health System (MHS) continuously assesses and analyzes the quality of care they provide. One mechanism for gathering objective information includes external healthcare professionals and organizations in the performance assessment process. The National Quality Management Program provides for the coordination of external review of care functions and is supported through contracted services managed by the Office of the Chief Medical Officer at TMA. Thomson Reuters has received continual feedback from DoD and the TMA Clinical Quality Management Support Team indicating the solutions provided under this contract are extremely beneficial for improving quality patient care, Joint Commission accreditation, and management oversight.

- **Department of the Navy—**Thomson Reuters provides comprehensive evidence-based drug, disease, toxicology, and patient education reference information to Navy healthcare providers through multiple platforms, including: Internet, Intranet, Personal Digital Assistants (PDAs), and CD-ROM for 63 hospitals and clinics throughout the world.

- **Food and Drug Administration—**Thomson Reuters provides the FDA comprehensive evidence-based drug, complementary and alternative medicine, disease, and toxicology reference information for use in their programs.

- **Indian Health Services—**Thomson Reuters provides comprehensive evidence-based drug, disease, toxicology, and patient education reference information to IHS Albuquerque, New Mexico hospital healthcare providers. These solutions save time, improve patient safety, and quality of care by reducing medical errors, aligning with emerging standards of care and integrating evidence-based medicine and best practices for patient diagnosis and treatment.

- **National Institutes of Health—**Thomson Reuters provides comprehensive evidence-based drug, disease, and toxicology reference information for use in their programs.

- **Veterans Integrated Service Networks—**Thomson Reuters provides comprehensive evidence-based drug, disease, toxicology, and patient education reference information to VA healthcare providers through multiple platforms, including: Internet, Intranet, Personal Digital Assistants (PDAs), and CD-ROM for VA hospitals throughout the country.

d. For up to five projects in each category, the bidder shall provide the following items in the project summaries:

1. **Project title**
2. **Client organization name**
3. **Client reference contact name, title, and current telephone number**
4. **Original contract start and end dates**
5. **Total contract value to the bidder's organization**
6. **Average staff hours in FTEs during operations**
7. **Workload statistics**
8. **Brief description of scope of work that demonstrates relevance to this contract**

Proof of the quality of Thomson Reuters systems and services is available through feedback gathered from the best possible source – their customers. With this in mind, we encourage communication with current Thomson Reuters customers to hear first-hand the value they received.. In the following pages, we are pleased to provide the requested project information.

Client Organization	**Georgia Department of Community Health (DCH)**
Project Title	Data Warehouse System with Decision Support and Executive Information Capabilities
Client Reference Name	Darrell Dees
Client Title	Manager, DSS Analysis Unit
Client Telephone	(404) 656-5395
Client E-mail	ddees@dch.ga.gov
Original Contract Start	July 1996
Contract End Date	June 2007 with up to 4 annual renewals possible through June 2011)
Average Staff Hours (in FTEs) During Operations	8.85 FTEs
Contract Value to Thomson Reuters	$13,900,000 (current contract base term)
Workload Statistics	Approximately 650 million stored claim rows

Description of Work—Thomson Reuters is the prime contractor for a data warehouse and decision support system that integrates data from the State of Georgia's Medicaid program and State Health Benefit Plan (SHBP) for state employees. Thomson Reuters has held this contract since 1996, through one competitive re-procurement. We designed, developed, implemented, maintained and operated the original decision support system, which was replaced by a new system under the 2006 contract.

Under the new contract, Thomson Reuters has integrated what were two separate Medicaid and State Employee databases into one combined solution that enables DCH users to analyze data on all 2.2 million lives covered under the different programs. Thomson Reuters maintains up to 72 months of data on line.

Client Organization	**Missouri Department of Social Services** **MO HealthNet Division (MHD)**
Project Title	Fraud and Abuse Detection system
Client Reference Name	Julie G. Creach
Client Title	Assistant Deputy Director, Program Integrity & Cost Recovery—MO HealthNet Division
Client Telephone	Phone: (573) 751-3399
Client E-mail	Julie.G.Creach@dss.mo.gov
Original Contract Start	March 20, 2002
Contract End Date	June 30, 2009 with 5 remaining 1-year renewals
Average Staff Hours (in FTEs) During Operations	5.5 FTEs
Contract Value to Thomson Reuters	Approximately $20 million, if all renewals are exercised
Workload Statistics	Approximately 90 million per year

Description of Work—Since 1997, Thomson Reuters has been the prime contractor providing a comprehensive decision support system (DSS) for managing the MHD Medicaid program. A competitive re-bid resulted in renewal of the contract and the replacement of the original DSS in 2002 with the newest Thomson Reuters' services and software as a Fraud and Abuse Detection System (FADS). Thomson Reuters has delivered more than 45 fraud algorithms to date. The system supports the agency's overall program monitoring and investigation needs and is used to manage health costs, quality, and access to care. MHD has approximately 40 users accessing our databases, which are hosted and maintained in the Thomson Data Center. In 2007, Thomson Reuters assumed primary responsibility for claims-based investigation for MHD Program Integrity, with the goal of streamlining the investigative process.

