REQUEST FOR PROPOSAL: 3491

TECHNICAL PROPOSAL
External Quality Review Organization
State of Nevada

Submitted by:

Germane SOLUTIONS

10552 Success Lane, Suite A
Dayton, OH 45458
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February 22, 2018 by 2:00 p.m. MST

SECTION I. TITLE PAGE

Part IA – Technical Proposal	
RFP Title:	EQRO
RFP:	3491
Vendor Name:	Germain & Co., Inc dba Germane Solutions
Address:	10552 Success Lane, Suite A Dayton, OH 45458
Opening Date:	2/22/18
Opening Time:	2:00 PM

SECTION II. TABLE OF CONTENTS

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SECTION III. VENDOR INFORMATION SHEET

SECTION III. VENDOR INFORMATION SHEET

V1	Company Name	Germane Solutions	
V2	Street Address	10552 Success Lane, Suite A	
V3	City, State, ZIP	Dayton, OH 45458	
V4	Telephone Number		
	Area Code: 404	Number: 867-4079	Extension:
V5	Facsimile Number		
	Area Code: 706	Number: 216-0915	Extension:
V6	Toll Free Number		
	Area Code:	Number:	Extension:
V7	***Contact Person for Questions / Contract Negotiations, including address if different than above***		
	Name: Tracy Kulik		
	Title: Vice President, Health Access		
	Address:		
	Email Address: tkulik@germane-solutions.com		
V8	Telephone Number for Contact Person		
	Area Code: 404	Number: 867-4079	Extension:
V9	Facsimile Number for Contact Person		
	Area Code: 706	Number: 216-0915	Extension:
V10	***Name of Individual Authorized to Bind the Organization***		
	Name: Tracy Kulik	Title: Vice President, Health Access	
V11	Signature ***(Individual shall be legally authorized to bind the vendor per NRS 333.337)***		
	Signature: Tracy Kulik		Date: February 20, 2018

SECTION IV. STATE DOCUMENTS

SUBJECT:	Amendment 1 to Request for Proposal 3491
RFP TITLE:	External Quality Review Organization (EQRO)
DATE OF AMENDMENT:	February 2, 2018
DATE OF RFP RELEASE:	January 10, 2018
OPENING DATE:	February 22, 2018
OPENING TIME:	2:00 PM
CONTACT:	Ronda Miller, Purchasing Officer II

The following shall be a part of RFP ***3491.*** If a vendor has already returned a proposal and any of the information provided below changes that proposal, please submit the changes along with this amendment. You need not re-submit an entire proposal prior to the opening date and time.

Vendor must sign and return this amendment with proposal submitted.

Vendor Name: Germain & Co., Inc. dba Germane Solutions

Authorized Signature: Tracy Kulik

Title: Vice President, Health Access Date: 2/20/2018

SUBJECT:	Amendment 2 to Request for Proposal 3491
RFP TITLE:	External Quality Review Organization (EQRO)
DATE OF AMENDMENT:	February 8, 2018
DATE OF RFP RELEASE:	January 10, 2018
OPENING DATE:	February 22, 2018
OPENING TIME:	2:00 PM
CONTACT:	Ronda Miller, Purchasing Officer II

The following shall be a part of RFP ***3491.*** If a vendor has already returned a proposal and any of the information provided below changes that proposal, please submit the changes along with this amendment. You need not re-submit an entire proposal prior to the opening date and time.

Vendor must sign and return this amendment with proposal submitted.

Vendor Name: Germain & Co., Inc. dba Germane Solutions

Authorized Signature: Tracy Kulik

Title: Vice President, Health Access Date: 2/20/2018

ATTACHMENT A – CONFIDENTIALITY AND CERTIFICATION OF INDEMNIFICATION

Submitted proposals, which are marked "confidential" in their entirety, or those in which a significant portion of the submitted proposal is marked "confidential" shall not be accepted by the State of Nevada. Pursuant to NRS 333.333, only specific parts of the proposal may be labeled a "trade secret" as defined in NRS 600A.030(5). All proposals are confidential until the contract is awarded; at which time, both successful and unsuccessful vendors' technical and cost proposals become public information.

In accordance with the submittal instructions of this RFP, vendors are requested to submit confidential information in separate files marked "Part IB Confidential Technical" and "Part III Confidential Financial".

The State shall not be responsible for any information contained within the proposal. If vendors do not comply with the labeling and packing requirements, proposals shall be released as submitted. In the event a governing board acts as the final authority, there may be public discussion regarding the submitted proposals that shall be in an open meeting format, the proposals shall remain confidential.

By signing below, I understand it is my responsibility as the vendor to act in protection of the labeled information and agree to defend and indemnify the State of Nevada for honoring such designation. I duly realize failure to so act shall constitute a complete waiver and all submitted information shall become public information; additionally, failure to label any information that is released by the State shall constitute a complete waiver of any and all claims for damages caused by the release of the information.

This proposal contains Confidential Information, Trade Secrets and/or Proprietary information.

Please initial the appropriate response in the boxes below and provide the justification for confidential status.

Part IB – Confidential Technical Information			
YES	X	NO	
Justification for Confidential Status			
Proprietary Software –RHONDA & BUSINESS INTELLIGENCE			
Part IB – Confidential Financial Information			
YES	X	NO	
Justification for Confidential Status			
Financial Information for Germane Solutions			

Germain & Co. Inc. dba Germane Solutions
Company Name

Signature Tracy Kulik

Print Name Tracy Kulik, Vice President of Health Access Date February 20, 2018

ATTACHMENT B – VENDOR CERTIFICATIONS

Vendor agrees and shall comply with the following:

(1) Any and all prices that may be charged under the terms of the contract do not and shall not violate any existing federal, State or municipal laws or regulations concerning discrimination and/or price fixing. The vendor agrees to indemnify, exonerate and hold the State harmless from liability for any such violation now and throughout the term of the contract.

(2) All proposed capabilities can be demonstrated by the vendor.

(3) The price(s) and amount of this proposal have been arrived at independently and without consultation, communication, agreement or disclosure with or to any other contractor, vendor or potential vendor.

(4) All proposal terms, including prices, shall remain in effect for a minimum of 180 days after the proposal due date. In the case of the awarded vendor, all proposal terms, including prices, shall remain in effect throughout the contract negotiation process.

(5) No attempt has been made at any time to induce any firm or person to refrain from proposing or to submit a proposal higher than this proposal, or to submit any intentionally high or noncompetitive proposal. All proposals shall be made in good faith and without collusion.

(6) All conditions and provisions of this RFP are deemed to be accepted by the vendor and incorporated by reference in the proposal, except such conditions and provisions that the vendor expressly excludes in the proposal. Any exclusion shall be in writing and included in the proposal at the time of submission.

(7) Each vendor shall disclose any existing or potential conflict of interest relative to the performance of the contractual services resulting from this RFP. Any such relationship that might be perceived or represented as a conflict shall be disclosed. By submitting a proposal in response to this RFP, vendors affirm that they have not given, nor intend to give at any time hereafter, any economic opportunity, future employment, gift, loan, gratuity, special discount, trip, favor, or service to a public servant or any employee or representative of same, in connection with this procurement. Any attempt to intentionally or unintentionally conceal or obfuscate a conflict of interest shall automatically result in the disqualification of a vendor's proposal. An award shall not be made where a conflict of interest exists. The State shall determine whether a conflict of interest exists and whether it may reflect negatively on the State's selection of a vendor. The State reserves the right to disqualify any vendor on the grounds of actual or apparent conflict of interest.

(8) All employees assigned to the project are authorized to work in this country.

(9) The company has a written equal opportunity policy that does not discriminate in employment practices with regard to race, color, national origin, physical condition, creed, religion, age, sex, marital status, sexual orientation, developmental disability or handicap.

(10) The company has a written policy regarding compliance for maintaining a drug-free workplace.

(11) Vendor understands and acknowledges that the representations within their proposal are material and important, and shall be relied on by the State in evaluation of the proposal. Any vendor misrepresentations shall be treated as fraudulent concealment from the State of the true facts relating to the proposal.

(12) Vendor shall certify that any and all subcontractors comply with Sections 7, 8, 9, and 10, above.

(13) The proposal shall be signed by the individual(s) legally authorized to bind the vendor per NRS 333.337.

Germain & Co., Inc dba Germane Solutions

Vendor Company Name

Tracy Kulik

Vendor Signature

Tracy Kulik

Print Name

February 20, 2018

Date

ATTACHMENT H – CERTIFICATION REGARDING LOBBYING

Certification for Contracts, Grants, Loans, and Cooperative Agreements

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

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

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

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

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

By: Tracy Kulik
Signature of Official Authorized to Sign Application

February 20, 2018
Date

For: Germain & Co., Inc dba Germane Solutions
Vendor Name

External Quality Review Organization (EQRO)

Project Title

SECTION V. SCOPE OF WORK

Nevada has experienced a dramatic increase in Medicaid enrollment since 2013, increasing by 90% or by almost 300,000 (298,568 people) despite a gubernatorial veto to pass Medicaid buy-in legislation. Medicaid was expanded in 2014 through the Affordable Care Act, with approximately 266,000 people becoming newly eligible for coverage. Four (4) carriers were awarded Medicaid managed care contracts in late 2016, doubling the carriers that provide Medicaid managed care in the state. Health Plan of Nevada (United Healthcare) and Amerigroup (Anthem) were existing plans, with additions of Better Health of Nevada (Anthem) and Silver Summit Health Plan (Centene). Open enrollment occurred in Spring of 2017 (April 1 through June 30th) to allow Medicaid enrollees to select their carrier from this widened payer base. The lower reimbursement rates of Medicaid (compared to Medicare or private insurance) has resulted in fewer providers willing to accept Medicaid (68.9% acceptance rate by doctors for new Medicaid patients compared to 83.7% for Medicare and 84.7% for private insurance plans). A dearth of primary care providers adds to this access issue.

More than three-quarters of current Medicare enrollees are covered by Medicaid managed care. The passage of expanded Medicaid has resulted in a significant drop in the uninsured rate (down almost 40% from 2013 to 2015), from 20.7% to 12.3%. Enrollment has also increased among those who were already eligible for Medicaid. In addition, CHIP (Children's Health Insurance Program) enrollment has substantially increased from 70.6% in 2012 (compared to 88% in 2015).

Eligibility for adult is at 138% of the Federal Poverty Level and for pregnant women, at 160%.

Children are eligible for CHIP in households up to 200% of the Federal Poverty Level.

The Quality of Care in Nevada is measured using Core Set Measures with related indicators.

Table 1. HEDIS® Measures for Nevada Medicaid & Nevada Check-Up, 2016

NEVADA MEDICAID (19 measures)	NEVADA CHECK-UP (15 measures)
Child: Access 1) Access to Primary Care Practitioners 2) Access to Annual Dental Visit Preventive 3) Adolescent Well Care Visits 4) Childhood Immunization Status 5) Immunizations for Adolescents 6) Well Child Visit in first 15 months of life 7) Well Child Visit in 3rd, 4th, 5th, 6th years of life	Child & Adolescent: Access 1) Access to Primary Care Practitioners 2) Annual Dental Visits Preventive 3) Adolescent Well-Care Visits 4) Childhood Immunization Status 5) Immunization for Adolescents 6) Well Child Visit in first 15 months of life 7) Well Child Visit in 3rd, 4th, 5th, 6th years of life

8) *Weight Assessment and Counseling for Nutrition & Physical Activity-Child/Adolescent* 9) *Human Papilloma Virus for Adolescent Females* *Maternity* 10) *Prenatal and Postpartum Care* 11) *Frequency of Ongoing Prenatal Care* *Care for Chronic Conditions* 12) *Comprehensive Diabetes Care* 13) *Medication Management for People with Asthma* *Behavioral Health* 14) *Follow-up after Hospitalization for Mental Illness* 15) *Follow-up for Children prescribed ADHD medication* 16) *Use of multiple concurrent antipsychotics for Children & Adults* *Utilization and Diversity of Membership* 17) *Mental Health Utilization - Total* 18) *Ambulatory Care – Total* 19) *Weeks of Pregnancy at Time of Enrollment*	8) *Weight Assessment and Counseling for Nutrition & Physical Activity-Child/Adolescent* 9) *Human Papilloma Virus for Adolescent Females* *Care for Chronic Conditions* 10) *Medication Management for People with Asthma* *Behavioral health* 11) *Follow-up after Hospitalization for Mental Illness* 12) *Follow-up Care for Children Prescribed ADHD Medications* 13) *Use of Multiple Concurrent Antipsychotics in Children & Adolescents* *Utilization and Diversity of Membership* 14) *Mental Health Utilization-Total* 15) *Ambulatory Care – Total*

Table 2. Pre-On site, On site and Post-On-Site Activities for Protocol

Pre-On site	On Site	Post-On Site
Define the Scope of Validation	Review Information Systems Underlying Performance Measurement	Determine Preliminary Validation Findings for Each Measure
Assess the Integrity of the MCO's Information System	Assess Data Integration and Control for Performance Measure Calculation	Assess Accuracy of MCO's Performance Measure Reports to the State
Select Measures for Detailed Review	Review Performance Measure Production	Submission of Validation Report to the State
Initiate Review of Medical Record Data Collection	Conduct Detailed Review of Selected Measures	
Prepare the MCO Onsite Visit	Assess the Sampling Process (if applicable)	
	Preliminary Findings and Outstanding Items	

2.1.1 TASKS AND FUNCTIONS

2.1.1.1 Performance Improvement Project Validation

Performance Improvement Projects ('PIP') are designed to promote improvement in the quality of care and outcomes for members of the MCO (Managed Care Organizations), DBA (Dental Benefits Administrator), and PAHP (Pre-Paid Ambulatory Health Plans). The PIP process is data-driven and requires identification of a problem, a source for the data needed to measure the problem, baseline data, an expected outcome, the intervention and barriers to achieving the outcome. Germane uses a Plan-Do-Study-Act approach in developing PIPs and can utilize its information technology resources to mine additional sources of data that may not have been previously readily available.

Germane will assess each PIP study methodology, offering insights into the topics, questions, state-selected indicators/measures, study population sampling and data collection procedures. Our performance improvement methods have been used in a variety of settings from states, counties and cities to provider agencies in primary care, behavioral health and long-term care settings.

To determine appropriateness of the study topic, Germane will review documentation to answer the questions:

1. ***Did the State require the PIP topic, goal and/or study methodology?***
2. ***Were specific MCO, DBA/PAHP or State enrollee demographic characteristics and health risks considered?***
3. ***Is the topic consistent with demographic and epidemiologic information of the current enrollees?***

Germane will determine if the MCO/DBA/PAHP considered input from enrollees who are users of or concerned with specific areas such as mental health or substance abuse. The PIP, over time, should address a broad spectrum of enrollee care and services. Some of the areas that could be addressed include: children with special health care needs, preventive care, acute and chronic condition care, high-volume and high-risk services, specialized care received from centers such as burn, transplant and cardiac surgery centers, continuity or coordination of care from multiple providers, appeals and grievances or access to and availability of care.

