KEPRO
INTELLIGENT VALUE

November 26, 2013

Ms. Marcy Troescher
State of Nevada, Purchasing Division
515 E. Musser Street, Suite 300
Carson City, NV 89701

Re: Request for Proposal # 3084; Utilization Management and Large Case Management

Dear Ms. Troescher:

The KePRO Acquisition, Inc. (KEPRO) is pleased to submit our proposal to the State of Nevada's Purchasing Division, on behalf of the Public Employee's Benefits Program (PEBP), in response to your Request for Proposal # 3084 to provide Utilization Management and Large Case Management services for the participants of the PEBP plan.

We acknowledge, understand, and agree to all of the requirements of RFP, including all addendums. We also understand and will facilitate the desired program goals and objective set forth by the PEBP board. Throughout our proposal we demonstrate the long history of success KEPRO has had in achieving outstanding results for similar projects and we are very interested in supplying Public Employee's Benefits Program (PEBP) with the services defined in the RFP.

We look forward to the opportunity to further discuss our proposed solutions and working collaboratively with the State. Please do not hesitate to contact me with any questions or comments concerning this submission.

Sincerely,

Joseph A. Dougher
President & Chief Executive Officer

TITLE PAGE

Part I A – Technical Proposal

RFP Title: Utilization Management and Large Case Management Services

RFP: 3084

Vendor Name: KePRO Acquisitions, Inc. (KEPRO)

Address: 777 East Park Drive, Harrisburg, PA 17111

Proposal Opening Date: December 3, 2013

Proposal Opening Time: 2:00 PM

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VENDOR INFORMATION SHEET

VENDOR INFORMATION SHEET FOR RFP 3084

Vendor Must:

A) Provide all requested information in the space provided next to each numbered question. The information provided in Sections V1 through V6 will be used for development of the contract;

B) Type or print responses; and

C) Include this Vendor Information Sheet in Tab III of the Technical Proposal.

V1	Company Name	***KePRO Acquisitions, Inc. (KEPRO)***
V2	Street Address	***777 East Park Drive***
V3	City, State, ZIP	***Harrisburg, PA, 17111***

V4	Telephone Number		
	Area Code: ***717***	Number: ***564-8288***	Extension: ***7026***
V5	Facsimile Number		
	Area Code: ***717***	Number: ***564-3862***	Extension:
V6	Toll Free Number		
	Area Code:	Number: ***800-222-0771***	Extension:

V7	***Contact Person for Questions / Contract Negotiations, including address if different than above***
	Name: ***Karen Eaton***
	Title: ***Vice President, Growth and Development, Public Programs***
	Address: ***777 East Park Drive, Harrisburg, PA, 17111***
	Email Address: keaton@kepro.com

V8	Telephone Number for Contact Person		
	Area Code: ***717***	Number: ***564-8288***	Extension: ***7010***
V9	Facsimile Number for Contact Person		
	Area Code: ***717***	Number: ***564-3862***	Extension:

V10	***Name of Individual Authorized to Bind the Organization***	
	Name: ***Joseph A. Dougher***	Title: ***President and CEO***

V11	Signature ***(Individual must be legally authorized to bind the vendor per NRS 333.337)***	
	Signature:	Date: ***11/27/2013***

STATE DOCUMENTS

ALL ELSE REMAINS THE SAME FOR RFP 3084.

Vendor must sign and return this amendment with proposal submitted.

Vendor Name: KePRO Acquisition, Inc. (KEPRO)

Authorized Signature: M Doughey

Title: President and CEO Date: 11/27/2013

This document must be submitted in the "State Documents" section/tab of vendors' technical proposal.

96. Regarding requirement 4.4, Vendor Staff Resumes, a. Please provide examples on who the State considers "key personnel" b. Is it your intention that the "relevant professional experience" represents current clients under service with the vendor? c. Are the references at the bottom of the form the same three from the relevant professional experience section above on the form?

PEBP expects that the vendor will propose qualified staff that can best meet the needs of the State and participants of the plan.

97. With regard to requirement 3.5 VENDOR STAFFING (3.5.3), what are the desired qualifications of staff in the UM decision making process - to meet the needs of PEBP participants, and PEBP providers?

See the response to question #37.

ALL ELSE REMAINS THE SAME FOR RFP 3084.

Vendor must sign and return this amendment with proposal submitted.

Vendor Name: KEPRO Acquisition, Inc. (KEPRO)

Authorized Signature: M. Doughty

Title: President and CEO Date: 11/27/2013

This document must be submitted in the "State Documents" section/tab of vendors' technical proposal.

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" **will 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 binders marked "**Part I B Confidential Technical**" and "**Part III Confidential Financial**".

The State will not be responsible for any information contained within the proposal. Should vendors not comply with the labeling and packing requirements, proposals will 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 will be in an open meeting format, the proposals will 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 will constitute a complete waiver and all submitted information will 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 as defined in ***Section 2 "ACRONYMS/DEFINITIONS."***

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

Part I B – Confidential Technical Information			
YES		NO	***X***
Justification for Confidential Status			

A Public Records CD has been included for the Technical and Cost Proposal			
YES	***X***	NO	

Part III – Confidential Financial Information			
YES	***X***	NO	
Justification for Confidential Status			
In accordance with RFP requirements in section 9.5.			

KePRO Acquisitions, Inc. (KEPRO)
Company Name

Signature

Joseph A. Dougher, President and CEO — Print Name

11/27/2013 — Date

This document must be submitted in Tab IV of vendor's technical proposal

ATTACHMENT C – VENDOR CERTIFICATIONS

Vendor agrees and will comply with the following:

(1) Any and all prices that may be charged under the terms of the contract do not and will 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, will 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, will 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 must 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 must be in writing and included in the proposal at the time of submission.

(7) Each vendor must 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 should 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 will automatically result in the disqualification of a vendor's proposal. An award will not be made where a conflict of interest exists. The State will 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 will 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 must certify that any and all subcontractors comply with Sections 7, 8, 9, and 10, above.

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

KePRO Acquisitions, Inc. (KEPRO)

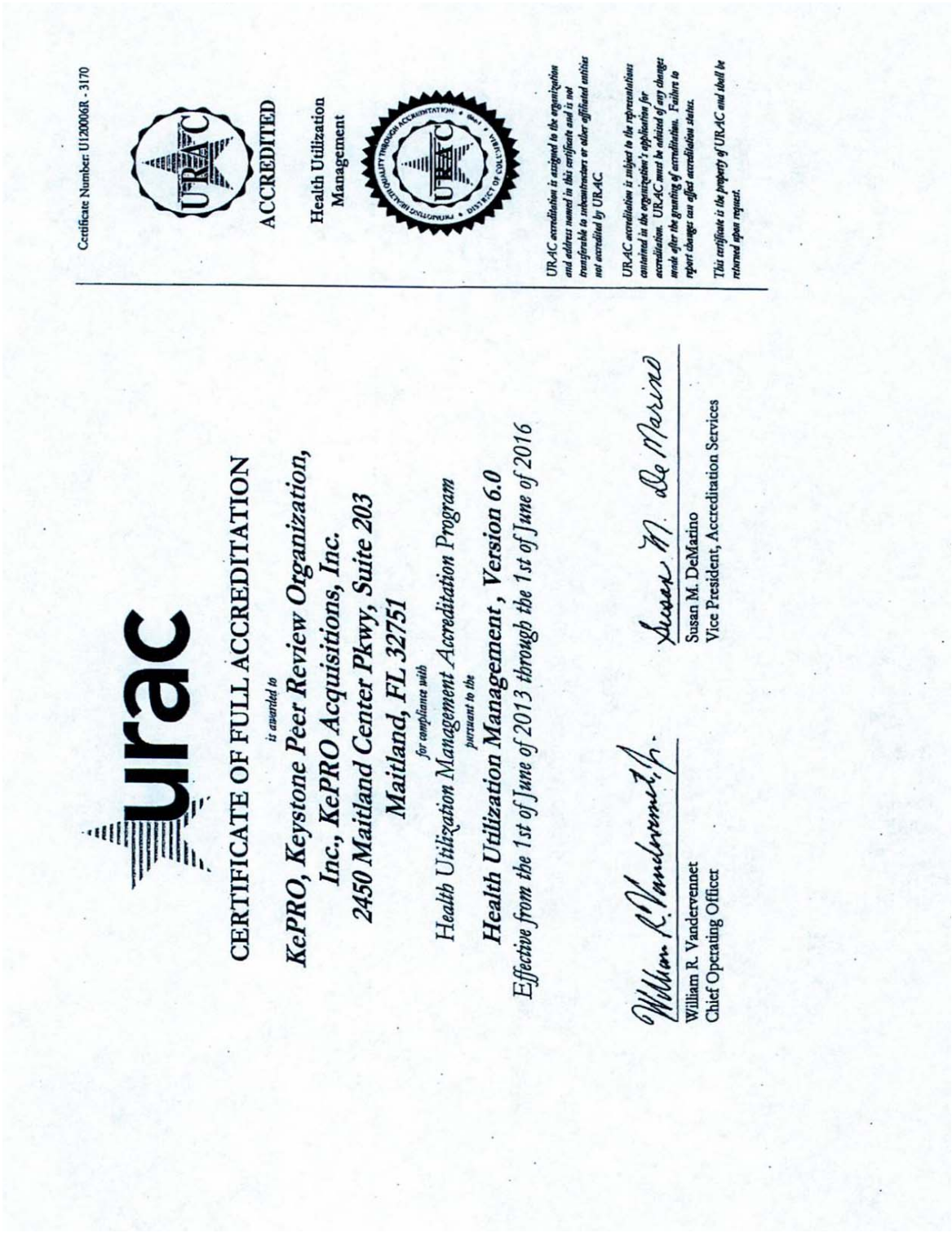
Vendor Company Name

Vendor Signature

Joseph A. Dougher, President and CEO — ***11/27/2013***

Print Name — Date

This document must be submitted in Tab IV of vendor's technical proposal



urac

CERTIFICATE OF FULL ACCREDITATION

is awarded to

KePRO, Keystone Peer Review Organization, Inc., KePRO Acquisitions, Inc.
2450 Maitland Center Pkwy, Suite 203
Maitland, FL 32751

for compliance with

Health Utilization Management Accreditation Program

pursuant to the

Health Utilization Management, Version 6.0

Effective from the 1st of June of 2013 through the 1st of June of 2016

William R. Vandervennet, Jr.

William R. Vandervennet
Chief Operating Officer

Susan M. DeMarino

Susan M. DeMarino
Vice President, Accreditation Services

Certificate Number: U120006R - 3170

URAC

ACCREDITED

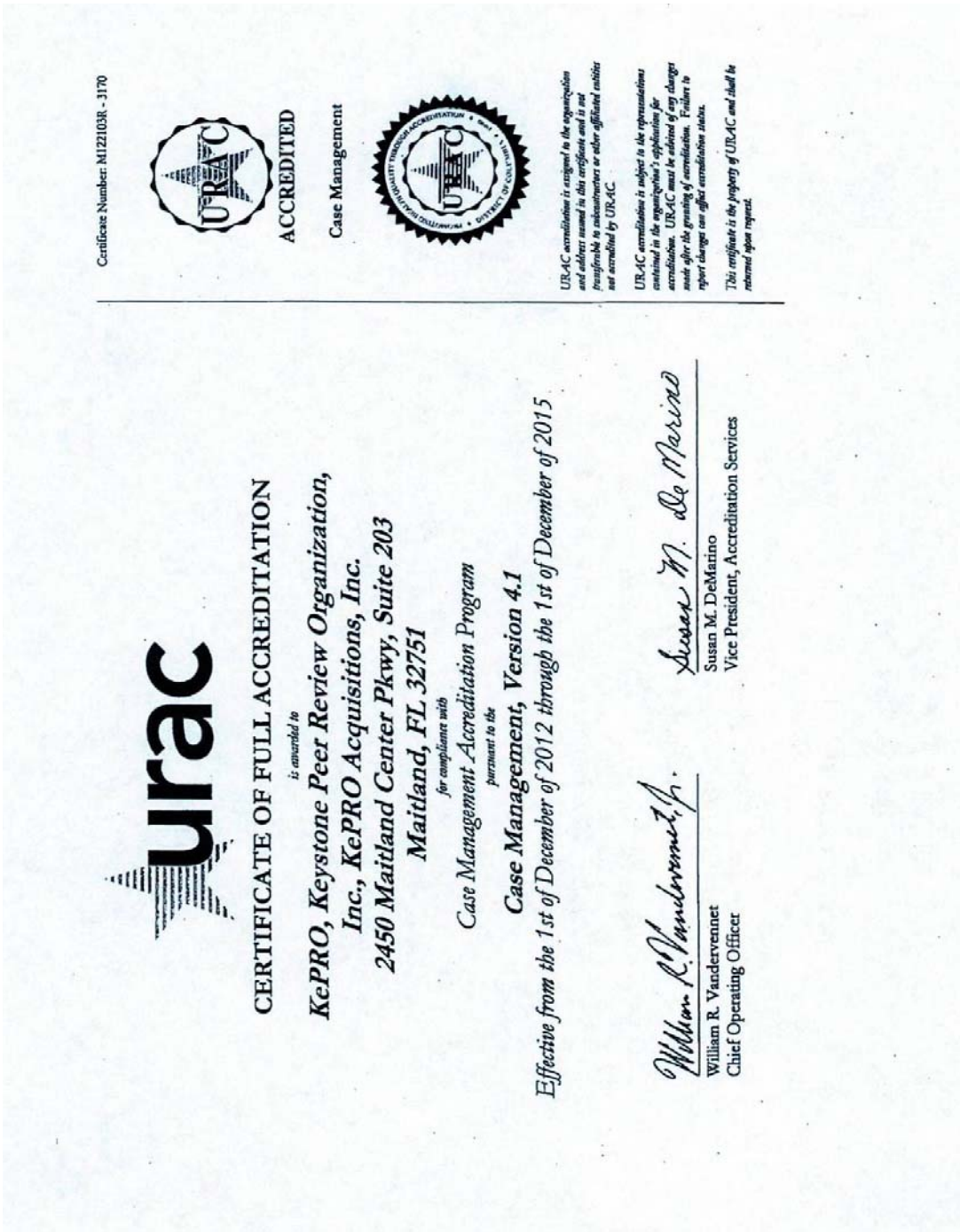
Health Utilization Management

PROMOTING HEALTHCARE QUALITY THROUGH ACCREDITATION • DISTRICT OF COLUMBIA • EST. 1990

URAC accreditation is assigned to the organization and address named in this certificate and is not transferable to subcontractors or other affiliated entities not accredited by URAC.

URAC accreditation is subject to the representations contained in the organization's application for accreditation. URAC must be advised of any changes made after the granting of accreditation. Failure to report changes can affect accreditation status.

This certificate is the property of URAC and shall be returned upon request.



urac

CERTIFICATE OF FULL ACCREDITATION

is awarded to

KePRO, Keystone Peer Review Organization, Inc., KePRO Acquisitions, Inc.
2450 Maitland Center Pkwy, Suite 203
Maitland, FL 32751

for compliance with

Case Management Accreditation Program

pursuant to the

Case Management, Version 4.1

Effective from the 1st of December of 2012 through the 1st of December of 2015

William R. Vandervennet, Jr.

William R. Vandervennet
Chief Operating Officer

Susan M. DeMarino

Susan M. DeMarino
Vice President, Accreditation Services

Certificate Number: M122103R - 3170

URAC

ACCREDITED

Case Management

URAC accreditation is assigned to the organization and address named in this certificate and is not transferable to subcontractors or other affiliated entities not accredited by URAC.

URAC accreditation is subject to the representations contained in the organization's application for accreditation. URAC must be advised of any changes made after the granting of accreditation. Failure to report changes can affect accreditation status.

This certificate is the property of URAC and shall be returned upon request.

SECRETARY OF STATE

STATE OF NEVADA

FOREIGN CORPORATE QUALIFICATION

I, ROSS MILLER, the duly elected and qualified Nevada Secretary of State, do hereby certify that **KEPRO ACQUISITIONS, INC.** did on October 14, 2010 file in this office a Foreign Qualification in this State and is now on file and of record in the office of the Nevada Secretary of State, and that further, that said Corporation is at the date of this Certificate duly qualified to exercise therein all the powers recited in its Foreign Qualification and to transact business in the State of Nevada in accordance with the laws governing Corporations in said State.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the Great Seal of State, at my office on October 14, 2010.

ROSS MILLER
Secretary of State

Certified By: Sandra Kraatz
Certificate Number: C20101014-0503
You may verify this certificate online at **http://www.nvsos.gov/**

COMMONWEALTH OF PENN

DEPARTMENT OF ST

Filed in the office of	Document Number
Ross Miller Secretary of State State of Nevada	20100772792-57
	Filing Date and Time 10/14/2010 8:35 AM
	Entity Number E0496952010-7

OCTOBER 13, 2010

TO ALL WHOM THESE PRESENTS SHALL COME, GREETING:

I DO HEREBY CERTIFY THAT,

KEPRO ACQUISITIONS, INC.

is duly incorporated under the laws of the Commonwealth of Pennsylvania and remains a subsisting corporation so far as the records of this office show, as of the date herein.

IN TESTIMONY WHEREOF, I have hereunto set my hand and caused the Seal of the Secretary's Office to be affixed, the day and year above written.

Basil L. Merenda

Secretary of the Commonwealth

Certification Number: 8055985-1
Verify this certificate online at http://www.corporations.state.pa.us/corp/soskb/verify.asp

ROSS MILLER
Secretary of State
204 North Carson Street, Suite 4
Carson City, Nevada 89701-4520
(775) 684 5708
Website: www.nvsos.gov

Filed in the office of	Document Number
Ross Miller Secretary of State State of Nevada	20100772791-46
	Filing Date and Time 10/14/2010 8:35 AM
	Entity Number E0496952010-7

Qualification to do Business in Nevada

(PURSUANT TO NRS CHAPTER 80)

USE BLACK INK ONLY - DO NOT HIGHLIGHT

ABOVE SPACE IS FOR OFFICE USE ONLY

1. Name of Corporation: (must be the same as shown on the certificate of existence)
KePRO Acquistions, Inc.

2. State of Incorporation:
Pennsylvania

3. Registered Agent for Service of Process: (check only one box)
[X] Commercial Registered Agent: CSC Services of Nevada, Inc.
Name
[ ] Noncommercial Registered Agent (name and address below) OR [ ] Office or Position with Entity (name and address below)
Name of Noncommercial Registered Agent OR Name of Title of Office or Other Position with Entity
Street Address | City | Nevada | Zip Code
Mailing Address (if different from street address) | City | Nevada | Zip Code

4. Authorized Stock: (set forth the total authorized stock indicating number of par shares, par value per share and/or number of no par shares; mark appropriate box if entity is a nonprofit corporation with or without stock; submit required documentation to support statement; stock statement must match documentation exactly)
Total Authorized Stock: 100,000
(a) Number of shares *with* par value: 100,000
(b) Par value per share: $ 1.00
(c) Number of shares *without* par value:
If a Nonprofit Entity: [ ] This is a nonprofit entity *with* authorized stock, as listed above. [ ] This entity is a nonprofit, non-stock corporation.

5. Purpose: (required; continue on additional page if necessary)
The purpose of the corporation shall be:
medical management services

6. Name, Title and Signature of Officer Making Statement:
Gary C. Baker
Name
CFO
Title of Officer
X Gary C. Baker
Officer Signature

7. Certificate of Acceptance of Appointment of Registered Agent:
I hereby accept appointment as Registered Agent for the above named Entity.
CSC Services of Nevada, Inc.
X By: C. Woodrich
Authorized Signature of Registered Agent or On Behalf of Registered Agent Entity
10-15-10
Date

This form must be accompanied by appropriate fees.

Nevada Secretary of State NRS 80 Qualification
Revised: 10-16-09

KEPRO ACQUISITIONS INC
777 EAST PARK DRIVE
PO BOX 8310
HARRISBURG PA 17105-8310

Scott Kipper, Commissioner of Insurance

KEPRO ACQUISITIONS INC

License Number 20091

is licensed to engage in the business of insurance in the State of Nevada in the capacity stated below, subject to applicable laws and regulations.

License Type: Utilization Review

Effective Date: 02-08-2006

Expiration Date: 03-01-2015

Qualifications:

Licensees must notify the Division of any change of address within 30 days of the change. You are subject to revocation for noncompliance.
Individuals – If you are affiliated to a business entity it will not print on the license. Individuals must be properly affiliated to the business entity's license prior to transacting insurance on the entity's behalf. The individual and the business entity are responsible for maintaining the affiliation.

A producer of insurance acting as an agent of the insurer must be appointed by the insurer prior to transacting insurance.

This license must be conspicuously displayed in your place of business that is open to the public.

KEPRO ACQUISITIONS INC

License Number 20091
National Producer ID

Is licensed to engage in the business of insurance in the State of Nevada in the capacity stated below, subject to applicable laws and regulations.

LICENSE TYPE	EFFECTIVE DATE
Utilization Review	02-08-2006
QUALIFICATIONS	EXPIRATION DATE
	03-01-2015

ATTACHMENT B, TECHNICAL PROPOSAL CERTIFICATION OF COMPLIANCE WITH TERMS AND CONDITIONS OF RFP

ATTACHMENT B – TECHNICAL PROPOSAL CERTIFICATION OF COMPLIANCE WITH TERMS AND CONDITIONS OF RFP

I have read, understand and agree to comply with ***all*** the terms and conditions specified in this Request for Proposal.

YES ***X*** I agree to comply with the terms and conditions specified in this RFP.

NO _____ I do not agree to comply with the terms and conditions specified in this RFP.

If the exception and/or assumption require a change in the terms in any section of the RFP, the contract, or any incorporated documents, vendors ***must*** provide the specific language that is being proposed in the tables below. If vendors do not specify in detail any exceptions and/or assumptions at time of proposal submission, the State will not consider any additional exceptions and/or assumptions during negotiations.

KePRO Acquisitions, Inc. (KEPRO)
Company Name

Signature

Joseph A. Dougher, President and CEO — ***11/27/2013***
Print Name — Date

Vendors MUST use the following format. Attach additional sheets if necessary.

EXCEPTION SUMMARY FORM

EXCEPTION #	RFP SECTION NUMBER	RFP PAGE NUMBER	EXCEPTION (Complete detail regarding exceptions must be identified)
N/A			

ASSUMPTION SUMMARY FORM

ASSUMPTION #	RFP SECTION NUMBER	RFP PAGE NUMBER	ASSUMPTION (Complete detail regarding assumptions must be identified)
N/A			

This document must be submitted in Tab V of vendor's technical proposal

EXECUTIVE SUMMARY

KEPRO is a client-focused partner, delivering results 100% of the time!!

Our 28 years of utilization management and case management experience enables us to provide cost-effective results and measureable improvements, including a significant return on investment for our clients.

2012 Clients' ROI: 16:1

KEPRO is the best partner to support Nevada's Utilization Management and Large Case Management Services Program. We have continuously delivered timely reviews, quality outcomes, case management results, data analysis, and recommendations to improve each clients' programs for more than 28 years. And with this experience comes results – in 2012, we delivered a 16:1 return on investment (ROI) for our clients. This means that for every dollar invested, our customer saves $16.

We will demonstrate why KEPRO is the MOST QUALIFIED and BEST CHOICE vendor to perform the work for Nevada's Utilization Management and Large Case Management Services Program by:

1. ***Demonstrating our understanding of the:***
    - ***Challenges facing Nevada's***
        - ***Utilization, Quality, and Case Management Scope of Work (SOW)***
        - ***Utilization management and large case management***
        - ***Pre-certification of specified medical services to determine medical necessity;***
        - ***Concurrent and retrospective review; and***
        - ***Management reporting.***
    - ***Objectives and intended results of the project***
2. ***Proving KEPRO's long-term success as a valuable and trusted partner***
3. ***Highlighting our offer of proven solutions that demonstrate KEPRO is the Best Qualified to perform the work***

DEMONSTRATING OUR UNDERSTANDING of PEBP GOALS

KEPRO will work collaboratively to help PEBP achieve its goals for utilization and large case management program. We have developed a customized approach ideally suited for PEBP that includes:

- ***Comprehensive utilization and large case management services for all participants***
- ***Best practices in designing and implementing a successful program including the development of on-site case management program***

- ***Development and Implementation of Centers of Excellence Program***
- ***A partnership equally committed to high levels of customer service and promoting informed healthcare decisions***
- ***Designing and implementing the PEBP vision by making program goals our priority and collaborating with PEBP to develop creative alternative solutions as program needs change.***

Understanding the Challenges Facing Nevada Government

It is more critical than ever to select the Best-Value Vendor that can efficiently and effectively provide timely utilization management services, deliver quality case management outcomes, automate the process, and serve as a partner to the Nevada Board of Public Employees' Benefit Program (PEBP). We will work with the PEBP to address the State's unique environment and future challenges presented by health care reform, and to reduce unhealthy behaviors that significantly contribute to potentially avoidable utilization of health care services.

Dedicated, Local Service Delivery

KEPRO will support this contract by providing a local Nevada-based team supplemented with additional paraprofessionals, administrative, operations, and information technology support personnel based in our Orlando, Florida Office. This also includes subject matter experts for both Utilization and Case Management, Quality Assurance, Customer service and program support.

KEPRO is committed to a local service delivery model as a best practice. Local operations and personnel that are passionate, focused, knowledgeable and trusted by clients are essential to providing holistic and proactive solutions.

Local Service Delivery: Key Staff

Leading our comprehensive solution are two highly skilled healthcare leaders. Our proposed Account Manager, Ms. Chandra Tucker, RN, BSN, CCM has 25 years of senior healthcare management experience across all RFP spectrums. She is an accomplished leader with a proven track record of effective critical thinking skills, outstanding customer relationships, seamless implementation management and excellent conceptual and analytic skills. Ms. Tucker will be fully dedicated to the PEBP program and has direct experience with the Nevada population and government. She has led QI/UR and case management programs for large industry players including United Healthcare, Amerigroup and Sierra Health Services. She is a native of Nevada.

Our proposed Medical Director, Douglas Peters, MD, is board-certified in Internal Medicine, licensed in Nevada, and has over 25 years of clinical and medical management experience. He has served as the Medical Director for several healthcare companies such as St. Mary's HealthPlans, Blue Cross Blue Shield of North Carolina and Cigna health care. He is

experienced in serving populations with medically complex needs and is an expert in both Utilization and Care Management. Dr. Peters is also a native to Nevada and is intimately familiar with the nuances unique to the State.

Integrity

KEPRO has been a QIO or QIO-like entity since 1985. We have both State and National contract experience in UM/QI /CM. We are URAC accredited in utilization management, case management and disease management. This triple accreditation demonstrates that KEPRO not only experienced, but successful in providing all services described in the RFP.

KEPRO has served the Department of Defense's (DoD's) military health system and other agencies with politically sensitive and visible programs. In fact, during our 28 years in business KEPRO has never had a breach in HIPAA compliance or confidentiality.

Implementation-Commitment to Exceed Right from the Start

The best indicator of future success is past performance. We would like PEBP to focus on our satisfied clients as proof of our abilities to provide a seamless transition. KEPRO has transitioned in & out of more than 125 contracts in just the past 5 years and knows the importance of coordination of all parties to ensure we please new clients.