Client Organization	**North Dakota Department of Human Services**
Project Title	Decision Support System and Data Warehouse
Client Reference Name	Erik Elkins
Client Title	Assistant Director, Policy
Client Telephone	(701) 328-4011
Client E-mail	soelke@state.nd.us
Original Contract Start	July 1, 1999
Contract End Date	June 30, 2009 with Contract 2—through June 30, 2014
Average Staff Hours (in FTEs) During Operations	Contract 1—approximately 2 FTEs Contract 2—approximately 4 FTEs
Contract Value to Thomson Reuters	Approximately $10,000,000
Workload Statistics	Approximately 5,400,000 per year

Description of Work—In 1996, Thomson Reuters was retained to build and implement a data warehouse and DSS that integrated data from all of the State's healthcare payers (private and public including Medicare). In November 1999, the database was converted for DHS' use for monitoring the Medicaid program and the Medicaid database was expanded, enhanced, and extended.

Thomson Reuters was responsible for designing the database, providing comprehensive implementation services, updating the database, and maintaining the software. Thomson Reuters also provides ongoing analytic consultation. North Dakota's Medicaid program covers approximately 60,000 individuals and contains 11 years of data. DHS uses the system to project the cost of proposed benefit changes for this population, track the impact of previous plan and program changes, detect waste, fraud and abuse, monitor prescription drug utilization and costs, and design disease management initiatives, among other applications.

Client Organization	**South Carolina Dept. of Health and Human Services (DHHS)**
Project Title	Decision Support System / SURS, Executive Information System, and Advanced Fraud Module
Client Reference Name **Client Title** **Client Telephone** **Client E-mail**	***Thomson is re-bidding the Decision Support System / SURS, Executive Information System, and Advanced Fraud Module proposal. At this time, the requested client information is unavailable.***
Original Contract Start	July 2005
Contract End Date	July 2010
Average Staff Hours (in FTEs) During Operations	4.5 FTEs
Contract Value to Thomson Reuters	$10,976,837
Workload Statistics	Approximately 350 million claim lines

Description of Work—The DHHS operates South Carolina's Medicaid program, which provides healthcare coverage for more than 850,000 South Carolinians served by more than 30,000 doctors, hospitals, and other healthcare providers. In 2005, the state awarded Thomson Reuters a five-year contract to provide a healthcare decision support system (DSS) and executive information system (EIS).

DHHS uses the DSS to strengthen its management of Medicaid expenditures and improve the quality of healthcare coverage for Medicaid enrollees. The system supports program planning and evaluation, financial reporting, medical policy development, healthcare utilization management, Medicaid eligibility analysis, actuarial rate setting, and other functions. It also serves as the DHHS surveillance and utilization review system (SURS). In conjunction with the DSS/SURS, we also provide DHHS with an Advanced Fraud Module, which includes a series of fraud algorithms tailored to the state's fraud analysis priorities and data sources. DHHS staff uses the results to target on-site provider reviews, initiate provider self-audits, support cases under investigation by the Attorney General, etc.

Client Organization	**Idaho Department of Health and Welfare Division of Medicaid**
Project Title	Decision Support System / Data Warehouse / MARS / SURS
Client Reference Name	Patti Campbell
Client Title	Medicaid Project Manager
Client Telephone	(208) 373-1404
Client E-mail	**Campbell@dhw.idaho.gov**
Original Contract Start	November 2007
Contract End Date	November 2014
Average Staff Hours (in FTEs) During Operations	Approximately 6 FTEs
Contract Value to Thomson Reuters	Approximately $8,700,000
Workload Statistics	Over 9 million transactions per year

Description of Work—Thomson Reuters is designing, developing, and implementing a comprehensive healthcare decision support system and data warehouse (DSS/DW) for the Idaho Department of Health and Welfare (DHW) as part of the State's efforts to modernize its Medicaid Management Information System. The DSS/DW system will improve DHW's ability to manage and mine data from 9 million healthcare claims submitted to the state Medicaid program each year.

The contract was awarded in late 2007 and the implementation process is well underway. DHW will use the analytic and reporting capabilities of the DSS/DW to strengthen management of Medicaid programs, measure cost effectiveness and quality of care, forecast budgets, and fulfill federal Management and Administrative Reporting (MAR) requirements. The system will generate information that supports program planning and evaluation, financial reporting, healthcare utilization management, Medicaid eligibility analysis, actuarial rate setting, and other functions. It will also serve as the Department's Surveillance and Utilization Review System (SURS), which is mandated for every state Medicaid program by the federal government to help detect healthcare fraud and abuse.

The Thomson Reuters solution integrates an analytically ready data warehouse with advanced methodologies and business intelligence applications, including Advantage Suite, to provide a powerful decision support system. It will be specifically configured to meet the unique needs of the Idaho Medicaid program and will replace the program's existing information system.

Client Organization	**Kentucky Cabinet for Health and Family Services, Department of Medical Services**
Project Title	Fraud Detection System—Surveillance & Utilization Review Services
Client Reference Name	Alyce Embree
Client Title	Contract Director
Client Telephone	(502) 564-1012 ext. 4168
Client E-mail	aembree@hce.org
Original Contract Start	July 1, 2008
Contract End Date	June 30, 2010
Average Staff Hours (in FTEs) During Operations	Approx. 1.75 FTEs
Contract Value to Thomson Reuters	$936,000/year
Workload Statistics	6 million claim lines a month

Description of Work—Thomson Reuters was selected to assist in providing data analysis services for Kentucky's Medicaid fraud detection program. We provide these services as a subcontractor to Health Care Excel – a healthcare utilization management and quality improvement organization. Health Care Excel is providing Surveillance and Utilization Review Services (SURS) to the Kentucky Medicaid program, which includes the analysis of medical claims and healthcare delivery patterns to identify unusual billing practices such as inconsistent, excessive, duplicative, or otherwise suspicious claims.