Reviewing the study questions is the second step in this review (per the CMS protocol[1]) and Germane will determine if the study questions are clear, simple and answerable. Supporting information for this step will be gathered from QI study documentation, relevant clinical literature, enrollee focus groups/surveys, and enrollee/provider representatives on Quality Committees.

In reviewing the study population, each MCO, DBA, and PAHP will be reviewed to determine whether the entirety of a population or a sample was used. The following questions must be

[1] *EQR Protocol 3, Validation of Performance Improvement Projects (PIPs).* Centers for Medicaid and Medicare Services. September 2012.

considered (according to the CMS protocol) in determining whether the study population is clearly identified:

1. ***How was the "at risk" population defined?***
2. ***Are all individuals clearly defined in terms of the identified study question(s) and relevant indicators?***
3. ***Is the entire study population or a sample used? If the organization can collect and analyze data through an automated data system, is it possible to study the whole population? If the data must be collected manually, sampling may be more realistic.***
4. ***Did the definition of the study population include requirements for the length of the study populations' members' enrollment in the MCO, PAHP, and CMO? The required length of time will vary depending on the study topic and study indicators.***
5. ***If the entire population was studied, did the data collection approach capture all enrollees to whom the study question applied?***

Each PIP should have one or more measured indicators to track performance and improvement over a specific period. All measured indicators are objective, clearly defined, based on current clinical knowledge or health services research and enrollee outcomes or a valid indicator of these outcomes. Germane will review the project documentation to determine if appropriate measures are used. Examples of acceptable measures include NCQA's HEDIS® measures.

2.1.1.2 Performance Measurement Validation

Germane will review the sampling methods for each MCO, DBA, PAHP, and CMO (Care Management Organization) to determine the appropriateness and validity of the sampling methods. Appropriate sampling is necessary to ensure valid and reliable information. The team will consider questions such as:

- ***A. Did the methods…***
  - ***a. …calculate the required sample size?***
  - ***b. …consider and specify the true or estimated frequency of the event?***
  - ***c. …identify the confidence level to be used?***
  - ***d. …identify an acceptable margin of error?***
- ***B. Are valid sampling techniques used?***

In reviewing the data collection procedures, Germane will ensure that the data used to measure performance are valid and reliable. Valid data measure what is intended to be measured, while reliable data produces consistent results. The data collection plan needs to specify the data to be collected, the data sources, how and when the data are to be collected, who will collect the data and instruments that will be used to collect the data.

Germane will review each MCO's, DBA's, PAHP's, and CMO's adherence to the statistical analysis techniques defined in the data analysis plan. Questions to be answered in this review include:

A. ***Is the analysis of the findings conducted in accordance with the data analysis plan?***
B. ***Are numerical results and findings presented in an accurate, clear and easily understood manner?***
C. ***Does the analysis identify:***
- ***Initial and repeat measurements of project outcomes?***
- ***Realistic and unambiguous targets for the measures?***
- ***The statistical significance of any differences between the initial and repeat measurements?***
- ***Factors that influence the comparability of initial and repeat measurements?***
- ***Factors that threaten the internal or external validity of the findings?***

D. ***Does the analysis of the study data include an interpretation of the extent to which its PIP is successful and what follow-up activities are planned as a result?***

Germane will collect this information in its RHONDA database and be able to produce reports for the State and DHCFP. RHONDA ('Real Health Outcomes Need Data Analytics') is a user-friendly web-based data warehouse that is used to collect quality outcomes based on the measures' numerator and denominator defined in the performance measure description. The RHONDA tool is a secure online portal with two main purposes. It is designed to capture quality improvement information and then generate actionable data and reports. The RHONDA tool records details of medical charts without capturing any PHI (Protected Health Information).

In assessing whether the MCO's, DBA, PAHP's improvement strategies will achieve true improvement, Germane will look at the interventions and their relation to causes and barriers identified through data analysis and quality improvement processes. Were the interventions based on a root cause analysis of the problem that the PIP addressed? Are the interventions proposed sufficient to be expected to improve processes or outcomes (did they do enough to cause change)? Are the interventions culturally and linguistically appropriate?

Germane also must assess whether the improvement is real improvement. To what extent did the improvement occur? Are there any documented improvements in processes or outcomes of care? Does the improvement in performance appear to be the result of the planned quality improvement intervention (is it relational)? Is there any statistical evidence that any observed performance improvement is true improvement?

We must also examine documentation to ensure the improvement on a project is sustained. Is sustained improvement demonstrated through repeated measurements over comparable time periods? Germane's team will evaluate this aspect of each MCO, DBA, and PAHP PIPs and document it in RHONDA for later comparison and reporting.

Worksheet 2: Performance Measure Validation Worksheet Template

PERFORMANCE MEASURE {Insert name of performance measure}

(Meets Validation Requirements)

Validation Component	Audit Element	Yes	No	N/A
Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source code.			
Denominator	Data sources used to calculate the denominator (e.g., eligibility files, claims files, provider files, pharmacy records) were complete and accurate.			
	Calculation of the performance measure adhered to the specifications for all components of the denominator of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9 or ICD-10, CPT-4, DRGs, UB-92, member months calculation, member years calculation, and adherence to specified time parameters).			
Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO's network) are complete and accurate.			
	Calculation of the performance measure adhered to the specifications for all components of the numerator of the performance measure (e.g., clinical codes such as ICD-9 or ICD-10, CPT-4, LOINC, DRGs, pharmacy data, relevant time parameters such as admission/discharge dates or treatment start and stop dates, adherence to specified time parameters, number or type of provider).			
	If medical record abstraction was used, documentation/tools were adequate.			
	If hybrid method was used, the integration of administrative and medical record data was adequate.			
	If hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.			
Sampling	Sample was unbiased.			
	Sample treated all measures independently.			
	Sample size and replacement methodologies met specifications.			

EQR Protocol 2 Attachment A
Performance Measure Validation Worksheets
September 2012 5

Figure 1. CMS Performance Measure Validation Worksheet Template

In preparation for each site visit, Germane will contact the MCO to explain the procedures and timelines for performance measure validation activities, communicate Germane's policies and procedures for safeguarding confidential information and sign confidentiality agreements and organize the onsite visit to ensure the availability of necessary documentation and staff.

Preparing for and scheduling site visits for quality review is a process Germane is very familiar with from projects in Texas, Florida, Louisiana, New York and Connecticut. We have conducted hundreds of onsite reviews for quality performance from multiple funding sources and under multiple sets of criteria.

During the on-site visit Germane will confirm, observe and query systems used to produce performance measure results (including membership, medical, pharmacy, provider and ancillary data sources); investigate and follow-up on issues identified in the IT assessment; assess data integration and control procedures for accurate production of the performance

measures; assess data completeness; and confirm the process for calculating and reporting the performance measures. The confirmation will occur through staff interviews, primary source verification, system and process review, observation and data file review, per the CMS protocol.

Germane, instead of using the worksheet templates shown, would develop within its proprietary RHONDA tool ('Real Health Outcomes Need Data Analytics'), the criteria for each review and be able to report out on each element that is being tracked in real time across all the MCO's being reviewed. The RHONDA database is currently being used in quality reviews for the State of Texas and Florida Ryan White Part B programs and the same processes and resulting reports will be used for EQRO activities as well.

RHONDA ('Real Health Outcomes Need Data Analytics') is a user-friendly web-based data warehouse that is used to collect quality outcomes based on the measures' numerator and denominator defined in the performance measure description. The RHONDA tool is a secure online portal with two main purposes. It is designed to capture quality improvement information and then generate actionable data and reports. The RHONDA tool records details of medical charts without capturing any PHI (Protected Health Information). The end user is simply shown a list of questions that they answer yes/no. Once the data has been collected there are several reports with the flexibility to add more. This lack of manual entry allows information to move quicker and with increased accuracy from the auditor, through the reporting structure and to DHCFP. Compliance and outcomes are calculated based on the percentage of yes/total responses, with the ability to derive performance measures.

Additional database services include: MCO/DBA/PAHP reporting by service category and indicator, aggregate reporting by Region/by indicator/program, full aggregated reporting by service category/indicator for the State. Comparison reports are available for any service and/or specific indicators that show year-over-year comparison for quality improvement initiatives. RHONDA has the capacity to pull numerator and denominators for each indicator directly from EPIC, eClinicalWorks, or any other Electronic Medical Record. RHONDA can incorporate demographic data that is not PHI to trend target populations for health outcomes. An example of the RHONDA data and performance measure comparison year-over-year is provided below.

Figure 2. RHONDA Performance Measures, 2016 Baseline vs. 2017

Referrals

21 - Referrals Made: Documentation that referrals were made as needed to specialized medical/mental health providers/services.

O Yes O No O NA

22 - Referral Outcomes: Documentation is present in the client's primary record of the referral and the outcome of the referral.

O Yes O No O NA

Discharge Planning

23 - DC Planning Completed: Documentation is present that discharge planning was completed with the client.

O Yes O No O NA

Discharge

24 - Reason for DC: Documentation of reason for discharge is located in the client's primary record and is consistent with agency policy.

O Yes O No O NA

SAVE

SAVE AND ADD NEW

CANCEL

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Figure 3. Germane's Proprietary RHONDA Database Example

<u>Business Intelligence</u> is our tool to provide benchmark comparisons for HEDIS® measures.

Business Intelligence (BI) leverages software and services to transform data into actionable information that informs an organization's strategic and operational business decisions. Germane Solutions has years of experience analyzing healthcare data from EMRs (Electronic Medical Records), PMs (Performance Measures) and other operational and financial data sources. Germane Solutions can provide diverse reporting/software methods to meet specific user requirements such as mobile friendly custom .NET website applications, email subscription-based reports utilizing SQL Server Reporting Solutions, cube building with SQL Server Analysis Services and Power BI. Germane Solutions' BI capabilities include integrating data from various sources, national benchmarking and producing graphics with high data visualizations, so you can make better business decisions.