To ensure successful Implementations, KEPRO marshals both corporate and project resources through our Project Management Office (PMO) and a designated Implementation Manager. Our proven track record of successful implementations, combined with a team of implementation experts and daily monitoring of transition activities ensures an effective and efficient startup.

Reporting Capabilities-More Tools and Useful Data for Decision-Making

KEPRO's proprietary medical management system, Atrezzo, is designed with a clinical focus, a web-enabled architecture and a rules-driven workflow engine. The flexibility inherent in the Atrezzo software architecture offers significant advantages which will be discussed throughout our response.

Atrezzo provides a comprehensive set of tools to facilitate independent, impartial evaluation of care, and support a whole array of health care services. Atrezzo capitalizes on more than 20 years of successful KEPRO innovation and experience to deliver greater functionality and flexibility.

KEPRO commits to more varied and useful data to support informed decision-making now and as PEBP's needs change over the contract period. We will start with weekly dashboard reporting on review status and other updates, including ROI. PEBP to perform its own queries as often as it likes (with help-line support to do so). KEPRO thoroughly understands the state's need for information quickly and often, and supports that in our bid and through our extensive experience.

Summary

KEPRO offers vast utilization and case management experience generating the most cost savings for our clients. In addition to our expertise, we also bring a long history of program success, innovation and efficiencies, as well as the ability to work with you as a partner and trusted advisor to build a stronger program by integrating other cost savings initiatives.

INTELLIGENT VALUE…THIS IS KEPRO

SECTION 3 – SCOPE OF WORK

3. SCOPE OF WORK

The Public Employees' Benefits Program (PEBP) is seeking a vendor that will work in partnership with PEBP and other PEBP vendors to assure the continued success of the PEBP CDHP. Vendors are required to duplicate the level of service presently offered to the participants of the PEBP CDHP. This does not, however, preclude proposing vendors from presenting alternative solutions that relate to Utilization Management and Large Case Management services.

UM services shall include, but will not be limited to, the following:

- Utilization management and large case management;
- Pre-certification of specified medical services to determine medical necessity;
- Concurrent and retrospective review; and
- Management reporting.

PEBP oversees the administration of the CDHP medical and dental plans. The medical plan requires the services of a Utilization Management (UM) vendor to provide pre-certification services, utilization management, large case management, and other medical management services for the participants of the PEBP CDHP as described in this RFP.

KEPRO RESPONSE:

Understanding the Department's Utilization and Large Case Management Scope of Work
Facing the challenges of keeping all healthcare related costs in check are critical to the PEBP's ability to provide for employees healthcare and to carry out the duties outlined in this scope of work.

We also understand and agree to maintain ready access for service providers to submit all utilization management and large care management requests, and that we will ensure a seamless implement. We will evaluate and make determinations regarding (but will not be limited to) pre-certification services, utilization management, large case management, and other medical management services described in this RFP for the participants of the PEBP self-funded consumer driven health plan (CDHP). UM services shall include, but will not be limited to, the following:

- ***Utilization management and large case management;***
- ***Pre-certification of specified medical services to determine medical necessity;***
- ***Concurrent and retrospective review; and***
- ***Management reporting***

As we do for all of our customers, we will perform professional and technical services and other duties in accordance with, and subject to, applicable Federal and State statutes and regulations, and all PEBP policies and procedures.

Our ability to customize solutions and adapt to the evolving healthcare marketplace, allow KEPRO to accommodate ongoing changes as needed throughout the contract. Changes might include federal and state legislation, regulation, policy changes, or even recommendations KEPRO makes to improve the efficiency and effectiveness of the Utilization Management and Large Case Management Services Program and processes.

Because our systems are proprietary, we can customize to capture data required for comprehensive analysis and reporting to meet your specific needs. And because our systems are fully automated, we can generate numerous reports, many in real time, to give clients a clear understanding of current utilization of medical services, trends within their populations, and other vital information to make necessary program improvements and contain costs. We will deliver our reports within the identified time frames as detailed in Sections 3.4 and 3.12, Management Reporting Requirements.

KEPRO is known for the high quality education and training support given to our providers, especially during new contract implementation. Our dedication and expertise in provider outreach is based on our foundation of ownership by the Pennsylvania Medical Society, which represents 17,000 Pennsylvania physicians. We work closely with our clients and their provider communities to consistently deliver impressive results and improved health outcomes.

To accomplish this successfully, it requires extensive interaction with PEBP leadership and providers to achieve high provider participation rates. We provide program materials on our contract-specific website to educate providers about our electronic processing system, as well as program policies and processes. We will also offer web-based training seminars to educate providers regarding care management, utilization management, submission of prior authorization requests, quality of care and the use of data and analytics to improve performance.

Understanding the Objectives and Intended Results of the UM and CM Project

KEPRO understands that, given the rising costs of health care, utilization and case management programs must achieve the intended results. All health care services and supplies must be medically appropriate and:

- ***Necessary to meet the basic health needs of the client;***
- ***Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the covered service;***
- ***Consistent in type, frequency, duration of treatment with scientifically based guidelines of national medical, research, or health care coverage organizations agencies;***
- ***Consistent with the diagnosis of the condition;***

- ***Required for means other than convenience of the client or his or her physician;***
- ***No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;***
- ***Of demonstrated value; and***
- ***No more intense level of service than can be safely provided.***

The program must also:

- ***Assist members in improving their health along the care continuum by taking a more proactive role in managing their health and complying with prescribed treatment plans***
- ***Safeguard against unnecessary or inappropriate use of healthcare services and against excess payments;***
- ***Assess the quality of those services; and***
- ***Provide for the control of the utilization of services.***

Achieving the Intended Results for the Program

As a Quality Improvement Organization, KEPRO understands the importance of designing processes to achieve the desired outcomes. We also understand the importance of data collection and integrity to validate outcomes. Our quality improvement program routinely monitors performance and makes modifications as necessary to guarantee success.

3.1 CURRENT PLAN CENSUS

The CDHP plan covers all eligible State employees, certain non-state local government agencies, full-time employees of the Nevada System of Higher Education, and members of the Nevada Senate and Assembly. Dependents of the above-mentioned groups may also be covered. Benefits are also extended to retirees who are receiving benefits from specified public retirement systems, their surviving spouses, and/or eligible dependent children.

As of August 1, 2013, PEBP has approximately 42,183 plan participants who include active and retired individuals from the state and from several local government employers. Of those, 19,332 have elected the self-funded medical Consumer Driven Health Plan (CDHP) and dental PPO Plan; 11,146 participants have elected coverage from a Health Maintenance Organization (HMO) for medical benefits; and 9,761 participants are on the Medicare Exchange for medical benefits. Only those participants and their covered dependents enrolled in the CDHP are eligible for utilization management/large case management as defined under this contract.

	Primary	Dependents	Total
State Active			
CDHP	14,754	13,095	27,849
Non-state Active			
CDHP	7	6	13
State Retiree			
CDHP	2,866	1,168	4,034
Non-state Retiree			
CDHP	1,705	244	1,949
Totals	19,332	14,513	33,845

KEPRO RESPONSE:

KEPRO understands and acknowledges that the Consumer Driven Health Plan (CDHP) covers all enrolled, eligible State employees (active and retired,) certain non-state local government agencies, full-time employees of the Nevada System of Higher Education, and members of the Nevada Senate and Assembly. In addition, dependents of the above-mentioned groups may also be covered. Benefits are also extended to retirees who are receiving benefits from specified public retirement systems, their surviving spouses, and/or eligible dependent children.

We are experienced at managing similar populations both in size and location, as well as larger volume participants.

3.2 CURRENT PEBP VENDORS

- HealthSCOPE Benefits - Third Party Claims Administrator, HSA and HRA Administrator (CDHP), FSA Administrator, National Medical PPO Network;
- Catamaran Rx - Pharmacy Benefits Manager (CDHP);
- Walgreens Pharmacy and Walgreens Specialty Pharmacy – Subcontractor of Catamaran Rx for mail order and specialty drug services;
- Extend Health - Medicare Exchange and HRA Administration for participants on the Exchange;
- Sierra Healthcare Options and Hometown Health Providers – Nevada Statewide Medical PPO Network (PPO Plan);

- Diversified Dental Services - Dental PPO Network (HMO and CDHP);
- Health Claim Auditors - Health Plan Auditor services (Excludes HMO vendors);
- Aon Hewitt - Actuary/ Consultants;
- Hometown Health Plans – Northern Nevada HMO;
- Health Plan of Nevada - Southern Nevada HMO; and
- Hometown Health Providers - Utilization Management, Large Case Management.

KEPRO RESPONSE:

KEPRO has great expertise with quickly establishing trusting partnerships and collaborative relationships with a large variety of stakeholders. During implementation we identify the role of each of the PEBP vendors and work collaboratively with them to establish seamless, integrated processes and interfaces that allow for a seamless experience for members and providers. For more detailed discussion, please see section 3.9

3.3 UTILIZATION MANAGEMENT, CASE MANAGEMENT, AND PRE-CERTIFICATION

Please refer to PEBP's Master Plan Document (MPD) for a complete list of services that require pre-certification at www.pebp.state.nv.us. Please note that the MPD posted on the PEBP website is indicative of the current plan year only.

KEPRO RESPONSE:

KEPRO has read, understands and acknowledges all content in the PEBP Master Plan Document (MPD). We understand that the services noted on the website are indicative for the current plan year only.

For over a quarter of a century, KEPRO has provided utilization management solutions to public and commercial clients. We began providing utilization management services in 1992 and case management services in 2006. Today, KEPRO is the leading Quality Improvement and Care Management organization offering outcomes-focused solutions to reduce the utilization of healthcare resources and optimize quality of care for our clients. For PEBP, this means an experienced, proven, innovative partner who is prepared to evolve with our clients to meet the ever-changing needs of the healthcare marketplace.

Figure 1 demonstrates our prior authorization review volume experience on the next page.

Figure 1. Prior Authorization Review Experience By Contract		
Contracts	***# of Years***	***Annual Volume***
Florida Medicaid	***10***	***450,000***
Virginia Medicaid	***7***	***375,000***
Maryland Medicaid	***4***	***175,000***
Commercial Accounts	***7***	***80,000***
South Carolina Medicaid	***1***	***74,000***
Wyoming Medicaid	***1***	***180,000***
Hillsborough County, FL	***7***	***40,000***
Nevada		***20,0000***
New Hampshire Medicaid	***1***	***20,000***
Tenncare	***6***	***18,000***
Minnesota Medicaid	***1***	***60,000***
Total	***45***	***1,307,000***

Our case management experience is just as impressive. Approximately 300,000 lives were eligible for our general or large case management programs in 2013. With an expected enrollment of at least 1 percent of the population, we manage a minimum of 3,000 cases annually.

Our experience gives us a unique insight into the needs of PEBP and your members. We understand the challenges of implementing large-scale programs, and we possess the expert knowledge, skills, and resources to successfully fulfill the requirements of the contract.

3.3.1 The plan's current utilization management program includes the following services:

KEPRO RESPONSE:

Regardless of the review type, we apply the same basic utilization management process relative to submitting requests, completing medical necessity reviews, requesting additional information, referring to medical director review, notifying members and providers of the determination, and processing appeals. For reference, our utilization management workflow is included in each relevant section.

The goal of Utilization Management (UM) is to maintain the quality and efficiency of health care delivery by caring for patients at the appropriate level of care, by coordinating health care benefits, ensuring the least costly but most effective treatment benefit and the presence of medical necessity. And to further manage appropriate use of health care resources, UM must also allow for managing the member's health across the care continuum outside of the prior authorization process – through large and general case management programs. Below we provide a very brief example of factors considered when managing the listed services.

3.3.1.1 Case management and large case management;

KEPRO RESPONSE:

Please reference section 3.11.1.4 (General Case Management) and section 3.11.1.5 (Large Case Management for a description of our case management programs and philosophy.

3.3.1.2 All elective inpatient hospital admissions, including planned use of a hospital for a dental purpose;

KEPRO RESPONSE:

Reviewing elective admissions provides the opportunity to:

- ***Ensure the inpatient setting is the most appropriate level of care for the planned services/procedures***
- ***Refer members to general case management for the purpose of initiating discharge planning activities. As an example, prior to being hospitalized for knee or hip replacement, the case manager can work with the member on home modifications required to support the recovery process such as setting up a bed on the first level until the member is able to manage stairs.***
- ***Enrolling members in general case management to educate them on alternative treatment options (shared decision making) and/or on what to expect and how to prepare for pre/post procedure.***

Exception: a pregnant mother does not need to notify the UM company about the admission for delivery unless the stay will exceed 48 hours for a vaginal delivery or 96 hours for a C-section.

KEPRO RESPONSE:

We understand this exception for pregnant mothers. We do suggest educating pregnant mothers – and women who plan on becoming pregnant – on the benefits of self-referral to large case management in the event they are diagnosed as high risk.

3.3.1.3 All admissions to a skilled nursing facility or sub-acute facility;

KEPRO RESPONSE:

Please refer to section 3.3.1.4 below.

3.3.1.4 All admissions to any hospital or rehab facility for rehabilitation therapy;

KEPRO RESPONSE:

Admissions to skilled nursing facilities, sub-acute facilities, or admissions to any inpatient setting for rehabilitation therapy again are an opportunity to assess for appropriate level of care. It is also important to refer the member to general or large case management to review and monitor the plan of care to determine if it is evidence based and supports the member's prognosis (recovery goals are realistic). Review for continuation of services determines if the member is progressing along the care continuum and if not, may warrant a peer to peer discussion to determine if alternative care is more appropriate to achieve the member's recovery goals. It is important to recognize when the member has maximized their recovery – especially for rehabilitative therapy. This is done through close collaboration with the member, the member's physician and, in the case of rehabilitation, the member's therapists.

3.3.1.5 All organ/tissue pre-transplantation related expenses, including the admission for transplantation services;

KEPRO RESPONSE:

Once the transplant has been certified as medically necessary, the member is managed in large case management until such time they are seamlessly transitioned to the Center of Excellence case manager. Depending on the member's status, we may resume oversight and support once discharged from COE.

- ***We educate the member and family on the pre/post transplant care,***
- ***Identify and address any barriers to treatment plan compliance,***
- ***Facilitate a self management plan (both pre/post transplant)***
- ***Support the member in remaining transplant eligible***
- ***Monitor pre-transplant and post-transplant related expenses and determine which services are included in the COE contract***
- ***Assist member/family with post op care coordination and/or referrals to community support resources***

Please refer to section 3.11.1.8 and 3.11.1.9 for information on how we collaborate with COE networks.

3.3.1.6 Foot surgeries such as bunionectomy, correction of hammer toes, or corrective procedures on metatarsals, phalanges (toes), metatarsophalangeal joint, and interphalanageal joint;

KEPRO RESPONSE:

Once the surgery has been certified as medically necessary, the member is referred to general case management to coordinate post-op DME requirements and assist the member with preparing the home to accommodate temporary limitations.

3.3.1.7 Carpal tunnel surgery;

KEPRO RESPONSE:

Because of the potential complications, lingering side effects, and possibility of a second surgery in the near future, it is important to ensure all credible, non-invasive therapies are tried before resorting to this surgery.

3.3.1.8 Genetic testing and/ or counseling for, but not limited to amniocentesis, chorionic villus sampling (CVS), alphafetoprotein (AFP), BRCA1 and BRCA2, and apo E;

KEPRO RESPONSE:

A genetic counselor can provide information about the pros and cons of testing; genetic testing results may help a person make life decisions such as family planning. Member's and their family may benefit from psychosocial support and counseling based on testing results so a referral to general case management may be in order – especially if test results indicate probable issues and the family opts to continue with a pregnancy.

3.3.1.9 Weight-loss surgery;

KEPRO RESPONSE:

Member's approved for weight-loss surgery are referred to general case management to ensure the member and their family understand that the surgery alone will not guarantee long term weight loss. Members should understand the post-op care and what to expect during their recovery period. Members are educated on the need to follow special diets, adapt different eating habits, take food supplements the rest of their life, and see their physician on a regular basis.

3.3.1.10 All spinal surgeries, inpatient or outpatient, to include but not limited to laminotomy, discectomy, stereotaxis and neurostimulators;

KEPRO RESPONSE:

Studies show it's difficult to accurately predict who will benefit from back surgery and who won't. For this reason, and because most back pain improves with time, non-surgical treatments like physical therapy should be tried before back surgery is considered. Medical necessity review will determine if non-surgical treatments were tried and to what level of success. A general case management referral may or may not be necessary (depending on type of surgery and expected recovery) to coordinate post op care and support services.

3.3.1.11 Dialysis- Inpatient and Outpatient;

KEPRO RESPONSE:

Large case management interventions include monitoring the member's compliance and, depending on the member's prognosis, coordinating with the member and member's physician on transplant options and/or end of life considerations.

3.3.1.12 Cardiac Pace Makers;

KEPRO RESPONSE:

Medical necessity review first determines if the Pace Maker is to be temporary or permanent. If temporary, the member is normally hospitalized while the temporary device is in place; expected length of stay is evaluated for medical necessity. If permanent, the member is referred to general case management to verify their understanding special precautions And the importance of having the device checked regularly.

3.3.1.13 Illnesses requiring chemotherapy;

KEPRO RESPONSE:

Medical necessity review for chemotherapy should be done in conjunction with a review of the complete treatment plan – to include surgeries and radiation therapy – to ensure that the plan is consistent with evidenced based practice guidelines. Members on chemotherapy are always referred to large case management where interventions include (but are not limited to):

- ***Determining if the chemotherapy agents are available at lower cost (directly from the PBM rather than purchased from the oncologist)***
- ***Verifying that the member and family understand the prognosis***

- ***Assisting the member with treatment plan compliance (to reduce complications and avoidable use of health care resources)***
- ***Providing psychosocial support to the member and family; may include referral to behavioral health and/or community support groups***
- ***Facilitating end of life discussions (prognosis dependent)***

3.3.1.14 Any procedure that might be deemed to be experimental and/or investigational; and

KEPRO RESPONSE:

Experimental and/or investigational procedures are seldom deemed to be medically necessary nor covered under the benefit plan. In rare instances though, procedures still listed as experimental or investigational have become "evidenced based" practice for certain conditions. In such instances, requests are forwarded to the medical director and/or one of our specialty consultants to determine medical necessity. Depending on plan language, coordination with the benefit plan advisors may be required prior to authorizing services in these rare instances.

3.3.1.15 Durable medical equipment when the cost is expected to exceed $1,000.00.

KEPRO RESPONSE:

A number of factors are considered as part of the medical necessity review process or as general case management interventions (depending on the DME). They include, but are not limited to:

- ***Cost effectiveness of authorizing rental versus purchase***
- ***Length of time the member will need the DME***
- ***(Depending on the DME and length of time it will be used) Whether maintenance is included in the price***
- ***Who is responsible for repair should it malfunction***
- ***Whether the member has this particular DME already and if so, is it in safe working condition***
- ***Does the member need educated on safe use***

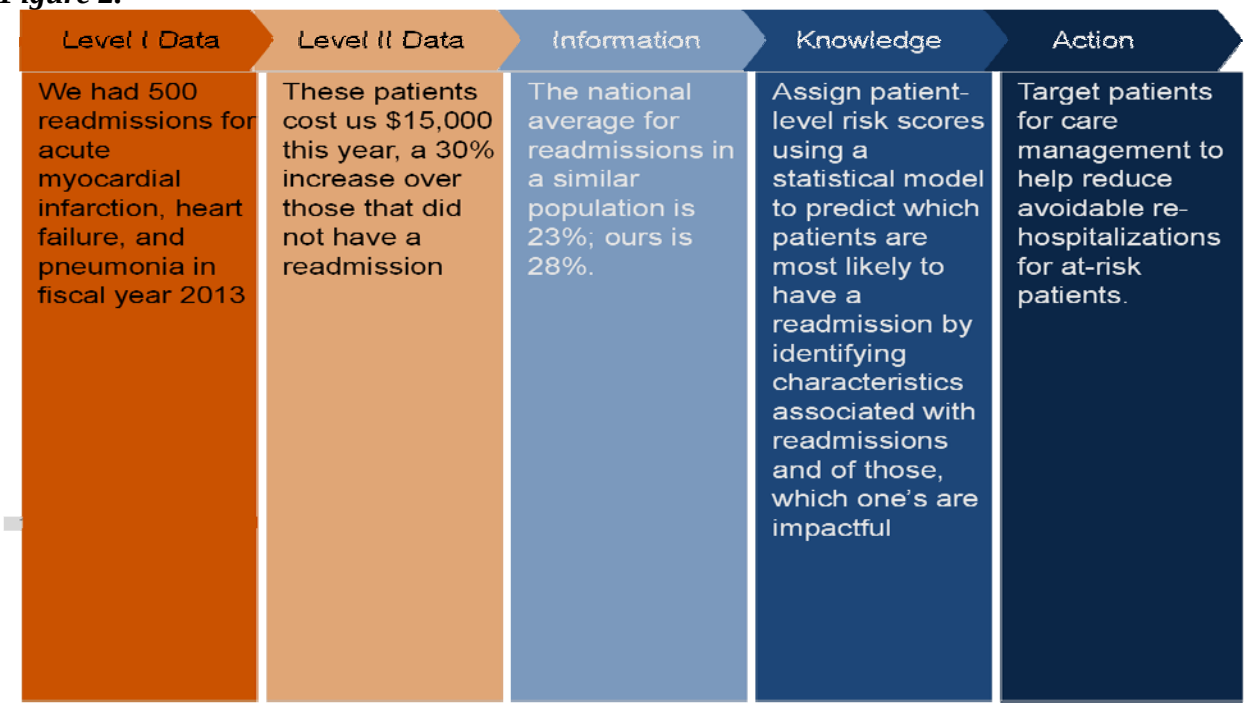
3.4 MANAGEMENT REPORTING

3.4.1 The UM vendor must provide management reports in a form and content approved by PEBP. These reports will be provided at PEBP's request in a hard copy and/or electronic media format to PEBP and PEBP's actuary/consultant when requested. PEBP is looking to its vendors to propose reporting that could best meet the needs of the State and the program.

KEPRO RESPONSE:

KEPRO will provide management reports in either hard copy and/or electronic media in a mutually agreed upon schedule. KEPRO understands that well designed management reports will often turn up more questions than answers that then serve as ideas for future investigation and ad hoc reports. Our reports help to further inform our clients and enable them to consider potential policy and benefit design decisions. Understanding that analytic work and the development of additional areas to drill into is as much about the journey as it is the destination. Our approach to management reporting is to take clients across the analytic spectrum from data to knowledge, and ultimately action as described in an example below in figure 2.

Figure 2.



For over 28 years KEPRO has utilized a comprehensive toolkit of analytic techniques to provide management reports that range from classic statistical methods to the newest in technological modeling and algorithms to answer a variety of health utilization and quality improvement questions. KEPRO understands that the research question is the foundation of any statistical analysis that supports care management activities and our analytic team is comprised of Masters level specialists from all disciplines of health service research including epidemiology, bio-statistics, informaticians, and medical directors.

Our management reports have included dozens of successful deep-dive analyses that often requires the merging of disparate databases or sources of information including inpatient and

outpatient medical claims, pharmacy data, audits of patient medical records, and many publicly available sources. These studies have investigated topics such as:

- ***Drivers of 30 day hospital readmissions***
- ***Ventilator-associated pneumonia***
- ***Lower back pain treatment and outcomes***
- ***Predictors of maternal-fetal risk***
- ***Evaluation of patients presenting with new chest pain to assess adherence to best practice guidelines in determining hospitalization or outpatient monitoring.***

All of our management reports are driven by evidence-based insights and are compiled using the same rigor and scrutiny that is found the peer reviewed medical literature.

KEPRO accomplishes this high level of analytics by staffing its Health Intelligence team with professionals with many years of experience and training in healthcare delivery analysis. The Health Intelligence team is responsible for Management Reports and is overseen by Ms. Meghan Harris. Meghan is the chief operating officer for KEPRO and brings nearly 15 years of experience in the health services research field, with expertise in biostatistics, experimental design, sampling, regression, health outcomes, and savings calculations. Meghan earned her Bachelor of Science degree in Mathematics from Malone College in Canton, Ohio; and her Master of Science degree in Statistics from the University of Akron. She's a member of the Cleveland Chapter of American Statistical Association, the American Society for Quality, and the American Health Quality Association. With oversight of both the operations and analytics teams Meghan ensures that information flows freely between both groups and the collaboration from centralized operations and analytics functions provides the operations team access to valuable information.

The day to day activities of KEPRO's Health Intelligence team is led by Mr. Benjamin Novinger, Director of Health Services Research. Ben has more than 15 years of experience in health technology for health plans and care management organizations, and has exceptional ability to combine proprietary and publicly available data with statistical methods and the latest in information technology advances to identify opportunities for improvement in clinical outcomes. Ben received his Bachelor of Arts degree in Business Administration, with an economics concentration from Catawba College in Salisbury, North Carolina. He received his Masters of Science degree in Public Health Science from Penn State University where he was the recipient of the Mark J. Young Award for Outstanding Scholarship. Ben received the Managed Healthcare Professional Designation from the Health Insurance Association of America. Ben has also been published in the medical literature, specifically for this work in predictive analytics. His publications can be seen in the Journal of Population Health Management and the American Journal of Managed Care.

3.4.2 UM vendor must provide access to the UM vendor's web-based reporting tools to assigned PEBP staff.

KEPRO RESPONSE:

KEPRO offers clients an extensive number of comprehensive, online, real-time reports presented in a reader-friendly format with multiple parameter/filter capabilities. Clients can conduct queries on numerous fields to monitor additional areas or gain additional insights. KEPRO's reports are designed to help clients with improved decision-making and initiate improvements in quality of care, health care delivery, and cost savings.

3.4.3 The UM vendor must also have the capability to provide ad hoc reports at PEBP's request at no additional cost. Proposing vendors should include sample copies of reports as an attachment to their proposals.

KEPRO RESPONSE:

KEPRO agrees to work with the PEBP to modify data elements of report formats as requested. We recognize that reporting of data is important to:

- ***Continuously monitor quality of data sets, including reliability and validity of all data***
- ***Identify patterns and trends within data sets that may indicate actionable responses***
- ***Validate that KEPRO is meeting contractual requirements related to abstracting activity.***

KEPRO has the capability to accommodate multiple file formats if at any time to provide the underlying data to support a report. KEPRO's reports are built using multiple point-and-click options for selecting parameters and are easily modified to help answer any ad hoc questions from PEBP.

Sample reports are included in Attachment 4.

3.5 VENDOR STAFFING

The UM vendor must maintain sufficient staff to meet the needs of PEBP and PEBP participants, including but not limited to the following:

3.5.1 An account manager, whose primary responsibility is PEBP;

3.5.2 Registered nurses, whose primary responsibility is PEBP; and

3.5.3 Technicians whose primary responsibility is to assist PEBP staff, PEBP participants, and PEBP providers with answers to questions.

3.5.4 Nursing licensure requirements may be required in all 50 states. Vendors are encouraged to review current licensing capabilities and compare them with the requirements in the State of Nevada www.nursingboard.state.nv.us.

KEPRO RESPONSE:

KEPRO has been ranked in the top 100 best places to work.