Utilizing our data mining solution DataProbe, we provide augmentation to the HCE/KY SURS system. Working with our partner HCE and Kentucky Medicaid, we provide five quarterly Medicaid healthcare fraud algorithms to HCE/KY Medicaid for detailed investigation to supplement the SURS reporting system.

Client Organization	**Centers for Medicare & Medicaid Services**
Project Title	One Program Integrity and Integrated Data Repository
Client Reference Name	Theresa Schultz,
Client Title	Contracting Officer, Office of Acquisition and Grants Management
Client Telephone	(410) 786-8496
Client E-mail	theresa.schultz@cms.hhs.gov
Original Contract Start	October 2007
Contract End Date	October 2012
Average Staff Hours (in FTEs) During Operations	Not applicable
Contract Value to Thomson Reuters	$4,000,000 (2009 AR)
Workload Statistics	Not applicable ***Note: "Thomson Reuters is a subcontractor on this project; any communication with CMS should go through the prime contractor. We will be happy to provide that information to IME as needed."***

Description of Work--One Program Integrity: One PI is a CMS initiative to link Medicaid and Medicare data analytically in support of cross-program fraud detection analytics ("Medi-Medi") at the national level. Thomson Reuters is part of a team to deliver the Medicaid integrated data repository for CMS, linking the Medicaid data to Medicare data in support of Medi-Medi program integrity analytics. The architecture for this project uses the Teradata relational database management system as the back-end database and Business Objects and Thomson Reuters decision support tools as the initial front-end analytic applications. The overall solution enables advanced analytics of Medicare and Medicaid data via a modernized portal infrastructure. The solution includes advanced methods such as episodes of care, hospital admissions, and other analytic constructs from Thomson Reuters that will provide enhanced fraud and abuse detection capabilities. The solution integrates data across the Medicare and Medicaid programs and will integrate all claim types (Part A, Part B, DME, Home Health and Hospice, and potentially Part D) into a single repository that will provide proven views to help detect fraud, waste, and abuse.

The initial data sets included in the implementation of this data warehouse are the Ohio and Pennsylvania Medicaid claims and enrollment data. Separate data are received per state as well as per data type (professional, facility, drug, eligibility and provider), making the data loading process complex. The project focus has shifted to Medicare data this year with the goal of incorporating all 45 million beneficiaries into the data warehouse. Thomson Reuters' experience in healthcare, data integration, and data quality has played a key role in the success of building the One PI system. We have developed 30+ in-depth fraud scenarios and have demonstrated their effectiveness to CMS. Recent studies have focused on provider profiling and providers with suspect activity.

Integrated Data Repository (IDR)—The Integrated Data Repository (IDR) is a CMS initiative to create an integrated database of Medicaid and Medicare data for every state in the union. The IDR project exists to support joint program integrity analytics at the national level and is part of the One PI project. As noted above, Thomson Reuters is implementing a decision support tool which will access the IDR data. To date, the IDR data includes the nation's Medicare data. End users will be able to access the system and use Thomson Reuters decision support tools specifically to research and investigate fraud, waste, and abuse

7.2.9.3 Corporate References

Letters of reference from the following organizations can be found in this section on the following pages.

1. Iowa Medicaid Fraud Control Unit , page 330
2. Centers for Medicare & Medicaid Services, pages 331—335
3. Centers for Medicare & Medicaid Services, pages 336—340
4. Ohio Department of Mental Health, 341

IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

DEAN A. LERNER, DIRECTOR

December 15, 2009

Jennifer Vermeer
Director, Iowa Medicaid Enterprise
Iowa Dept. of Human Services
100 Army Post Rd.
Des Moines, Iowa 50315

Re: Iowa's Surveillance Utilization Review Service (SURS) Unit
Letter of Recommendation

Dear Jennifer:

I have been the Director of the Iowa Medicaid Fraud Control Unit (MFCU) since Dec 1, 2008. Over the past year I have had the opportunity to further cultivate and strengthen MFCU's relationship with Brian Fisher and other personnel from the Surveillance and Utilization Review Service (SURS) Unit for the State of Iowa.

Brian and his staff at SURS have always provided MFCU Investigators with requested records, documentation, and results of investigative queries in a timely, complete and professional manner. MFCU investigators and SURS reviewers have begun to engage each other in training and investigation endeavors which have led to several successful investigations by MFCU.

In addition to our bi-weekly meetings where MFCU and SURS personnel discuss current cases, recent referrals, and other Medicaid fraud related issues, Brian and his staff at SURS continually work to keep MFCU apprised of SURS' efforts and the status of projects being conducted by SURS and IME personnel as part of MFCU investigations.

I look forward to furthering the progress and relationships made between MFCU and Brian and the SURS Unit and working with SURS to identify, investigate and prosecute Medicaid provider fraud within Iowa.