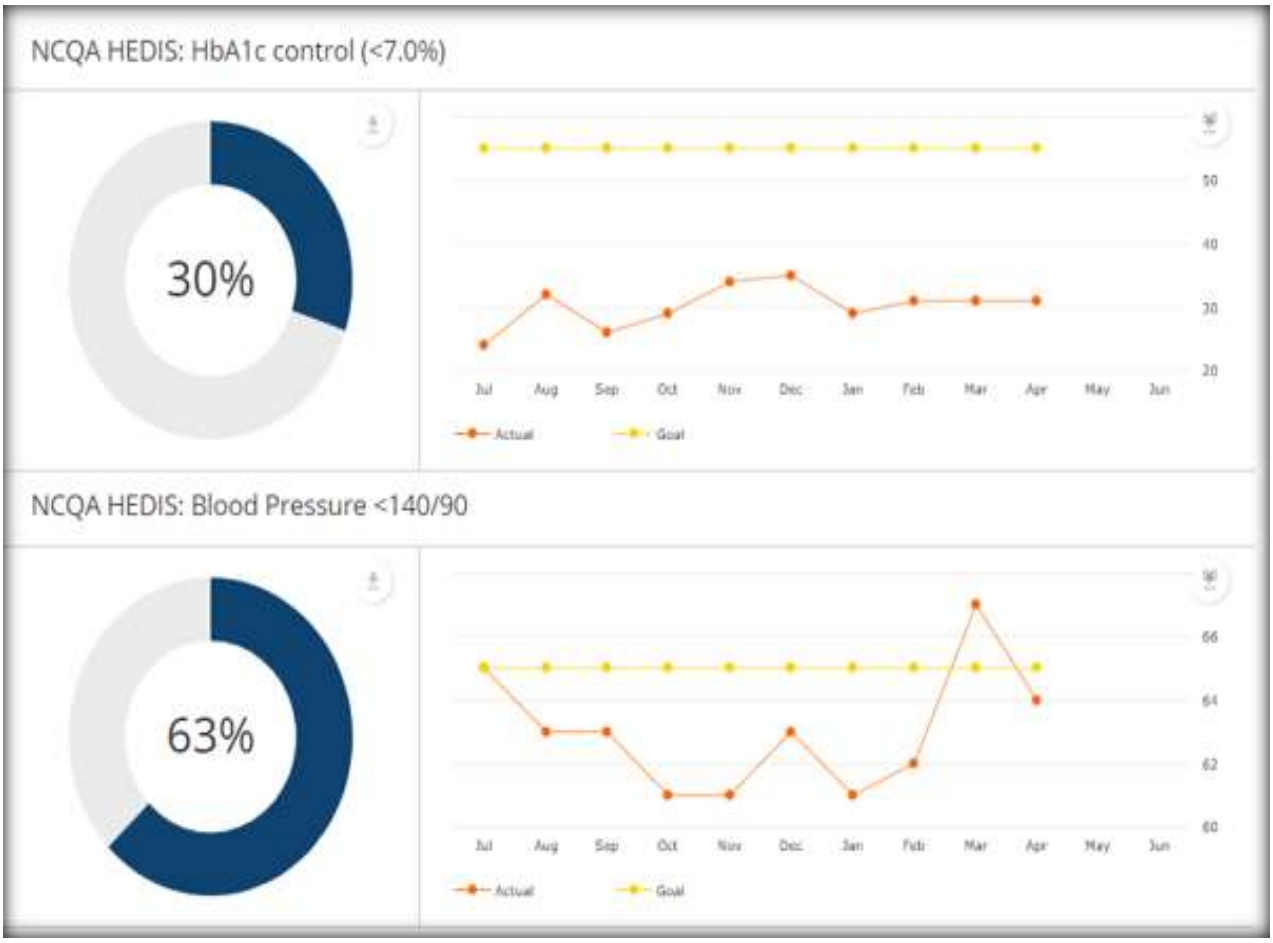

Figure 4. Germane's Proprietary Business Intelligence Database Example 1

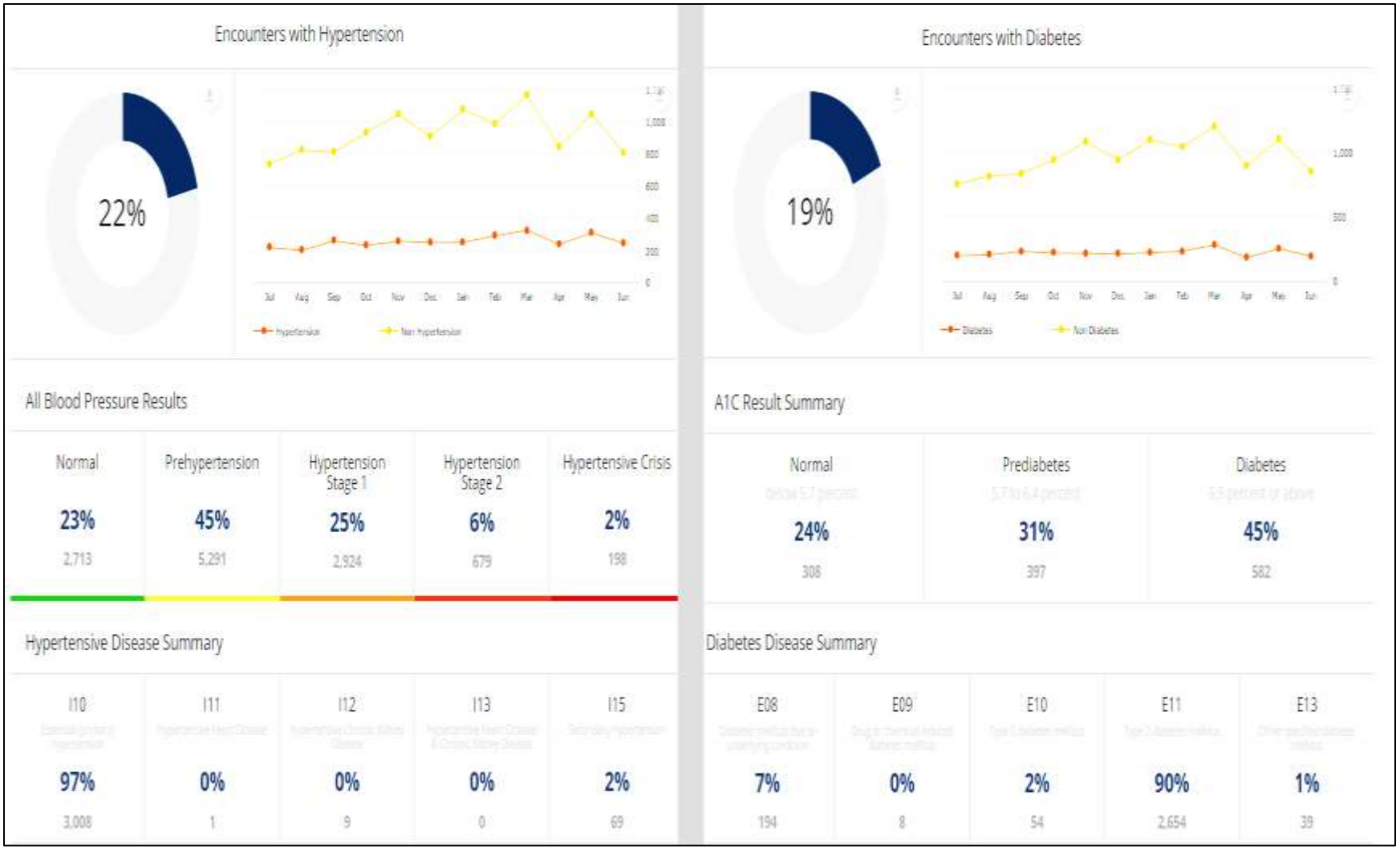

Figure 5. Germane's Proprietary Business Intelligence Database Example 2

2.1.1.3 Review to determine Plan's Compliance with Standards

Germane Solutions understands that the State's desire is to implement innovative approaches that will improve the quality of care and outcomes for Medicaid recipients and provide better value to its citizens.

Federal regulations at 42 CFR Part 438, subpart E set forth the parameters that the State of Nevada must follow when conducting an external quality review (EQR) of their contracted managed care organizations (MCOs). An EQR is the analysis and evaluation by an external quality review organization (EQRO) of aggregated information on quality, timeliness, and access to the health care services that a MCO, or their contractors, furnish to Medicaid recipients.

The EQR process consists of three (3) mandatory and five (5) optional EQR-related activities. Each of these EQR-related activities has a corresponding EQR protocol which provides detailed instructions on how to complete the activity.

42 CFR 438.358

(a) General rule. The State, its agent that is not an MCO or an EQRO may perform the mandatory and optional EQR-related activities in this section
(b) Mandatory activities. For each MCO and the EQR must use information from the following activities:

(3) A review, conducted within the previous 3-year period, to determine the MCO's or 's compliance with standards (except with respect to standards under Sec. 438.240(b) (1) and (2), for the conduct of performance improvement projects and calculation of performance measures respectively) established by the State to comply with the requirements of Sec. 438.204(g).

42 CFR 438.204

At a minimum, State strategies must include the following:

(g) Standards, at least as stringent as those in the following sections of this subpart [Subpart D], for access to care, structure and operations, and quality measurement and improvement.

Figure 6. Code of Federal Regulation (CFR) governing EQRO reviews

2.1.1.4 Network Adequacy Validation

The Centers for Medicare and Medicaid Services (CMS) requires statistics to set threshold standards to ensure that the provider network by plan is adequate to handle capacity, particularly in a period of intense growth experienced from 2013 to present by Nevada.

The transparency of these standards is also critical with specific standards established for:

- ***Time and distance for***
  - ***Primary care (adult and pediatric patients);***
  - ***Obstetrician/gynecologists;***
  - ***Behavioral health;***

- ***Specialists (adult and pediatric);***
- ***Hospitals;***
- ***Pharmacy;***
- ***Pediatric dental; and***
- ***Additional provider types reflective of the objective of that state's Medicaid program.***

2.1.2 OPTIONAL ACTIVITIES

2.1.2.1 Validation of Encounter Data

Encounter data is the electronic record of services provided to MCO enrollees by both institutional and practitioner providers (regardless of how the providers were paid), when the services would traditionally be a billable service under fee-for-service (FFS) reimbursement systems. Encounter data provide substantially the same information that is found in traditional claim submissions, but not always in the same format. Encounter data is used to assess and improve quality, monitor program integrity and determine capitation payment rates.

Germane will assist the state in establishing standards (per the CMS protocol) for encounter data, including:

1. ***An operational definition of an "encounter" and the types of encounters (e.g., physician, hospital, dental, vision, laboratory, etc.) MCOs must report;***
2. ***Standards for encounter data accuracy and completeness; and***
3. ***Objective standards to which encounter data will be compared.***

The protocol calls out five sequential activities:

1. ***Review State requirements for collecting and submitting encounter data;***
2. ***Review the MCO's capacity to produce accurate and complete encounter data;***
3. ***Analyze MCO electronic encounter data for accuracy and completeness;***
4. ***Review of medical records for confirmation of findings of analysis of encounter data; and***
5. ***Submission of findings.***

Germane will complete each of these activities following the protocols as outlined and has experience conducting these types of validations for states and counties under other funding streams.

Our team also has access to information technology resources and systems that will be deployed in this effort to assist with more comprehensive reviews than the State may have received previously. Germane's Business Intelligence™ tool provides a collaborative data repository for benchmarking and improving patient care activities. By importing encounter data into our Business Intelligence™ tool, we can offer insights into encounter data that have not been previously identified.

Figure 7. Germane Solutions Business Intelligence™ Outpatient and Inpatient Dashboards

Germane's proprietary Business Intelligence™ information system provides a collaborative data repository for benchmarking and improving patient care activities and the associated claims information. Originally designed to enhance the performance of graduate medical education programs, the software has evolved to incorporate an enterprise data warehouse, benchmarking and analysis platform, a decision support component, revenue cycle and advanced reporting capabilities. Business Intelligence™ will be used throughout this project to enhance the efforts of the Department in evaluating its MCO's and the various requirements in external quality review.

<u>Project Launch</u>

Germane will first conduct a project launch to meet with DHCFP staff, review the work plan to produce a detailed work plan within the first week post-project launch, and obtain all needed contacts, both within DHCFP, the CMO and for the MCOs, DBA, PAHP and FFS providers.

<u>Review State Requirements</u>

The purpose of the review of State requirements is to ensure the process follows guidance around collecting and submitting encounter data that is specific to Nevada. Germane will require DHCFP to provide:

1. ***Requirements for the types of encounters that must be validated;***
2. ***The State's data dictionary;***
3. ***A description of the information flow from the MCO/DBA/PAHP to DHCFP, including the role of any contractors or data intermediaries;***

4. ***State standards for encounter data completeness and accuracy***;
5. ***A list and description of edit checks built into the State's Medicaid Management Information System (MMIS) that identifies how the system treats data that fails edit checks;***
6. ***The time frames for data submission;***
7. ***The EQR reports for prior years validating encounter data; and***
8. ***Any other information DHCFP sees as relevant to encounter data validation.***

DHCFP will need to specify acceptable rates of accuracy and completeness for each data field submitted for each encounter type. The target error rate should be below 5 percent for each period that is reviewed.

Germane will use a version of the form provided by CMS in the attachment to the protocol related to encounter data validation to summarize these specifications and the data field validity requirements. Our team has worked with similar types of validations for other data sets as well as for Medicaid data on a variety of projects.

Acceptable Error Rates Specifications and Identified Areas of Concern Form

Encounter Type	Error Type	Acceptable Error Rate	Area of Concern (Yes/No) Describe
Office Visit - (excludes dental and mental health / substance abuse visits)	Missing	< %	
	Surplus	< %	
	Erroneous	< %	
Office Visit - mental health / substance abuse	Missing	< %	
	Surplus	< %	
	Erroneous	< %	
Office Visit – dental	Missing	< %	
	Surplus	< %	
	Erroneous	< %	
Inpatient admission - (excludes mental health / substance abuse visits)	Missing	< %	
	Surplus	< %	
	Erroneous	< %	
Inpatient admission - mental health / substance abuse	Missing	< %	
	Surplus	< %	
	Erroneous	< %	
Other types of encounters as specified by the State (e.g., laboratory, pharmacy, physical therapy).	Missing	< %	
	Surplus	< %	
	Erroneous	< %	

Note: The EQRO should add additional rows as necessary to incorporate all types of encounters specified by the State.

Definitions:

- Missing - Encounters that occurred but are not represented by an electronic record.
- Surplus - Encounter records for which an encounter did not occur or which duplicated other records.
- Erroneous - Encounters that occurred and are represented by an electronic record that contains incorrect data elements.
- Acceptable Error Rate - The maximum percentage of missing, surplus, or erroneous records that the State accepts.

EQR Protocol 4 Attachment A
Encounter Data Tables
September 2012

3

Figure 8. CMS Acceptable Error Rate Specification Form

Table 2: Data Element Validity Requirements

Instructions:

For each data element required for the types of encounter data to be validated, the EQRO should document the State's requirements for validity. The EQRO will analyze the encounter data set to determine the validity of specific data elements in the set.

Expectation: The EQRO should use this column to describe the characteristics of, or the test for, validity of each data element.

Validity Criteria: The EQRO should use this column to document the threshold for determining a data element is valid. Typically, this column will hold a quantitative expression of the description in the Expectation column.

Encounter Type		
Data Element	Expectation	Validity Criteria
Enrollee ID	This should be a valid ID as found in the State's eligibility file. Use the State's ID unless State also accepts SSN	100% valid
Date of Service	Dates should be evenly distributed across time	If looking at a full year of data, X% of the records should be distributed across each month
Unit of Service (Quantity)	The number should be routinely coded	X% non-zero < Y% should be 1 if CPT code in range 99200-99215, 99241-99291
Procedure Code	This is a critical data element and should always be coded	100% present (not zero, blank, 8- or 9-filled). 100% should be current, valid, State-approved codes, with X numbers of digits. The frequency and distribution of procedure codes should be consistent with those previously reported.
Revenue Code (Hospital)	If the facility uses a UB04 claim form, this should always be present	100% valid

Note: The EQRO should add additional rows as necessary to incorporate all data elements for which the State specifies specific validity requirements.

EQR Protocol 4 Attachment A
Encounter Data Tables
September 2012 4

Figure 9. CMS Data Element Validity Requirements Form

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

Using the Survey Validation Worksheet in EQR Protocol 5, Germane Solutions staff would confirm, with Nevada staff, the survey purpose and uses, and select an existing or develop a new survey instrument. Germane would develop a representative survey sampling frame to statistically mirror the target population. A recruitment strategy and action plan would be developed to ensure the target response rate by demographic or other detail of the target population. A quality assurance plan to ensure accurate data entry and input would be developed with quality checks on all data fields. The survey would then be implemented in the timeframe determined at the outset. Analysis of the survey and documentation of survey results would be submitted in a raw database, a question-by-question database, cross-tabbed by managed care product, region, demographic and subpopulations of interest. Findings would be accompanied by a narrative Executive Summary and full report with a presentation, possibly condensed into an InfoGraphic.

Using EQR Protocol 5, Germane Solutions staff will validate the results, from a statistical and representative basis, of consumer or provider surveys of quality care.

2.1.2.3 Calculation of Performance Measures in Addition to those reported by Health Plans

Using the Performance Measure Calculation Tables in EQR Protocol 6, Germane Solutions staff will confirm state technical specification for performance measures to be reviewed in addition to those that are mandated, calculate compliance, report findings and stack-rank performance by MCHP with narrative explanation of factors that may contribute to their performance. These could include staff (new vs. senior staff, turnover); client demographics (socio-demographics leading to higher risk or co-morbid conditions) or systems (recent changes in information technology).

2.1.2.4 Conduct Performance Improvement Plans in addition to those conducted by Health Plans

Using EQR Protocol 7, Germane Solutions staff will target improvement in either clinical or non-clinical services. Topics selected for study will reflect the Medicaid/CHIP enrollment in terms of demographic characteristics, prevalence of disease, and the potential consequences of the disease. Germane Solutions uses a Plan-Do-Study-Act (PDSA) format visually displayed in a Storyboard. Below is a representative example.

(1) TEAM INFORMATION	(2) CURRENT SITUATION	(3) REASONS FOR IMPROVEMENT SAMPLING METHOD/VARIABLES
▪ List team members, meet brief periods, even over phone, with data. ▪ 8-10 people at maximum	Purpose statement (driving need for improvement) succinctly stated with issue, relevance and time period in which issue presented.	List 3-4 reasons that this issue is critical or important. Develop sampling methodology/frame Determine Study Variables
(4) ANALYZE ROOT CAUSES	**(5) DEVISE POTENTIAL SOLUTIONS**	**(6) ANALYZE RESULTS**
Use flow diagrams, cause & effect tools, consensus scoring to determine root or underlying causes of symptoms of issue(s).	Summarize possible solutions with field tests and probabilities to determine best solution or set of solutions and sequence.	After field test, analyze results. Look for unintended consequences (good or bad) and behaviors/actions of people vs. what was expected.
(7) FUTURE PLANS	**(8) LESSONS LEARNED**	**(9) FOCUS OF NEXT CYCLE**
Focus on next opportunity specific to this issue (based on findings in 6) or related to this issue.	Summarize what was learned that wasn't known prior to this process and determine applicability to other issues.	Decide what the focus of the next cycle will be and if the team will be maintained or members cycle off.

Figure 10. Quality Improvement Storyboard or Performance Improvement Project (PIP) Process Elements

2.1.2.5 Conduct Studies on Quality that Focus on Particular Aspect of Clinical or Non-Clinical Services at a Point-In-Time

Using EQR Protocol 8, Germane Solutions staff will follow a process like that for the Performance Improvement Plan displayed above. Germane Solutions will specify that the study is more system-wide in nature, with the results of the study reported to the State.