KEPRO Staffing Plan

Our 28 years of health care management experience offers the Department well-established and proven corporate recruiting, credentialing, and retention capabilities. This experience has resulted in KEPRO's ability to maintain a 90% employee retention rate.

KEPRO develops a staffing plan for each contract that is customer-focused and community-integrated. We account for back-up personnel, support a sufficient number of supervisors, and use professional staff whose qualifications are appropriately matched. Our process mitigates PEBP's risk of our non-performance, or lower level of performance caused by an inadequate number of staff, inadequate supervision, and/or insufficient skill or experience levels.

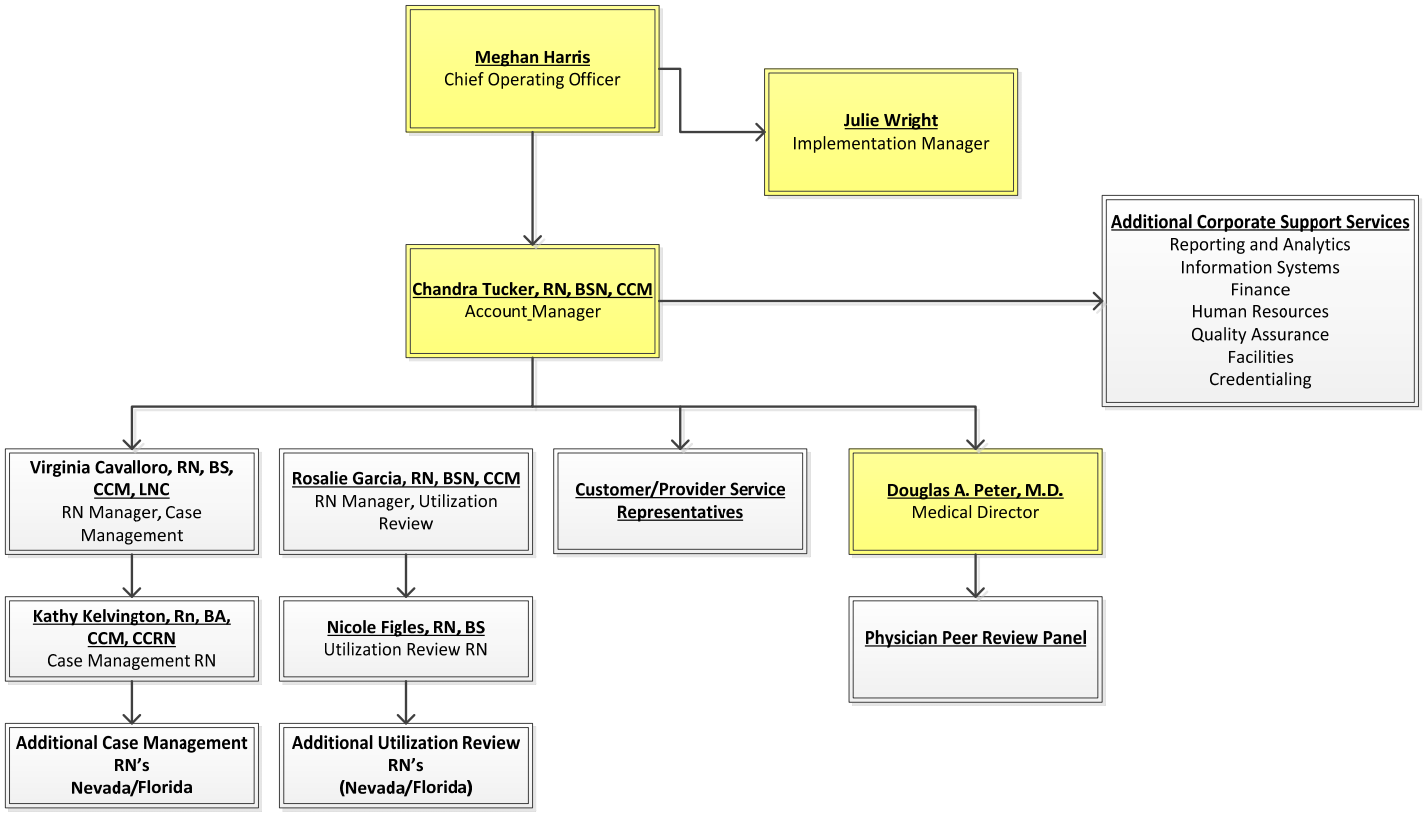
KEPRO's personnel plan has three objectives:

- ***Recruit and hire knowledgeable staff with experience that is relevant to the work required under the contract, and provide them with appropriate tools and training***
- ***Structure the organization in a way that supports communication and integration across contract responsibilities, but makes lines of authority clear to PEBP, all management and staff***
- ***Monitor the performance of staff at multiple levels on an ongoing basis to ensure customer satisfaction.***

To provide the most effective and efficient contract administration, KEPRO clearly delineates its staff reporting structures as shown in figure 3 our Organizational Chart below. Experience has shown that clearly defined lines of authority greatly enhance employee performance, efficient operations and increased customer and other stakeholder satisfaction.

A hallmark of KEPRO's plan is the achievement of flexible staffing levels made possible through judicious use of well-trained part-time (PRN) nurses and telecommuting staff. In an emergency situation or to accomplish special projects directed by PEBP, KEPRO is able to call on staff from all our office locations across the country. And we have also proven our ability to quickly train and bring online temporary staff when requested – both licensed and support staff, as appropriate to the need.

Figure 3. Organizational Chart



* Key Staff noted in yellow boxes

KEPRO Guarantees to Maintain the Adequate Staffing Levels

KEPRO is aware of the serious nature regarding the maintenance of proper staffing levels for superior customer service, high quality of work, and maintaining positive and productive relationships with the providers. We guarantee to maintain adequate staffing levels for the PEBP contract.

Key Staff-Qualifications and Roles

For this opportunity, KEPRO proposes the expertise and time of two high level managers who offer rich experience, expertise and leadership with the many facets of Utilization and Large Care Management including but not limited to those cited in the requirements. The qualifications of these crucial project staff and the proposed staffing plan as depicted in our Staffing Matrix (figure 7) demonstrate our acuity and capacity for all tasks to be performed under this contract.

KEPRO has 100% of the leadership team in place.
We are poised and ready to go!

KEPRO has identified the following key management team members:

- ***Julie Wright, Project Implementation Manager***
- ***Chandra Tucker, Account Manager***
- ***Douglas Peters, Medical Director***

Julie Wright, BA, MBA
Project Implementation Manager-*key personnel

Julie Wright is a proven, leader with more than 15 years experience the health care arena. Her hard work, dedication and drive made her one of KEPRO's "best of the best". With a solid track record of consistently meeting and exceeding corporate goals, objectives, and deliverables we are proud to present Ms. Wright as the project implementation manager. Her ability to identify problems through root cause analysis and take appropriate actions to resolve issues stems from her background as our corporate Compliance officer. She is an expert in a number of Medicaid contracting activities, as demonstrated by the following experience:

- ***Over 13 years Account Management experience in health care services for Federal, State, County, and private sector clients***
- ***Successful project implementation and management of more than 7 major Medicaid UM/CM contracts***
- ***Over 5 years of Government contracting experience, including ensuring overall contract compliance, licensure and maintaining specialty certifications.***

Chandra Tucker, RN, BS, MS, CCM
Account Manager- * key personnel

Ms. Chandra Tucker, RN, BSN, CCM has 25 years of senior healthcare management experience across all RFP spectrums. She is an accomplished leader in field of both utilization and case management. She has a proven track record of effective critical thinking skills, outstanding customer relationships, seamless implementation management and excellent conceptual and analytic skills. Ms. Tucker will be fully dedicated to the PEBP program and has direct experience with the Nevada population and government. She has led QI/UR and case management programs for large industry players including United Healthcare, Amerigroup and Sierra Health Services. She is a native of Nevada and is soon to complete her Master's Degree. She is an expert in a number of related contracting activities, as demonstrated by the following experience:

- ***Over 20 years of Account Management experience in the commercial and government environment, both in the State of Nevada and across the nation.***
- ***A wealth of experience from federal, state, and commercial providers, payer and contractor viewpoints and currently enjoys a successful working relationship with all her clients.***
- ***History of successful program start-ups and implementations with similar size projects.***
- ***Established and respected as an effective and collaborative leader, producing measureable improvements for each customer she serves.***
- ***10 years of experience with managed care organizations and compliance with Federal state and local regulations and standards.***

Douglas Peters, MD
Medical Director-*key personnel

Our proposed Medical Director, Douglas Peters, MD, is board-certified in Internal Medicine, licensed in Nevada, and has over 25 years of clinical and medical management experience. He has served as the Medical Director for several healthcare companies such as St. Mary's HealthPlans, Blue Cross Blue Shield of North Carolina and Cigna health care. He is experienced in serving populations with medically complex needs and is an expert in both Utilization and Care Management. Dr. Peters is also a native to Nevada and is intimately familiar with the nuances unique to State. He is well versed on Nevada policies and procedures, and has first-hand experience with the utilization management/service authorization and case management services.

- ***Expertise in developing and implementing clinical policy, utilization management, case management guidelines, product design, and provider incentive programs that align provider and member incentives with the Plan's objective of ensuring access to medically necessary and proven care.***
- ***Achieved documented health improvement for various populations and positive bottom-line impact for health plans and employer groups.***
- ***Able to work well with providers to develop and pilot innovative practice models to provide better and more resource efficient care to patients, including innovative reimbursement schemes.***
- ***Recognized for building good will and trust, and collaborating with providers to develop relationships that improve the odds for a payer trying to implement controversial or innovative changes in care delivery.***

All key staff resumes are included in Tab VIII.

In addition to our key staff, we also present the following Registered Nurse team members:

- ***Virginia Cavallaro, RN, BS, CCM, LNC- Over 15 years' experience in utilization management and large case management. Certified Case Manager. Nevada native.***
- ***Rosalie Garcia, BSN, CCM – 22 years of professional nursing experience, with the past 10 years specializing in utilization/case management. Nevada native***
- ***Kathy Kelvington, RN, BA, CCM, CCRN- Over 30 years professional nursing experience, with the past 15 years serving in case management. Nevada native.***
- ***Nicole Figles, RN, BS- over 10 years direct experience working in both utilization management and case management. Nevada native.***

Staffing Matrix

KEPRO presents our proposed Staffing Matrix (Figure 4) for this opportunity, including a description of our corporate support services.

After 28 years of experience providing healthcare management solutions, we have a thorough understanding of the staffing needs associated with all types of programs. Many factors are taken into consideration when calculating our proposed FTE counts for each deliverable. Given the size (volume) and complexity of the scope of work, KEPRO feels confident that our

proposed staffing levels will provide the adequate coverage and supervision necessary to meet the contract specifications. <u>If our estimates are incorrect and additional resources are required to support PEBP's requirements, additional resources will be added without additional expense to PEBP.</u>

Figure 4. Staffing Matrix

Position	Qualifications (including licensure and certification	Roles/Duties
Medical Director	Board certified, unrestricted license to practice medicine, with the relevant experience and capability to oversee the contract.	Monitors physician reviewer decisions to ensure appropriateness. Performs physician level reconsideration reviews for services that do not appear to meet initial criteria for coverage. Provides clinical leadership in the review and update of clinical review criteria. Shares medical knowledge with staff for interpretation of clinical criteria and/or other professional medical issues. Conducts peer-to-peer discussions with treating providers to validate treatment plans against evidence-based guidelines.
Physician Peer Reviewer	Licensed, Board-certified physicians with appropriate specialty areas	Used on consulting basis as needed. Access to consultation with other appropriate physicians to carry out utilization management activities. Completes credentialing and training program; review selected medical records to address potential utilization and/or quality concerns; participates in reconsiderations requested by providers as assigned.
Account Manager	Bachelors in healthcare or related field. Extensive experience (7+ years) in health care, managed care, or Medicaid/Medicare administration.	Manage the day to day operations and supervisory staff Ensure effective daily operations and high quality services for all state and commercial contracts administratively, operationally and fiscally Oversee and coordinate all activities associated with any KEPRO commercial and state government contracts Establish action plans, budgets, timetables and outcome measurements; obtain and allocate resources; and review progress of the program in order to accomplish objectives
Licensed Reviewers	Active RN license with a minimum of 5 years clinical experience and one year utilization management experience	Performs utilization and quality reviews; prepares correspondence; prepares cases for physician review; records review results utilizing appropriate review tool.

Position	*Qualifications (including licensure and certification*	*Roles/Duties*
Case Managers	*Registered nurses with minimum of 5 years clinical experience and one to two years case management experience; certification preferred; must agree to obtain certification within 2 years of hire*	*Serves as principle care manager responsible for coordinating with (but not limited to) the individual, individual's family/care giver(s), and individual's primary care physician, state, county, and local community/faith based organizations in developing and implementing a viable transition plan for assigned individuals. Also responsible for post inpatient transition follow up to reduce/prevent re-admissions.* *Conduct an in-depth initial assessment of the member and assess the ongoing progress of members by performing a thorough review of the person's medical history, current treatment modalities including all current and past medications; social history is collected in order to understand the unique needs of each individual and to understand his/her cultural, religious, and ethnic views on illness, treatment, and end of life.* *Primary care management responsibility for the development and implementation of the care plan for the member to assure that goals are defined and met.* *Perform ongoing assessments to monitor the ongoing progress of members by reviewing of any changes in medical status, treatments, and medications*
Customer/ Provider Service Representative	*HS grad or GED; 1 to 2 years of experience in managed care or hospital environment with experience in customer service, provider relations, admissions or call center. Strong keyboarding skills necessary.*	*Responsible for supporting the integrated care management process. Answers incoming calls and initiates requests by collecting and entering demographic, provider and procedure information into the system. Processes prior authorization requests received by fax, mail, or website. Generates and mails review letters. Adheres to all PEBP approved policies and procedures. Investigates and resolves or reports customer problems. Identifies and escalates difficult situations to the appropriate party. Also responsible for supporting the case management process through member outreach and enrollment activities; fulfillment functions, and other administrative support tasks.*

Nursing Licensure Requirements

Our organization has full time Quality Assurance, Compliance and Regulatory staff that continuously monitors and ensure compliance with all governmental regulations. Only clinicians with active, clear, and validated licenses are employed by KEPRO. Only licensed nurses conduct evaluations and interpret clinical data.

An electronic credentialing database is maintained and reviewed on a monthly basis to ensure licenses are current. For licenses due to expire, a reminder email is sent 10 weeks prior to expiration to the clinician, with a copy to her/his supervisor(s) reminding them of their pending expiration date and requiring them to bring in their renewed license. A second reminder is sent four weeks prior to expiration, and every week thereafter as necessary. Upon receipt, the credentialing database is updated. Under no circumstances will any KEPRO employee be allowed to perform any work without an active, clear and valid license as appropriate.

KEPRO is familiar with current licensure requirements nationwide. We have RNs licensed in multiple states, and through compact/reciprocal licensure we cover an even larger percentage. KEPRO will hire nurses licensed and located in Nevada as our primary utilization management and case management nurses and will supplement their licensure as needed to address states which do not employ compact or reciprocal licensure.

KEPRO employs the same licensing and credentialing standards for all of our medical directors and physician reviewer consultants.

3.6 QUALITY ASSURANCE

The UM vendor is responsible for internal quality control processes to regularly evaluate the performance and accuracy of the services provided. Findings of internal quality control evaluations will be provided to PEBP and will be included in quarterly reports provided to the PEBP Board.

KEPRO RESPONSE:

Our business philosophy is rooted in the principle of continuous quality improvement – ongoing improvement that is consistently planned, measured, and evaluated. This philosophy both requires and ensures that we:

- ***Comply with all federal and state legal and statutory requirements***
- ***Perform all contract activities in a professional and ethical manner***
- ***Provide products and services characterized by the utmost integrity and reliability.***

Utilization management and quality assurance are the gateways to other programmatic elements that, combined, ensure the right care in the right place at the right time. Utilization management is a crucial component of the overall QI program, acting as the first line of defense to effectively manage health care costs. We also minimize or eliminate inappropriate levels of care, admissions, and procedures, and prevent untimely or premature discharges. All these efforts support sufficient financial resources to allocate to those who need it.

To ensure quality, KEPRO assesses both first-level clinical reviewer and second-level physician reviewers for accuracy, timeliness, and reliability monthly to ensure we continually provide valid,

timely decisions. Monitoring falls into two categories, case audits (did the reviewer make the right decision in this particular case) and Inter-rater Reliability (given similar situations, will all reviewers make similar decisions).

KEPRO audits clinical reviewer performance against standards on a monthly basis. Each individual, physician and nurse, is assessed on the points described in Figure 5.

FIGURE 5. ASSESSMENT POINTS	
PERFORMANCE ITEM	***ASSESSMENT POINTS***
Case Identifiers	***Case ID*** ***Service Type*** ***Comments.***
Documentation	***Request Date*** ***Received Via?*** ***Was workflow documented?*** ***Comments.***
Completion - Timeliness	***Completion Date*** ***Completed w/in Timeframes?*** ***Comments.***
Diagnosis	***Is diagnosis code noted?*** ***Diagnosis Code Number*** ***Diagnosis Description*** ***Comments.***
Criteria	***Criteria Used*** ***Criteria Appropriate?*** ***Comments.***
Referral	***Referred Appropriately?*** ***Referral To*** ***Specialty of Reviewer*** ***Physician Reviewer Name*** ***Comments.***
Contract Compliance	***Was decision made based on contract guidelines?*** ***Comments.***
Outcome	***Outcome*** ***Reason Code.***

Nurse Reviewer QC Plan

We establish and maintain internal quality controls for monitoring, accuracy, productivity, and quality output for the program, which includes the following areas:

- ***Case Audits***
- ***Proficiency Testing and Inter-Rater Reliability***
- ***Statistical Process Control***

Case Audits

KEPRO's comprehensive audit plan ensures both nurse and physician reviewers are monitored for reliability and accuracy. KEPRO defines reliability as dependable, reproducible, consistent data, and defines accuracy as valid, correct data. We measure both reviewer types to ensure that quality services are being provided. The program contains two levels of monitoring, as outlined below, applicable to all active reviewers.

Reliability and accuracy in data collection are ensured through monitoring of a sample of cases per reviewer per month. Sampling strata include all providers and all service types to ensure that reliability studies are not biased by a particular case type. Areas reviewed during the audit include the following:

- ***Completeness of required documentation***
- ***Timeliness***
- ***Knowledge and application of criteria***
- ***Knowledge and application of client-specific policies***
- ***Knowledge and application of workflow***
- ***Appropriate referral of cases to higher level of review***
- ***Quality and accuracy of determinations.***

Our use of online review enables the manager to retrieve cases from the master review database and to evaluate the review activities performed by reviewers individually or as an aggregate. For new employees and contract activities, the ability to evaluate performance determines additional areas of training required and indicates the readiness of the reviewer to move to a live environment. Therefore, for any new contracts or new employees, monitoring takes place weekly, until the site achieves a satisfactory baseline score, then audits are performed monthly.

An overall accuracy rate of 90 percent or greater must be achieved. If this rate is not achieved, additional training is provided. If a reviewer does not meet a 90 percent accuracy rate after repeated training, additional corrective actions are taken.

Figure 6 shows results of our internal audits over the last three years.

FIGURE 6. KEPRO'S INTERNAL AUDIT RESULTS

	2010	2011	2012
Documentation	99.96%	99.95%	99.95%
Timeliness	98.66%	98.24%	98.70%
Criteria Application	99.52%	99.58%	99.56%
Workflow	99.52%	99.39%	99.52%
Contract Compliance	97.94%	98.47%	98.72%

IMPRESSIVE RESULTS!
KEPRO's IRR assessment score for the last 2 years: 99%

Proficiency Testing and Inter-Rater Reliability (IRR)

Reviewers are required to complete a set of test cases on a monthly basis to assess reliability and dependability of decisions and knowledge of the review process. These test cases are designed to measure the reviewer's proficiency in the following areas:

- ***Approval process***
- ***Application of review criteria***
- ***Application of workflows, especially referrals to medical directors.***

In addition, as all reviewers receive the same sample cases, KEPRO can analyze the agreement between reviewers (inter-rater reliability). Test cases will be given to all reviewers at the completion of initial training. Additionally, gold standard cases are assigned to assess reliability on a monthly basis.

With the detailed reporting from our auditing process, KEPRO is able to identify areas of weakness that may require additional training for a particular reviewer or may require additional training for a specific service type. The proficiency testing is performed monthly, and results are available to the management team for review. The Quality team and Management team work together to improve the process.

Figure 7 shows the results of our IRR assessment for one of our Medicaid accounts. This data measure commonality of outcomes among different reviewers given the same test cases. The accuracy rates shown exceed our internal quarterly benchmark of 90 percent.

FIGURE 7. IRR ASSESSMENTS				
	1ST QRTR	*2ND QRTR*	*3RD QRTR*	*YTD*
Approval	*92.6%*	*96.4%*	*97.3%*	*95.4%*
Criteria	*95.5%*	*99.2%*	*99.3%*	*98.0%*
Referral	*92.3%*	*96.2%*	*97.3%*	*95.3%*
Average	*93.5%*	*97.3%*	*97.9%*	*96.2%*

Physician Reviewer QC Plan

We also monitor performance of our physician reviewers. Before a physician can become a reviewer, he/she must successfully complete the credentialing process. We also ensure that our reviewers are licensed in the state in which they are performing review, area Board-certified, and are not on any State or Federal debarred or suspended lists. Our reviewers undergo vigorous training on contract-specific requirements and the KEPRO review process prior to performing "live" reviews.

Each quarter, the medical director conducts internal quality performance monitoring on a random set of reviewed cases to assess the quality and accuracy of each physician reviewer. Information from the monitoring process may identify areas for improvement, and ensures that a quality product is delivered. Several areas of the process are evaluated, including:

- ***Was the medical expert report timely?***
- ***Was the peer reviewer compliant with HIPAA confidentiality standards?***
- ***Does the rationale support the standard of care determination?***
- ***Were all pertinent questions answered?***
- ***Were evidence-based references contained in the report?***
- ***Was the report clear, concise, and easily interpreted?***
- ***Were all secondary factor/system problems identified?***

Physician reviewers failing to meet the standards are notified of the need for additional training, and may require the implementation of a corrective action plan, suspension or removal from our panel.

In addition to physician reviewer individual performance assessment, our physicians also participate in IRR assessments quarterly. The medical director selects actual cases by specialty (this rotates quarterly as well). The physicians with like specialties are selected and requested to complete the IRR test. The Quality team analyzes the results and then conducts follow-up meetings with the medical directors to discuss scores, successes, patterns of outcomes, and any opportunities for additional training.

Customer Service Representatives

KEPRO also audits customer service representatives (CSRs). Standard reporting from KEPRO's telecommunications system includes the following system service levels over the course of the work shift which allows us to continuously monitor performance. Along with the following call components, we can report on those callers who hang up while on hold, and the number of calls transferred to another staff member:

- ***Percent of calls answered***
- ***Average speed of answer***
- ***Length of calls in queue***
- ***Average holding time by caller/group***
- ***Agents (staff) required***
- ***Queue/split comparisons***
- ***Delay spectrum that reports abandoned and delayed calls hourly and over shift periods***
- ***Number of callers encountering busy signals to ensure that no one is hearing a busy signal***
- ***Information on trunk components such as idle and connect times.***

In addition to the overall telephone statistics for all staff, each CSR is monitored on five calls per month for the above standards and through silent monitoring by the Call Center Supervisor, which the system supports, for courtesy, efficiency and service. Specifically, the Supervisor monitors each CSR for the following:

- ***Greeting and professional communication; Verification***
- ***Navigation of Systems***
- ***Knowledge of Products/Procedures***
- ***Inquiry Resolution***

- ***Hold/Transfer Procedures***
- ***First Call Resolution***
- ***Call Closing.***

Each CSR is scored based on how well he or she performs during the call interaction, on knowledge of products and services and on navigation of KEPRO systems which includes logging and documentation of calls. For those performing below standards (a score of 85 percent or lower), we provide retraining and focused monitoring until results indicate improvement.

Statistical Process Control

Corporate processes for performing case reviews have been tested and verified for efficiency and effectiveness. Our processes include specific measures to ensure the staff execute at an above-average performance level. This approach results in the verification of expected outcomes, consistent application methodology, and increases the reliability of the review process. It facilitates staff training, process control, and performance monitoring.

Review managers use reports provided by the quality manager to make sure their assigned staff are meeting established standards. Reports of individual nurse reviewer workload (i.e., number of cases completed, timeliness) will be analyzed for exception activity (i.e., variation monitoring/statistical process control). In addition, all team members are given summary information about department-specific data and information regarding nonconformities, trends and patterns. Management provides ongoing reviews of the data to determine the need for corrective action, new assignment of responsibilities, or resolution of problems.

Outcomes

In addition to the internal quality measures, we also monitor utilization management outcomes to ensure we are providing value to our clients. We track the following and compare against MCG (formally Milliman USA) moderately managed benchmarks to measure our effectiveness. Measures include:

- ***Discharges/1000 (covered lives)***
- ***Bed days/1000***
- ***Average length of stay***

KEPRO consistently meets or exceeds MCG moderately managed benchmarks as reflected in the table below.

Figure 8. Utilization management Outcomes, 2013 YTD

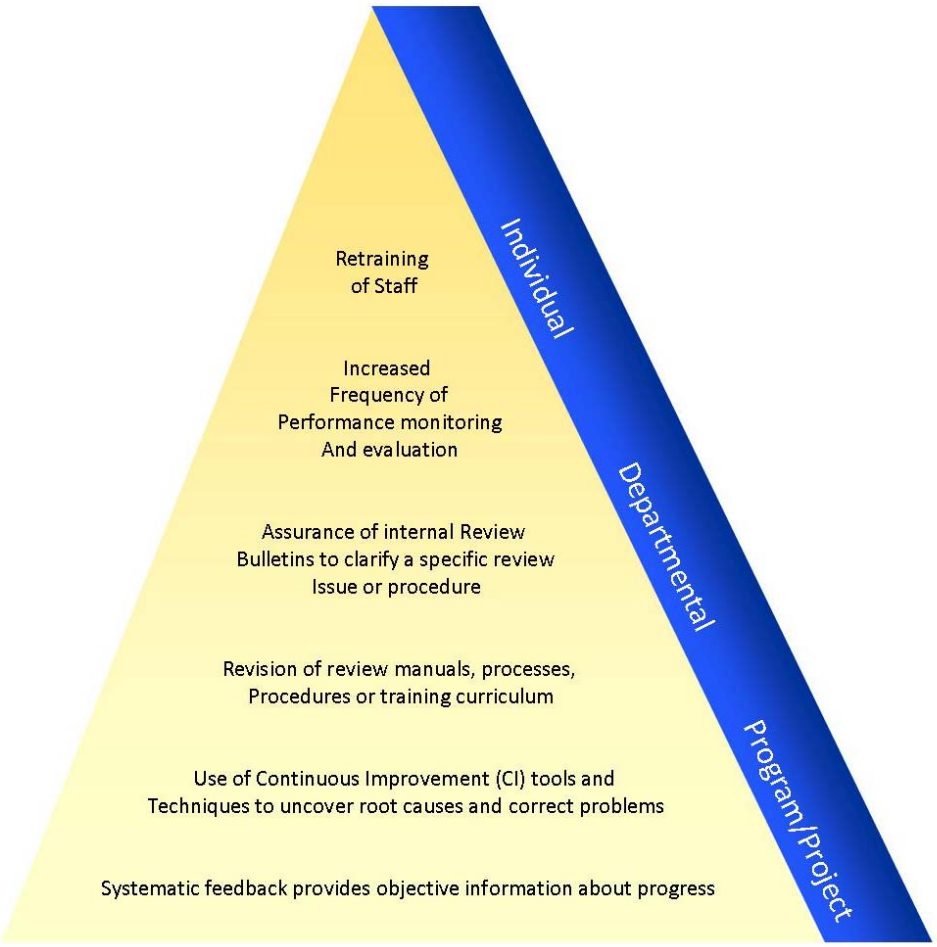
Utilization management Measure	*MCG Moderately Managed Benchmark*	*Outcomes*
Average LOS	*2012 Moderately Managed: 4.28*	*3.73*
Days/1000	*2012 Moderately Managed: 237.36*	*176.77*
Admits/1000	*2012 Moderately Managed: 55.51*	*44.21*

If we fail to at least meet the moderately managed benchmarks, we initiate a quality improvement project to identify the need for additional training, revised processes – or to identify case outliers that contributed to the increase in outcomes data.