Sincerely,

John Judisch

John Judisch
Director, Iowa MFCU

LUCAS STATE OFFICE BUILDING, 321 EAST 12TH STREET, DES MOINES, IOWA 50319-0083

ADMINISTRATION	ADMINISTRATIVE HEARINGS	HEALTH FACILITIES	INVESTIGATIONS
(515) 281-5457	(515) 281-6468	(515) 281-4115	(515) 281-5714
FAX: (515) 242-6863	FAX: (515) 281-4477	FAX: (515) 242-5022	FAX: (515) 242-6507

Telephone Number for the Hearing Impaired: (515) 242-6515

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 East 12th Street, Suite 235
Kansas City, Missouri 64106

Division of Quality Improvement

July 10, 2009

Ms. Mary Kapur, Interim CEO
Health Care Excel, Inc.-Indiana
2901 Ohio Boulevard, Suite 112
Terra Haute, Indiana 47803

Dear Ms Kapur:

I would like to thank you and your teams for your hospitality during my second onsite 9th Scope of Work (SoW) visit conducted on June 23-25, 2009, at Health Care Excel, Inc., Indiana (HCE-IN). The primary focus of this visit was to gain a high-level overview of your progress for the 9th SoW including administrative, labor & time card reviews; Theme-specific activities, performance metrics, and best practices.

A review of your Administration Internal Quality Control (IQC) dashboard included: (1) Compliance Plan & Governance Checklist consisting of two best practices: The appointment of a Compliance Officer, and the creation of a new tool, "Make a Difference," a hotline for HCE-IN employees to use if needed. Your Code of Bylaws, Board of Directors' position descriptions along with their compensation and travel reimbursement were also reviewed. (2) Confidentiality Plan Checklist supported by training log and examples of signed certificates; Protected Health Information Agreement and Confidentiality and Re-Disclosure of Information, signed by QIO employees as a part of your annual review process; and (3) Risk Management Plan describing how your QIO is meeting Project Officer's reports. You have a stable staff, as evidenced by your Organizational Chart.

For contract monitoring, CMS requests IQC dashboard reports in advance of monthly calls to demonstrate your progress. Health Care Excel will continue to be evaluated by CMS through quarterly surveillance reports and potential Performance Improvement Plans (PIPs). At the 18th and 28th months, as well as other points in time, your performance against a specified target will be assessed. If you fail to meet one of the specified performance targets, an opportunity to discuss the issues with CMS will be facilitated.

For the Financial Information and Vouchering System (FIVs), Donna Smith, Director, Medicare Client Services, will continue to send an e-mail that monthly vouchers have been authorized, with hardcopies sent using overnight FedEx. CMS appreciates that you have responded promptly to FIVs issues prior to certification, which assures timely payment. Review of your FIVS IQC dashboard demonstrated: Theme 6.1, 0.80% overspent due to a higher case load than originally anticipated; Theme 6.2, 9.49% under-spent, with the expectation that travel

will increase; Theme 6.3, 23.6% overspent, with recruitment and care management education more costly than originally anticipated; and Theme 7.2, 27.58% under-spent, since consultants were not used as originally planned.

Health Care Excel's Web site Home page has met all 508 compliance requirements using the "Cynthia Says" test, and is easy to navigate with current information readily available to visitors.

A labor and time care review was performed with five employees. The purpose of this exercise is to increase employees' awareness of the importance of properly billing and recording their time, and to provide early detection of any potential deficiencies and take appropriate action, if necessary. All five audits resulted in no concerns with all selected employees able to effectively demonstrate their daily use of the electronic Deltec time and tracking system along with the identification of resources available to them when questions arise.

The QualityNet Security Check List was completed, supported by your IT Security Training log, which confirms new staff training. The security walk around produced no concerns. Several best practices were identified: Separate name badge from proximity card resulting in no connection between these cards for building security; case review area for both the states of Indiana and Kentucky, is geographically separate from the rest of QIO work with double-lock entry access and dedicated incoming/outgoing fax and copy machines; and cover sheets are routinely placed on confidential medical records by case reviewers when not in use. This information was faxed to Tom Lantz, the CMS Security Point of Contract for the Quality Improvement Contracts.

For Theme 6.1, Beneficiary Protection, HCE-IN performs case reviews for both Indiana and Kentucky QIOs. You are cross-training staff on varied case reviews to provide contingency coverage, an identified best practice. Timeliness of case review is currently 95.31% for Indiana and 94.02% for Kentucky. Beneficiary satisfaction for Indiana and Kentucky is 100%; with beneficiaries agreeing to participate at 66% for both QIOs. The number of beneficiary complaints (PPR# 8300200, Helpline Calls by Subject Summary) since the beginning of the 9th SoW is 318 for IN and 201 for KY. The recorded number of Helpline materials sent (PPR# 8300300) is 36 for IN and 26 for KY. However, your internal tracking report for referral packets sent reflects 174 for IN and 119 for KY. This discrepancy between the number of beneficiary complaint calls and number of Helpline materials sent is due to the fact that not all calls result in quality of care complaints; are not captured in the CRIS application module, and therefore not recorded in PPR# 8300300. Other referral packet examples sent that are not reflected in the PPR #8300300 (based on your internal tracking report) include *Fraud & Abuse, Medicare & You 2009,* and *Choosing a Nursing Home.* New data definition sets with CRIS modules are in the process of being redesigned to accurately reflect the number and type of beneficiary calls received and the number of actual Helpline materials sent.