An example of a Quality Study that was discussed from a system-wide perspective is an examination of the Medical Transportation services in Long Island, New York, for Ryan White Part A clients. This study repositioned how transportation occurs for chronically ill patients. This effort was awarded a Gold Medal at the 2010 Ryan White All Parts Conference.

"ELIMINATING ROADBLOCKS" A QUALITY IMPROVEMENT STORYBOARD
NASSAU-SUFFOLK EMA

Debra Ross, Jacqueline Grossi, Georgette Beal and Myra E. Alston

United Way of Long Island

INTRODUCTION

In the Nassau Suffolk EMA PLWHA were successful in identifying and addressing transportation roadblocks that prevented them from accessing care by utilizing a quality improvement process.

Transportation has consistently been ranked a top service priority in the EMA.

The region's link on the western border is through New York City and on the eastern end splits into two peninsulas, known as the North Fork and South Fork. From the eastern portion of Suffolk County, a one way trip to the nearest Designated AIDS Center (DAC) is 71.4 miles and can take up to 3 hours.

Previous attempts of addressing this barrier were not getting to the root causes of the problem.

DEMOGRAPHICS

Demographics of Ryan White Part A transportation clients in the EMA

Race	Nassau	Suffolk	EMA
BLACK	77%	50%	52%
WHITE	22%	32%	27%
A/NA	0%	1%	1%
API	1%	2%	1%
MULTI	1%	17%	20%

Ethnicity	Nassau	Suffolk	EMA
Hist/Lat	20.8%	21.6%	21.2%
Non-Hist.	79.2%	78.4%	78.8%

PURPOSE

To provide efficient and client-sensitive transportation that allow clients to access and stay in primary medical care.

To address the root causes of the region's systemic transportation issues that create roadblocks for PLWHA.

PROBLEMS

Lack of adequate transportation resources due to the EMA's geography

Restrictiveness of other funding (i.e. Medicaid) and limitations of Ryan White eligibility

Underserved remote areas of the EMA particularly the east end

Long travel distances that increase travel time and limits range of services available

Insufficient number of rides allowed per month which limits PLWHA ability to make appointments

Local service providers including non-AIDS service organization's case managers are unaware of transportation resources available in the EMA

PLWHA are also unaware of resources available to them and documentation required to access services

METHODS/ACTIVITIES

The Planning Council's Quality Assurance & Membership (QAM) Committee, spearheaded by PLWHA, brought together AIDS service providers, local transportation companies and community members to examine the systemic issue surrounding transportation in an effort to ensure improved access to primary medical care for PLWHA.

The committee reviewed data provided by the Part A transportation programs. This data showed a 32.7% no show rate.

The QAM Committee met for a five month period and utilized quality improvement tools to address roadblocks in PLWHA's access to care.

The first method was the PDSA (Plan, Do, Study, Act) cycle.

METHODS/ACTIVITIES CONTINUED

Working with an external consulting group, Collaborative Research, the Committee was led through a Quality Improvement Storyboard. This systematic approach was used to guide participants through resolving the problem.

(1) TEAM INFORMATION	(2) CURRENT SITUATION	(3) REASONS FOR IMPROVEMENT
- List team members, meet brief periods, even over phone, with data - 5-10 people at maximum	Purpose statement (driving need for improvement) succinctly stated with issue, relevance and time period in which issue presented	List 3-4 reasons that this issue is critical or important
(4) ANALYZE ROOT CAUSES	**(5) DEVISE POTENTIAL SOLUTIONS**	**(6) ANALYZE RESULTS**
Use fine diagrams, cause & effect tools, consensus scoring to determine root or underlying causes of symptoms of issue(s).	Summarize possible solutions with field tests and probabilities to determine best solution or set of solutions and sequence.	After field test, analyze results. Look for unintended consequences (good or bad) and behaviors/actions of people vs. what was expected.
(7) FUTURE PLANS	**(8) LESSONS LEARNED**	**(9) FOCUS OF NEXT CYCLE**
Focus on next opportunity specific to this issue (based on findings in 6) or related to this issue.	Summarize what was learned that wasn't known prior to the process and determine applicability to other issues.	Decide what the focus of the next cycle will be and if the team will be maintained or members cycle off.

In between meetings, participants were given "homework." Their findings were brought back to the committee for discussion.

RESULTS

- Implement a six month pilot program with two east end service providers
- Develop a consumer rights and responsibilities document
- Educate and train direct service providers on Ryan White eligibility as payer of last resort as well as other resources available to PLWHA in the EMA
- Ongoing evaluation of the pilot program by the QAM Committee
- Annual quality management review of Part A transportation providers to measure no-show rates and increased access to PLWHA in underserved areas

LESSONS LEARNED

The committee was successful because of the collaboration among PLWHA and service providers who worked closely to identify and eliminate transportation roadblocks to care.

CONTACT INFORMATION

United Way of Long Island
819 Grand Boulevard
Deer Park, New York 11729
T: 631-940-3700
F: 631-940-3550
website: www.unitedwayli.org

Figure 11. Transportation to Medical Services QI Storyboard

2.1.2.6 Assistance with the Quality Rating System

A Quality Rating System('QRS') is based on a common set of performance measures across States that increases transparency in Medicaid and CHIP; allows States to compare plan performance; and provides enrollees with comparative information regarding quality of care for Medicaid/CHIP plans similar to what is available to privately insured individuals. Notice of the final Medicaid and CHIP QRS occurred in 2016[2], with Medicaid provisions in force for new contracts as of July 1, 2017 and for CHIP as of July 1, 2018. All EQR provisions apply no later than July 1, 2018.

Germane Solutions will provide a crosswalk between specific performance measures and indicators and the summary indicators adopted by Marketplace QRS. These ratings will be refined over the three-year implementation period.

2.1.3 VALIDATION OF MCO, DBA/PAHP AND CMO PERFORMANCE INDICATORS

The protocol to be deployed to validate performance measures is the Centers for Medicare and Medicaid Systems (CMS) EQR Protocol 2.[3] Germane Solutions project staff will review the information, data and procedures to determine performance indicator by plan for accuracy, reliability, and compliance with standards established by DHCFP for interpretation to ensure bias-free reporting.

Germane Solutions will conduct the first half of compliance, review of the Information Systems capabilities with the second half consisting of review of the HEDIS® data.

The intent of the NCQA HEDIS® Compliance Audit is to determine whether a managed care organization has adequate and sound capabilities for processing medical, member and provider information to derive accurate performance measurement, including HEDIS® reporting. Functions reviewed include:

- ***information practices and control procedures;***
- ***sampling methods and procedures;***
- ***data integrity;***
- ***compliance with HEDIS® specifications;***
- ***analytic file production; and***
- ***reporting and documentation.***

The audit verifies compliance of HEDIS® processes with specifications, with a sample of HEDIS® measures assessed to confirm that HEDIS® results are based on accurate source information. The audit focuses on data management processes and algorithmic compliance (translation of supplied data into HEDIS® statistics, specifications defined by NCQA & DHCFP).

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[2] Final Rule (CMS-2390-F); https://www.medicaid.gov/medicaid/managed-care/downloads/final-rule-overview.pdf

[3] EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR), Version 2.0, September 1, 2012.

2.1.3.1 Evaluate accuracy and extent to which Medicaid-specific performance measures follow HEDIS® specifications

Germane Solutions will use the HEDIS® Compliance Audit Standards, Volume 5 to evaluate the accuracy and extent to which the Medicaid-specific performance measures (19 for Nevada, see Table 1), follow HEDIS® specifications.

2.1.3.2 Verification of Methods used to collect HEDIS® Performance Measures

A. Validate HEDIS® and performance measures during preceding 12 months;

Germane Solutions plans to use the HEDIS® 2018 Technical Specifications, Volume 2 to validate the performance measures.

B. Audit HEDIS® data using Interactive Data Submission System (IDSS) with submission to NCQA

HEDIS non-survey data is collected through the Interactive Data Submission System (IDSS) and maintained in a central database with strict controls to protect confidentiality. Health Plans supply an Attestation with data identified for public reporting. This data has been audited by an NCQA-Certified HEDIS Compliance Auditor, marked Final in the Interactive Data Submission System (IDSS), and has an electronic Attestation of Accuracy, Public Reporting Authorization & Data Use Agreement ("Attestation"). Germane Solutions would affirm that this data is accurate, validate the methods used to collect the **HEDIS® Performance Measures, and verify the submission protocol.**

C. Use HEDIS® Comparative Analysis for SFY 2019 and subsequent EQR contract renewal years

Germane Solutions plans to analyze health plan data using the HEDIS® Comparative Analysis for SFY 2019 and subsequent EQR contract renewal years. Further provision of comparable benchmarks would occur using Business Intelligence™ through dashboards by performance measure, indicator level and by health product and plan.

D. Submit Comparative Analysis HEDIS® report using HEDIS® performance measures submitted by each MCO and DBA/PAHP

A Comparative Analysis HEDIS® report using HEDIS® performance measures would be submitted to DHCFP for each health plan.

2.1.3.3 Validation of Performance Improvement Projects

Germane Solutions will review all Performance Improvement Projects (PIPs) conducted by health plans to determine if they meet Nevada QAPIS goals, have sound quality improvement methodology, and have the potential to address deficits in Performance Measures.

2.1.3.4 Validation of MCO and DBA/PAHP network adequacy

Validation of MCO and DBA/PAHP network adequacy will be addressed using CMS (Centers for Medicare and Medicaid Services) standards to ensure that the provider network by plan is adequate to handle capacity, particularly in a period of intense growth experienced from 2013 to present by Nevada. Standards will address ratios of estimated population to provider, both primary care and specialists, geographic access and providers willing to accept Medicaid.

2.1.3.5 Validation of Nevada Division of Health Care Financing and Policy (DHCFP) Quality Assessment and Performance Improvement Strategy (QAPIS)

A. Evaluate completeness of QAPIS with Strength, Limitations and Improvements;

This review will trend the effectiveness of the Quality Assessment and Performance Improvement Strategy (QAPIS) over the prior three (3) years. The findings will be displayed using a Strength, Limitations and Improvement matrix to clearly illustrate recommendations.

B. Provide Technical Assistance to DHCFP to incorporate changes and recommendations to QAPIS;
Technical Assistance could potentially consist of clarifying the recommendations and related changes in a cross-walk to current components of the QAPIS, refining performance measurement data collection through development or updating of a Data Dictionary, to actual training of health plan providers.

C. Include evaluation of QAPIS with information annually about State's:

- **Progress, status of goals**
- **Trends in clinical or service quality performance improvement programs**
- **Corrective actions and sanctions**
- **Progress and status of value-based purchasing**
- **Assessment and Structure of QAPIS**

A document will be developed that clearly states the Goals and Objectives of the most recent version of Nevada's Division of Health Care Financing and Policy (DHCFP) the Quality Assessment and Performance Improvement Strategy and the progress towards achieving each goal. Support of that overarching assessment will be supplied through trending analysis of clinical or service performance improvement programs with cross-tabulation to selected

performance measures and their component indicators. Any corrective actions, sanctions or defunding of health plans will be addressed, including progress towards addressing these findings.

The status and progress of QAPIS will contribute to benchmarking against CMS' and DHCFP's intent to move to value-based purchasing, with a candid evaluation of status towards that goal. Finally, the current assessment and structure of QAPIS will be evaluated with findings related to possible refinements in the Strategy.

D. DHCFP requires an electronic copy of the final report in PDF and Word Format annually and three (3) hard copies of the final report for distribution.

Findings will be incorporated in a Chapter in the EQR Technical Report titled "External Quality Review Technical Report". All information will be provided in an electronic format with the final report in a PDF and WORD format including three (3) copies for distribution.

2.1.3.6 Produce Annual External Quality Review Technical Report

The following items will be reflected in the Annual External Quality Review Technical Report.

A. Table of Contents of EQR Technical Report:

- ***Objectives***
- ***Technical methods of data collection and analysis***
- ***Description of data obtained***
    - ***Validated performance measure data by activity***
- ***Conclusions***

B. Assessment of each MCO and DBA/PAHP's strengths and weaknesses for Medicaid beneficiaries related to:

The Centers for Medicare and Medicaid Services (CMS) requires states to address:

- ***Quality***
- ***Timeliness***
- ***Access to Health Care services***

In addition, they must determine:

- ***The extent to which beneficiary needs are met;***
- ***The availability of care and providers;***
- ***Changes in beneficiary service utilization; and***
- ***Comparison between Medicaid rates and rates paid by other public and private payers.***

The Centers for Medicare and Medicaid Services (CMS) issued a ruling that states have the flexibility to make data-driven decisions in changes to fee-for-service Medicaid payment rates

that ensure access to covered Medicaid services. Access monitoring plans validate these decisions, with the requirement that the plan reviews a core set of five (5) services:

(1) Primary Care;
(2) Physician specialist;
(3) Behavioral Health;
(4) Pre- and Postnatal Obstetrics;
(5) Home Health Services; and for Nevada,
(6) Dental Services.

C. Recommendations for improving quality of health care services furnished by each MCO and DBA/PAHP

- **How Nevada (DHCPF) can target goals & objectives in quality strategy (QAPIS)**
- **How to support improvement in the quality, timeliness & access to health care services for Medicaid recipients**

D. Methodologically appropriate, comparative information about MCO and DBA/PAHP performance

E. Assessment of degree to which MCO and PAHP addressed the recommendations made by the EQRO the prior year.

F. Revision. States may not substantively revise the content of the final EQR technical report without evidence of error or omission.

G. Availability of information. (1) The State must contract with a qualified EQRO to produce and submit to the State an annual EQR technical report in accordance with paragraph (a) of this section. The State must finalize the annual technical report by April 30th of each year.

H. Each year the Vendor will include a Chapter in the EQR Technical Report summarizing the findings from the assessment of the DHCFP's implementation of the State Quality Assessment, Performance Improvement Strategy and Performance Tracking Tool. DHCFP requires an electronic copy of the final report in PDF and Word Format annually and three (3) hard copies of the final report for distribution.

All information will be provided in an electronic format with the final report in a PDF and WORD format including three (3) copies for distribution.

2.1.4 CONDUCT A COMPLIANCE REVIEW

A standardized methodology for verifying the integrity of HEDIS® collection and calculation processes - the NCQA HEDIS® Compliance Audit will be implemented using the two-part program consisting of an information systems capabilities assessment (IS standards) followed by an evaluation of the MCO's ability to comply with HEDIS® specifications (HD standards). The NCQA HEDIS® Compliance Audit indicates whether a managed care organization has

adequate and sound capabilities for processing medical, member and provider information as a foundation for accurate and automated performance measurement, including HEDIS®reporting.

2.1.5 TECHNICAL ASSISTANCE AND OPTIONAL ACTIVITIES

Technical guidance or assistance may be offered to groups of Managed Care Health Plans experiencing the same issues whether with documentation, a category of personnel, or a specific HEDIS® measure.