Performance Improvement

Should any monitoring measures for nurse or physician reviewer or CSRs result in nonconformance or other measures of subpar performance against our predetermined standards, KEPRO will initiate performance improvement activities. Figure 9 illustrates how we monitor improvement through all levels of the program.

FIGURE 9: QUALITY MONITORING



Internal corrective action plans are designed to eliminate the cause of the problem, not just the symptoms. We identify root cause analyses to identify the best plan to eliminate the issue. Then those actions are monitored to ensure that the problem does not reoccur. Outcomes are reported to the staff and to corporate management.

KEPRO tracks all corrective actions in an internal system we have for such needs. This automated system tracks the following:

- ***Initiating a new corrective and preventive action request***
- ***Document root cause analysis***
- ***Document corrective and preventive action***
- ***Report generation to monitor for trends.***

Scorecards and dashboard reports are published to a companywide database that facilitates collaboration, provides content management, houses business processes, and provides access to company information essential to achieving KEPRO's organizational goals. Each month, the Quality Committee holds meetings to discuss the results of IQC audits and IRR results in comparison to corporate standards, and adjusts accordingly. KEPRO's outstanding reputation for 27 years is built on ensuring we perform within and across contracts.

KEPRO will develop Performance Improvement Plans when needed to support additional training and focused learning needs. Components of an effective performance improvement plan will include:

- ***Retraining of staff***
- ***Increased frequency of performance monitoring and evaluation***
- ***Issuance of internal review bulletins to clarify a specific review issue or procedure***
- ***Revision of review manuals, processes, procedures or training curriculum***
- ***Use of Continuous Improvement (CI) tools and techniques to uncover root causes and correct problems***
- ***Systematic feedback provides objective information about progress.***

Reporting

Findings of internal quality control evaluations will be provided to PEBP and will be included in quarterly reports provided to the PEBP Board. Figures 10-12 are sample reports that demonstrate our past performance and success on current contracts.

FIGURE 10. QUARTERLY TREND DATA FOR OVERALL REVIEWERS PERFORMANCE

REVIEWER TASK	Q1 2012	Q2 2012	Q3 2012	Q4 2012
Documentation	100.00%	99.84%	100.00%	99.78%
Timeliness	99.91%	99.40%	99.59%	93.88%
Diagnosis	99.67%	99.41%	99.76%	99.91%
Criteria	99.32%	99.36%	99.58%	99.01%
Workflow	99.91%	99.46%	99.48%	99.23%
Contract Compliance	96.34%	96.57%	99.26%	96.09%
Overall Average	99.19%	99.01%	99.61%	97.98%

Figure 11. Overall Average Performance Scores

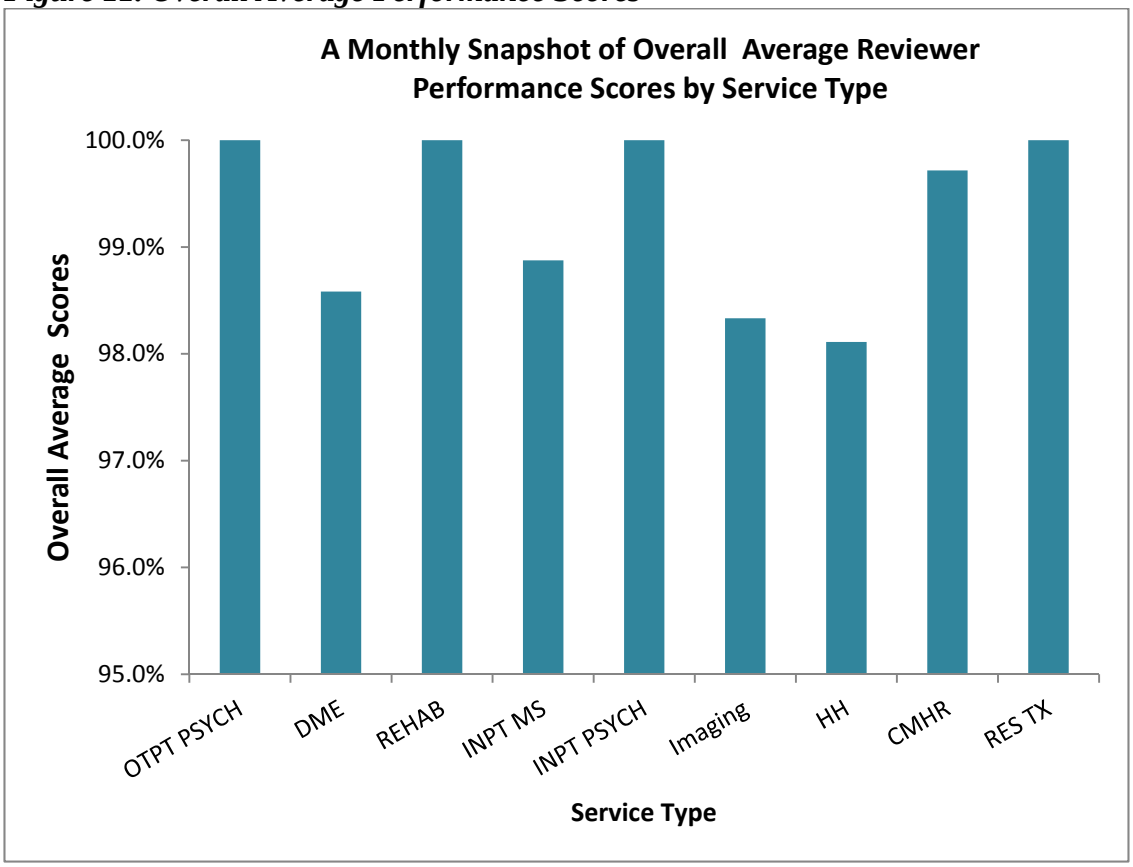


FIGURE 12. SUMMARY DATA ON INTER-RATER RELIABILITY					
	Q1 2012	*Q2 2012*	*Q3 2012*	*Q4 2012*	*YTD*
Decision	*98.33%*	*99.40%*	*98.61%*	*98.05%*	*98.60%*
Decision Criterion	*100.00%*	*98.94%*	*99.70%*	*100.00%*	*99.66%*
Physician Referral	*98.33%*	*99.40%*	*98.61%*	*98.55%*	*98.72%*
Overall Average	*98.89%*	*99.24%*	*98.97%*	*98.87%*	*98.99%*

3.7 UTILIZATION MANAGEMENT AND PRE-CERTIFICATION APPEAL RESOLUTION

The UM vendor is responsible for adhering to an appeal process certified by an accredited organization such as URAC. The current appeal process is outlined in PEBP's Master Plan Document (MPD) found at www.pebp.state.nv.us.

KEPRO RESPONSE:

KEPRO has read, understands and will comply with the current appeal process as outlined in PEBP's Master Plan Document. As part of our integrated care management program, KEPRO offers physician review and appeal services for the following review levels:

- ***Prospective***
- ***Concurrent***
- ***Retrospective***

KEPRO holds URAC accreditation for Health Utilization Management (UM), Case Management, and Disease Management (see Appendix 3). In addition, we are licensed in all 27 states which require Department of Insurance Utilization management Licensure (23 states do not require licensure), meaning that we are able to serve in all U.S. states and territories. Finally, KEPRO's program complies with all Department of Labor (DOL) and State Department of Insurance requirements as appropriate for employer groups. Formal appeals or special requests will be specialty matched as required by URAC Standards or state law, whichever standards are the most stringent.

KEPRO's program provides:

- ***Compliance with accrediting agency standards***
- ***Compliance with the DOI, DOL/ERISA, and/or client guidelines as applicable***
- ***Quality management oversight***
- ***Turnaround times that comply with state, federal, and national requirements***
- ***Credible, well documented review determinations***
- ***Processes that meet the needs of the client***
- ***Extensive, diverse physician panel to accommodate like-specialty match requirements for appeals***
- ***Credible outcomes that meet or exceed industry standards***

Please refer to Section 3.11.2.10 -3.11.2.13 for a detailed description of our appeals processes, including incorporation of PEBP-specific appeals process language.

3.8 NOTIFICATION OF SUB-CONTRACTORS

3.8.1 Disclosure of the names of all vendor subcontractors, as well as the physical locations where PEBP data is maintained and/or stored, must be communicated to PEBP at least 60 days prior to contract implementation.

3.8.1.1 Implementation will not be permitted until PEBP has provided written authorization to the vendor.

3.8.1.2 Failure of the vendor to notify PEBP of a change to (or addition of) an authorized subcontractor may result in a financial penalty.

A. The financial penalty is identified in the Performance Standards, Guarantees, and Penalties section of the RFP (Section 3.19.1).

B. Failure to disclose a subcontractor or other entity at least 60 days prior to the subcontractor or other entity having access to PEBP data will result in a penalty of 5% of the vendor's previous year's billed administrative charges per occurrence. Should subsequent billed charges not be sufficient to cover the penalty in full, the balance will

be billed by PEBP and considered due upon receipt. Vendors must indicate their organization's acknowledgement of this requirement.

KEPRO RESPONSE:

PEBP data will be stored and maintained securely in our Harrisburg Data Warehouse and offsite at an area Iron Mountain facility. Please refer to Attachment 1 details on our security, privacy and compliance standards.

KEPRO understands that implementation will not be permitted until PEBP has provided written authorization to proceed.

KEPRO has not proposed the use of subcontractor's for any of the work defined in this RFP however we have read, understand, acknowledge and will comply with said requirements should subcontractors be pursued in the future.

Our proposed solution is fully integrated and does not include subcontractors, providing PEBP a single-source vendor for this scope of work. In Section 3.19.3, we have outlined additional services that PEBP may elect to implement, some of which are performed by selected best-in-class vendor partners and subcontracts. KEPRO has reviewed and agrees to the penalties (Section 3.17.1) associated with failure to notify PEBP and receive written approval for any change related to the use of subcontractors to perform this or any additional scope of work.

3.9 COLLABORATION WITH PEBP AND PEBP VENDORS

KEPRO RESPONSE:

KEPRO has read, understands and will comply with all requirements in the RFP, including section 3.9, regarding collaboration and coordination with other PEBP and PEBP vendors/stakeholders.

As a valued collaborator, we will continue our long standing practice of being a "trusted partner and advisor" opposed to serving simple as the PEBP vendor. This collaboration is discussed in more detail throughout our response.

3.9.1 The UM/CM vendor will be required to allow PEBP's Third Party Administrator, HealthSCOPE Benefits, view-only access to its Utilization Management/Case Management IT system on a real-time basis.

KEPRO RESPONSE:

KEPRO understands and will comply with the requirement to allow PEBP's Thirds Party Administrator, HealthSCOPE benefits, view-only access to our Utilization Management/Case Management IT system on a real-time basis. We have worked directly with HealthSCOPE Benefits in the past and have maintained a collaborative and productive relationship.

3.9.2 The UM/CM vendor will be required to set up an electronic interface with PEBP's Third Party Administrator, HealthSCOPE Benefits, for daily feeds of pre-certifications and authorizations.

KEPRO RESPONSE:

KEPRO has set up file exchanges with HealthSCOPE Benefits in the past and will work in concert with HealthSCOPE Benefits to set up an electronic interface for daily feeds of pre-certifications and authorizations.

3.9.3 The UM/CM vendor will be required to host bimonthly calls with PEBP and other vendors as identified by PEBP for status reports on participants enrolled in large case management.

KEPRO RESPONSE:

KEPRO understands and agrees to host bimonthly calls with PEBP and other stakeholders identified by PEBP for status reports on participants enrolled in large case management. Over the past two decades, we have found that this level of collaboration always results in improved outcomes and enhances efficiency.

3.9.3.1 As the host, the UM/CM vendor agrees to provide a toll-free number and passcodes for PEBP approved vendors to access the bimonthly calls. These calls will allow for PEBP and its vendors to collaborate on the direction of care and provide solutions to any issues that may be identified.

KEPRO RESPONSE:

KEPRO will facilitate the bimonthly calls, provide a toll-free number and associated passcodes for the PEBP approved vendors participation, and ensure collaboration on developing solutions to all issues identified.

3.9.3.2 Before each call, the UM/CM vendor will send via secure email, a large case management report to PEBP and its participating vendors in a format approved by PEBP. The report will include, but not be limited to, the names of the individual patients who are under large case management, ID number of primary PEBP participant, the diagnosis(es), current treatment, and place of treatment. The discussion will include:

A. The case manager's recommendations (if any) for treatment based on the unique needs of each PEBP participant enrolled in large case management;

B. Any claim payment issues the participant may have experienced to allow PEBP's Third Party Administrator, HealthSCOPE Benefits, the opportunity to resolve; and

C. Any prescription drug issues the participant may have experienced to allow PEBP's pharmacy benefit manager, Catamaran, the opportunity to resolve.

KEPRO RESPONSE:

KEPRO has read, understands and will comply with all requirements noted in section 3.9.3.2. A- C.

3.9.4 There may be instances where a Letter of Agreement is warranted for services provided, for example, at an out-of-network provider. The UM/CM vendor understands that PEBP and its third party administrator, HealthSCOPE Benefits, will have full discretionary authority to determine the level of benefits that will be provided. Please indicate your organization's ability to provide these services with these requirements.

KEPRO RESPONSE:

KEPRO understands that there may be instances where a Letter of Agreement is warranted. We also understand that PEBP and HealthSCOPE Benefits have full discretionary authority to determine the level of benefits that will be provided.

KEPRO has experience with obtaining Letters of Agreement for out-of-network providers – especially when discounts have been negotiated. We have the ability to provide these services.

3.9.5 PEBP contracts with a health plan auditor to perform routine audits on behalf of PEBP. PEBP and its health plan auditor will comply with all applicable confidentiality laws and will not reveal any confidential information acquired as a result of the audit. PEBP has the right to review/audit records for the entire term of the contract without limitation. Any information, documents, etc., which the UM/CM vendor may deem as containing "trade secrets" or "proprietary information" will not preclude an examination of such items through the audit process. Please indicate that your organization would agree to this condition.

KEPRO RESPONSE:

KEPRO agrees to the routine audit provisions outlined in 3.9.5.

3.10 REVIEWED CASES

For the time period of July 1, 2012, through June 30, 2013, the current UM vendor provided the review services for PEBP as detailed in ***Attachment L – UM-CM Vendor Report Format***.

KEPRO RESPONSE:

KEPRO has read, understands and acknowledges the current vendors report format provided in Attachment L.

3.11 CARE COORDINATION

3.11.1 Case Management and Large Case Management

Case management is a collaborative process which assesses plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs through communication and available resources to promote quality and cost-effective outcomes.

3.11.1.1 How long has your organization provided case management services?

KEPRO RESPONSE:

KEPRO has been providing case management services for ten (10) years. Our case management services are designed with flexibility in mind to meet the specific needs of our clients. Our scope includes care coordination, general (short term/episodic) case management; care transition management, and large/complex case management. We have been URAC accredited for CM since 2007.

3.11.1.2 What location will house the staff (including nurses) that will be responsible for PEBP's case management?

KEPRO RESPONSE:

KEPRO will maintain a local presence in Nevada to support the Account Manager, Medical Director, and primary Registered Nurses responsible for overseeing utilization and case management services. We believe this presence is necessary to facilitate communications with PEBP staff and Nevada-based providers, and to maintain a Nevada-specific perspective on regional health care and regulatory requirements.

Additional Nurse utilization and case managers and non-clinical support staff will be located in our Orlando, Florida office which serves as base for all of our case management services. This allows us to designate experienced utilization and case management staff to this account and provide back-up services when designated case management and non-clinical support staff are out of the office. It also facilitates coordination with other clinical specialists on our case management team who support our primary case managers.

3.11.1.3 Does your organization provide telephonic case management services, onsite case management, or a combination of both?

KEPRO RESPONSE:

Our program primarily incorporates telephonic case management services. Telephonic interventions are augmented with electronic communications and web-based educational modules and tools via the secure member portal. For those without Internet access, we augment telephonic interventions with written materials.

On-site services in the member's home (or medical facility if that is the member's current location) may be provided in certain circumstances. For example, when the member's condition is so complex or cultural or psychosocial issues impede a thorough assessment, on-site services may be provided.

We also have the capability of expanding on-site services to the member and/or locating case managers in the physician's office if PEBP prefers this model.

3.11.1.4 Please describe in detail your organization's criteria for general case management services. Examples of general case management instances are provided below. The following information should be included as an attachment to your proposal:

KEPRO RESPONSE:

Members who qualify for general case management are relatively stable. They are able to effectively self-manage their condition and comply with their treatment plans all or most of the time. Their immediate care coordination needs are short term and require minimal interventions. Enrollment in general case management averages about 30 days. If a member requires longer term, more complex interventions they may be transitioned into the large case management program.

General case management services focus on conditions/care needs that require short term care coordination activities to facilitate transition from one level of care to another. This transition may be from one inpatient facility to another inpatient facility or outpatient facility or transition to home (with or without continued outpatient services). No or poor communications and care coordination during this transition significantly contributes to gaps in care which leads to avoidable use of health care resources such as emergency department visits or readmissions. We evaluate all inpatient admissions (acute, skilled nursing, rehabilitation, behavioral health facilities), regardless of diagnosis, to assess the member's transition risk; we outreach to all members who may benefit from care transition interventions. Members targeted include, but are not limited to, those with:

- ***Polypharmacy***
- ***Multiple providers (uncoordinated care)***
- ***Multiple follow up appointments***
- ***Home Health services***
- ***Durable medical equipment requirements***
- ***Home modifications needs***
- ***Cultural beliefs that may impact compliance***
- ***Low - moderate health literacy gaps***
- ***Other care needs identified through the discharge planning process***

Utilization management activities are the primary mechanism to identify potential candidates for general case management. Our proprietary system has criteria logic programmed to auto-generate a referral to general case management based on diagnosis and/or requested services. If the member is not system referred, the utilization management nurse may generate a referral if changes in the member's condition now indicate need for general case management.

Utilization management is not the only source of identification for general case management. Many conditions are treated in an outpatient setting and do not require prior authorization. Some members may need help with access to care so they can be treated. Member self-referrals, provider referrals, or referrals from other programs are an excellent identification source. Members may have some of the same needs as listed above or fall into one of the categories below:

- ***Need assistance with locating in-network, quality care providers/transitioning from out of network to in-network providers***
- ***Minimal support needs that may require coordinating with community resources***
- ***Hospice coordination***
- ***Newly diagnosed, stable condition; member requires initial education and assistance with developing a self-management plan***

This criterion is not all inclusive. Most short term care coordination efforts that return members to a stable health status are considered for general case management services.

A. Opportunities to transfer patients to facilities offering an appropriate level of care more cost effectively;

KEPRO RESPONSE:

Opportunities to transfer patients to facilities offering an appropriate level of care most cost effectively are typically identified through the prior authorization process. When a criterion, such as InterQual or MCG (formally Milliman USA Guidelines) indicates that quality, safe care may be provided at a lower level of care, the case is flagged for general case management intervention – Skilled Nursing Facility or Home Health rather than an inpatient admission for wound care as an example. Case managers coordinate with the physician and the member to discuss alternate level of care options. If the physician and member agree to the alternate level of care, the case manager identifies an in-network service provider and coordinates services as necessary.

More cost effective alternate levels of care are not always associated with a lower level of care. When benefit plans offer tiered provider networks, it may be necessary to coordinate with the member to find an appropriate tiered provider that can deliver the same quality care more cost effectively. An easy example is assisting the member in locating Centers of Excellence that provide needed services at a lower rate.

B. Meeting durable medical equipment needs;

KEPRO RESPONSE:

The cost of rental versus purchase is always considered when addressing DME needs – which includes evaluating the length of time the member will need the equipment, equipment maintenance, and the life expectancy of the equipment.

We locate an in-network DME provider near the member's home and arrange for pick up or delivery depending on the equipment and the member's capabilities. If the member is being discharged to home, ideally, the equipment should be delivered prior to the member's discharge. If this is not feasible, then delivery should be arranged for the day of discharge. If it's a piece of equipment that

will be returned to the DME provider, we also arrange for pick up when the member no longer needs the DME.

We also assess the member's ability to use the equipment and arrange for either the hospital staff to educate the member prior to discharge or for the DME vendor to educate the member and family/care giver when the equipment is delivered.

We follow up to ensure the equipment was delivered, that it is in good working order, and that the member is able to use it properly.

C. Planning for hospital discharges;

KEPRO RESPONSE:

Discharge planning starts when we receive the prior authorization request. Each member is evaluated for discharge planning needs. Members with moderate to complex discharge planning needs are referred to general case management for intervention. Please refer to our response to section 3.11.1.15 for detailed discussion of our discharge planning process.

D. Coordinating home health care needs;

KEPRO RESPONSE:

One of the first things to evaluate when home health is ordered is whether the member or family/care giver can be educated to provide the care safely and effectively. If so, we immediately coordinate resources to begin educating the member/family. Teach back methods work well in determining their understanding and capabilities.

If the member/family/care giver cannot provider the care; or the care requires professional clinical intervention, we identify an in-network home health agency close to the member's home and coordinate with them to deliver the required services. We provide the member with the name and contact information of the agency and information as to when and how often they will be in the member's home, how long they will be there, and what they will do when they arrive. .
We follow up with the member to ensure the home health services are being provided and that they are effective. We may also validate the member's progress with the agency. We continue to monitor the member's progress to ensure services are discontinued when the member's goals are met. If the member is not progressing along the care continuum, we coordinate with the member's physician to determine if a different course of care is required.

E. Coordinating hospice care; and

KEPRO RESPONSE:

Members with a terminal prognosis who have made their end of life decisions and communicated them to their family may just need assistance in locating an in-network hospice in their area. We ensure the member/family understands the role of hospice, what hospice includes/doesn't include, and that the hospice case manager will assume responsibility for their care needs. We coordinate with the member's physician to determine if they are associated with a particular in-network hospice provider

and whether he/she has already referred the member to their care. We coordinate with the hospice case manager to ensure a seamless transition for the member and family. We facilitate transfer at the most appropriate time to maximize hospice benefits.

We flag the member in our system to indicate that they are a hospice patient to ensure their end of life wishes are supported when future care needs are requested.

If end of life decisions have not been made, the case manager supports the member and family (as appropriate) in addressing such sensitive topics. Depending on religious and cultural beliefs, we may refer members to appropriate clergy or community support groups; social worker consultation may also be of value. We encourage members to consider powers of attorney and advance directives; we assist members in communicating their wishes to family and care providers.

F. Coordinating community based services.

KEPRO RESPONSE:

Often members have care needs that cannot be addressed through care providers, the benefit plan structure, or other employer services (such as EAP). In these instances, we coordinate government, community, or church based services to bridge the gap. Needs may include support groups, transportation, meals on wheels, help with grocery shopping/meal preparation, or any number of similar type of services.

We identify the community support options available in close proximity to the member and discuss options with the member/family. If the member prefers, we coordinate services and provide the member with a summary of who will be providing what and when and their contact information. We follow up with the member to determine how things are going and make adjustments as necessary.

3.11.1.5 Please describe in detail your organization's criteria for large case management. This information should be included as an attachment to your proposal. Examples of potential large case management instances are provided below:

KEPRO RESPONSE:

Members who qualify for large case management have complex needs that require longer term, more intense interventions. They may have unstable conditions that require long term treatment and/or may require extensive support to obtain the skills, knowledge, and abilities to self-manage their condition. Often barriers to treatment plan compliance exist that the member in unable to overcome. Enrollment in large case management exceeds 30 days and can be as long as 4 – 6 months. Members with catastrophic illness or injury, that requires long term treatment, may face benefit coverage challenges. Patient care conferences that include representatives from PEBP's benefits office may be required to determine how the benefit design supports the member's long term care needs. Case managers evaluate and address alternatives to benefit coverage as necessary to ensure un-interrupted care and support for the member.

Embedded within our medical management system are triggers that identify covered persons as potentially requiring large case management interventions. These triggers are comprised of ICD-9's and ICD-10's that have been identified as potential/actual catastrophic diagnoses or other factors requiring long term case management. These include but are not limited to:

- ***Repeated/frequent inpatient admissions, excessive length of stays***
- ***High-dollar claims***
- ***Skilled Nursing Facility or inpatient rehabilitation (acute/sub-acute)***
- ***Long term physical, occupational or speech therapy***
- ***Transplant cases***
- ***Catastrophic conditions***
- ***Complex/multiple diagnoses***
- ***Prolonged/severe illness and injuries, including chronic and progressive disease***
- ***Extensive discharge planning requirements***
- ***Cases that do not meet any of the above criteria but are of such intensity that they warrant clinical management and scrutiny e.g., a case that is a limitation/exclusion to the plan that has developed a complication, and the complication is covered by the plan.***
- ***Long term need for high dollar DME***
- ***High dollar pharmaceuticals***

Specific diagnosis triggers include, but may not be limited to, the following:

• *AIDS*	• *Huntington's disease*
• *Alzheimer's*	• *Leukemia*
• *ALS*	• *Liver Disease*
• *Bleeding disorders*	• *Cancer*
• *Brain tumor*	• *Multiple sclerosis*
• *CVA*	• *Muscular Dystrophy*
• *Cerebral hemorrhage*	• *Osteomyelitis*
• *Cerebral palsy*	• *Parkinson's Disease*
• *COPD*	• *Respiratory dependency*
• *Heart Failure*	• *Scleroderma*
• *Chronic Renal Failure*	• *Sickle cell anemia*
• *Cystic Fibrosis*	• *Spina bifida*
• *Diabetes*	• *Tuberculosis*
• *Failure to thrive*	• *Lupus Erythematosus*
• *Guillian-Barre*	• *Crohn's Disease*
• *Head injury/traumatic brain injury*	• *Knee/Hip Replacement*
• *High-Risk Pregnancy*	• *CABG (Coronary Artery Bypass Grafting)*
• *Hip fracture*	

The triggers for potential large case management were developed through combined efforts of our Chief Medical Officer, medical directors, clients, and reinsurers. The system's flexibility allows us to customize this trigger list to meet the specific requirements of our clients. During the implementation phase, we will work with PEBP to ensure the customized trigger list identifies covered members according to the plan document and existing medical claims cost drivers.