For the CRIS validation exercise, one concurrent (Code 101) and two retrospective beneficiary complaint cases (Code 102) revealed the following: The majority of the two concurrent & four retrospective cases pulled for both states were in alignment with the dates stamped on the letter from the complainant and on the file copy of the final determination letter with dates entered into CRIS, with the exception of three discrepancies related to dates on the final determination letter

and CRIS: (1) One letter was returned and resent to a new address on another date (IN); (2) The Case Reviewer mailed the letter three days prior to the CRIS date entered (IN); and (3) There was a one day discrepancy between the dates on the letter and CRIS due to the Thanksgiving Day holiday (KY).

On May 21, CMS placed Kentucky on a Performance Improvement Plan for not meeting its quality improvement activity (QIA) requirement for Quarter 3. As a result, you created and are implementing a new Standard Operating Procedure and identified best practice for Indiana and Kentucky to effectively monitor your QIA reviews by creating state folder color coding labels; a QIA internal tracking spreadsheet; and using the Director, Beneficiary Protection as the final reviewer for instituting a QIA. At the suggestion of Sharon Last, Regional Office representative who was present via telephone, CMS will invite the GTL to our next monthly QIA discussion.

You are currently passing Task 8. For FY 2009, 84 of 85 hospitals (98.82%) received the full Annual Payment Update (APU). For FY 2010, Indiana has 86 qualifying hospitals with the overall current average for percentage of providers passing the quarterly 80% validation rate at 95.27%. You are currently assisting two hospitals that have not met the APU requirements. Your QIO expressed concerns related to several hospitals failing validation due to the way the data elements "Chest X-ray" and "Comfort Measures" are being abstracted, which could affect their APU payment. Since there appear to be interpretation discrepancies between the Hospital Reporting Program (HRP) QIOSC and the Clinical Data Abstraction Center (CDAC), this issue was sent to Donna Williamson, GTL, and Rebecca Kliman, co-GTL, on July 6th.

For Theme 6.2, Patient Safety, Hospitals, SCIP/HF, you are at 100% for both questions regarding VTE and established prophylactic antibiotic protocol, as demonstrated on your IQC dashboard. Implementing QIO face-to-face visits; a LEAN workshop using an expert consultant for effective process mapping for provider performance improvement; and the SCIP-6/Community Zero interactive Web site are identified best practices. You reported that 75% of your hospitals have completed the Culture of Patient Safety survey. Using the Indiana State Department of Health Pressure Ulcer Collaborative, you are presently at 100% for asking hospitals on this optional pressure ulcer measure, with several who have expressed interest in joining the additional rural-focused provider group.

Jade Perdue, GTL, was present via telephone for the Patient Safety, MRSA discussion. You expressed concern about the MRSA project because of the difficulty in collecting and accessing data. On July 2 and 8, 2009, information was shared with Donna Smith that the QIOSC is working with QIOs to identify and assist their providers to correctly confer rights from their NHSN MDRO module to the QIOSC. Your best practice of using "positive deviance" as a technique to have QIO staff work as part of hospital teams has resulted in identifying and prioritizing opportunities for quality improvement.

Your team expressed concern about the HLQAT (Hospital Leadership Quality Assessment Tool) survey. On July 2, 2009, information from the GTL was shared with you that this survey is intended to be a self-assessment instrument that you may use to assist leadership to identify structures and processes within a hospital setting that are associated with high performance in clinical quality.

In order to plan for the upcoming August, 2009, CMS National Quality Information Leadership (NQIL) meeting, CMS informed you on July 2, 2009 that the Patient Safety QIOSC will be releasing a draft Agenda and information to target leaders in a call scheduled for July 16, 2009.

For your Drug Safety project, you are partnering with a pharmacy in Indianapolis that services a large nursing home chain and using Part D data for targeting two nursing homes, their pharmacist and identifying physicians that work in these homes. You have developed a partnership with PharmaTAP, Perdue University, as a resource to assist with the Indiana Pharmacy Alliance, to support your initiative. Your current IQC dashboard exhibits performance improvement for drug-drug-interactions (DDIs) and potential interactive medications (PIMs). You expressed interest in obtaining a roll-up report on all QIO Drug Safety projects to support this work; as a result I encouraged Donna Smith to enter this request into Quest on July 2, 2009.

For Patient Safety Nursing Homes, your IQC dashboard reflects improvement for pressure ulcers with a 52.32% relative improvement rate for physical restraints. Your work with the Nursing Home in Need continues to be resource-intensive, due to high staff turnover requiring re-education of staff. However, relative improvement rates continue to improve for both pressure ulcers and physical restraints. Since QI/QM data do not match PPR reports, you were asked to submit this issue to Quest. On July 7, 2009, information was shared from the GTL that "when the Quarterly Performance Topic Rates report is released at the end of the month, the Iowa Foundation for Medical Care is aligning each measure's measurement period with the contract quarters to make it easier for QIOs to determine what time period they are looking at." You anticipate that one of your nursing homes may close and merge; if so, you will notify CMS immediately. Several best practices have been identified: Partnering with the Indiana State Department of Health and Pressure Ulcer Collaborative; implementing resident satisfaction surveys; working with the resident council of the Nursing Home in Need; and garnering support for the Pioneer Network who selected the state of Indiana for its next 2010 annual conference.