2.1.5.1 Provide studies on Nevada Medicaid Fee-For-Service population activities

A. Clinical Focused Studies;
B. HEDIS® or HEDIS®-like calculations and audits;
C. Encounter data validation and omission studies; and
D. Consumer Assessment of Healthcare Providers and Systems (CAPHS) surveys.

2.1.5.2 Provide Nevada Medicaid Care Coordination program activities

A. A comprehensive on-site contract compliance audit of DHCFP's Care Coordination Vendor; and
B. Validation of up to five (5) performance measures for DHCFP's CMO vendor. The EQRO will conduct the validation of performance measures review using the CMS Protocol, Validating Performance Measures.

2.1.5.3 Develop and/or Implement Medicaid managed care quality rating system

A. Adopting the Quality Rating System developed by CMS; and
B. Adopting an alternative Medicaid managed care rating approved by CMS that uses different performance measures or an alternative methodology.

2.1.5.4 Conduct quality activities for 'new' Nevada Medicaid Aged, Blind & Disabled (ABD) managed care expansion program

A. Consulting to DHCFP for ABD performance measures

B. Conducting an Information Systems Readiness Review on selected ABD MCO vendors; and

C. Evaluating implementation of performance measures.

2.1.5.5 Quality Activities related to expansion of Managed care for TANF/CHAP

Quality activities that might relate to expansion of Managed Care could include the impact upon volume (need for additional health plans), by type (Title XIX- Nevada Medicaid/CHIP,

Title XXI-Nevada Medicaid Check Up, DBA Title XIX-Dental Medicaid, DBA Title XXI- Dental Medicaid/CHIP Check Up). Other potential findings would be the predicted impact on key performance measures as more high-risk or chronic individuals enter Medicaid managed care.

2.1.5.6 Additional Technical Assistance related to EQRO

A. A description of the major functions, tasks, and activities required;
B. The timeline/due date for any reports or identified deliverables;
C. Specifications as to the medium and/or format of the desired deliverable;
D. A listing of the EQRO's project requirements; and
E. Any other instructions, definitions, specifications, requirements, outcomes, tangible items, or projects expected.

The EQRO will submit to the DHCFP, for approval, its cost proposal for completing the technical assistance or consultative project according to the scope of work detailed in the DHCFP's request.

Technical assistance or consultative services may be offered related to EQRO activities.

2.2 QUALIFICATIONS OF EXTERNAL QUALITY REVIEW ORGANIZATIONS

2.2.1 The vendor and all subcontractors must meet all requirements of 42 CFR 438.354 and the mandatory DHCFP contract requirements as follows.

2.2.1.1 The vendor must have staff with demonstrated experience, knowledge and skills

A. Medicaid recipients, policies, data systems, and processes;
B. Managed care delivery systems, organizations, and financing;

Germane performs its external quality review functions in accordance with federal and state laws, regulations and policies that govern Medicaid, Ryan White, the Substance Abuse Prevention and Treatment Block Grant and various other funding sources – including standards and procedures related to waiver programs. Our team combines decades of experience managing large-scale state, managed care, and federal contracts. The Account Executive and Project Team have over eighteen (18) years providing comparable services to the public health sector.

2.2.1.2 Quality assessment and improvement methods; and

Germane currently provides external quality review services for the State of Texas, State of Florida, the City of New Haven (CT) and the City of Baton Rouge (LA) and has previously done quality review work for Nassau & Suffolk Counties (NY), Cleveland (OH) and other localities around the country. Prior work with States includes Arizona, Connecticut, Idaho, Maine, Nebraska, South Dakota and Wyoming.

2.2.1.3 Research design and methodology, including statistical analysis.

2.2.2 Sufficient physical, technological, and financial resources to conduct EQR or EQR-related activities

Germane has the resources to conduct the EQR and EQR related activities. Germane has sufficient software, hardware, expertise and security protections to carry out all technology components.

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

2.2.4 Independence. The EQRO and its subcontractors must be independent from the MCO, PAHP, or CMO entities. To qualify as "independent":

2.2.4.1 A State agency, department, university, or other State entity:

Not Applicable

2.2.4.2. May not have Medicaid purchasing or managed care licensing authority; and

Not Applicable

2.2.4.3 Must be governed by a Board or similar body the majority of whose members are

Not Applicable

2.2.5 As described in (described in §438.354(c)(2)) an EQRO may not:

2.2.5.1 Review any MCO, PIHP, PAHP, or PCCM entity or a competitor operating in the

A. Stock ownership;
B. Stock options and convertible debentures;
C. Voting trusts;
D. Common management, including interlocking management; and
E. Contractual relationships.

Not Applicable

2.2.5.2 Deliver any health care services to Medicaid beneficiaries;

Not Applicable

2.2.5.3 Conduct, on the State's behalf, ongoing Medicaid managed care program

Not Applicable

2.2.5.4 Review any MCO, PAHP or CMO entity for which it is conducting or has conducted

Not Applicable

2.2.5.2 Have a present, or known future, direct or indirect financial relationship with an

Not Applicable

2.2.6 The vendor must designate a contract manager to work with the assigned DHCFP program specialist or contract monitor(s).

2.2.7 The awarded vendor is, or will subcontract with, a National Committee for Quality Assurance (NCQA) certified Consumer Assessment of Health Plans Survey (CAHPS) vendor, if this optional activity is assigned.

2.2.8 The awarded vendor is or has on staff, or will subcontract with, an NCQA- Certified Health Employer Data Information Set (HEDIS) Compliance Auditor.

Allen Iovannisci is an NCQA-Certified HEDIS Compliance Auditor. Allen is highly experienced in conducting HEDIS Compliance Audits, performing CMS data validation audits and performance measure validation audits.

2.3 VENDOR OPERATING STRUCTURE AND STAFFING

2.3.1.1 Updated Organizational Chart

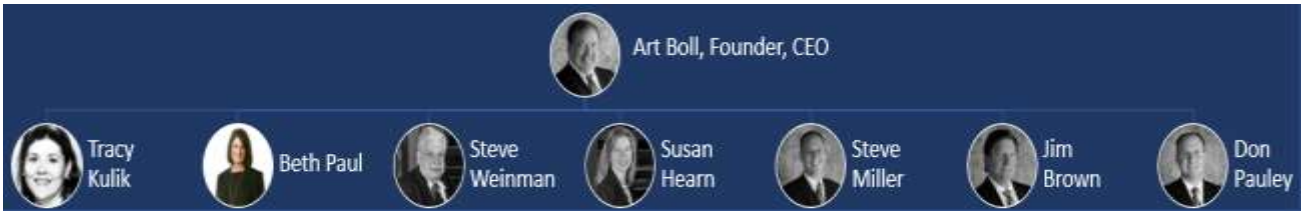

Figure 12. Germane Solutions Leadership Structure

Tracy Kulik, Vice President of Health Access, will function as the Account Executive on this engagement, supported by Amy Fleischer, Project Manager; Rhonda Stewart, Director of Quality Improvement; and Jordan McCown, Senior Consultant with extensive behavioral health experience. Displayed below is an organizational chart for the Health Access Section.

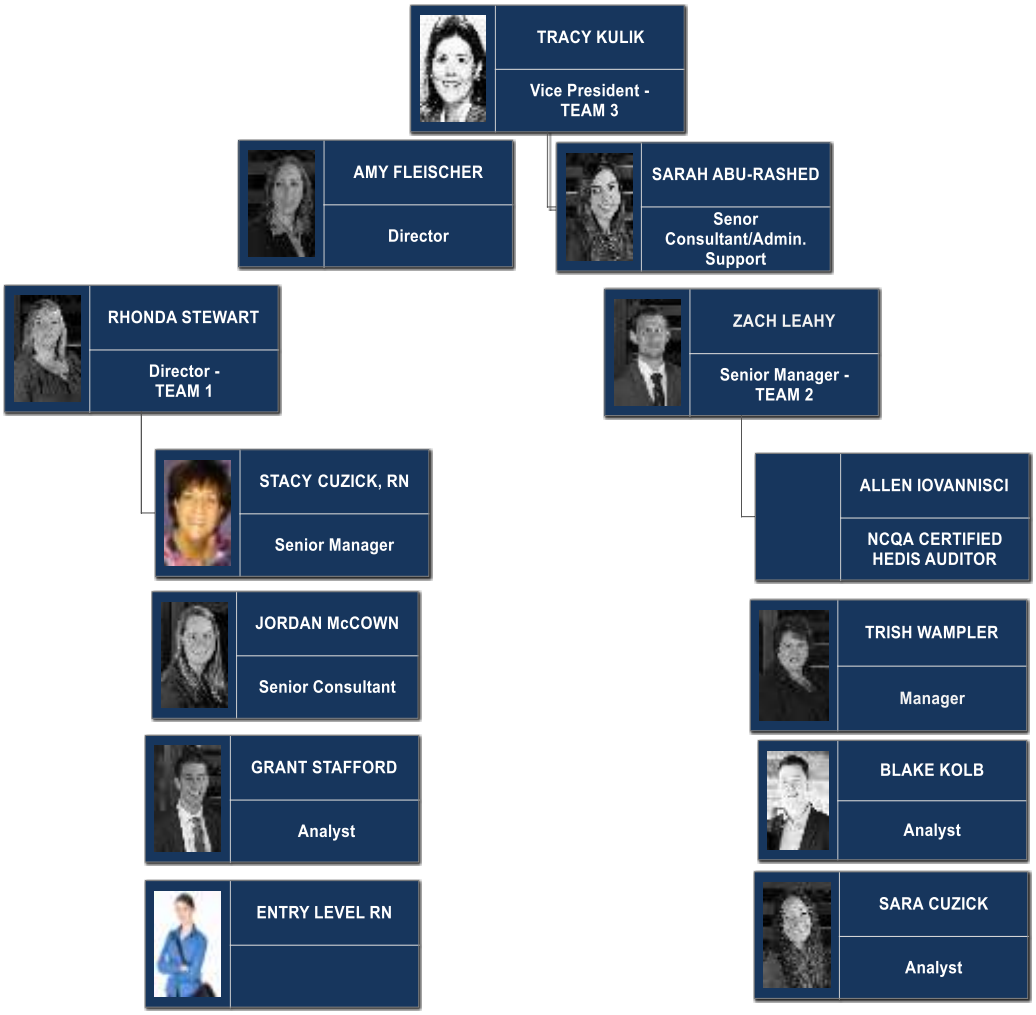

Figure 13. Health Access Section of Germane Solutions

2.3.1.2 Organizational, Management & Administrative Systems to fulfill contract

Germane Solutions is a firm that was founded to develop solutions to the Graduate Medical Education arena. In 2014, the Health Access section was acquired with a prior twelve-year history serving the clinical quality needs of Medicaid managed care organizations, public health entities and recipients of federal health and social service grant funds.

The Quality Improvement review function has evolved from disease-specific compliance audits and Plan-Do-Study-Act (PDSA) models to statewide quality and program compliance reviews, Performance Improvement Plans and filing to become a National Committee for Quality Assurance (NCQA) CAPHS-certified provider for surveys of consumers and providers. Our plan is to become fully NCQA-certified for CAPHS surveys in 2018.

Our management and administrative support reflects this evolution, with growth from a three-person staff in 2014 to 9 in 2016 and 12 in 2017; with plans to expand to 18-25 dedicated staff. Targeted recruitment occurred in qualified survey professionals, behavioral health experts, and most importantly, dedicated Information Technology expertise.

Administrative support includes development and refinement of a Business Intelligence system focused on quality review and internal development of RHONDA (Real Health Outcomes Need Data Analytics). This data collection system is HIPAA compliant, with data collected on-site through a comprehensive review of consumer clinical and non-clinical charts using the HRSA sampling methodology of a 90% confidence level with a +/-10% confidence interval of the total unduplicated clients served by the sub-recipient per service category for a pre-determined 12-month measurement year. Data abstracted on-site is documented in the monitoring tools with preliminary outcomes determined 'real time' by indicator/performance measure to discuss with the sub-recipient during the exit briefing. At no time during the clinical and non-clinical chart abstraction review will patient health information be collected by the Germane Solutions review team.

2.3.1.3 Acknowledged Responsibility for Subcontractor

Not Applicable – no use of Subcontractors.

2.4. IMPLEMENTATION

2.4.1 Develop Detailed Work Plan and Timeline for First Contract Year

RFP Reference	Deliverables	MCO Title XIX	MCO Title XXI	DBA Title XIX	DBA Title XXI	CMO-FFS
Mandatory		**NV Medicaid**	**NV MA Check Up (NCU)**	**Dental NV MA**	**Dental NV MA Check Up (NCU)**	**Care Management Organization**
2.1.1.1	Performance Improvement Project Validation	✓	✓	✓	✓	
2.1.1.2	Performance Measurement Validation	✓	✓	✓	✓	✓
2.1.1.3	Review to determine Plan's Compliance with Standards	✓	✓	✓	✓	
2.1.1.4	Network Adequacy Validation	✓	✓	✓	✓	
Optional						
2.1.2.1	Validation of Encounter Data	✓	✓	✓	✓	
2.1.2.2	Administration or Validation of CAPHS	✓	✓	✓	✓	
2.1.2.3	Calculation of Performance Measures in Addition to those reported by Health Plans	✓	✓	✓	✓	
2.1.2.4	Conduct Performance Improvement Plans in addition to those conducted by Health Plans	✓	✓	✓	✓	
2.1.2.5	Conduct Studies on Quality that Focus on Particular Aspect of Clinical or Non-Clinical Services at a Point-In-Time					✓
2.1.2.6	Assistance with the Quality Rating System					✓

RFP Reference	Deliverables	MCO Title XIX	MCO Title XXI	DBA Title XIX	DBA Title XXI	CMO -FFS
Detail Work Plan		**NV Medicaid**	**NV MA Check Up (NCU)**	**Dental NV MA**	**Dental NV MA Check Up (NCU)**	**Care Management Organization**
2.1.3 (2.1.1.2)	VALIDATE MCO, DBA/PAHP AND CMO PERFORMANCE INDICATORS	✓	✓	✓	✓	
2.1.3.1	Evaluate accuracy and extent to which Medicaid-specific performance measures follow HEDIS® specifications	✓	✓	✓	✓	
2.1.3.2	Verification of Methods used to collect HEDIS® Performance Measures	✓	✓	✓	✓	
2.1.3.3	Validation of Performance Improvement Projects	✓	✓	✓	✓	
2.1.3.4	Validation of MCO and DBA/PAHP network adequacy	✓	✓	✓	✓	
2.1.3.5	Validation of Nevada Division of Health Care Financing and Policy (DHCFP) Quality Assessment and Performance Improvement Strategy (QAPIS)	✓	✓	✓	✓	✓
2.1.3.6	Produce Annual External Quality Review Technical Report	✓	✓	✓	✓	✓
2.1.4 (2.1.1.3)	CONDUCT A COMPLIANCE REVIEW					
2.1.5	TECHNICAL ASSISTANCE AND ***OPTIONAL ACTIVITIES***					✓
2.1.5.1	Provide studies on Nevada Medicaid Fee-For-Service population activities					✓
2.1.5.2	Provide Nevada Medicaid Care Coordination program activities					✓

RFP Reference	Deliverables	MCO Title XIX	MCO Title XXI	DBA Title XIX	DBA Title XXI	CMO -FFS
Detail Work Plan		**NV Medicaid**	**NV MA Check Up (NCU)**	**Dental NV MA**	**Dental NV MA Check Up (NCU)**	**Care Management Organization**
2.1.5.3	Develop and/or Implement Medicaid managed care quality rating system	✓	✓	✓	✓	✓
2.1.5.4	Conduct quality activities for 'new' Nevada Medicaid Aged, Blind & Disabled (ABD) managed care expansion program	✓	✓	✓	✓	✓
2.1.5.5	Quality Activities related to expansion of Managed care for TANF/CHAP	✓	✓	✓	✓	✓
2.1.5.6	Additional Technical Assistance related to EQRO	✓	✓	✓	✓	✓

2.4.2 Update Initial Work Plan and Timelines, identifying adjustment per DHCFP

Germane Solutions will update the initial work plan and timelines following the Project Launch after contract award.