The prior authorization process is not the only source of identifying members for large case management. Direct referrals from other programs such as Disease Management, Employee Assistance Program, and other vendors are an important part of total integration. We have also set up relationship with high volume physicians and provider s that allows them to directly refer members to our programs.

A. Repeated in-patient admissions, excessive length of stay, or frequent treatment;

KEPRO RESPONSE:

Repeated admissions and frequent treatments may be an indication of poorly managed conditions – which may be a result of physician non-compliance with evidenced based practice guidelines or member non-compliance with prescribed treatment plans and/or lack of knowledge required to effectively manage their existing conditions. They may also be related to care required to treat a complex condition – a serious injury requiring multiple surgeries as an example.

Regardless of the reason, each triggers for large case management as does excessive length of stay which may indicate a catastrophic illness or injury that requires monitoring to ensure the member progresses along the care continuum and that he/she is moved to alternate levels of care appropriately. The case manager assesses each case to determine the underlying cause of the problem and develops an applicable case management plan of care.

B. Potentially large-dollar claims;

KEPRO RESPONSE:

Members trigger for large case management because they have an actual large-dollar claim or, based on our predictive model, have the potential to generate a large-dollar claim. The goal in this instance is to intervene early enough to avoid/control costs. A comprehensive assessment is completed to determine the potential/actual issues driving cost; a case management plan of care is created in coordination with the member, their family/care giver, and physician(s) that systematically address each issue.

C. Chronic or progressive disease;

KEPRO RESPONSE:

Chronic conditions, for the most part, cannot be cured but they can be controlled. Members with chronic disease must learn to adjust their lifestyle and health habits to prevent the complications that will, over time, lead to a progression of the disease that decreases the member's quality of life and

increases the use of health care resources. A diagnosis of a chronic condition in and of itself does not necessarily require large case management. Claims analysis tells us if the disease is well controlled, whether gaps in care exist, and if the physician is following evidenced based practice guidelines. Poor control is definitely a trigger for large case management.

As indicated above, progressive disease may be an indication of poor control related to physician non-compliance with evidenced based practice and/or member non-compliance and poor self-management. In any event, large case management is warranted. Progressive disease may also indicate a need for end of life and palliative care decisions. Depending on the member's prognosis, the case manager introduces end of life discussions at the appropriate time to assist the member and family in dealing with these sensitive decisions.

D. Lack of qualified care-givers in the home setting;

KEPRO RESPONSE:

Lack of qualified care givers in the home may warrant a referral to general or large case management depending on the reason the member requires a care giver and the solution to the problem. Case managers determine if care giver support is long or short term and, if family/care givers are available, what coordination is required to resolve the issue – moving the member to the care giver's location as an example.

When family members are not available, willing, or able and the member requires long term support, obviously a long term solution is required. All options are evaluated such as capable and willing friend of the member, home health aide coverage, church or community resources, or even government programs such as Medicaid (assuming the member meets eligibility requirements).

E. Multiple diagnoses;

KEPRO RESPONSE:

Members with multiple diagnoses are frequently receiving care from multiple providers and, more often than not, the care is not coordinated. The potential for quality of care concerns and over-utilization of health care resources exist. Members may be receiving duplicate medications or medications that are contraindicated for one of the other conditions. Members may not understand which condition is causing their complications and see more than one of their physicians to address their signs/symptoms.

The goal of large case management is to ensure the member has a primary care physician/medical home that takes responsibility for all of the member's co-morbidities. If specialty care is required, the medical home coordinates the member's care with the specialist to ensure totally integrated treatment plan.

The member's health literacy relative to each condition is assessed – to include the reactions/interactions of each condition. Case managers facilitate the development of an integrated self-management plan that enables the member to respond appropriately to avoid complications of each condition.

F. Acute or subacute rehabilitation of physical, speech, or occupational therapies which exceed three (3) months of treatment;

KEPRO RESPONSE:

When members require physical, occupational, or speech therapy for longer than three months, the primary focus must be on ensuring the therapy is having an impact; that the member is progressively regaining functionality.

Case managers start by coordinating with the member's physician to understand the member's prognosis and the expected level of recovery. Each interaction with the member and the therapy team is an opportunity to measure the member's progress and ensure the therapy plan is adjusted accordingly as the member improves. The therapy plan should include the projected time when the member can be moved to an alternate level of rehabilitation and ultimately to home rehabilitation with follow up appointments to measure continued progress.

Home modifications and/or DME support – short or long term – are considered and coordinated based on the member's expected level of recovery.

G. IV therapy or parenteral nutrition;

KEPRO RESPONSE:

As with therapies, the case manager coordinates with the member's physician to understand the plan of care and determine the expected length of treatment. While IV therapy normally has an end point, parenteral nutrition may be an on-going treatment. The case manager coordinates with the member, their family, and the member's physician to ensure the most appropriate, cost effective level of care consistent with InterQual or MCG guidelines. If home treatments are an option and can be done by a lay person, the case manager will facilitate educational sessions for the care giver with teach-back verification of their understanding and abilities. As with any long term care, the case manager continues to monitor treatments to ensure its effectiveness. When the situation is stable and no direct case management interventions are required, the member may be discharged from active management and placed in a monitoring status. The case manager will periodically call the member/care giver to verify their status.

H. Severe injuries; and

KEPRO RESPONSE:

Severe injuries often require long term care from multiple providers – both inpatient and outpatient. The same type of situations may occur as described under paragraph E. (Multiple diagnoses) above. If a primary care provider/medical home doesn't exist, the case manager coordinates with each provider to determine who will take primary responsibility for coordinating the member's care. Normally inpatient care is relatively coordinated; issues have a greater chance of occurring once the member moves to outpatient services. The primary physician should be identified and an integrated treatment plan created prior to the member's discharge.

If members have suffered cognitive impairment, case manager's work with the family/care giver designated as having medical power of attorney to address the member's care and support needs. In most situations of severe injury, the family will need case management intervention to cope with the short and long term impact of the member's injury.

The primary care physician should be responsible for coordinating an integrated medical treatment plan for the member that includes the member's prognosis. The case manager uses this treatment plan to assist the member/care giver in projecting current and future health care support needs and goals – both long and short term. This may include home modifications, job retraining, DME, and other long term support.

I. Non-compliance with medical treatment plan as prescribed by physician or other health care provider.

KEPRO RESPONSE:

Frequent admissions, use of the emergency department, and evidence of gaps in care may be an indication of non-compliance with medical treatment plans which most certainly requires a referral to large case management. Please see our response to section 3.11.1.7 which incorporates our approach to non-compliant members.

3.11.1.6 Does your organization allow self-referrals for large case management? Will your organization allow PEBP to refer covered individuals for large case management? These services shall be provided at no additional cost.

KEPRO RESPONSE:

We incorporate a variety of mechanisms to identify members for potential case management – all of which are included at no additional cost. Additional fees may apply if PEBP requires customized communications beyond what we mention below.

Referral sources may include medical and pharmacy claims analysis, referrals from other programs such as the PEBP Live Well, Be Well (Wellness and Disease Management), referrals from HealthSCOPE Benefits, or direct referrals from PEBP. Referrals can be made by phone, secure fax, secure email, or any other mechanism convenient for the referring entity. We work with each entity during implementation to establish an efficient referral process.

The ideal source of identification though are member self-referrals, provider referrals, and referrals from the Utilization Management process as these have a tendency to occur in "real time" – meaning members self-refer or are referred at the point of service/diagnosis that signals the need for case management services. This allows for timely case management intervention to immediately begin addressing the identified health care issues.

Our utilization management system has triggers built-in that will "auto-refer" members for case management. A case management case is automatically initiated and placed in the case management

department's work queue to initiate outreach and assessment efforts. This case management trigger logic can be customized to ensure your members are appropriately referred based on requirements in the Master Plan Document.

To facilitate provider and member self-referrals, we work with PEBP staff to develop a clear communications strategy to promote program awareness. We use mail, email, office/break room posters, and other mechanisms to market the program – all branded with the PEBP logo and text. We are experienced at assisting our clients in developing an awareness campaign that is best suited to your population. And, given the diversity of your population, you may require different strategies for the State and Non-state active and retiree populations.

3.11.1.7 Please describe your organization's philosophy regarding large case management. For example, is the goal of your organization to assist with restoration of the patient health and function, management of outcomes, and prevention of primary and secondary complications? Please describe your organization's philosophy in detail, explaining how your organization maintains its philosophy and achieves maximum outcomes for complicated large cases.

KEPRO RESPONSE:

Our Philosophy

KEPRO's philosophy regarding large case management is based on the theory of self-care (self-management) and compliance. Each individual has the ability to perform self-care and is responsible for their health as well as the health of their dependents. Self-care is the activities that individuals perform on their own behalf to maintain life, health, and well-being and to recover from disease or injury, or cope with the effects of the disease or injury. A self-care deficit exists when the patient or family member is not able to provide care for him/herself; case management's goal then is to overcome these deficits and/or coordinate services to compensate. This philosophy reinforces the member responsibilities listed in the Nevada PEBP 2013 Master Plan Document, page v – vi; specifically:

- ***"You have the responsibility to take personal responsibility for your overall health by adhering to healthy lifestyle choices. Understand that you are solely responsible for the consequences of unhealthy lifestyle choices."***
- ***"Follow your physicians recommended treatment plan and ask questions if you do not fully understand your treatment plan and what is expected of you."***

Non-compliance with prescribed treatment plans drives a significantly high percentage of avoidable health care cost. Non-compliance with treatment plans causes:

- ***33– 69 percent of all medication-related admissions in the US at a cost of $100 billion***
- ***Three times as many doctor visits and $2,000 per year in additional costs compared to patients who follow their treatment plan***
- ***10 – 25 percent of hospital and nursing home admissions, resulting in 340 deaths per day***

Medication non-adherence costs alone are estimated at $290 billion avoidable medical spending in the United States each year.

Members who comply with treatment plans are able to effectively self-manage their condition(s) and live healthier lifestyles. They are able to prevent primary and secondary complications which normally results in fewer, if any, episodes of avoidable use of health care resources – such as emergency department visits and acute hospitalizations. Members who are able to self-care and comply are able to effectively restore their health and functionality to the greatest extent possible (based on their prognosis) and are more productive in their work and daily lives. Their overall quality of life and behavioral health is enhanced. What does this mean to you? The PEBP benefits from a healthier population by realizing a decrease in absenteeism, more productive employees, and a decrease in medical cost trends.

Our philosophy of self-care and compliance drives our primary goals of empowering members to take control of their health, adopt effective self-management plans, and work more collaboratively with their physician(s) and other health care providers – which are also in line with PEBP member responsibilities. We accomplish our goals by working collaboratively with members and their physician(s) to increase the member's health literacy, remove barriers to compliance, and help develop his/her self-management plan.

Maintaining the Philosophy

Each step of our care management process maintains focus on ensuring the member has all of the skills, knowledge and tools necessary to support their self-care – starting with the initial assessments completed when members consent to participate in the program. Using our own proprietary medical management system allows us to customize assessments to support our philosophy and case management goals. Our assessments serve multiple purposes. Not only do they capture information about the member's general and condition specific health, they also:

- ***Determine if prescribed treatment plans are evidenced based***
- ***Identify barriers to compliance***
- ***Evaluate the member's health literacy relative to their conditions***
- ***Identify self-care deficits***
- ***Target areas that require direct case management intervention on behalf of the member (such as care coordination of resources)***

The results of this assessment generate a member-specific case management plan which includes the member's health care goals. Prior to finalizing the plan, we coordinate with the member's physician(s) and family/care giver as appropriate, to ensure we have a complete perspective on the member's health status. The resulting care plan documents the type and frequency of interventions required to remove barriers to self-care and compliance. We also identify who is responsible for the interventions/actions – especially when the member's condition requires short or long term assistance with self-care. During each interface with the member, the case manager evaluates the progress made towards self-care and compliance; the plan is adjusted as necessary to ensure the desired outcomes of the program are realized.

To facilitate self-care, the case manager acts as a "coach" in many instances – empowering the member to "take charge" of their health and work collaboratively with their physicians. Adjustments are made to the member's self-management plan when certain aspects are not effective. Through "teach back" methodology, the case manager determines the member's understanding of the potential

complications of their condition, how to avoid them through compliance with their treatment and self-management plan, and the appropriate course of action should they occur.

The case manager supports the member (family, and caregiver), follows up to determine what, if any, assistance they need, and intervenes on their behalf when required. As an example, members with long term rehabilitation needs may require assistance until such time they are able to function independently. The case manager coordinates with the family and/or care giver to determine their ability and availability to provide assistance. If family or care givers are not available, the case manager coordinates with the member's physician for other health care provider support (such as home health aides) or refers the member to community resources depending on benefit plan coverage and availability of community resources.

All interventions and progress towards realizing the member's goals are documented in the member's case in Atrezzo. Once all goals are met, the case manager completes a final assessment of the member's ability to comply and self-manage before they are discharged from the program.

Achieving Maximum Outcomes

We start with desired outcomes in mind when creating our programs and services. In the instance of case management, the desired outcomes are decreasing avoidable use of health care resources (which decreases medical cost trends) and maximizing the quality of life and behavioral health of members.

As stated earlier, treatment plan compliance is vital to realizing these outcomes. Our case management interventions are designed to empower members to work more collaboratively with their physician, take a proactive role in managing their health, and create and follow effective self-management plans. We track and trend our ability to realize these outcomes.

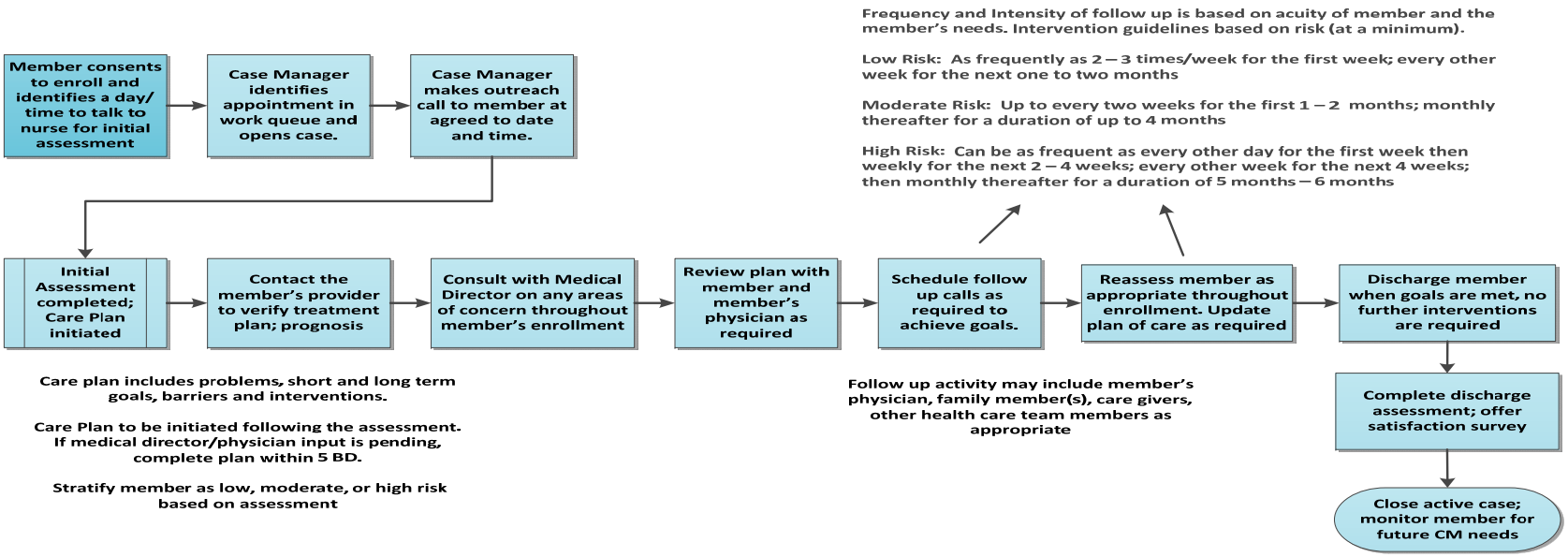
- ***We analyze claims data to track medical cost trends and a decrease in gaps in care for those enrolled in the program.***
- ***We assess member's quality of life (using the SF12) and behavioral health (using the PHQ9) at time of enrollment and at discharge and report on the member's perceived improvement in their status.***
- ***We assess the member's improve ability to comply with their prescribed treatment plan and self-manage their condition (self-reported data plus evidence in a decrease in medical costs and gaps in care).***
- ***We assess the member's overall satisfaction with the program and it' ability to support their health goals***

To date, we have realized up to a 5:1 ROI for our clients and an average of 90% compliance with treatment plans and self-care.

A high level workflow that represents the assessment and intervention phase of our large case management process is below in figure 15.

Figure 13.

Complex/Large Case Management - Assessment and Interventions



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3.11.1.8 Please describe in detail how your organization coordinates transplant cases. This information should be provided as an attachment to your proposal.

KEPRO RESPONSE:

Our standard process for coordinating transplant cases is summarized below. We will review this in more detail with PEBP during implementation and customize as necessary to mirror your existing solution.

Transplant cases are normally identified through the utilization management process when our customer service representatives receive a call or web portal request to prior authorize a transplant. Once the transplant is approved as medically necessary (which includes verification of benefits), the member is referred to large case management.

One of the first actions of the case manager is to ensure the COE contract is executed. Depending on the client's preference, our case managers may coordinate directly with the COE facility or with another entity that has responsibility for the COE network. It is our understanding that the third party administrator, HealthSCOPE Benefits, is responsible for coordinating the transplant services with the COE facility. We will work with PEBP and HealthSCOPE Benefits during implementation to determine how our case managers can best support this phase of the transplant process.

Once the contract is finalized, the case manager works with the member and family on a number of interventions designed to ensure a successful transplant. These interventions include, but are not limited to:

- ***Educating on the contract to ensure members and family understand the scope of services that are included such as pre and post op care, transportation and hotel accommodations (if travel is required), etc.***
- ***Supporting the member with pre-transplant compliance to ensure he/she remains transplant eligible***
- ***Educating on what to expect pre and post-transplant – both immediately following and long term post-transplant***
- ***Assisting the member in drafting a self-management plan that can be adjusted as the member becomes more knowledgeable about their condition post-transplant***
- ***Coordinating with the COE and member as required and appropriate***
- ***Supporting family in completing any home modifications that may be required to support the member immediately post-op***

As the member moves closer to the actual transplant, our case manager calls the transplant case manager to summarize the member's history and current status. He/she then "warm transfers" the member to the COE case manager by coordinating an introductory conference call with the COE case manager and the member and their family. The COE is responsible for coordinating services during the transplant phase.

KEPRO's case manager stays abreast of the member's condition by coordinating with the COE case manager on a regular basis. He/she resumes responsibility for managing the member once COE contract coverage is exhausted. The member remains in active in KEPRO's large case management program until they are able to effectively manage their own condition and have shown the ability to comply with their treatment plan most – if not all – of the time. The member is discharged from active management and may be placed in a monitoring status for periodic follow up.

3.11.1.9 PEBP's third party administrator coordinates transplant services with recognized Centers of Excellence. Does your organization work with a Centers of Excellence referral program? Will your organization agree to work in cooperation with PEBP's third party administrator assisting the participants who require care at a Center of Excellence?

KEPRO RESPONSE:

KEPRO does not work with a specific Centers of Excellence (COE) referral program. However, we integrate with the COE network as offered by the each benefit plan as part of our care planning process. We will work in cooperation with PEBP's third party administrator to assist participants who require COE care.

It is our understanding (per Amendment 2 of this Request for Proposal) that requests for transplant services will typically come through the utilization management process. Once determined to be medically necessary, our case manager will coordinate with the third party administrator, who will then coordinate with the COE to ensure contracts are signed between the COE entity and the member. If the third party administrator prefers, our case manager will coordinate directly with the COE.

3.11.1.10 For an account the size of PEBP, how many covered individuals would your organization expect to meet large case management criteria?

KEPRO RESPONSE:

Across our book of business, approximately 1-2% of the overall membership meets criteria for large case management. This represents the top tier of utilization, usually those members most in need of intervention. We assume similar benchmarks for PEBP; however if we receive claims data we can provide a more detailed estimate.

3.11.1.11 Please describe in detail how your organization's case managers would interact with patients, patients' families, and PEBP.

KEPRO RESPONSE:

Regardless of the reason the member was targeted for case management – chronic or progressive disease, multiple diagnoses, lengthy rehabilitation, severe injuries, non-compliance, or other reasons – the basic approach is the same. The method, frequency, and type of interaction with members and their families are driven by the member's risk, the number and complexity of their health care goals,

and the member's ability to complete tasks on their own. The frequency of interactions may be as often as a couple of times a day to as little as once/month depending on the member's needs and goals. How much the case manager does on the member's behalf versus coaching the member to do independently will depend on where the member is along the self-care continuum. The nurse may intervene directly more often during the initial stages of enrollment and slowly transition responsibilities to the member as they progress along their self-care goals.

The methods of interactions are multi-faceted and include:

- ***Telephonic interactions as our primary method of interacting with patients and families.***
- ***Written materials may be sent to the member at various intervals throughout their enrollment in the program. Written materials may include enrollment letters, welcome packets, program brochures, and educational materials.***
- ***Secure member portal offers the member educational materials, surveys, learning quizzes, tracking tools, exercise modules, and nutritional planning. The member portal also provides the patient and case manager an opportunity to communicate electronically.***
- ***On-site at the member's home or health care facility in rare situations where the members condition is so complex and/or their cultural/psychosocial issues are hinder the ability to complete an accurate assessment.***

The case manager primarily interacts with the member unless their condition is such that they are not capable of making decisions on their own. In this scenario, the case manager works with the family/care giver designated as being responsible for the member's care.

In instances where the member's condition and support needs require family participation, the case manager suggests, and then obtains the member's permission to include designated family members in the case management process. (Permission is necessary to honor the member's right to confidentiality of PHI.) We do encounter situations where the member defers all care decisions to a spouse or adult son/daughter and prefers that we work directly with him/her in managing the member's health care needs.

We also work directly with all family members, as necessary, to address their own needs relative to the member's current health status. As an example, when a member is diagnosed with cancer, the family more often than not needs help in dealing with this diagnosis and the impact it has on the family. This is most evident if the member has a terminal diagnosis and end-of-life considerations must be addressed. We may intervene directly and/or refer family members to other resources such as Employee Assistance Programs, community support groups, church groups, or other health care professionals.

The first case manager interaction with the member/family is the initial assessment. As a result of this assessment, a problem list and corresponding case management plan is initiated. Reinforcing our goal of empowering members to take control of their health, the case manager coaches the member/family in prioritizing the problems so as not to be overwhelmed by trying to address everything at once. As problems are resolved and goals met, remaining problems will be activated and added to the plan.

Interventions designed to resolve the problem and achieve goals are discussed and timelines for each are identified. To the greatest extent possible, the case manager supports the member/family in taking

action themselves. As examples: suggesting that they call their primary care physician as soon as possible to tell them about side effects they are having from their medication or coaching them on the types of questions to ask the physician during the next appointment. The case manager will follow up with the member/family to ensure they called their physician and that they asked questions during their last appointment. The case manager will also determine if the member/family understands the responses from the physician and provide further education with "teach back" scenarios to ensure they understand and can apply principles to self-management.

Significant emphasis is placed on behavioral modification (when existing behaviors are negatively impacting the member's ability to comply with treatment plans) and increasing the health literacy of members and families. Education is at the core of most interactions. The case manager will educate directly and also refer the member/family to the portal for more detailed information; the next session focuses on member/family "teach back" to show their understanding. The case manager monitors the member's actions to see how well they are incorporating what they learned into their self-management plan. Monitoring also includes checking the on-line classes suggested to see if they were completed or if the member is tracking important information such as weight for those with congestive heart failure or glucose for diabetics.

Often the case manager completes actions on behalf of the member such as finding community resources to support needs such as transportation to appointments or support groups for members/families with chronic or progressive disease. The case manager may call the member's physician directly, even though they instructed the member call, to ensure the member talked with their physician. An example is notifying the physician that the member is not taking their medications because they don't like the side effect. The case manager will determine if the physician can order an effective substitute medication without side effects to ensure the member complies with their prescribed medication plan.

The case manager's interactions become less frequent as:

- ***The member/family is complying with their prescribed treatment plan***
- ***The member/family has developed and is following an effective self-management plan***
- ***Resources are in place to allow the member to self-manage (such as DME or home modifications)***
- ***Support resources are arranged and effectively compensate for gaps in self-care – such as home aide or community support for members without adequate family/care giver support***

Once all goals are met, the case manager continues to monitor the member/family to ensure modified behaviors have become part of their daily routine and that they are complying with their self-management plan – which also supports compliance with their prescribed treatment plan. Members are discharged from active management and offered the opportunity to complete a satisfaction survey that measures the member's perceived effectiveness of the program. The case manager may place a follow up call post discharge to continue to monitor the member's progress.

Please refer to section 3.11.1.12 below for a description on how our case managers will interact with PEBP staff.

3.11.1.12 Please describe in detail how your organization's case managers will interact with PEBP staff. Under what circumstances does your organization expect to interact with PEPB staff?

KEPRO RESPONSE:

KEPRO expects to interact with PEPB staff for multiple purposes throughout the life of the contract which include, but are not limited to:

Implementation

Our dedicated implementation team interacts with PEPB staff throughout the implementation – starting with a review of an extensive project plan to review the tasks, timelines, and responsible parties. Primary KEPRO contact for all implementation tasks is the account manager assigned to PEBP; other members include the operational manager responsible for day-to-day operations, analytics/reporting, and information technology, We discuss every aspect of the scope of work to include: existing processes – what's working/not working, customization, reporting (other than our recommended standard report packages), data exchange/file extracts, secure email processes, provider communications, member communications, standing meetings, other vendor interfaces, referral processes (for case management), and key contacts just to name a few topics. Weekly status meetings – if not daily in some instances –will occur between KEPRO, PEBP staff, and other vendor staff as dictated by the topic. Meetings continue after go-live to conduct an after action review and monitor operations to determine any need for adjustments.

Day to Day Operations

The KEPRO account manager and operational management staff become the primary points of contact for all contract related issues after go-live. The account manager is the primary point of contact and responsible for coordinating all aspects of the contract to include contract modifications, routine and ad hoc status meetings, action logs, data and process questions, and reports. The account manager monitors and reports on all deliverables and performance guarantees and is responsible for presenting reports along with other members of our operations team.

PEB operations staff may interface directly with our operations manager on all items related to day to day operations. This direct contact allows for timely interface with subject matter experts on the status of all case management activities. The operations manager is responsible for coordinating all operational issues/action items and coordinating and facilitating regular or ad hoc operations meetings with PEBP operations staff to ensure timely communications and data exchange.

Case managers

The extent to which our case managers will interact with PEPB staff is largely driven by PEPB's needs. Their involvement is primarily related to direct management of members enrolled in the program. They may, however, be included in discussions aimed at improving existing processes or determining the impact of potential changes.