Annette Kussmaul, M.D., co-GTL was present via telephone for our Theme 6.3 Prevention discussion. As exemplified by your IQC dashboard, you are on target to meet July 31, 2009 quarterly deliverables on reporting data for 30 participating practices (PPs) on 4 measures, and have no overall concerns. It was validated onsite that 15 PP consent forms were signed between 8/1/08 – 10/31/08 and 15 PP consent forms were signed between 11/1/08 – 1/31/09. You reported that financial incentive programs, developed internally by practices or health care networks, have a positive impact on implementing and sustaining change in workflow processes.

You have made great strides in targeting three acute care healthcare systems located in Evansville and Vicennes, including some that cross lines into Illinois for Theme 7.2, Care Transitions. You are exceeding Contract requirements for all I- and O-measures except for I-6, where you are using PDSA cycles to get providers to implement and measure interventions; O-1a and O-1b (HCAHPS) & 0-5c (Pneumonia discharge); however, you are on track with your internal thresholds. You are implementing several best practices: Development of a Situation-Background-Assessment-Recommendation (SBAR) tool for health literacy and patient competency; partnership with Area Agency on Aging board members that represent 15 targeted community participants; and collaboration with providers and stakeholders representing 6 major

partnerships that can impact health outcomes change resulting in a Quality Improvement Community.

This letter and the enclosures contain information derived from discussions conducted during the site visit. Acting on any suggestions and observations discussed does not ensure that a QIO will succeed in its contract and be non-competitively renewed. The 9th SoW is performance-based and CMS observations are advisory in nature and should not be interpreted as to how Health Care Excel's work should be carried out with regard to activities during this contract.

At this time, you appear to be making good progress in the Contract. As surveillance data are provided to me by CMS, I will continue to share any information or reports that concern your performance. I will also share any best practices gleaned from other QIO monthly calls that may assist you in overcoming barriers to Theme progress. Thank you again for your staff time and flexibility provided to me during this informative site visit.

Sincerely,

/S/

Maribeth Ann Fonner, MPH
Project Officer
Division of Quality Improvement
Kansas City Regional Office
(816) 426-6349

Enclosures

cc: Naomi Haney-Ceresa, Contracting Officer
Christina Heller, Contract Specialist
Lisa McAdams, Consortium Administrator Special Assistant
Teresa Titus-Howard, Division of Quality Improvement, Midwestern Region, Associate Regional Administrator

5

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 East 12th Street, Suite 235
Kansas City, Missouri 64106

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Division of Quality Improvement

August 4, 2009

Ms. Mary Kapur, Interim CEO
Health Care Excel, Inc., Kentucky
1941 Bishop Lane, Suite 400
Louisville, KY 40223

Dear Ms Kapur:

I would like to thank you and your teams for your hospitality during my second onsite 9th Scope of Work (SoW) visit conducted on July 21-23, 2009 at Health Care Excel, Inc., Kentucky (HCE-KY). The primary focus of this visit was to gain a high-level overview of your progress for the 9th SoW including administrative, labor & time card reviews; Theme-specific activities, performance metrics, and best practices.

A review of your Administrative Internal Quality Control (IQC) dashboard included: (1) Compliance Plan & Governance Checklist consisting of two best practices: The appointment of a Compliance Officer, and initiating a new corporate-wide Culture Change program that focuses on customer service, communication and recognizing valued employees. Learning circles are employed to provide a structured way of conversation that ensures all staff are a part of the sharing, facilitated by an experienced employee to promote open dialogue. The creation of a new Helpline tool, "Make a Difference," is available to all employees to call in work-related issues and is operated by an independent contractor to preserve confidentiality. Your Code of Bylaws, Board of Directors' position descriptions along with their compensation and travel reimbursement were also reviewed. (2) Confidentiality Plan Checklist supported by training log and examples of signed certificates; Protected Health Information Agreement and Confidentiality and Re-Disclosure of Information, signed by QIO employees as a part of your annual review process; and (3) Risk Management Plan describing how your QIO is meeting Project Officer's reports. You have a stable staff, as evidenced by your 0% turnover rate since the beginning of the 9th SoW, supported by your Organizational Chart.

For contract monitoring, CMS requests IQC dashboard reports in advance of monthly calls to demonstrate your progress. Health Care Excel, Kentucky will continue to be evaluated by CMS through quarterly surveillance reports and potential Performance Improvement Plans (PIPs). At the 18th and 28th months, as well as other points in time, your performance against a specified target will be assessed. If you fail to meet one of the specified performance targets, an opportunity to discuss the issues with CMS will be facilitated.

For the Financial Invoicing and Vouchering System (FIVS), Donna Smith, Director, Medicare Client Services, will continue to send me an e-mail that monthly vouchers have been authorized,

with hardcopies sent using overnight FedEx, which is an identified best practice to ensure that timely certification occurs when automatic notification of authorizations are not received. Review of your FIVS IQC dashboard demonstrates overall over-spending by 4.10%: Theme 6.1 is 12.46% over-spent due to a higher case review workload than originally anticipated; Theme 6.2 is 12.44% under-spent, with the expectation that travel will increase with the implementation of education for your additional rural provider work; and Theme 6.3, is 36.78% over-spent, due to labor hours and travel required for redundancy of education given to targeted practices.

Health Care Excel's Web site Home page has met all 508 compliance requirements using the "Cynthia Says" test, and is easy to navigate with current information readily available to visitors.