2.4.3 Submit within ten (10) working days of service start date, all deliverables to permit DHCFP identified modifications

Deliverables will be submitted within the revised work plan and are subject to DHCFP modification.

2.5 PRESENTATION OF FINDINGS

The awarded vendor must obtain DHCFP's approval prior to publishing or making formal public presentations of statistical or analytical material that includes information about enrolled recipients. This material must protect specific individual recipient privacy and confidentiality to the extent required by both federal and state law and regulation.

Germane Solutions agrees to this requirement and will communicate with DHCFP prior to any published material regarding the Nevada EQRO engagement.

2.6 HIPAA COMPLIANCE REQUIREMENTS

2.6.1 Validation of Encounter Data

Germane Solutions will validate encounter data from contracted health plans. Validation will occur through EQR Protocol #4. Encounter data are the electronic record of services provided to managed care health plan enrollees by providers. Encounter data provide the information found on claim forms (e.g., UB-04 or CMS 1500. States use encounter data to assess and improve quality, monitor program integrity, and determine capitation payment rates.

This protocol specifies procedures for EQROs to assess the completeness and accuracy of encounter data submitted by MCOs to the State. The State establishes standards for encounter data, including: 1. An operational definition of an "encounter" and the types of encounters (e.g., physician, hospital, dental, vision, laboratory, etc.) MCOs must report; 2. Standards for encounter data accuracy and completeness; and 3. Objective standards to which encounter data will be compared. The protocol consists of five sequential activities:

1. Review State requirements for collecting and submitting encounter data;
2. Review the MCO's capacity to produce accurate and complete encounter data;
3. Analyze MCO electronic encounter data for accuracy and completeness;
4. Review of medical records for confirmation of findings of analysis of encounter data; and
5. Submission of findings.

2.6.1.1 Conformance with HIPAA Requirement and Regulations

Germane Solutions represents and warrants that all HIPAA requirements and regulations will be fully complied with, and conformance will be assured. Further, use of RHONDA ('Real Health Outcomes Need Data Analytics') as the data collection tool ensures that no personally identifiable information is collected. This will assist in not exposing any Protected Health Information (PHI) or Personally Identifiable Information (PII).

SECTION VI. COMPANY BACKGROUND AND REFERENCES

3.1 VENDOR INFORMATION

Question	Response
Company name:	Germain & Co., Inc. dba Germane Solutions
Ownership (sole proprietor, partnership, etc.):	Partnership
State of incorporation:	Ohio
Date of incorporation:	July 23, 2002
# of years in business:	16
List of top officers:	Art Boll, Tracy Kulik, Jim Brown
Location of company headquarters, to include City and State:	10552 Success Lane, Suite A Dayton, OH 45458
Location(s) of the office that shall provide the services described in this RFP:	10552 Success Lane, Suite A Dayton, OH 45458
Number of employees locally with the expertise to support the requirements identified in this RFP:	0
Number of employees nationally with the expertise to support the requirements in this RFP:	12
Location(s) from which employees shall be assigned for this project:	10552 Success Lane, Suite A Dayton, OH 45458

3.1.2 Nevada Business and 5% Preference

NOT APPLICABLE

3.1.3 Foreign Corporation License

Germane Solutions will provide upon contract award.

3.1.4 Nevada Business License

Question	Response
Nevada Business License Number:	SEE BELOW—ON ORDER
Legal Entity Name:	Germain & Co., Inc.

E-Payment Confirmation

Jiffie Hart
Germain & Co., Inc.
10552 Success Ln Ste A
Centerville OH 45458-3664

QUESTIONS? GET IN TOUCH:
CT Corporation
Phone: (844) 255-1854
Email: SmallBusinessTeam@wolterskluwer.com

ORDER NUMBER	ORDER DATE	CUSTOMER NUMBER
10840902 - SO	02/13/2018	8765697

CUSTOMER REFERENCE - 1	CUSTOMER REFERENCE - 2
NV Registration	

REQUESTED BY
Jiffie Hart

Payment Amount	(-1289.00)
Transaction Date	02/13/2018
Master Card	XXXX XXXX XXXX 8776
Confirmation Number	E575982

Is "Legal Entity Name" the same name as vendor is doing business as?

Yes		No	x

This was a formative decision, given middle surname of owner as 'Germain'. The business name, Germane Solutions, also refers to the initial prime focus of Graduate Medical Education (GME).

3.1.5 Germane Solutions Prior Contract with State of Nevada Agency

3.1.5 Has the vendor ever been engaged under contract by any State of Nevada agency?

Yes		No	x

3.1.6 Germane Solutions prior employee of State of Nevada or its agencies, departments or divisions

3.1.6 Are you now or have you been within the last two (2) years an employee of the State of Nevada, or any of its agencies, departments, or divisions?

Yes		No	x

3.1.7 Disclosure of prior or ongoing contract failures, breaches, litigation – NOT APPLICABLE

3.1.7 Disclosure of any significant prior or ongoing contract failures, contract breaches, civil or criminal litigation in which the vendor has been alleged to be liable or held liable in a matter involving a contract with the State of Nevada or any other governmental entity. Any pending claim or litigation occurring within the past six (6) years which may adversely affect the vendor's ability to perform or fulfill its obligations if a contract is awarded as a result of this RFP shall also be disclosed.

Does any of the above apply to your company?

Yes		No	x

If "Yes", please provide the following information. Table can be duplicated for each issue being identified.

Question	Response	
Date of alleged contract failure or breach:		
Parties involved:		
Description of the contract failure, contract breach, or litigation, including the products or services involved:		
Amount in controversy:		
Resolution or current status of the dispute:		
If the matter has resulted in a court case:	Court	Case Number
Status of the litigation:		

3.1.8 Germane Solutions and Insurance Requirements

Germane Solutions will provide the insurance requirements per Attachment D, Insurance Schedule for RFP 3491.

3.1.9 Germane Solutions Company Background/History or Qualifications

Since 2002, Germane Solutions has been providing solutions to the healthcare services field, including being actively engaged in quality improvement efforts for states, managed care organizations, funders, county systems, local health departments, hospitals and health systems across the country. Germane currently provides external quality review services for the State of Texas, State of Florida, the City of New Haven (CT) and the City of Baton Rouge (LA) and has previously done quality review work for Nassau & Suffolk Counties (NY), Cleveland (OH) and other localities around the country. Prior work with States includes Arizona, Connecticut, Idaho, Maine, Nebraska, South Dakota and Wyoming.

Figure 14. Map of Germane Solutions Clients

Germane performs its external quality review functions in accordance with federal and state laws, regulations and policies that govern Medicaid, Ryan White, the Substance Abuse Prevention and Treatment Block Grant and various other funding sources – including standards and procedures related to waiver programs.

3.1.10 Length of Time Providing Services in RFP to the Public and/or Private Sector

Our team combines decades of experience managing large-scale state, managed care, and federal contracts. Germane has a sound and refined project management process and a long track record of successful implementations. The Account Executive and Project Team have over eighteen (18) years providing comparable services to the public health sector.

3.1.11 Financial Information & Documentation

3.1.11 Financial Information and Documentation

3.1.11.1 Dun and Bradstreet

Dun and Bradstreet Number: ***079211332***

3.1.12 Germane Solutions Prior Contract with State of Nevada Agency

Federal Tax Identification Number: ***20-0242557***

3.1.13 Last two years and current year interim (2015, 2016 and 2017-provisional)

The last two years and current year interim (2015, 2016 and 2017-provisional)

- **A. Profit and Loss Statement**
- **B. Balance Sheet**

A. Profit and Loss Statement

9:45 AM
02/24/17
Accrual Basis

Germane Solutions
Profit & Loss
January through December 2015

	Jan - Dec 15
Ordinary Income/Expense	
Income	
Consulting Revenue	5,603,210.74
Expense Reimbursement	695,834.00
Intercompany Transfer	568,490.00
PROMPT Revenue	169,450.00
Total Income	7,036,984.74
Cost of Goods Sold	
Commission on Sales Lead	6,000.00
Project Related Costs	361,062.66
Total COGS	367,062.66
Gross Profit	6,669,922.08
Expense	
Accounts to Review	-11.38
Administration	1,494.50
Corporate Expenses	854,363.99
Ownership	182,560.84
Personnel Cost	4,357,552.80
State Filing Costs	3,591.85
Travel Cost	1,049,483.05
Total Expense	6,449,035.45
Net Ordinary Income	220,886.63
Other Income/Expense	
Other Income	
Interest Income	736.19
Total Other Income	736.19
Other Expense	
Collaborative Lawsuit	50,000.00
Income Taxes	51,735.16

	Jan - Dec 15
Interest Expense	12,461.41
Total Other Expense	114,196.57
Net Other Income	-113,460.38
Net Income	107,426.25

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02/24/17
Accrual Basis

Germane Solutions
Profit & Loss
January through December 2016

	Jan - Dec 16
Ordinary Income/Expense	
Income	
Consulting Revenue	7,381,658.58
Expense Reimbursement	812,323.15
Inter-Co X-Charges	1,729,013.25
Intercompany Transfer	796,905.54
PROMPT Revenue	554,575.00
Uncategorized Income	13,256.05
Total Income	11,287,731.57
Cost of Goods Sold	
Commission on Sales Lead	23,225.00
Project Related Costs	67,533.28
Total COGS	90,758.28
Gross Profit	11,196,973.29
Expense	
Accounts to Review	213.33
Administration	2,833.18
Corporate Expenses	1,278,268.07
Ownership	162,968.09
Personnel Cost	7,237,167.52
Servers & Hosting	12,110.19
State Filing Costs	4,311.81
Travel Cost	1,198,888.70
Total Expense	9,896,760.89
Net Ordinary Income	1,300,212.40
Other Income/Expense	
Other Income	
Interest Income	180.98
Total Other Income	180.98
Other Expense	
Income Taxes	57,183.07
Interest Expense	1,679.04
Total Other Expense	58,862.11
Net Other Income	-58,681.13
Net Income	1,241,531.27

Germane Solutions
Profit and Loss Summary by Division

As of Date:

	Year To Date 12/31/2017
Revenue	
Revenue - Consulting	10,786,014.91
Revenue - Licenses	485,850.00
Revenue - Reimbursed Travel	762,328.16
Revenue - Sales Commission	94,219.37
Revenue - Division Investment Credit	59,893.19
Revenue - Division Protected Time Credit	308,393.36
Division X-Utilization Revenue	916,368.06
Overhead Reimbursement from Divisions	1,211,956.44
Total Revenue	14,625,023.49
Cost of Revenue	
Commission Expense	235,325.53
PROMPT Fees	83,250.00
Sub-Contractors	442,210.84
Labor Costs - X-Utilization	115,701.34
Total Cost of Revenue	876,487.71
Gross Profit	13,748,535.78
Operating Expenses	
Payroll and Related Expenses	8,765,318.86
Travel Expenses	1,402,349.67
Corporate Overhead Allocation	1,211,956.44
General and Administrative Expenses	949,997.29
Depreciation and Amortization Expense	28,172.84
Taxes and Insurance	117,788.99
Total Operating Expenses	12,475,584.09
Other Income (Expense)	
Interest Income	2,217.86
Other Income	(37,816.28)
Interest Expenses	(19,561.02)
Total Other Income (Expense)	(55,159.44)
Income Taxes	223,609.03
Net Income (Loss)	**$ 994,183.22**

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B. Balance Sheet

10:22 AM
12/05/17
Accrual Basis

Germane Solutions
Balance Sheet
As of December 31, 2015

	Dec 31, 2015
ASSETS	
Current Assets	
Checking/Savings	
Pay Pal	3,747.57
PNC Checking	61,128.09
Total Checking/Savings	64,375.66
Accounts Receivable	
Accounts Receivable	1,231,240.41
Total Accounts Receivable	1,231,240.41
Other Current Assets	
Accrued Federal Income Tax	100,094.00
Life Insurance - CSV	4,999.19
Prepaid Expense	4,267.72
Total Other Current Assets	109,360.91
Total Current Assets	1,404,976.98
Fixed Assets	
Computer and Server	100,612.00
Leasehold Improvements-Dayton	66,297.26
Snippets License	
Snippets AccumDep	-309,000.00
Snippets License - Other	309,000.00
Total Snippets License	0.00
Software	8,012.10
SS & C-Accumulated Dep	-97,191.27
Total Fixed Assets	77,730.09
Other Assets	
Deferred Comp Deposit	637,397.53
Deferred Tax Benefit	167,730.00
Equity Contribution	189,915.00
UDecx Investment	39,000.00
Total Other Assets	1,034,042.53
TOTAL ASSETS	2,516,749.60
LIABILITIES & EQUITY	
Liabilities	
Current Liabilities	
Accounts Payable	
Accounts Payable	-26,835.12
Total Accounts Payable	-26,835.12
Credit Cards	
CC Arthur Boll #6459	-339.58
CC Don Pauley #0031	4,738.21
CC Jakub Jedynak #9034	7,873.26
CC Joe Catanese #6814	-53.36
CC Kathleen (Casey) Hoffman #66	3,345.09

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12/05/17
Accrual Basis

Germane Solutions
Balance Sheet
As of December 31, 2015

	Dec 31, 2015
CC Kris Vilamaa #1004	1,399.12
CC Marcos Alcorn #4222	-370.20
CC Matthew Hendricks #4646	4,809.90
CC Maureen (Tracy) Kulik #4265	-184.36
CC Megan Mitchell #2993	646.51
CC Mike Benck #1877	4,062.18
CC Rhonda Stewart #4273	-3,456.69
CC Sarah Abu-Rashad #0820	29.85
CC Steve Miller #0824	4,474.41
CC William Deighton #9991	-42.50
CC Zach Leahy #4612	441.48
Total Credit Cards	27,373.32
Other Current Liabilities	
Credit Balances - A/R	23,399.23
Flexible Spending	7,960.27
Total Other Current Liabilities	31,359.50
Total Current Liabilities	31,897.70
Long Term Liabilities	
Deferred Comp – Jim	239,775.00
Deferred Comp Payable - Equity	93,900.00
Elective Defer Comp - A & N	175,430.80
PNC - New Office Loan	42,576.18
Total Long Term Liabilities	551,681.98
Total Liabilities	583,579.68
Equity	
Capital Stock	10,000.00
Contributed Capital	483,293.04
Retained Earnings	1,242,148.98
Net Income	197,727.90
Total Equity	1,933,169.92
TOTAL LIABILITIES & EQUITY	2,516,749.60