We do attempt to limit case manager involvement in "administrative" type of meetings given their time is focused on scheduled interactions with enrolled members and their families, and physicians. We establish standard/custom reports during implementation that ensure you receive the required

information relative to enrolled members. However, case managers are included in all member-specific discussions to ensure the most detailed, up-to-date information is presented. These discussions may include (but are not limited to):

- ***Verifying patient eligibility and benefits. If the referred member is not listed in the eligibility files, our case management department contacts PEBP to verify eligibility (often we are referred to the Third Party Administrator's customer service department to verify eligibility). And, if the case manager has questions about the benefit plan design, he/she contacts PEBP benefits office for an interpretation.***
- ***Patient care conferences: Members with complex, long term care needs may warrant a patient care conference to discuss the member's prognosis, expected treatment plan, and benefit plan implications. If the plan allows "flexing benefits", those options may be discussed here. Patient care conferences allow for long term benefit planning ensuring the member has access to appropriate, quality care within benefit plan design. It also allows PEBP to project long term implications as required.***
- ***Air transport: Members may be away from home when care needs are identified – such as a severe injury. Care may/may not be provided by network providers; air transport may be required to return the member to network providers and/or the member's home environment where family/community resources are available to assist with their care.***
- ***Stop Loss Updates: Case summaries, as part of our standard report package, are prepared monthly. We understand that stop loss carriers may require updates before the case summaries are prepared. Case managers are available to discuss the most current status with PEBP and/or stop loss carrier staff.***
- ***Quality of care concerns: Case managers may identify quality of care concerns and/or fraud and abuse. This information is documented and forwarded to PEBP staff per processes determined during implementation.***
- ***Member or provider complaints: Complaints that members may have about their provider or care access and complaints members or providers may have about PEBP policy and procedures are forward to the appropriate PEBP staff.***

Policy meetings: Case managers may attend PEBP policy planning meetings to provide subject matter expertise.

3.11.1.13 Please describe in detail the qualifications that your organization requires of your case managers.

KEPRO RESPONSE:

We apply rigorous standards to the education and experience of our clinical staff. Our case managers are registered nurses with an active, unrestricted nursing license consistent with the requirements of the state issuing their license. They must have five or more years of directly related experience, including at least three years of acute clinical nursing experience plus case management experience. Many of our case managers have a BSN or related degree and advanced certification such as Certified Case Manager (CCM). RNs that don't possess advanced certification at the time they are hired must obtain it within two years of hire as a condition of employment.

Our case managers use critical thinking and apply sound clinical judgment and assessment skills when assisting members with case management needs. They also possess excellent interpersonal skills and build a one-to-one relationship with the member that fosters trust. Strong negotiation and time management skills are key to the role, as are computer, and web-based knowledge. Case managers are experienced clinicians who prioritize their case loads to ensure each member receives appropriate interventions designed to successfully meet their goals.

3.11.1.14 What is your ratio of licensed staff to total covered lives?

KEPRO RESPONSE:

KEPRO determines case management staffing needs after completing a claims analysis that identifies the prevalence of risk and the percent of the population that would benefit from case management. The average case load for our complex case management staff ranges from 50 – 65 depending on the severity mix of the cases assigned to the case manager. While the ratio of case managers to covered lives can vary depending on the demographics, utilization history, and risk factors of the population, KEPRO's ratio of case managers to covered member lives is currently 1:20,000.

3.11.1.15 At what point during a hospital admission is discharge planning initiated? Please describe your organization's involvement with hospital discharge planning.

KEPRO RESPONSE:

Discharge planning starts when the request for authorization is received. The utilization management nurse will determine the extent of discharge planning, potential/actual services required post discharge, and whether any interventions can be completed prior to admission (for scheduled admissions). The nurse reviewer works in conjunction with the member, the member's family/care givers, member's provider(s), hospital discharge planning staff, and other health care providers as appropriate to ensure timely transfer from one level of care to another.

Discharge planning needs are assessed with each interaction the nurse reviewer has with the utilization management department. Members can be admitted with no or minimal projected discharge planning needs however, change in the member's health status during the admission can generate the need for more complex discharge planning. One of the most important elements of our discharge planning process is the capability to make real-time referrals to case management. Because we start discharge planning early in the process, member needs for more intense discharge planning can be identified and the member can be referred to case management. Case management interventions with the member and family can begin before the member is discharged.

Overarching goal of discharge planning is to ensure the member is transitioned to the most appropriate level of care based on health status and care needs – to include transition to home. This also includes ensuring the member is not discharged prematurely which often results in readmissions within 30 days of discharge. Another integral goal is to reduce/avoid complications that result in avoidable use of health care resources – such as emergency department visits or re-admissions. This care transition is an excellent opportunity to reconcile medications and coordinate communications between health care providers to avoid gaps in care.

Typically, KEPRO works closely with the facility utilization management department and treating providers to coordinate discharge planning. In some instances, where discharge planning presents unique or challenging circumstances and/or requires the participation of the member, the case manager may contact the member or the member's family, directly to ensure they understand the discharge plan and have the skills, knowledge, and abilities to comply. Any self-care deficits, compliance issues, and care gaps are identified prior to discharge and a plan to address each issue is developed in conjunction with the member and their family and physician.

An integral part of discharge planning is educating the member/family and ensuring that the member can be cared for at home. The case manager assess the home environment to identify required modifications (relocating sleeping quarters to the first floor as an example) and determines the family/care giver's willingness and capability of providing required care. The case manager assists with coordinating appropriate supplies and equipment and ensures the family/care giver has the required training to deliver safe, appropriate home care.

Case managers may follow up post discharge to reinforce the discharge plans and provide support during this care transition. This follow up may last up to 30 days and just require periodic monitoring and intervention to prevent readmissions or, the member may be enrolled in large case management to assist with complex health care needs.

3.11.1.16 How does your organization calculate return on investment for case management expenses? Please provide a sample copy of your organization's return on investment report as an attachment to your proposal.

KEPRO RESPONSE:

KEPRO understands cost savings calculations in care management programs are complex and varied. KEPRO relies on industry standard methods such as those developed and published by the Care Continuum Alliance to guide cost savings and return on investment (ROI) estimates.

We use a savings methodology in which both hard and soft savings are calculated to evaluate the success of our programs. Hard savings are defined as savings derived from coordination of alternative care, reduction in the duration or level of care, and any negotiated or agreed upon reduction of provider fees. Soft savings are associated with "cost avoidance" activities that reduce utilization and are attributed to proactive education of participants and their families, resulting in behavior modification and change in lifestyle choices, as an example. Savings criteria include but may not be limited to the following:

- ***Decreased number of office visits or services***
- ***Decreased in hospital admissions and re-admissions***
- ***Reduced length of stay***
- ***Transition to lower level of care/alternate level of care***
- ***Stringent clinical management of treatment and services to ensure quality***
- ***Non-certification of unnecessary visits/services***
- ***Out-of-plan negotiation when services can be obtained at lower cost***

KEPRO evaluates the effectiveness of our program by tracking, trending, and evaluating financial, clinical and humanistic outcomes. While most programs track only financial and humanistic outcomes, we firmly believe that these do not by themselves represent the fullest indicators of whether the member's quality of life is maximized by program interventions.

As a physician-driven quality improvement and medical management organization, our corporate philosophy is to apply and disseminate knowledge to advance the quality and efficiency of healthcare delivery and patient centric health outcomes. Our care management model leverages innovative technology, data analytics, evidence-based guidelines and other resources to remove barriers to self-management, strengthen the patient-physician relationship while optimizing the care and satisfaction of members. We deliver results that significantly bend the trend of healthcare costs for your clients' entire population.

Our methodology to calculate ROI includes:

- ***Negotiated Savings: Savings through re-pricing or alternative arrangements for services***
- ***Hard Savings: Savings by direct intervention to obtain same or equivalent service at lower cost without negotiation:***
  - ***Change in care setting (e.g., moving from hospital to home, hospice, clinic)***
  - ***Substitution with lower-cost, clinically-equivalent supplies, services, drugs***
  - ***Elimination of redundant or unnecessary fees***
- ***Cost Avoidance Savings: Costs avoided through direct, documented intervention:***
  - ***Reduced hospital utilization (ER and in-patient stays) through improved compliance and patient support***

Financial Outcomes

As noted, KEPRO uses a savings methodology in which both hard and soft savings are reported. Savings criteria used when factoring savings dollars include the following:

- ***Decreased number of visits or services requested***
- ***Reduced length of stay by promoting early discharge to home or less acute alternatives (where applicable)***
- ***Transition to lower level of care***
- ***Use of community resources where applicable***
- ***Suggestions and use of alternative care***
- ***Stringent clinical management of treatment and services to ensure quality***
- ***Outcomes: use of standardized clinical criteria (e.g., InterQual®)***
- ***Negotiation with provider of services***
- ***Non-certification of unnecessary visits requested***
- ***Decreased hospital re-admissions***
- ***Transition of patients to alternate/appropriate level of care such as hospice***
- ***Out-of-plan negotiation when services can be obtained at lower cost***

Clinical Outcomes

KEPRO measures outcomes that reflect our ability to remove barriers that prevent members from appropriately coordinating their own care and complying with medical treatment plans. These factors have a significant positive impact on the member's overall clinical status and quality of life, reducing

unnecessary utilization and decreasing cost for the plan. The following are examples of outcomes we track and evaluate:

- ***Care access and utilization. Our goal is to ensure every member has a medical home/care team and that the member is using this medical home on an appropriate schedule. In addition, the member must have access to appropriate specialty networks as their condition warrants***
- ***Member's compliance with a prescribed medical plan of care that they understand and adhere to. This includes complying with treatment requirements such as medications, diet, physiologic monitoring, etc.***
- ***Member's ability to maximize their activity level relative to their condition***
- ***Member's ability to maximize their behavioral health relative to their medical and mental condition***
- ***Appropriate use of hospice relative to the member's condition***
- ***Utilization related to complications of the member's condition.***

Humanistic Outcomes

Each member discharged from our case management program is provided the opportunity to complete a satisfaction survey. Survey questions are designed to determine if, as a result of their participation in the program, the member:

- ***Has a better understanding of their condition and medical treatment plan***
- ***Is better able to work with their physician(s) in coordinating their own care***
- ***Agrees that the program had a positive impact on helping to maximize their quality of life relative to their condition.***

KEPRO's Methodology to evaluate program success is bulleted below with detailed calculations documented in Attachment 2:

- ***Pre-Post Intervention***
  - ***Compares medical and pharmacy claims cost prior to the case management model with costs after program implementation to assess savings***
- ***Trend Analysis***
  - ***Project costs for members in case management programs as if they had not been managed and compare projected to actual costs to assess savings***
- ***ROI = (Negotiated Savings + Medical and RX Claims Savings)/Total Costs***

Please refer to Attachment 2 for the KEPRO return on investment report. Please note that reports are embedded throughout the narrative of this attachment.

3.11.1.7 Is your organization's case management service for behavioral health and substance abuse managed by a separate subcontracted vendor and/or provided at a different location from the location indicated in ***section 3.10.1.2***? If yes, is the case management protocol different from other general case management services? Please describe the differences, if any.

KEPRO RESPONSE:

KEPRO does not subcontract any case management services. All case management services for behavioral health and substance abuse will be managed out of the same location as indicated in section 3.10.1.2 using the same protocols and philosophy as described for general and large case management.

3.11.1.18 If your organization does not contract with a separate behavioral health and substance abuse case management vendor, please describe your organization's protocol for managing these cases, or indicate if behavioral health/substance abuse protocol is the same as for other care management services. This information may be provided as an attachment to your proposal.

KEPRO RESPONSE:

KEPRO incorporates the same general philosophy, protocols, and processes for behavioral health and substance abuse services as we do for other case management services. The goal is self-management and compliance although often members with behavioral health and substance abuse diagnoses require greater support and more intense interventions over a longer period of time – as does the family who normally need help coping with and understanding the member's behaviors. And in some instances, the member may never progress to total self-management or consistent compliance.

We complete the same general assessment, which incorporates the SF12 and PHQ9, and condition specific assessments which focus on behavioral health and substance abuse diagnoses. If the member has medical conditions, we also complete a condition specific assessment to address medical co-morbidities. All problems are reflected in an integrated, member-centric case management plan. In these instances, close coordination with all health care providers is essential to maximize quality outcomes for all conditions.

Members who are moderate or high risk and require high intensity interventions are managed by nurse case managers with behavioral health education and experience who understand the evidenced based behavioral health treatment protocols. If they have questions or concerns about the prescribed treatment protocols, they consult with the appropriate board certified Behavioral Health Specialist on our medical review panel. Closer interaction with the member's physician/health care provider is paramount to understanding the current and projected long term treatment course and options. If the member has medical co-morbidities, the behavioral health case manager may consult with one of the other case managers on our team with clinical expertise consistent with the member's medical diagnoses.

Often members with chronic or progressive conditions have behavioral health needs – mostly related to depression – which may be identified when completing the PHQ9 assessment. For this reason, all of our case managers are educated in the management of depression. Members whose behavioral health needs are low risk and secondary to their medical needs may be managed by a medical case manager. He/she consults with one of our behavioral health case managers as needed to assist the member in meeting each health care goal.

3.11.1.19 Many PEBP participants reside outside of the state of Nevada, requiring licensed case management nurses in all states where PEBP participants reside. Please indicate any state(s) in which your organization does **not** currently have a licensed case management nurse.

KEPRO RESPONSE:

KEPRO understands state licensure requirements for nurses and we currently employ nurses in 10 or more states to support our nationwide clients. Many of our nurses hold active, un-restricted licenses in multiple states. Additionally, we are very familiar with compressed/compact states which grant privileges to a nurse licensed in one of these states to practice in all compact states under that single license. Non-compact states grant reciprocity and make it easy for nurses to obtain licensure in that state. Prior to go-live, we will ensure licensure for all 50 states as required by PEBP to support participants residing in all states.

3.11.2 Pre-certification

Pre-certification is the review of "need" for an inpatient hospital admission or other specified medical services before the services are rendered by a healthcare provider. For a list of services that currently require a pre-certification, please refer to PEBP's Master Plan Document located on the PEBP website at www.pebp.state.nv.us.

KEPRO RESPONSE:

KEPRO has read, understands and acknowledges all pre-certification services required in this scope of work as outlined in the Master Plan Document.

3.11.2.1 Describe your organization's process for managing inpatient hospital pre-certification requests.

KEPRO RESPONSE:

Tested, compliant processes, custom-tailored to PEBP requirements

KEPRO has successfully combined the many components of a comprehensive utilization management together through an integrated solution designed to save our clients money and improve quality of care. URAC accredited to perform Health Utilization Management (UM) since 2004, KEPRO contracts achieved up to a 16:1 ROI and savings of $273 million for clients across our book of business last year. We routinely exceed URAC Standards for Health Management Utilization, Department of Labor regulations and client mandated processing requirements.

Reviews are completed based on member eligibility and client benefit plan design, and our process includes, but is not limited to, the following functions:

- ***Channeling to network providers***
- ***Negotiating out of network fees***
- ***Medical necessity and level of care determination based on nationally recognized guidelines (such as Milliman or Interqual) and client-specific criteria.***

- ***Discharge or post-care planning for inpatient admissions and outpatient treatments to drive member compliance or ensuring the member has a post service plan for outpatient treatments***
- ***Early identification and referrals to other medical management programs as appropriate.***

Each review by the nurse and medical director is completed within the benefit plan design to ensure services provided are covered under the plan. All determinations are documented in our medical management system Atrezzo and transferred to the claims payer in the nightly file extract. If there are any questions about the coverage/interpretation of the plan document, the nurse will call the designated client contact to ensure proper interpretation of coverage prior to reviewing the request. Services not covered under the plan are indicated as "benefit plan denials" and can be tracked, trended, and reported to the client for use in making potential benefit plan modifications. The process for benefit plan denials is established during the implementation process based on the client's specific needs.

During contract implementation we document all PEBP's pre-certification, pre-notification and prior authorization requirements in our medical management system. We also request access to current plan documents and provider network files and develop data interfaces to receive daily eligibility files. Review staff references these tools during the review process, and establishing interfaces and an ongoing process for updates early ensures we have access to the most up-to-date member information. Plan design changes are communicated to staff and updated in our system as soon as they are communicated to us by PEBP.

Accountability

The ultimate authority and oversight responsibility for the KEPRO Utilization Management program lies with KEPRO's Chief Medical Officer (CMO). KEPRO's PEBP-designated medical director reports to the CMO and supports the processes and programs that address the coordination of medical review processes for pre-admission reviews, concurrent and retrospective reviews, and appeals and reconsiderations. The medical director also manages the oversight of the review process, including overflow and distribution of reviews to assistant medical directors or outside reviewers. Our Chief Operating Officer manages all nursing and non-nursing staff delivering our UM services. In addition, our Vice President of Operations oversees the delivery of the utilization management product, forecasting and resource management, planning, assigning and directing work, and process improvement.

Detailed Process Description

The following outlines each step of our pre-certification process, from initial receipt of the request through discharge planning and handoff to case management or other available care management resources as appropriate.

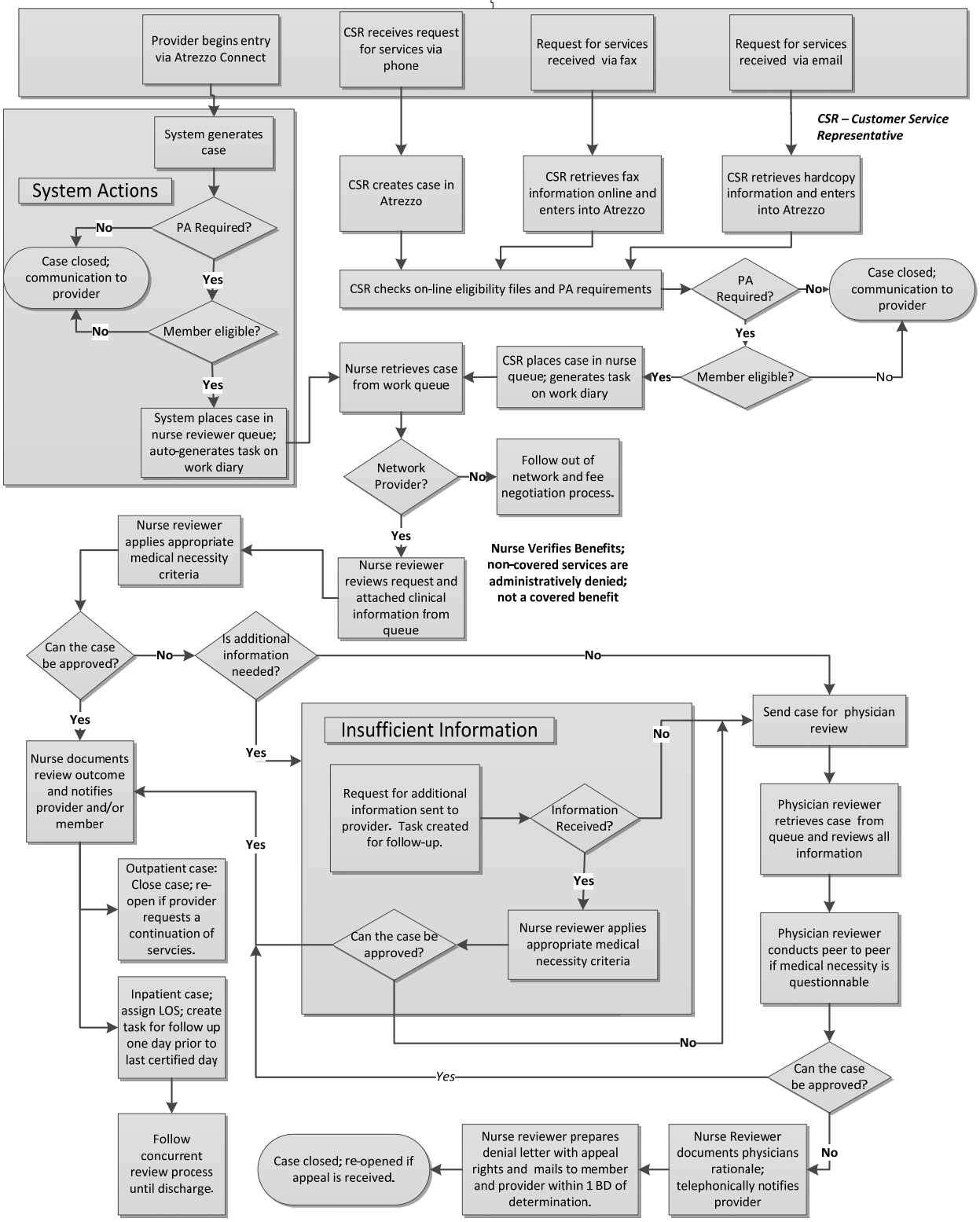
Intake Process

Pre-certification or prior authorization requests are initiated by the provider or member via phone, fax, or mail. Additionally, we can offer a Web-based system as a buy-up option. This functionality works best when the members being served are highly concentrated in a specific geographic area and the program supports a high level of provider engagement.

Intake staff creates cases for requested services and procedures that require pre-certification or prior authorization based on PEBP specific eligibility requirements. Members are redirected to the benefit plan if eligibility cannot be determined. Alternatively, eligible members who meet criteria for case management, disease management, wellness programs or other available health management programs are referred accordingly. We consider the point of pre-certification a teachable moment and can drive early identification of members who will most benefit from care management.

As an aide, we have provided figure 12 as high level visual overview of our standard operating procedure (SOP) for prior authorization.

FIGURE 14. DRAFT NEVADA PRIOR AUTHORIZATION (PA) PROCESS



Overview of the Pre-certification Process

Inpatient Pre-certification

If the request for a review is not submitted via the web our CSRs manually enter service authorization requests received by fax or mail, into our proprietary medical management system. This automatically triggers our system to verify eligibility prior to the start of a PA review. They attach documents, faxes, or other forms to the request and they then become a permanent part of the record. CSRs check the request for completeness and accuracy, then route the cases to the appropriate work queues for processing by trained and experienced clinical review staff. Our processes for conducting reviews are the same for all type and service requests.

Clinical Assessment

The first step in the review process involves a complete clinical assessment. Supporting documentation, history and physical, physicians' orders, and any other documentation requested to support the need for services will be reviewed by properly credentialed, licensed and qualified clinical reviewers.

Medical Necessity Determination

The reviewer will apply PEBP approved criteria, guidelines, policies, procedures, and processes to make determinations to ensure that medically necessary services are rendered in the most appropriate setting. All PA's will be approved, denied, modified, or pended within the required time frames specified in the RFP. We thoroughly train our review staff on all contract-specific clinical review criteria and benefits management requirements and monitor their performance for consistency, accuracy, and timeliness by application of our Quality Control plan (see Section 3.6). The information submitted with the request will be review, if appropriate, the medical record and any supporting documentation in order to perform a comprehensive review for medical necessity.

Medical Necessity Determination

Clinical information is obtained from a number of sources to determine medical necessity for both inpatient and outpatient services, including the facility's utilization management department, the attending physician's office, and in some cases the member or the member's family or representative. Past medical records may be requested to document previous treatments and/or the member's response to treatment. Our medical director may also request a peer to peer discussion with the attending physician to best understand the plan of care before making any determination.

The utilization management nurse records all available clinical information and compares it to the appropriate nationally recognized criteria set (such as InterQual and Milliman) and client specific requirements to determine medical necessity. If the RN reviewer determines that additional clinical information is necessary, they contact via telephone the attending physician, discharging hospital staff, family members and/or representatives to solicit additional information regarding the patient's condition. Any questionable case is referred to the physician reviewer for final determination. If additional information is not received within a specified time frame (to meet URAC or PEBP standards) the case will be forwarded to the medical director for determination based on existing information.

A service is deemed "medically necessary" when:

- ***Services are reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity***
- ***Services must be of a quality that meets professionally recognized standards of health care, and must be substantiated by records including evidence of such medical necessity and quality***
- ***Clinical information supports evidence-based medicine, benefit plan design and State and/or Federal regulations when appropriate***

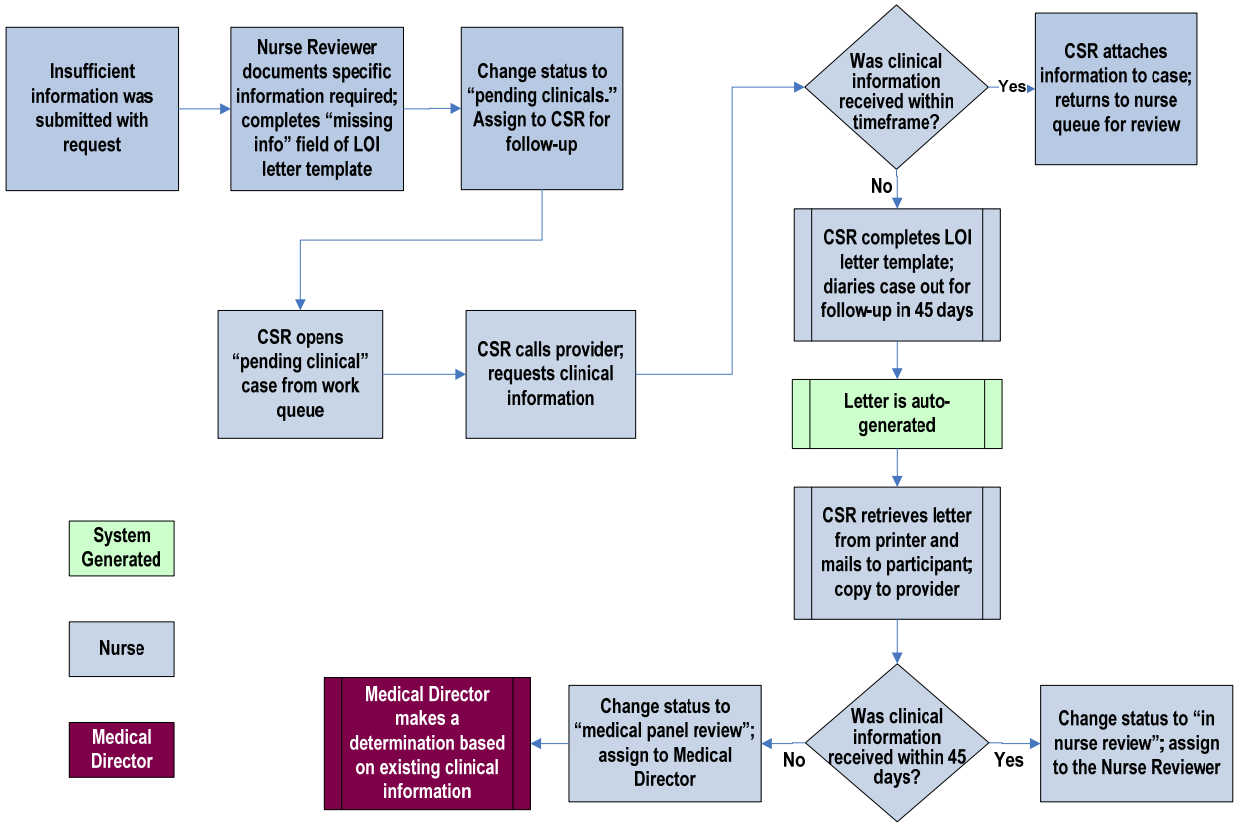
As part of the medical necessity review, the nurse reviewer is considering whether the level of care requested is appropriate for the planned services/procedures. If criteria indicates a lower level of care (for example: skilled nursing facility instead of acute inpatient), the nurse reviewer may discuss this option with our medical director then make the recommendation to the attending physician. If the attending physician does not agree with the recommendation, the nurse reviewer will forward the request to our medical director for review and potential denial of requested level of care.