A labor and time care review was performed onsite with five employees. The purpose of this exercise is to increase employees' awareness of the importance of properly billing and recording their time, and to provide early detection of any potential deficiencies and take appropriate action, if necessary. All five audits resulted in no concerns with all selected employees able to effectively demonstrate their daily use and competency related to your electronic Deltek time and tracking system along with the identification of resources available to them when questions arise.

The QualityNet Security Check List was completed, supported by your IT Security Training log, which confirms new staff training. The security walk around produced no concerns. Several model best practices were identified: Separate name badge from proximity card resulting in no connection between these cards for building security, and front and side cameras present in foyer and entry doors of hallway. Your Data Center has the following: A dedicated and monitored AC/humidity control; a fire suppression system; a breaker/switch box for network room, one 4' x 4' fireproof safe for storage of back-up tapes with limited media sent offsite; surveillance equipment for employee access cards that tracks staff entrance and exit by each door and time; Demarc centralization with electric telephone circuits to an extended sophisticated circuit managed and controlled by the QIO; and UPS switch on bottom of QIO separate locked Dell server cabinet to provide electricity for 15 minutes in the event of an un-planned shut-down. Your Security Check List was faxed on July 29, 2009 to Tom Lantz, the CMS Security Point of Contract for the Quality Improvement Contracts.

For Theme 6.1, Beneficiary Protection, Health Care Excel-Indiana performs case reviews for both Indiana and Kentucky QIOs. According to your IQC Dashboard, timeliness of case reviews is currently 93.68%; meeting the 90% timely, cumulative through end of current quarter requirement. The number of beneficiary complaints (PPR# 8300200, Helpline Calls by Subject Summary) since the beginning of the 9th SoW is 201 for KY. The recorded number of Helpline materials sent (PPR# 8300300) is 26. However, your internal tracking report for referral packets sent reflects 119 for KY. This discrepancy between the number of beneficiary complaint calls and number of Helpline materials sent is due to the fact that not all calls result in quality of care complaints; are not captured in the CRIS application module, and therefore are not recorded in PPR# 8300300. Other referral packet examples sent that are not reflected in the PPR #8300300 (based on your internal tracking report) include *Fraud & Abuse, Medicare & You 2009,* and *Choosing a Nursing Home*. New data definition sets with CRIS modules are in the process of

being redesigned to accurately reflect the number and type of beneficiary calls received and the number of actual Helpline materials sent.

For the CRIS validation exercise completed on June 24, 2009 at your Indiana site, one concurrent (Code 101) and two retrospective beneficiary complaint cases (Code 102) revealed the following: The majority of the one concurrent & two Kentucky retrospective cases pulled were in alignment with the dates stamped on the letter from the complainant and on the file copy of the final determination letter with dates entered into CRIS, with the exception of a one day discrepancy between the dates on the letter and CRIS due to the Thanksgiving Day holiday.

On May 21, CMS placed Kentucky on a Performance Improvement Plan for not meeting its quality improvement activity (QIA) requirement for Quarter 3. As a result, you created and are implementing a new Standard Operating Procedure and identified best practice for Kentucky and Indiana to effectively monitor your QIA reviews by creating state folder color coding labels; a QIA internal tracking spreadsheet; and using the Director, Beneficiary Protection as the final reviewer for instituting a QIA.

You are currently passing Task 8, but expressed concerns for RHQDAPU Validation, in that some data elements may be overly weighted (chest X-rays, pneumonia & comfort measures), with discrepancies in interpretation of the definitions by the HRP QIOSC & CDAC. You asked if there would be updates made to the SPECs Manual to clarify these definitions, and a response was obtained from Allison Lee, Subject Matter Expert on July 14, 2009. On July 20, 2009, you followed up with further validation concerns sent to Allison Lee, for which we are awaiting a response.

On July 24, 2009, Holly Davis, Statistician, asked for clarification on information related to Tasks 3a and 3b for measuring case review timeliness using PPR # 8993300 per guidance from SDPS Memos 09-158-CO and 09-258-CO. On July 28, 2009, you submitted this question to QNet Quest, ID number 1228739613534. On July 31, 2009, SDPS Memo 09-280-CR instructed QIOs not to run PPR #s 8993300; 8993700 and 8994603 until further notice.

According to your IQC Dashboard for Theme 6.2, Patient Safety, you are exceeding Contract requirements for all clinical measures, with the exception of Nursing Home in Need (NHIN)—high risk long-stay residents who have pressure sores and who were physically restrained; where you are presently not passing. However, these results are being closely monitored for new data to hopefully show improvement by the July 31, 2009 deliverable date.

Three best practices are identified: (1) Your Medical Director, Dr. John Lewis, identifies and sends letters to physician outliers persuading them to change behaviors related to MRSA & SCIP that consists of literature, national or specialty guidelines/best practices, malpractice issues, quality and credentialing information to present a "gold standard" update of professionally recognized standards of care; (2) You have identified Senator Bunning's assistant as an advocate to support MRSA education, who has experienced MRSA first-hand; and (3) You continue to use Partners Promoting Quality and "positive deviance" to leverage educational opportunities for nursing homes and hospitals that support statewide collaborative efforts and quality improvement communities. Jade Perdue, GTL, present via telephone for this discussion, encouraged you to continue to share these interventions and best practices with CMS.