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02/24/17
Accrual Basis

Germane Solutions
Balance Sheet
As of December 31, 2016

	Dec 31, 16
ASSETS	
Current Assets	
Checking/Savings	
National City - Savings	250,000.06
PNC Checking	339,680.14
Total Checking/Savings	589,680.20
Accounts Receivable	
Accounts Receivable	2,172,458.84
Total Accounts Receivable	2,172,458.84
Other Current Assets	
Life Insurance - CSV	50,291.41
Prepaid Expense	51,836.44
Undeposited Funds	12,675.00
Total Other Current Assets	114,802.85
Total Current Assets	2,876,941.89
Fixed Assets	
Leasehold Improvments - New Off	66,297.26
Snippets License	0.00
Software	8,707.10
SS & C-Accumulated Dep	-92,416.73
Total Fixed Assets	-17,412.37
Other Assets	
Deferred Comp Deposit	681,122.73
Deferred Tax Benefit	215,730.00
Equity Contribution	207,523.00
UDecx Investment	39,000.00
Total Other Assets	1,143,375.73
TOTAL ASSETS	**4,002,905.25**

Page 1

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02/24/17
Accrual Basis

Germane Solutions
Balance Sheet
As of December 31, 2016

	Dec 31, 16
LIABILITIES & EQUITY	
Liabilities	
Current Liabilities	
Credit Cards	
Bruce's Credit Card 1	23.47
CC Arthur Boll #6459	-673.08
CC Cynthia Powell #2633	326.83
CC Dale Carlson #2923	1,414.81
CC Don Pauley #0031	5,341.48
CC George Ibrahim #8978	355.49
CC Gloria Robles #8279	1,423.37
CC Jakub Jedynak #9034	5,717.92
CC Joe Catanese #6814	-53.36
CC Jordan McCown #0126	396.46
CC Kelsey Hogan #8127	48.07
CC Kris Vilamaa #1004	334.95
CC Matthew Hendricks #4646	4,036.52
CC Maureen (Tracy) Kulik #4265	1,609.06
CC Megan Mitchell #2993	1,933.84
CC Michelle Vilamaa #3275	-53.67
CC Mike Benck #1877	2,636.75
CC Ozgur Gencdur #4433	204.05
CC Patricia Wampler #0366	581.52
CC Rhonda Stewart #9075	-1,857.55
CC Sarah Abu-Rashad #0820	214.09
CC Stacy Cuzick #1662	-64.65
CC Steve Miller #0824	1,659.58
CC Tricia Gohlke #6873	252.93
CC William Deighton #9991	-42.50
CC Zach Leahy #4612	441.48
PNC Control - New	37,671.68
Total Credit Cards	63,879.54
Other Current Liabilities	
Accrued Fed Tax Liability	943.00
Credit Balances - A/R	23,399.23
Flexible Spending	11,883.27
Loan from StringRay Media	5,832.70
Loan To/From Shareholders	5,000.00
Project Acceptance Fees	189,500.00
Total Other Current Liabilities	236,558.20
Total Current Liabilities	300,437.74

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02/24/17
Accrual Basis

Germane Solutions
Balance Sheet
As of December 31, 2016

	Dec 31, 16
Long Term Liabilities	
Deferred Comp – Jim	328,744.90
Deferred Comp - Staff	30,000.00
Deferred Comp Payable - Equity	145,740.94
Elective Defer Comp - A & N	167,243.60
PNC - New Office Loan	28,646.46
Total Long Term Liabilities	700,375.90
Total Liabilities	1,000,813.64
Equity	
Capital Stock	-89,915.93
Contributed Capital	500,901.04
Retained Earnings	1,349,575.23
Net Income	1,241,531.27
Total Equity	3,002,091.61
TOTAL LIABILITIES & EQUITY	4,002,905.25

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Germane Solutions
Balance Sheet

As of Date: 12/31/2017

	01/01/2017 Through 12/31/2017
Assets	
Current Assets	
Cash and Cash Equivalents	508,803.78
Accounts Receivable, Net	2,925,340.00
Prepaid Expenses	54,422.40
Other Current Assets	242,649.07
Total Current Assets	3,731,215.25
Fixed Assets, Net	
Fixed Assets	100,936.12
Total Fixed Assets, Net	100,936.12
Intangible Assets, Net	
Intangible Assets	186,003.20
Total Intangible Assets, Net	186,003.20
Other Assets	
Employee Advances / Loans	16,100.00
Other Assets	585,761.45
Total Other Assets	601,861.45
Total Assets	**$ 4,620,016.02**
Liabilities and Equity	
Current Liabilities	
Accrued Liabilities	328,500.84
Accrued Taxes	23,862.36
Deferred Revenue	113,000.00
Loan Payable	92,474.13
Other Current Liabilities	157,075.37
Total Current Liabilities	714,912.70
Long Term Liabilities	
Long Term Debts	30,000.00
Total Long Term Liabilities	30,000.00
Other Liabilities	
Other Liabilities	846,203.00
Total Other Liabilities	846,203.00
Stockholders Equity	
Capital Stock	(259,020.37)

Retained Earnings	2,293,737.47
Net Income (Loss)	994,183.22
Total Stockholders Equity	3,028,900.32
Total Liabilities and Equity	**$ 4,620,016.02**

Created on: 02/09/2018 02:45 PM

3.2.1 Conformance with HIPAA Requirement and Regulations

Does this proposal include the use of subcontractors?

Yes		No	X

3.3 BUSINESS REFERENCES

3.3.1 *Three (3) Business References for last three (3) years*

Table 1. Reference Projects

Name of Contractor/ Contract/ Contract Value	*Contract Description*	*Period*	*Contracting Officer's Name and Telephone Number*
Texas State Department of State Health Services (Ryan White B) ***Annual Contract $910,000*** ***Clinical Quality Management/ Training & Technical Assistance/ ARIES support***	***Assess and monitor provision of HIV health services in twenty-six (26) Health Service Delivery Areas in Texas. Developed and maintains aggregated comprehensive database for all service categories with provision of training and technical assistance to DSHS, all Administrative Agencies and providers.***	***November 2015- Present***	***Michelle Berkoff*** ***HIV Care Services Grant Coordinator*** ***Texas Department of State Health Services*** ***(512) 533-3080*** ***Michelle.Berkoff@dshs.state.tx.us***
Florida Department of Health (Ryan White B) ***Contract - $175,000*** ***Evaluation of HIV Delivery System***	***Evaluation of HIV Delivery System throughout Florida including Continuous Quality Management process, Allocations, Provider Procurement and Service Delivery.***	***August 2017- Present***	***Shelley Taylor-Donahue*** ***Community Programs Supervisor*** ***850-245-4448 (phone)*** ***Shelley.TaylorDonahue@flhealth.gov***
Cuyahoga County Department of Health/Office of Health & Human Services (OH) ***Contract - $90,000*** ***Quality Improvement then Formation of Cuyahoga Health Access Partnership (CHAP)***	***Developed Service Standards for 10 funded services then conducted annual QI site visits to determine compliance.*** ***Assisted Cuyahoga County's Office of Health Policy define a Business Case to reduce non-urgent visits to County Emergency Departments. Resulted in creation of Cuyahoga Health Access Partnership (CHAP), a health access network that migrated to a Health Insurance navigator role.***	***2003 to Present*** ***2003 – 2006 QI and Support of Ryan White*** ***2010-2014 – Formation of CHAP*** ***2015- Strategic Plan for CHAP***	***Sabrina Roberts*** ***Administrator, Health Policy & Programs*** ***Office of*** ***(216) 698-2316*** ***sroberts@cuyahogacounty.us***
Orange County Health Services Department (FL) ***Contract - $138,000*** ***Quality Improvement***	***Initially evaluated HIV System of Care for Orlando area (5 counties) then developed AOHS, MCM, EIS, Oral Health Service Standards***	***November 2016 - Present***	***John Goodrich*** ***Assistant Executive Director, Fiscal and Operational Support Division*** ***(407) 836-7689*** ***John.Goodrich@ocfl.net***
Department of Health & Human Services ***Baton Rouge (LA)*** ***Contract - $150,000*** ***Quality Improvement***	***Clinical Quality Management/ Comprehensive Plan/ Annual Grant/ QA Committee Facilitation/*** ***Needs Assessments***	***2008-Present***	***Shamell Lavigne*** ***Program Administrator*** ***(225) 358-1954*** ***slavigne@brgov.com***

3.3.2 *Attachment E, Reference Questionnaire*

Sent to:

(1) Texas State Department of State Health Services

(2) Florida Department of Health

(3) Cuyahoga County Department of Health/Office of Health & Human Services (OH)

(4) Orange County Health Services Department (FL)

(5) Department of Health & Human Services of Baton Rouge (LA)

3.4 VENDOR STAFF RESUMES

SECTION VII. ATTACHMENT F – PROPOSED STAFF RESUMES

Company Name Submitting Proposal:	***Germane Solutions***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	***X***	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Tracy Kulik***	**Key Personnel: (Yes/No)**	***Yes***
Individual's Title	***Vice President of Health Access Division***		
# of Years in Classification:	***39***	**# of Years with Firm:**	***4***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE ***Information should include a brief summary of the proposed individual's professional experience.***

Ms. Kulik is Vice President of the Health Access division of Germane Solutions and previously, President of Collaborative Research. Ms. Kulik supports community leaders in the planning, operations, policy and funding of non-profit services. She has 39 years of experience in healthcare administration, in not-for-profit organizations.

Her expertise is in Medicaid managed care since 1994 and focus on quality improvement and statistical process control.

RELEVANT EXPERIENCE ***Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.***

Extensive experience in Medicaid Managed Care since 1994 related to Children's Hospitals and lead in conversion to Medicaid Managed Care for the Ohio State University Hospital. Followed by consultative capacity at leading firm with four (4) states supported in crafting Children's Health Insurance Program (CHIP)—Arkansas, Georgia, Kentucky & Virginia. Led projects with American Medical Centers in late 1990s on Medicare and Medicaid risk projects including determination of capitation payment, allocation of dollars and negotiation for insurer (Coventry) to acquire a leading academic medical center's health insurance plan. Since 2002, focuses on quality improvement review of publicly funded entities including lead on Florida. Specific projects, timeframe, and contract details of clients, location, and Ms. Kulik's position title and role are listed below.

REFERENCES *A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.*		
COMPANY NAME/ TIMEFRAME/LOCATION/POSITION	***PROJECT DETAILS***	***CONTACT INFORMATION***
Florida Department of Health ***Tallahassee, Florida*** ***August 2017-Present*** ***TK position: Account Executive***	***Evaluation of statewide HIV Service Delivery System including Allocations, Quality Improvement, Information Technology review***	***Shelley Taylor-Donahue*** ***Community Programs Supervisor*** ***HIV/AIDS Section - Patient Care Unit*** ***Division of Disease Control and Health Protection/Florida Dept. of Health*** ***PH: (850) 245-4448*** ***FX: (850) 245-4920*** ***Shelley.TaylorDonahue@flhealth.gov***
Orange County Health Services Department ***Orlando, Florida*** ***November 2016 – present*** ***TK position: Account Executive***	***Initially evaluated HIV System of Care for Orlando area (5 counties) then developed AOHS, MCM, EIS, Oral Health Service Standards***	***John Goodrich, Assistant Director*** ***Fiscal & Operational Support Division*** ***Orange County Health Services Department*** ***PH: (407) 836-7689*** ***FX: (407) 836-7634*** ***John.Goodrich@ocfl.net***
Office of Health & Human Services ***Cuyahoga County, Ohio*** ***Cleveland, Ohio*** ***2003-2015*** ***TK position: Account Executive***	***2003: Started with development of Service Standards for 10 funded service categories and QI site visits to determine compliance*** ***2010-14: Created CHAP then 2015: conducted CHAP Strategic Plan***	***Sabrina Roberts Administrator*** ***Health Policy & Programs*** ***Office of Health & Human Services of Cuyahoga County*** ***PH: (216) 698-2316*** ***FX: (216) 443-7000*** ***sroberts@cuyahogacounty.us***

EDUCATION *Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.*

M.S.P.H. University of Massachusetts at Amherst, Massachusetts - February 1980
Major: Hospital Administration Minor: Health Care Finance

B.S. Canisius College, Buffalo, New York - May 1977; Major in Premedical Science/Biology

CERTIFICATIONS *Information required should include: type of certification and date completed/received.*

- ***ACURP – American College of Utilization Review, 1995***
- ***ASQ – American Society of Quality, member since 2002***
- ***CPHQ – Certified Professional in Healthcare Quality, 1995***

REFERENCES *A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.*		
COMPANY NAME/ TIMEFRAME/LOCATION/POSITION	***PROJECT DETAILS***	***CONTACT INFORMATION***
Florida Department of Health ***Tallahassee, Florida*** ***August 2017-Present*** ***TK position: Account Executive***	***Evaluation of statewide HIV Service Delivery System including Allocations, Quality Improvement, Information Technology review***	***Shelley Taylor-Donahue*** ***Community Programs Supervisor*** ***HIV/AIDS Section - Patient Care Unit*** ***Division of Disease Control and Health Protection/Florida Dept. of Health*** ***PH: (850) 245-4448*** ***FX: (850) 245-4920*** ***Shelley.TaylorDonahue@flhealth.gov***
Orange County Health Services Department ***Orlando, Florida*** ***November 2016 – present*** ***TK position: Account Executive***	***Initially evaluated HIV System of Care for Orlando area (5 counties) then developed AOHS, MCM, EIS, Oral Health Service Standards***	***John Goodrich, Assistant Director*** ***Fiscal & Operational Support Division*** ***Orange County Health Services Department*** ***PH: (407) 836-7689*** ***FX: (407) 836-7634*** ***John.Goodrich@ocfl.net***
Office of Health & Human Services ***Cuyahoga County, Ohio*** ***Cleveland, Ohio*** ***2003-2015*** ***TK position: Account Executive***	***2003: Started with development of Service Standards for 10 funded service categories and QI site visits to determine compliance*** ***2010-14: Created CHAP then 2015: conducted CHAP Strategic Plan***	***Sabrina Roberts Administrator*** ***Health Policy & Programs*** ***Office of Health & Human Services of Cuyahoga County*** ***PH: (216) 698-2316*** ***FX: (216) 443-7000*** ***sroberts@cuyahogacounty.us***

Company Name Submitting Proposal:	*Germain & Co., Inc* *Germane Solutions*

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	***X***	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Rhonda Stewart***	**Key Personnel: (Yes/No)**	***Yes***
Individual's Title	***Director of Quality Improvement***		
# of Years in Classification:	***12***	**# of Years with Firm:**	***4***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Ms. Stewart has extensive experience in operations of Federally Qualified Health Centers (FHQCs). She has over 10 years of experience in the HIV/AIDS field, focusing on improving clinical access and design in Ryan White Outpatient/Ambulatory Health Services for Persons Living with HIV, as well as clinical operations specific to program compliance with Federal grants. Prior to Germane, Ms. Stewart worked in the public health community in the San Antonio, Texas TGA for CentroMed, the local FQHC, with responsibilities for the RWHAP Part C Program and Healthcare for the Homeless grant-funded clinic operations, client level data reporting, and quality management activities and design. Her focus areas are Quality Management (QM), Outcome Measures, and utilization of client level data to strategically design improvement processes in the medical community. Ms. Stewart is an accomplished grant writer, developing federal health and social service grant opportunities from major federal funders.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

Leads all quality improvement projects for the Health Access section of Germane Solutions with Account Executive function for the statewide review of Texas and South Dakota. Twelve years of experience in quality improvement for publicly funded entities with substantial grant-writing proficiency. Adept at developing performance measures and reviewing, with eponymous creation of RHONDA (Real Health Outcomes Need Data Analytics), a HIPPA compliant data collection tool that allows for cloud-based compliance.