If clinical information does not support medical necessity, cases are routed to our medical director staff for final determination.

Insufficient Information

If the provided information is insufficient to meet criteria, the KEPRO reviewer will place the case in a "pend" status in our Atrezzo system. We track these requests for additional information in our web-based system, along with all supporting documentation for each review, and adhere to all required timeframes to meet PEBP client deliverables. Tracking this information in our system enables us to respond promptly to State agency requests for the status of all cases, including those that are awaiting additional information. Please refer to figure 15 below visually describing our "Request for Additional Information" process.

Figure 15. Request for Additional Information



Notification of Determination

All review decisions will be posted to Atrezzo, and display electronically on our provider web portal. Providers can submit additional clinical information through Web portal, email, or fax:

- ***Appropriate severity of illness clinical factors***
- ***Appropriate treatment elements in their services***
- ***Application of any other clinical guidelines approved by PEBP***
- ***Covered services applicable as described in the PEBP Master Plan Document.***

Once the clinical reviewer validates that criteria are met the case is routed into a "Complete" status in Atrezzo. Once we receive all necessary information, we will post the determination to the provider web portal, and notify providers if appropriate.

Physician Review for Prior Determinations

When criteria are not met for an authorization request, our clinical reviewer will forward the coverage determination to a physician reviewer who is licensed in the state of Nevada. Our physician reviewers will have received extensive training on PEBP criteria and appropriate Federal and State regulations in order to render an appropriate decision.

Our physician evaluator will review the medical record and all supporting documentation pertaining to an admission before rendering a decision. If the physician requires more information or clarification to make a determination, he/she will attempt to contact the ordering physician/hospital for the documentation before making a decision or suspending the case. If the attending physician is unavailable, the peer reviewer informs the attending physician's staff of the purpose of call, verbal instructions on how to arrange a peer-to-peer discussion, telephone number, and name. If no peer-to-peer discussion occurs, we will issue our written determination.

Reconsiderations

Providing appeals and addressing medical challenges of our authorization reviews and benefits determinations has been a component in our contracts for 28 years. Providers and beneficiaries who disagree with a KEPRO determination to deny/reduce services can submit a request for appeal or expedited appeal to KEPRO within the established approved DHHS timeframe. All cases with adverse decisions will be eligible for additional levels of review according to DHHS standards.

Our process for reconsideration review is as follows:

- ***We fax/email/web portal an acknowledgement of receipt of a request for reconsideration to the provider and beneficiary that we have received an appeal and that they have a comment period for submitting additional information. The KEPRO appeals staff places the case in an electronic tickler file during the comment period.***

- ***Once the comment period has passed and/or we have received additional information, we generate a reconsideration worksheet and forward the case to a specialty matched peer reviewer who is:***
    - ***Licensed and board certified in the same specialty as the attending physician***
    - ***Not associated with the original denial***
    - ***Not related to the beneficiary***
    - ***Not responsible for the care of the beneficiary.***

Our peer reviewer uses the information that led to the denial determination, the complete medical record, any additional information submitted, and PEBP policies and approved criteria to make his/her decision. We will render our decision upon receipt of all necessary information for an appeal, but will work with PEBP to establish the timeframe should you so desire.

The peer reviewer will make an attempt prior to reach the attending physician after the additional information was received. During the peer-to-peer discussion, the attending physician may provide additional information to assist KEPRO's peer reviewer in making his or her determination. Our peer reviewer will provide his or her determination to the attending physician during the telephone discussion.

If the attending physician is unavailable, the peer reviewer informs the attending physician's staff of the purpose of call, verbal instructions on how to arrange a peer-to-peer discussion, telephone number and contact information. If no peer-to-peer discussion occurs, we will issue our written determination.

When requests do not meet clinical review criteria, we fax a written denial notice to the provider and mail a letter to the beneficiary. The notification includes all required information. Please see figure 8 for our detailed process.

Pre-Notification

Pre-notification requires that the member/provider notify us of any planned/unplanned services however, supporting clinical information and a medical necessity review is not required. Conditions, procedures, or drugs that might be considered for pre-notification only are those that are normally approved however may warrant case management oversight. These conditions may be identified through analysis of the client's claims trends over time and/or the type of medical management programs offered by the client to it employees. For example, if an employer offers a maternity management program, maternity cases should require prior-notification at the time of the initial visit to the obstetrician so that each pregnant member can be assessed for high risk factors and managed accordingly.

Pre-notifications also initiate our concurrent review and discharge planning processes which monitor expected discharge dates and the need for continued services when they exceed the initial planned discharge.

Written Notification

When we make a determination to approve or deny (in part or in full) a request, we use the following three classifications to communicate review status:

- ***Approved – the request has met all authorization criteria***
- ***Denied – the request does not meet authorization criteria***
- ***Pended – the provider has not submitted sufficient information for us to approve or deny a request. Additional information is required and will be requested in order to make a determination.***

If the determination is to deny, reduce, terminate, delayed or suspend the requested service, a letter (and Web portal notification) are system generated from KEPRO to the provider. This letter includes appeal rights as outlined in PEBP policy, along with all other specifications per the above requirements. We will post notification on our online provider portal, in the MMIS, and send written notification of our determinations within one business day of our decision to the client, provider, and PEBP.

All related procedures will be approved by PEBP prior to implementation. We will data enter the results of cases that go to PEBP for Administrative Appeal in our Atrezzo system so that we have a complete history of all cases, once the department shares the information with us.

Discharge Planning and Concurrent Review

Discharge planning starts when the request for authorization is received. The utilization management nurse will determine the extent of discharge planning, potential/actual services required post discharge, and whether any interventions can be completed prior to admission. The nurse reviewer

works in conjunction with the member, the member's family/care givers, member's provider(s), hospital discharge planning staff, and other health care providers as appropriate to ensure timely transfer from one level of care to another. If the discharge plan qualifies the member for case management under the PEBP, the utilization management nurse will initiate an automated referral and discuss the member's discharge plan with the case manager prior to transferring the case.

The review staff follows up with the provider or hospital utilization management department to verify progress against the medical treatment plan. If additional days/services are required, a medical necessity review is conducted as outlined in the above process – to include referral to the medical director if clinical status does not support a continued stay. The nurse reviewer may refer a case to the medical director at any point during the admission to discuss the medical treatment plan and/or extended lengths of stays. This process continues until the member is discharged in which case the discharge date is recorded and the case is closed.

Early identification of needs and cross programmatic referrals
Early identification of members who may benefit from case management or chronic care management is key to ensuring optimal health outcomes and providing a positive impact on healthcare costs. KePRO programs have early identification and referral triggers built-in. Members may be auto-referred to case management based on trigger conditions. The nurse reviewer may also refer the member at any point in the utilization management process if the member's condition and/or discharge plan warrants based on PEBP guidelines. The case manager and utilization management nurse coordinate to seamlessly transfer the member to case management oversight.

3.11.2.2 What is the average length of time for your organization to pre-certify inpatient hospital admissions?

KEPRO RESPONSE:

KEPRO's policy is to conduct utilization decisions, notifications and confirmations in an expedient manner to increase care coordination, continuity of care and to accommodate clinically "urgent" review scenarios. On average, we process and make determinations on inpatient pre-certification reviews within 24 hours of receipt of all required information.

We adheres to the following URAC designated time frames for prospective review:

- ***a. For prospective review, the organization issues a determination:***
  - ***i. As soon as possible based on the clinical situation, but in no case later than 72 hours of the receipt of request for a utilization management determination, if it is a case involving urgent care; or***
  - ***ii. Within 15 calendar days of the receipt of request for a utilization management determination, if it is a non-urgent case.***

3.11.2.3 Describe your organization's process for managing outpatient surgery pre-certification requests.

KEPRO RESPONSE:

Similar to our review process for inpatient procedures, our pre-certification of outpatient procedures begin with a request for pre-certification. Once the request has been categorized as outpatient, it is further categorized as a procedure, high-dollar diagnostic, therapy, or service. All reviews are conducted based on established URAC standards and Department of Labor regulations, as applicable.

KEPRO follows a comprehensive pre-certification process that includes verification of eligibility, benefits coverage, network status, and a clinical review for appropriate level of care, actual medical necessity and appropriateness of the surgery or service being requested, necessity for a proposed preoperative hospital stay, necessity for 23 hour observation. While KEPRO has a recommended list of outpatient surgeries that should be pre-certified, we will customize the surgery authorization list to accommodate PEBP requirements.

3.11.2.4 What is the average length of time for your organization to pre-certify outpatient surgical services?

KEPRO RESPONSE:

The length of time for outpatient pre-certification is the same as inpatient however, most determinations are made within three business days once all required clinical information has been received, in line with PEBP's benefit plan.

KEPRO adheres to the following URAC designated time frames for prospective review:

- ***a. For prospective review, the organization issues a determination:***
  - ***i. As soon as possible based on the clinical situation, but in no case later than 72 hours of the receipt of request for a utilization management determination, if it is a case involving urgent care; or***
  - ***ii. Within 15 calendar days of the receipt of request for a utilization management determination, if it is a non-urgent case.***

3.11.2.5 Does your organization refer to established medical necessity guidelines for pre-certification, such as those published by Milliman?

KEPRO RESPONSE:

KEPRO is richly experienced and adept with incorporating various clinical criteria in our review processes for clients. In addition to experience with industry standards such as MCG (Formally Milliman Care Guidelines) for evidence-based decision support, we also have the ability to incorporate InterQual® and/or client specific criteria based on the client's corporate goals such as higher savings and/or higher member satisfaction. We have access to the full complement of InterQual and MCG which allows us to manage all services/specialties across the care continuum.

We know from experience that the use of nationally recognized, proven, and validated criteria will provide the following benefits to our clients:

- ***Assign credibility to – and support consistency of – our review decisions through a legally supportable source***
- ***More appropriately identify questionable care and ultimately result in higher denials or recommendations for alternative care***
- ***Keep decisions current with industry standards through regular updates.***

The Milliman Care Guidelines® are widely regarded as the industry's resource for evidence-based knowledge at the point of care. Designed to be used in conjunction with healthcare professionals' expert clinical judgment, these criteria sets are used to provide informed, consistent decisions when determining the most appropriate level of care and the duration and frequency of that care. If the nurse reviewer has questions about the clinical justification, or, in his or her clinical judgment, the medical appropriateness of the request, he or she consults with our Medical Director who oversees the review process. In all instances where the clinical justification does not meet medical necessity, the request is forwarded to the Medical Director for review/determination.

Guidelines are maintained in an electronic format for easy access by KEPRO Nurse Reviewers in order to evaluate the medical necessity of care and/or setting for the requested service.

3.11.2.6 How are pre-certifications accepted? Please complete the following table by double-clicking the appropriate responses below.

Method	Accepted
Telephone	☒Yes ☐ No
E-mail/Internet	☒Yes ☐ No
Facsimile	☒Yes ☐ No
Regular mail	☒Yes ☐ No
Other (please describe)	

3.11.2.7 Does your organization provide written confirmation when a pre-certification request is approved or denied? Please provide a sample of your pre-certification approval and denial notifications as an attachment to your proposal.

KEPRO RESPONSE:

Yes. KEPRO's policy is to provide both verbal and written confirmation on all approved pre-certification requests to the requesting facility or provider. When a denial occurs, this determination is also communicated verbally to the requesting provider and in writing to the facility, provider and PEBP participant. All review determinations can be accessed by PEBP, the Provider and facility via

our webportal. Written confirmation of the determination is consistent with URAC, Department of Labor or appropriate State Department of Insurance requirements and includes the rationale with references in support of the determination and, if non-certified, appeal rights, instructions on the appeal process, and contact information.

Written notification is mailed to the member with a copy to the provider and the facility where services are being provider within one business day of the determination.

All written, non-certified notifications will include:

- ***Rationale for the non-certification in both laymen terms and the specific plan provision used in making the non-certification. Including the clinical rationale and criteria used for the decision.***
- ***Detailed description of appeal rights, including applicable time limits for filing appeals***
- ***Instructions on appeal process/procedures***
- ***Statement that an approval does not constitute a guarantee of payment***

Please refer to Attachment 3 for a copy of our standard appeal letter.

3.11.2.8 Concerning PPO plans for which your organization provides pre-certification services: During the time periods of July 1, 2011 – June 30, 2012, and July 1, 2012 – June 30, 2013, what percentage of inpatient hospital pre-certification requests were denied by your organization? Please list each time period separately.

KEPRO RESPONSE:

The table below illustrates KEPRO's denial rates for inpatient hospitalization requests for the periods requested for non-gatekeeper plans. Additionally we have included the savings amounts for these denials in figure 16.

	July 1 2011 - June 30 2012	July 1 2012 - June 30 2013
Services Denied	1,756	3,517
Services Processed	51,067	58,412
Percentage Denied	3.4%	6.0%
Savings from Denials	$16,557,729	$26,631,420

3.11.2.9 What are the credentials, qualifications, and experience of staff determining pre-certifications for inpatient and outpatient services?

KEPRO RESPONSE:

Please refer to our response in Section 3.3 above. Clinical staff performing pre-certifications include RN Reviewers, Medical Directors and Physician Consultants.

3.11.2.10 Please describe in detail your organization's denial process. Describe inpatient and outpatient services separately.

KEPRO RESPONSE:

Unless otherwise dictated by PEBP policy, a nurse may non-certify based on eligibility or benefits; only a physician can issue a medical necessity denial determination.

If the clinical information does not support medical necessity or level of care, the request is forwarded to one of our staff medical directors for review. In conjunction with InterQual or MCG, the medical director uses professional experience, currently accepted practice guidelines and benefit plan coverage as part of the review process.

They may also contact the requesting provider to discuss the case and better understand the treatment plan. Every reasonable attempt is made to contact the provider if a peer to peer discussion was requested prior to a non-certified determination. The medical director may also consult with one of the practicing physician consultants before making a determination. We have over 3,200 board certified, practicing physicians in a wide variety of specialties available for consultation on an as-needed basis.

If the request is denied in total or in part, the case is returned to the nurse reviewer who telephonically notifies the requesting party of the medical director's decision and informs them of appeal rights. Written notification is then mailed within one business day of the determination to the member, requesting provider, and the facility where services are being provided. The written notification contains specific rationale as to why the services were non-certified. All aspects of the denial process are documented in the member's automated record for auditing and retrieval purposes.

We follow this same process for both inpatient and outpatient denials. In both inpatient and outpatient denials, we close the case and re-open it if the denial is appealed. The exception is denials for an inpatient continued stay. In this instance, we do not close the case; we document the last certified day but continue to follow the member through discharge to monitor for quality of care concerns and document the final discharge date.

3.11.2.11 Please describe your criteria for determining medical necessity for weight loss surgeries such as gastric bypass or lap band surgery.

KEPRO RESPONSE:

KEPRO employs both InterQual and Milliman criteria for determining medical necessity for weight loss surgeries such as gastric bypass or lap band surgery. Additionally, our RNs will access specific PEBP benefit plan language, evidence-based criteria appropriate to the treatment and member-specific information from the treating provider.

In the event the clinical information provided does not support medical necessity, our medical director will offer peer-to-peer discussion to best understand the treating physician's perspective and obtain more specific details of the member's clinical and psychological condition. The medical director may also consult with one of the specialty reviewers on our panel.

3.11.2.12 Please confirm that your organization has reviewed PEBP's current pre-certification requirements as described in the PEBP Master Plan Document and your ability to provide this service.

KEPRO RESPONSE:

KEPRO confirms that our organization has reviewed PEBP's current pre-certification requirements as described in PEBP Master Plan Document. We have extensive experience in all areas and are extremely capable of successfully providing this service.

3.11.2.13 If PEBP expands the number of services that require pre-certification, please confirm that your organization will not increase its fees as quoted in your original cost proposal.

KEPRO RESPONSE:

KEPRO confirms that we will not increase our fees as quoted in our original cost proposal if PEBP expands the number of services that require pre-certification.

3.11.3 Concurrent Review

3.11.3.1 Please describe your organization's process for inpatient hospital concurrent reviews. This information may be provided as an attachment to your proposal in the form of a narrative and/or flow chart.

KEPRO RESPONSE:

The processes and criteria (InterQual and/or MCG) used for hospital concurrent reviews are essentially the same as those used for prior authorization however; the turnaround time for determinations is much shorter. Please refer to section 3.11.2 for a description of the prior authorization process and criteria.

We follow up with the facility's utilization management department at least one day before the last certified day to get an update on the member's condition, treatment plan, and expected length of stay. If this department does not have sufficient information on which to make a determination, we follow up that same day or the next to facilitate the review. Concurrent reviews evaluate the medical necessity of requested services, appropriateness of level of care – to include bed type, avoidable hospital days, and days required to treat hospital acquired conditions. We also monitor for other quality of care concerns. All findings and review determinations are captured in the member's case for tracking, trending, and reporting purposes. Concurrent reviews continue until the member is discharged at which point we document the discharge date and close the inpatient case. The member may be followed in general or large case management.

All extended length of stay cases are periodically reviewed with the medical director. And, if the nurse reviewer has concerns about the member's progress and/or the stated treatment plan, he/she will refer

the case to our medical director for review and consultation. When the clinical information does not support continued stay, the case is also referred to the medical director for medical necessity determination.

We communicate the review determination to members and providers consistent with the prior authorization process. Members receive mailed notices; providers receive copies of the member's letter via mail, fax, or the provider web portal.

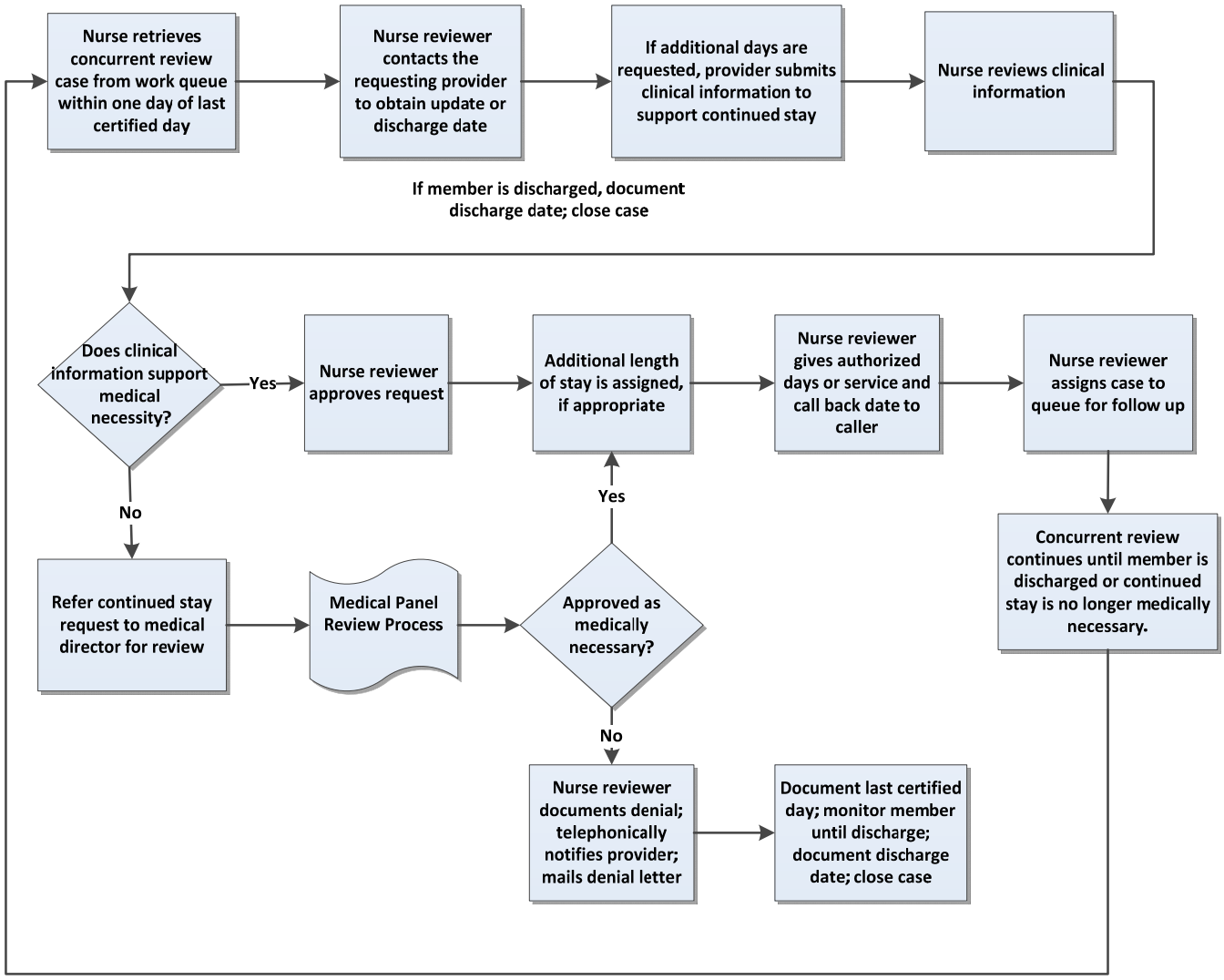
Our turnaround times for making a determination are consistent with URAC standards which reinforce DOL requirements. Some state regulatory agencies may have specific timeframes for review that are more restrictive than DOL regulations in which case we follow state requirements. When previously approved course of treatment is reduced or terminated, we issue the determination early enough to allow the member to request a re-review and receive the results of that review before the reduction or termination occurs.

When we receive a request to extend a hospital stay, we issue the determination within the following minimum standards. In most cases though, the determination is made within one business day.

- ***24 hours of the request if the case involves urgent care and the request for extension was received at least 24 hours before the expiration of the currently certified course of treatment***
- ***72 hours of the request if the case involves urgent care and the request for extension was received less than 24 hours before the expiration of the currently certified course of treatment.***

Please refer to figure 17 below visually describing our "Concurrent Review" process.

Figure 17. Concurrent Review Process Flow



3.11.3.2 How frequently does your organization re-assess a patient's need for continued hospitalization under the concurrent review process?

KEPRO RESPONSE:

The member's condition and expected length of stay influences the frequency with which our review nurses or case managers re-assess a member's need for continued acute inpatient hospitalization. When the admission is initially authorized, we assign a length of stay of no more than 1 – 3 days unless

the member is expected to have an extended length of stay – such as a member who suffered a severe injury and is being treated in intensive care. In this instance, nurse reviewers may authorize up to 5 days. We realize that the member will require far greater than 5 days however, we do feel it is important to routinely check on the member to monitor quality of care, determine their current status (has it improved faster than expected or taken a turn for the worse), ensure the member is transitioned to lower levels of care within the acute care facility (move to the step-down unit from intensive care) as their condition stabilizes, and begin coordinating discharge plans. Frequent concurrent reviews also allow us to provide the most up-to-date information on high dollar cases to PEBP and other appropriate PEBP vendors.

3.11.3.3 Please describe your organization's criteria for determining continued medical necessity.

KEPRO RESPONSE:

Our review nurses and physicians use InterQual and/or MCG (formally Milliman Care Guidelines) criteria for determining continued medical necessity. We also incorporate client specific criteria if it exits. Medical Directors also consider evidenced based practice guidelines and professional clinical experience in conjunction with the national criteria.

3.11.3.4 If your organization refers to its own medical necessity guidelines, please describe your guidelines in detail. This information should be included as an attachment to your proposal.

KEPRO RESPONSE:

Not applicable. KEPRO uses nationally recognized guidelines or client specific guidelines as listed in the previous response.

3.11.3.5 Please provide examples of all provider and participant communications related to this function and how your organization delivers these communications.

KEPRO RESPONSE:

As a standard, determination letters are addressed to the member; a copy of the letter is sent to the treating physician and the facility (when appropriate). Examples of our communications are at Attachment 3.

Letters are mailed to members however; physicians/providers may receive copies via the provider web portal, fax, or hard copy mail depending on their preference.

3.11.4 Retrospective Review

3.11.4.1 Please describe the process and criteria used for retrospective review. This information may be provided as an attachment to your proposal in the form of a narrative and/or flow chart.

KEPRO RESPONSE:

The process and criteria (InterQual and/or MCG) used for retrospective reviews are essentially the same as those used for prior authorization and continued medical necessity review. Please refer to section 3.11.3.4 for a description of this process and criteria.

There are a few minor differences which are defined by when we get the request for medical necessity review, who submits the request, and how we obtain the clinical information on which to make a determination. Retrospective reviews may be considered in the following instances (as dictated and allowed by PEBP policy). We have extensive experience with each scenario.

Health Care Services are in progress when we get the request for medical necessity review.
We conduct a retrospective review from the date services began to the date we received the request to determine medical necessity and appropriateness of level of care. Such requests are usually made by the provider who is also able to provide required clinical information on which to make a determination. Requests may be made telephonically, or by fax or secure provider web portal. Additional continued medical necessity reviews then fall into the "prior authorization" category. Determinations are entered into the member's case; members and providers are notified via written, faxed, or provider portal communications consistent with our prior authorization process. The Claims Administrator is notified via the nightly file extract. In this instance, we would not be determining if charges are Usual and Customary.

Health Care Services have been provided but the claim has not been submitted.
The provider notifies us telephonically or by fax or provider portal. We request the complete medical records be mailed or faxed to our office; the review determines medical necessity of the initial services, level of care, and continuation of services. The member and provider are notified of review determinations as above.

In this instance we do not determine if charges are Usual and Customary unless the provider also submits a draft of the claim. If we identify any quality of care concerns, we document such in the member's case record and notify PEBP per established protocols. If we completed a "Usual and Customary" review we also notify the Claims Administrator.