For your Theme 6.2, Patient Safety, Drug Safety project, you continue to make progress by leveraging on a coalition of stakeholders to modify prescription behaviors (like the nursing home facility Therapeutic Committee), and developing articles for the National Government Services and Kentucky Medical Society publications, resulting in shared best practices. On July 22, 2009, we asked Madie Eshete, GTL, present via telephone, to provide a QIO Drug Safety project list for sharing, for which she will ask the QIOSC to create.

For your Theme 6.3, Disparities project, you have identified 5 counties in Southeastern Kentucky and targeted 5 rural providers representing lower socio-economic status impacted by access to health care along with health literacy issues. You are effectively using your Partners Promoting Quality coalition to identify barriers and opportunities for education, like the Strategic Standards Committee and the Kentucky Association of Healthcare Facilities, to promote critical interventions supporting quality improvement.

On July 23, 2009, Annette Kussmaul, MD, co-GTL, was present via telephone for our Theme 6.3 Core Prevention discussion. You reported that all 19 participating practices (PPs) are reporting data on all four clinical measures. To date, you have met all thresholds as set in alignment with Contract requirements. You performed a Root Cause Analysis which identified weaknesses in your internal processes, resulting in identifying and targeting opportunities for improvement. You created a Communications & Actions Log along with a Tracking Tracker that incorporates all SDPS/TOPS Memos, Quest answers, ListServ responses and CMS guidance to more effectively monitor your progress which has resulted in a best practice. Your questions related to evaluation were addressed in the July 24, 2009 SDPS Memo 09-268-CO. It was validated onsite that 10 PP consent forms were signed between 8/1/08 – 10/31/08 and 9 PP consent forms were signed between 11/1/08 – 1/31/09, totaling 19 PPs.

This letter and the enclosures contain information derived from discussions conducted during the site visit. Acting on any suggestions and observations discussed does not ensure that a QIO will succeed in its contract and be non-competitively renewed. The 9th SoW is performance-based and CMS observations are advisory in nature and should not be interpreted as to how Health Care Excel, Kentucky's work should be carried out with regard to activities during this contract.

At this time, you appear to be making good progress in the Contract. As surveillance data are provided to me by CMS, I will continue to share any information or reports that concern your performance. I will also share any best practices gleaned from other QIO monthly calls that may assist you in overcoming barriers to Theme progress. Thank you again for your staff time and flexibility provided to me during this informative site visit.

Sincerely,

/S/

Maribeth Ann Fonner, MPH
Contract Officer/Technical Representative
Division of Quality Improvement
Kansas City Regional Office (816) 426-6349

4

Enclosures

cc: Naomi Haney-Ceresa, Contracting Officer
Christina Heller, Contract Specialist
Lisa McAdams, Consortium Administrator Special Assistant
Teresa Titus-Howard, Division of Quality Improvement, Midwestern Region, Associate Regional Administrator

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Ohio | Department of Mental Health

Ted Strickland, Governor
Sandra Stephenson, Director

December 17, 2009

Mary Kapur, CEO
Health Care Excel
2629 Waterfront Parkway East Drive
Suite 200
Indianapolis, IN 46214

Dear Ms. Kapur:

Since 1996, Health Care Excel (HCE) has successfully provided services for the State of Ohio's Utilization Review Program for Inpatient Psychiatric (URIP) care provided to Medicaid Recipients. The URIP program was awarded through a competitive bidding process with the most recent period of performance being July 2009 to June 2010. This is the third of three consecutive five year contracts that HCE has successfully managed.

Provider relations and education is an integral part of this contract. A positive working relationship has been developed over time with private psychiatric services providers across the state. This has been achieved in part by prompt attention to questions and concerns raised by individuals either in person during post-payment reviews or via simple telephone discussions.

The HCE staff has been, and continues to be, extremely accessible to all workforce members of the Ohio Department of Mental Health. Communications and discussions that are active, constructive, and positive comprise a significant portion of the daily management process. There has always been a high level of responsiveness to Department and contract requirements. This has been accomplished, in part, by HCE's commitment to staffing the Ohio office with extremely knowledgeable and expert staff.

I want to acknowledge the very satisfactory level of performance of this contract by HCE and would certainly recommend them to others who might seek their services.

Sincerely,

Terry R. Jones, LISW-S
Manager of Medicaid Program Compliance
Office of Medicaid
30 E. Broad Street, 7th Floor
Columbus, OH 43215-3430

7.2.9.4 Felony Disclosures

Neither HCE nor its Officers have ever been convicted of a felony.

7.2.9.5 Certifications and Guarantees

Signed Attachments B through J have been provided on the following pages. All attachments have been signed by Mary Kapur, the Chief Executive Officer, who is authorized to bind the company.

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7.2.9.5 Certifications and Guarantees

Cover Sheet for Attachment I—Business Associate Agreement (BAA)

Attachment I, the Business Associate Agreement (BAA) has been included in Tab 9. Per Requirement 7.2.9.5, Certifications and Guarantees, page 137 of the RFP, "***The bidder must include signed copies of Attachment B through J inclusive. Signature must be from an individual authorized to bind the company.***"

Health Care Excel agrees to abide by all terms and conditions of Attachment I, BAA, if chosen as the IME Program Integrity contractor.

_____ _____

Mary Kapur
Chief Executive Officer

Date