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

Bachelors of Science in Kinesiology, University of Texas at El Paso, May 1997

CERTIFICATIONS *Information required should include: type of certification and date completed/received.*

REFERENCES *A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.*		
COMPANY NAME/ TIMEFRAME/LOCATION/POSITION	***PROJECT DETAILS***	***CONTACT INFORMATION***
Texas Department of State Health Services (DSHS) ***Austin, Texas*** ***November 2015 – present*** ***RS position: Account Executive***	***Assess and monitor provision of HIV health services in twenty-six (26) Health Service Delivery Areas in Texas. Develop and maintain comprehensive database for all service categories with provision of training and technical assistance to DSHS, Administrative Agencies and sub-recipients***	***Michelle Berkoff, HIV Care Services Grant Coordinator*** ***Texas Department of State Health Services*** ***PH: (512) 533-3080*** ***X: (512) 776-7111*** ***Michelle.Berkoff@dshs.state.tx.us***
Orange County Health Services Department ***Orlando, Florida*** ***November 2016 – present*** ***RS position: Project Manager***	***Initially evaluated HIV System of Care for Orlando area (5 counties) then developed AOHS, MCM, EIS, Oral Health Service Standards. (Ambulatory Health Services, Medical Case Management, Early Intervention Services)***	***John Goodrich, Assistant Director Fiscal & Operational Support Division*** ***Orange County Health Services Department*** ***PH: (407) 836-7689*** ***FX: (407) 836-7634*** ***John.Goodrich@ocfl.net***
City of Baton Rouge/Parish of E. Baton Rouge ***Department of Health & Human Services*** ***Baton Rouge, Louisiana*** ***July 2008 – Present*** ***RS position: Project Manager***	***Clinical Quality Management/ Comprehensive Plan/ Annual Grant/ QA Committee Facilitation***	***Shamell Lavigne, Program Administrator*** ***City of Baton Rouge/Parish of East Baton Rouge*** ***PH: (225) 358-1954*** ***FX: (225) 358-4561*** ***slavigne@brgov.com***

Company Name Submitting Proposal:	*Germain & Co., Inc dba Germane Solutions*

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	***X***	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Jordan McCown***	**Key Personnel: (Yes/No)**	***Yes***
Individual's Title	***Manager of Quality Improvement***		
# of Years in Classification:	***5***	**# of Years with Firm:**	***2***

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Ms. McCown has experience working with community-based and hospital not-for-profit systems in the behavioral health, substance abuse and HIV/AIDS fields. Prior to joining Germane Solutions, Ms. McCown served as the HIV Administrative Agency Program Supervisor for the PanWest and West Texas regions, providing programmatic and fiscal oversight to Ryan White Part B and Housing Opportunities for Persons with AIDS (HOPWA) service providers. Ms. McCown has also served as a staff member at Children's Medical Center Dallas, working with children and families with behavioral health disorders. Since joining Germane Solutions in 2016, Ms. McCown has participated in a pilot project with the Texas Department of State Health Services (DSHS) focusing on Quality Improvement for Ryan White Part B and State Services, completed Ryan White Part A grant applications for Dallas EMA, developed a Policies and Procedures Manual and revised the Quality Management Plan for the South Dakota Ryan White Part B program and assisted in quality reviews for HIV service providers in the Baton Rouge TGA.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

Jordan is a licensed rehabilitation counselor and chemical dependency counselor with significant expertise in administering regional programs in Texas related to special needs populations. She has five (5) years of experience in quality improvement/ performance review.

EDUCATION

Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.

- ***Texas Tech University, Lubbock, TX: Master of Business Administration, August 2016***
- ***University of North Texas, Denton, TX: Master of Science, August 2013, Rehabilitation Counseling***
- ***Texas Tech University, Lubbock, TX: Bachelor of Arts, May 2011***

  Major: Psychology, Minor: Addictive Disorders and Recovery Studies

CERTIFICATIONS *Information required should include: type of certification and date completed/received.*

- ***Certified Rehabilitation Counselor***
- ***Commission on Rehabilitation Counselor Certification, 2013***
- ***Licensed Chemical Dependency Counselor***
- ***Texas Department of State Health Services, 2014***

REFERENCES *A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.*		
COMPANY NAME/ TIMEFRAME/LOCATION/POSITION	***PROJECT DETAILS***	***CONTACT INFORMATION***
Texas Department of State Health Services (DSHS) ***Austin, Texas*** ***November 2015 – present*** ***JM position: Behavioral Health***	***Assess and monitor provision of HIV health services in twenty-six (26) Health Service Delivery Areas in Texas. Develop and maintain comprehensive database for all service categories with provision of training and technical assistance to DSHS, Administrative Agencies and sub-recipients***	***Michelle Berkoff, HIV Care Services Grant Coordinator*** ***Texas Department of State Health Services*** ***PH: (512) 533-3080*** ***FX: (512) 776-7111*** ***Michelle.Berkoff@dshs.state.tx.us***
Orange County Health Services Department ***Orlando, Florida*** ***November 2016 – present*** ***JM position: Behavioral Health***	***Initially evaluated HIV System of Care for Orlando area (5 counties) then developed AOHS, MCM, EIS, Oral Health Service Standards.*** ***(Ambulatory Health Services, Medical Case Management, Early Intervention Services)***	***John Goodrich, Assistant Director Fiscal & Operational Support Division*** ***Orange County Health Services Department*** ***PH: (407) 836-7689*** ***FX: (407) 836-7634*** ***John.Goodrich@ocfl.net***
City of Baton Rouge/Parish of East Baton Rouge ***Department of Health & Human Services*** ***Baton Rouge, Louisiana*** ***July 2008 – Present*** ***JM position: Behavioral Health***	***Clinical Quality Management/ Comprehensive Plan/ Annual Grant/ QA Committee Facilitation***	***Shamell Lavigne, Program Administrator*** ***City of Baton Rouge/Parish of East Baton Rouge*** ***PH: (225) 358-1954*** ***FX: (225) 358-4561*** ***slavigne@brgov.com***

Company Name Submitting Proposal:	*Germain & Co., Inc dba Germane Solutions*

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	*X*	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	*Amy Fleischer*	**Key Personnel: (Yes/No)**	*Yes*
Individual's Title	*Director of Business Intelligence*		
# of Years in Classification:	*10*	**# of Years with Firm:**	*7*

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Ms. Fleischer is a business intelligence developer with 10 years of experience with data architecture, ETL (Exchange-Transfer-Load), and Reporting in Healthcare. Ms. Fleischer has created many data warehouses from various healthcare data sources: quality, encounters, operational and financial. She provides experience in overseeing data reporting solutions and project management.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

TIMEFRAME/COMPANY NAME/ LOCATION/POSITION	*PROJECT DETAILS*	*CONTACT INFORMATION*
Riverside University Health System Moreno Valley, CA 2015-2017 AMF Position: Business Intelligence Support for 10-site FQHC Assessment	*Assessment, HRSA OSV Preparation, Financial Review, for 10-site FQHC (Federally Qualified Health Center)*	*Lynette Beckedahl, Executive Clinically Integrated Network Riverside Medical Clinic PH: (951) 285-8022 FX: (951) 782-3050 Lynette.Beckedahl@rmcps.com*
AMS: Affiliated Medical Services Houston, Texas; June 2017-present AMF Position: Business Intelligence Support for Primary Care Consortia for Affiliated Medical Services (AMS), Texas not-for-profit corporation with two members – Baylor College of Medicine (BCM) & University of Texas Health Science Center of Houston (UT Health).	*Review alternative affiliation models and contractual terms (including value-based models to determine areas where AMS is open to new terms versus those which are non-negotiable*	*Julie Page, Medical School Dean University of Texas as Houston PH: (713) 500-5169 FX: (713) 500-0620 Julie.T.Page@uth.tmc.edu*

Central Michigan University Health ***Saginaw, Michigan*** ***March 2016 – October 2017*** ***AMF Position: Business Intelligence Support for Resident Productivity***	***Assisted Operations with analysis and review of current resident programs***	***Evan Paulus, Operations Director*** ***Central Michigan University Health*** ***PH: (989) 746-7906*** ***FX: (989) 583-6885*** ***evan.paulus@cmich.edu***

EDUCATION ***Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.***

- ***ONLC, Cincinnati, Ohio 2010***
- ***Business Intelligence: Reporting, Analysis, & Integration Services***
- ***Miami University, Oxford Ohio 2007***
- ***B.A., Management: Organizational Leadership***

CERTIFICATIONS ***Information required should include: type of certification and date completed/received.***

Access 2007 Microsoft Certified Application Specialist certification

REFERENCES ***A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.***		
COMPANY NAME/ TIMEFRAME/LOCATION/POSITION	***PROJECT DETAILS***	***CONTACT INFORMATION***
Riverside University Health System ***Moreno Valley, CA; 2015-2017*** ***AMF Position: Business Intelligence Support for 10-site FQHC Assessment***	***Assessment, HRSA OSV Preparation, Financial Review, for 10-site FQHC (Federally Qualified Health Center)***	***Lynette Beckedahl, Executive*** ***Clinically Integrated Network*** ***Riverside Medical Clinic*** ***PH: (951) 285-8022*** ***FX: (951)782-3050*** ***Lynette.Beckedahl@rmcps.com***
AMS: Affiliated Medical Services ***Houston, Texas; June 2017-present*** ***AMF Position: Business Intelligence Support for Primary Care Consortia for Affiliated Medical Services (AMS), Texas not-for-profit corporation with two members – Baylor College of Medicine (BCM) & University of Texas Health Science Center of Houston (UT Health)***	***Review alternative affiliation models and contractual terms (including value-based models to determine areas where AMS is open to new terms versus those which are non-negotiable***	***Julie Page, Medical School Dean*** ***University of Texas as Houston*** ***PH: (713) 500-5169*** ***FX: (713) 500-0620*** ***Julie.T.Page@uth.tmc.edu***

Central Michigan University Health ***Saginaw, Michigan*** ***March 2016 – October 2017*** ***AMF Position: Business Intelligence Support for Resident Productivity***	***Assisted Operations with analysis and review of current resident programs***	***Evan Paulus, Operations Director*** ***Central Michigan University Health*** ***PH: (989) 746-7906*** ***FX: (989) 583-6885*** ***evan.paulus@cmich.edu***

Company Name Submitting Proposal:	***Germain & Co., Inc. dba Germane Solutions***

Check the appropriate box if the proposed individual is prime contractor staff or subcontractor staff.			
Contractor:	***X***	**Subcontractor:**	

The following information requested pertains to the individual being proposed for this project.			
Name:	***Allen Iovannisci***	**Key Personnel: (Yes/No)**	***No***
Individual's Title	***HEDIS® Auditor***		
# of Years in Classification:	**16**	**# of Years with Firm:**	**16**

BRIEF SUMMARY OF PROFESSIONAL EXPERIENCE

Information should include a brief summary of the proposed individual's professional experience.

Mr. Iovannisci has conducted audits and quality improvement projects, using NCQA certification as a HEDIS® Compliance Auditor. He conducts performance measure analysis for Medicaid, Medicare, Commercial and Marketplace lines of business. Allen provides technical assistance on strategic planning and quality improvement, with over 18 years of experience in the health insurance arena.

RELEVANT EXPERIENCE

Information required should include: timeframe, company name, company location, position title held during the term of the contract/project and details of contract/project.

Since 2002, Allen has worked as an NCQA certified HEDIS® auditor. He worked six years prior to this capacity (2008-2014) for HealthNow in Buffalo, NY as a Medical Economics/HealthCare Services Analyst and Business Intelligence Analyst. Prior to that, Allen worked from 1999 to 2008 for Preferred Care in Rochester, NY as a Medical Cost Data Analyst, Data Analyst/ Application Specialist for HEDIS®, and as a System Configuration Analyst.

EDUCATION *Information required should include: institution name, city, state, degree and/or Achievement and date completed/received.*

- ***M.S. from New School for Social Research, New York, NY 2000***
- ***B.A. from LeMoyne College, Syracuse, NY 1993***

CERTIFICATIONS *Information required should include: type of certification and date completed/received.*

- ***NCQA Certified HEDIS® Compliance Analyst – since October 2006***
- ***CPHQ Certified (Certified Professional in Healthcare Quality) – November 2007***

REFERENCES *A minimum of three (3) references are required, including name, title, organization, phone number, fax number and email address.*		
COMPANY NAME/ TIMEFRAME/LOCATION/POSITION	***PROJECT DETAILS***	***CONTACT INFORMATION***
Anthem (CareMore) ***Long Beach, CA*** ***Time: 2012-present*** ***AI Position: HEDIS® Auditor***	***HEDIS® Audit, long-term relationship***	***Erika Tigno, Director of Quality Management*** ***Anthem (CareMore)*** ***(562) 622-2848*** ***Frederika.Tigno@caremore.com***
Alignment HealthCare ***Orange, CA*** ***Time: 2012-present*** ***AI Position: HEDIS® Auditor***	***HEDIS® Audit, long-term relationship***	***Bhavin Shah, Director IT Application Development*** ***Quality Management*** ***Alignment HealthCare*** ***(505) 301-0999*** ***BShah@ahcusa.com***
PRIMEWEST Health ***Alexandria, MN*** ***Time: 2011-present*** ***AI Position: HEDIS® Auditor***	***HEDIS® Audit, long-term relationship***	***Bethany Krafthefer*** ***Director of Quality & Utilization Management*** ***PRIMEWEST Health*** ***(320) 335-5392*** ***Bethany.Krafthefer@primewest.org***

SECTION VIII. OTHER INFORMATIONAL MATERIAL