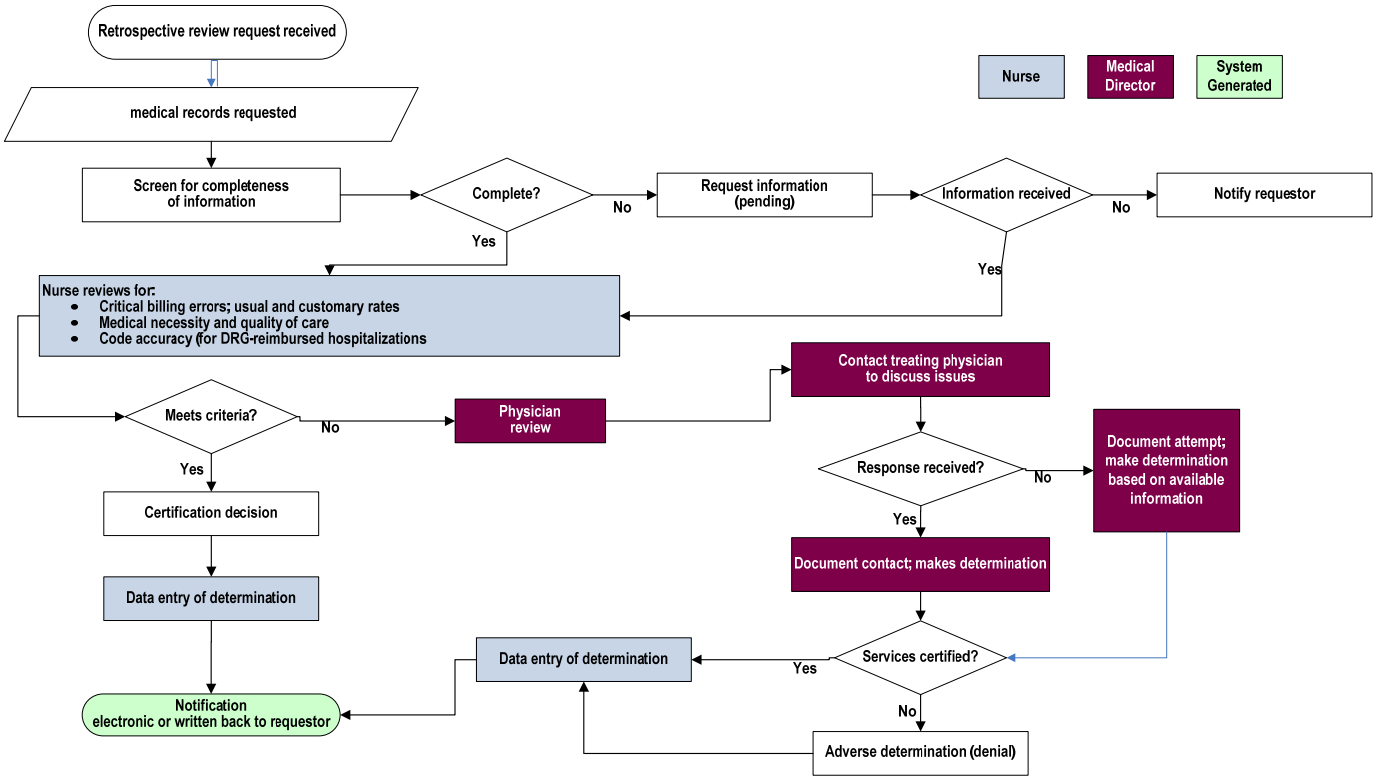
Health Care Services have been provided and the claim has been submitted.
This is the most typical scenario. The Claims Administrator receives a claim for services that, by Master Plan Document, require medical necessity determination but there is no medical necessity determination in their system. The Claims Administrator will notify KEPRO of the need for a retrospective review and pend the claim until they receive the determination.

KEPRO will contact the provider to request complete medical records and review the records to determine medical necessity of services, level of care, continuation of services, and Usual and Customary charges. We also document any quality of care concerns.

We communicate the results to the Claims Administrator in writing. We do not communicate the determination to the member or provider although we can customize the process to include member and/or provider notification if PEBP prefers.

A high level workflow of our Retrospective Review process is depicted below in figure 18.

Figure 18. Retrospective Review Process



3.11.4.2 Does your organization perform retrospective reviews on-site, telephonically, or a combination of both?

KEPRO RESPONSE:

Given that retrospective reviews are completed after services have already been provided, retrospective reviews are normally done through a medical record review. In the majority of cases, the medical

records are no longer at the point of service. We request a copy of the medical record be mailed or faxed to our Orlando office for review. We may follow up with a call to the provider to clarify information in the record before we determine medical necessity.

A telephonic review may be completed if the request for medical necessity is received shortly after the care has been provided. In this instance, the member's medical records may still be at the point of service. In this case, we can complete a telephonic review. If the provider prefers, they can submit the request and the records via the provider portal or they can fax the records to our office via secure fax.

We do complete retrospective reviews on-site if the contract requires on-site. This is frequently the case when the benefit plan's policy is to review all admissions retrospectively and facilities have a large volume of admissions. Copying/mailing and faxing the records would be a significant drain on the facility's resources. In such circumstances, we locate nurse review staff remotely, in close proximity to the facilities, to complete on-site retrospective reviews.

3.11.4.3 What are the credentials, qualifications, and experience of staff handling retrospective review?

KEPRO RESPONSE:

The same staff responsible for prior authorizations and continued stay reviews also handles retrospective reviews. Please refer to 3.11.2.9 for details on credentials, qualifications, and experience of our review staff.

3.11.4.4. How is the need for retrospective review determined?

KEPRO RESPONSE:

The need for retrospective review is determined by the date of the request and the date(s) of service. If the service is on-going at the time of the request, we treat the request as a "prior-authorization". We do ask for clinical information going back to the start of service/treatment to determine medical necessity for the service and level of care. This initial retrospective review also considers medical necessity of continued stay/treatment. Additional continued stay reviews are conducted just as we would with non-retrospective review requests.

If the service/treatment has been completed at the time of the request, we consider the review retrospective. Whether the member/provider is permitted to request a retrospective review is dictated by the plan. Some plans may levy financial penalties for late submissions. In these instances we can track, trend, and report this data.

3.11.4.5 Please provide examples of all participant communications related to this function and how your organization delivers these communications.

KEPRO RESPONSE:

The type of communications used for retrospective reviews may vary depending on who is requesting the review. If the member or provider is requesting the review before the claim has been submitted, we

communicate directly to the member with copy to the provider. In this instance we use the same prior authorization letter templates as displayed at Attachment 3.

If the request for retrospective review comes from the claims administrator, we communicate the determination back to them via secure email (secure email process is established during implementation.) The letter is formatted to the claims administrator's specifications such that they can "copy/paste" medical necessity determinations, summaries of quality issues, or "usual and customary rate" findings from our letter and insert into their template. The letter format is decided during implementation.

3.12 MANAGEMENT REPORTING

3.12.1 Please describe and list your organization's standard reports and provide examples of each. Your standard reports should include but not be limited to case management reports; outcomes; bed days approved, denied, and saved; average length of stay; and large case management status reports.

KEPRO RESPONSE:

KEPRO's standard reports contain information designed to provide quick answers and facilitate the decision making process. Our suite of reports contains the following:

- ***Program Dashboards: Separate summarized and focused views customized to your specific areas of monitoring interest and build with recommendations of our analytic consultants the program dashboard contains at-a-glance direction status graphics for your most important metrics.***
- ***Case Management outcomes: A suite of reports that include a dashboard to summarize outcome results and patient goal status as well as detailed supporting results listing goals met by program, goal compliance stratified by risk score, individual goal and metric results, cost avoidance savings by goal type, and patient level information containing referral source, risk level, and diagnosis information.***
- ***Utilization Management service performance: A comprehensive package of performance monitoring and program tracking reports that contain:***
  - ***Service Snapshot: consolidated measures that include average length of stay, admissions per 1000, and bed days per 1000, both trended and compared against industry benchmarks, trended denial rates, top submitting providers, and proportional submission methods for authorizations.***
  - ***Operational Intelligence Volumes: Dynamic date functionality driven report that tracks new requests submitted, approved, and denied, by service type (i.e. inpatient, outpatient, home health, etc.) for any period of time the user selects.***
  - ***Timeliness by Service Type: Counts of cases approved and denied with specific turnaround time rates by service type including dynamic date functionality.***
  - ***Utilization Management Savings Summary: A savings report by savings type (inpatient days denied, outpatient units denied, inpatient agreed reductions, and outpatient agreed reductions) factored against KEPRO savings rates. Includes the ability to select any time period.***
  - ***Top 25 Diagnosis: A ranking report of requests by ICD9 code of the top 25 diagnosis type requests for any period of time chosen by the user.***
  - ***Top 25 Procedures: A ranking report of requests of the top 25 procedure codes requested by any period of time chosen by the user.***

KEPRO has provided all of the reports described above in the appendix for your review.

3.12.2 Are your reports available via the web?

KEPRO RESPONSE:

Yes, our standard reports are available via the secure client portal. KEPRO offers clients an extensive number of comprehensive, online, real-time reports presented in a reader-friendly format with multiple parameter/filter capabilities. Clients can conduct queries on numerous fields to monitor additional areas or gain additional insights. KEPRO's reports are designed to help clients with improved decision-making and initiate improvements in quality of care, health care delivery, and cost savings.

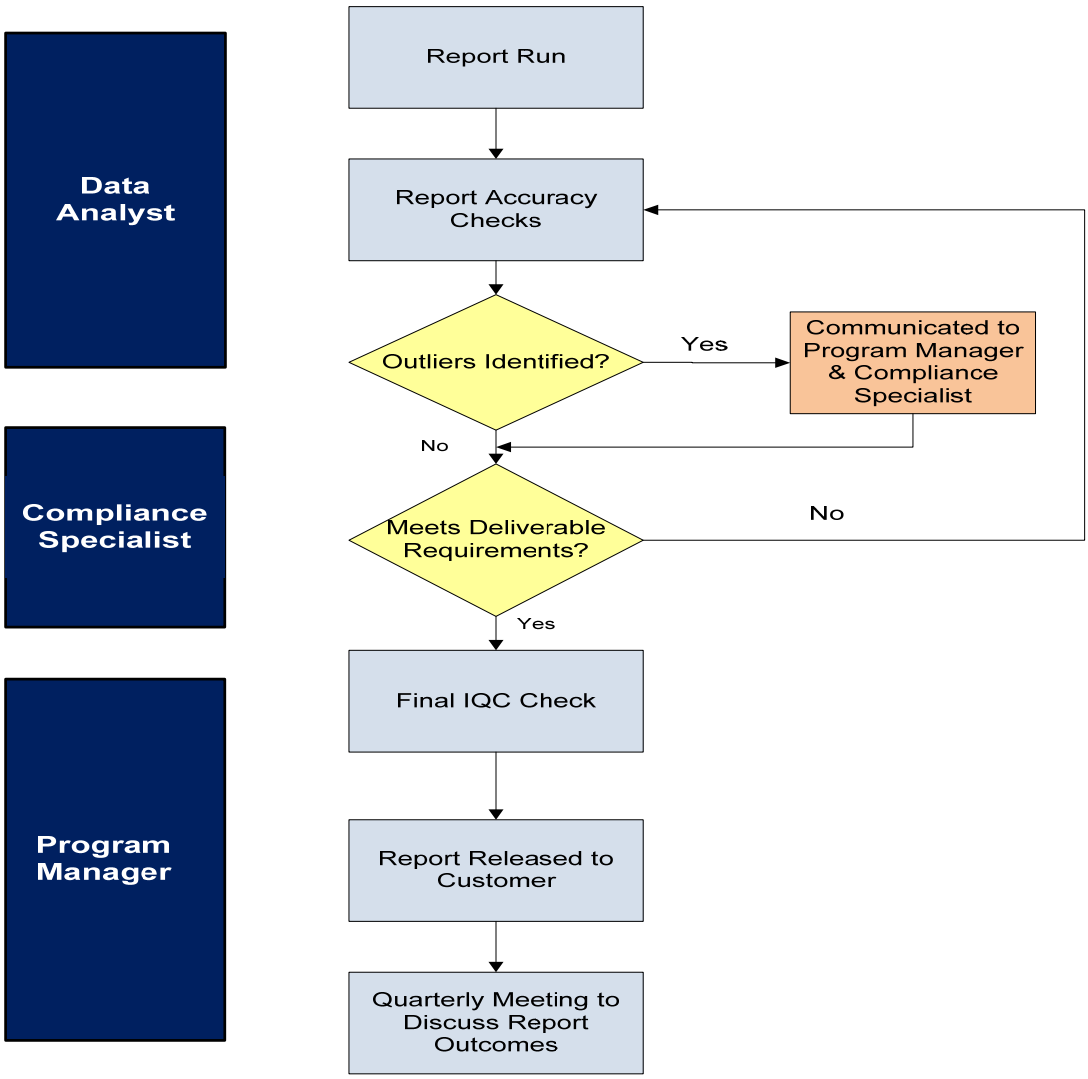
3.12.3 Please describe the process for requesting ad hoc reports and list the average turnaround time for each. Please confirm that ad hoc reports will be provided to PEBP at no additional cost.

KEPRO RESPONSE:

KEPRO will work with PEBP and key stakeholders to develop ad hoc reports at no additional cost. Ad hoc report requests are typically completed within 1- 2 days depending on the complexity of the request. We utilize a process for ad hoc reports where each report will be defined with an agreement and sign off process between KEPRO and PEBP. Once this step is completed, a mock report will be produced by the data analyst to ensure agreement and understanding of requirements. The report is then programmed by the analyst and taken through KEPRO's internal reports quality process. This process demonstrates that one analyst produces an initial report and another analyst checks the programming before being submitted to the requestor.

Once the report is completed, it enters KEPRO's deliverable quality process which includes roles for the data analyst, quality specialist and program manager. Each person has a role in making sure the report is accurate and meets the deliverable requirement, adding layers of oversight and opportunities to explore outliers and potential programmatic developments. The process for validating reports is depicted in figure 19 and begins with the initial run of the report.

Figure 19. Ad Hoc Report Validation Process



The data analyst reviews the report to make sure that all the summary information matches the detailed and that all columns and rows reconcile. At this point any outliers are identified and communicated to the project director and compliance specialist. Once the analyst signs off on the report, it is forwarded to the compliance specialist who reviews the report for any formatting changes and to ensure it is the complete deliverable. Once the compliance specialist signs off, the project manager drafts a memo, checks the numbers once more, and is then responsible to ensure the delivery of the report. This process is expedited to ensure timely delivery of requested reports.

Once the report is delivered to the client, KEPRO solicits feedback about the information and the format provided. We also set up a periodic formal meeting to discuss all of our findings and any observations and recommendations we have at that time.

3.12.4 Does your organization provide the following standard reports? Double-click each appropriate response.

Report	Provided
Outcome Management	☒Yes ☐ No
Patterns of Care	☒Yes ☐ No
Inpatient utilization	☒Yes ☐ No
Utilization by diagnosis	☒Yes ☐ No
Case specific detail	☒Yes ☐ No
Activity and days reduced	☒Yes ☐ No
Savings summary	☒Yes ☐ No

3.13 FACILITY CHANNELING

3.13.1 Please describe the process and criteria used by your organization that will direct PEBP participants to in-network facilities.

KEPRO RESPONSE:

Channeling to in-network providers and facilities is a standard component of all of our medical management programs. If channeling is not feasible, we follow PEBP out of network benefit plan requirements when coordinating care outside of the network.

During implementation, we obtain and load provider files into our medical management system; files are updated monthly (preferably). If provider files are not available, we indicate the network(s) in our system and our staffs access the provider network web site to verify the requesting/servicing provider's status. We are able to load/indicate up to four networks which allows us to not only steer to network but to steer to preferred providers within a network. And if a web-search is not conclusive, we contact the PEBP/Third Party Administrator's provider relations department to determine a provider's status.

Urgent/Emergent Care

If care is urgent/emergent and the out of network facility/provider is the only option available, out of network care is facilitated. Aggressive utilization management and discharge planning is required to ensure the member is discharged or transferred to a network provider as soon as their condition allows. Transfer may be to the same or a lower level of care depending on the member's health status and availability of network providers when the member is stable enough to transfer. In all instances, quality of care and cost benefit should be considered before transferring the member. The closest network facility must be capable of treating the member and able to provide/coordinate care across the continuum. And, the estimated cost of the expected length of stay must be weighed against the cost of transporting the member – by air ambulance as an example. In such instances we coordinate with PEBP benefit office to determine the most cost effective, quality option.

Non-Urgent/Emergent Care

Our staffs always start by researching network health care resources to determine if the servicing provider is in-network. If the servicing provider is a non-network provider, we will determine if there is a network facility within an acceptable geographic range (as defined by the benefit plan) that is qualified to provide the service(s) and if so, if the member's attending physician is credentialed to provide services at that facility.

If the member's plan does not cover out of network services (such as bariatric surgeries or other COE type of care) – or covers only a portion – we notify the provider to ensure they understand the member's coverage relative to out of network providers. We also ensure the member understands their financial obligations should they opt for out of network care – to include any required follow up care. We also let the member know that there are qualified network facilities/providers within their geographic range and offer to coordinate appointments with network providers who are credentialed to provide services within the network facilities.

When members live in more rural/remote locations, qualified network facilities/providers are not always available. In this instance, we will coordinate with PEBP Benefits Office to determine if care will be covered at participating benefit rates for the member. If approved, we coordinate with the Third Party Administrator to ensure proper claims processing. We aggressively coordinate discharge plans to facilitate discharge or transfer to a lower level of care within a participating facility as soon as their medical condition allows.

We track and trend all network channeling and redirection efforts in our medical management system, including the results of those actions. Cost savings or cost avoidance associated with the redirection is also captured and reported.

3.13.2 If a bed is not available at an in-network facility, will your organization negotiate a discount with an out-of-network facility? Is there a separate fee for providing this service?

KEPRO RESPONSE:

If out of network use is appropriate and authorized, for emergent or non-emergent care, we attempt to negotiate rates that are either consistent with PEBP's participating rates or at least 25 percent less than

usual and customary regional rates. Negotiating discounts with out of network providers is part of our standard offering and therefore included in our quoted price.

3.13.3 How are out-of-network negotiated discounts communicated to PEBP and PEBP's third-party administrator?

KEPRO RESPONSE:

The negotiated rate is documented in the case record and communicated to the third party administrator via the nightly pre-cert file and via on-line, real-time client reports. Some providers clients require a Letter of Agreement, that stipulates the negotiated rate, be signed by both parties. If PEBP prefers a Letter of Agreement process, we will work with you during implementation to define the process and roles/responsibilities of all parties.

3.13.4 Attach a detailed description of the entire discount negotiation process, including communications between all parties involved in the process.

KEPRO RESPONSE:

Our standard discount negotiation process is summarized below and depicted at a high level in the workflow that immediately follows the narrative. We will discuss this process with PEBP during implementation and revise as necessary to meet your specific requirements. The extent to which PEBP is involved in the process is up to you. The process outlined below includes all of the potential areas where PEBP may be involved. The majority of our clients do not participate in this process. Rates are communicated to the claims payer through the nightly file extract. Monthly or quarterly client reports itemize the negotiated cases and resulting cost savings.

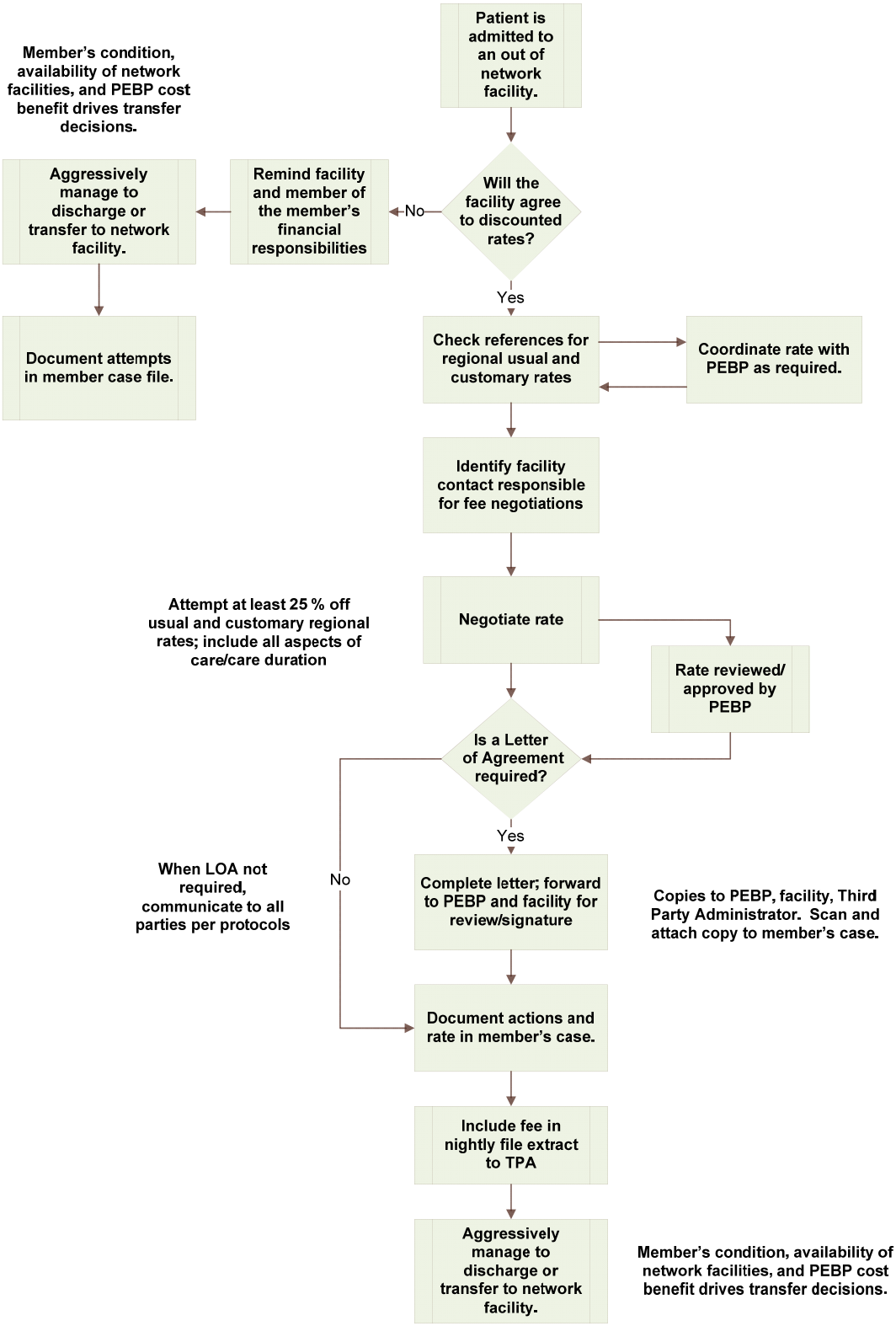
- ***Determine usual and customary rates: Health care is regional and so are rates. We review our up-to-date resources and augment with Internet search as necessary. Rates must be all inclusive of the member's projected care so it's important to capture all projected care/services.***
- ***Discuss possible discount rate(s) with PEBP: We review regional rates, discuss results of previous negotiations with this facility or for the same or similar services. PEBP may communicate discount parameters that are agreeable to them.***
- ***Identify out of network facility responsible party: Once usual and customary fees are identified and discussed with PEBP, we identify the person at the facility who has the authority to negotiate discounts. We determine how the facility bills for the projected services – bundled, itemized coding, etc. – and what they expect to bill for these services. Our goal is to obtain at least a 25 percent discount off of the usual and customary rates. This negotiation may take just one call or a series of calls. Additional discussions with PEBP may be required before negotiations are final.***
- ***Review discounted rates with PEBP: Before any agreements are finalized, the negotiated rate is reviewed/approved by PEBP.***
- ***Letter of Agreement (LoA): Often providers ask for a Letter of Agreement that outlines the discounted rates and summarizes the care included at this rate. Once signed, a copy is forwarded to the facility and PEBP for their records. We electronically attach a copy of the letter to the member's case in our proprietary system. Our nurses also document all activities related to network channeling and fee negotiations in the case for tracking and reporting purposes.***

- ***Notify the Third Party Administrator (TPA): The TPA is notified of the negotiated rate, at a minimum, via the nightly file extract. This method is acceptable if the charge is expected to be a flat rate. If the rate is variable, a written description is provided or, if a LoA was executed, a copy is forwarded to the TPA.***
- ***Communicate discount to the member: A step not depicted in the flow is communicating the discounts to the member. If the member will be responsible for any portion of the out of network costs, they need to know that the facility has agreed to a discounted rate and how that discount will affect their portion of the cost.***

Even with a discounted rate, our nurses aggressively manage the member's stay and facilitate the discharge plan to ensure the member is discharged or transferred to a network facility at the earliest possible opportunity – based on the member's health status.

The flow below depicts our Out of Network Discount Negotiation Process in figure 20.

Figure 20. Out of Network Discount Negotiation Process



3.14 ACCOUNT SERVICE

3.14.1 During what hours (and time zones) will your organization's telephone lines be staffed?

3.14.1.1. For PEBP staff?
3.14.1.2. For PEBP participants?
3.14.1.3 For providers?

KEPRO RESPONSE:

Our utilization management toll-free line for PEBP staff, participants and providers will be available Monday-Friday, from 8 am-5 pm Pacific time (excluding holidays). Confidential voicemail is available for after-hours callers. Providers accessing the provider portal may do so 24 hours a day, 7 days a week – to include holidays.

PEBP staff, participants, and providers can reach the case management department Monday – Friday, from 8 am – 5 pm and Saturday, from 9 am – 1 pm Pacific time.

3.14.2 PEBP requires vendors to assign a dedicated account manager to meet with PEBP on a regular basis to discuss performance, address administration issues, and review reports. Please confirm that your organization agrees to this requirement.

KEPRO RESPONSE:

KEPRO agrees and has assigned Ms. Chandra Tucker as the account manager for PEBP.

3.14.3 From what location will the account manager be servicing PEBP?

KEPRO RESPONSE:

Our assigned account manager, Ms. Chandra Tucker, will be located in Nevada along with the other core professional staff.

3.14.4 Can you receive electronic enrollment and eligibility data? Please confirm that your organization will accept electronic enrollment information in a format determined by PEBP.

KEPRO RESPONSE:

Yes. KEPRO has extensive experience with electronic data exchanges. Our member centric data warehouse allows us to extract, transform and load the data in a normalized and standard format. Our preference is to receive enrollment/eligibility files daily to ensure we have the most up-to-date information and to allow KEPRO's systems to automatically verify member eligibility when the request is made. This automated eligibility checking insures that unnecessary reviews for members are not done.

3.14.5 Do you employ the services of a Medical Director? If so, please list the Director's qualifications, credentials, and experience.

KEPRO RESPONSE:

KEPRO employs four full time and three part time medical directors to support our book of business. Douglas Peters is the medical director providing clinical oversight of and utilization management/case management support for KEPRO's PEBP operations.

3.15 IMPLEMENTATION SERVICES

3.15.1 Describe your implementation plan to meet a start date of July 1, 2014. Include steps required to implement the program such as notification to PEBP participants, providers, and other vendors.

KEPRO RESPONSE:

Upon contract award, we conduct an in-depth implementation assessment to determine data interfaces requiring a build and any other unique customizations that may require development. Details are built into our comprehensive implementation plan to ensure all deliverables are captured, assigned, and met. We also recognize that a certain amount of ongoing implementation exists in any contract. As we view each client relationship as a partnership, we will make recommendations throughout the contract period to fine-tune the program and drive outcomes.

KEPRO knows how to organize a smooth contract transition and implementation. With this experience comes our ability to provide realistic estimates to meet deliverable due dates and a methodical approach to implementing contracts. This means PEBP receives deliverables in a timely manner.

We are the low risk choice in all phases of the new contract for several reasons, including:

- ***Our corporate experience with contract transitions***
- ***Our proven ability to perform during a transition phase***
- ***Our implementation team consisting of full time employees already knowledgeable in transition from an existing vendor/contractor.***

KEPRO will oversee all contract activities and management of programs, and we will designate a single point of contact for PEBP. Our operations will have the benefit of corporate management and oversight to ensure adequate resources are allocated, contract requirements are met, and that PEBP is satisfied with our performance/ collaborative working relationship. Selecting competent and qualified personnel to assume the responsibilities required under this contract is one of the most critical components for successful contract operations. KEPRO has assembled the right team for success. Figure 24 illustrates our approach at a high-level.

Figure 21 – Key Implementation Activities

Sample Implementation – Key Activities

Managed Through:
1) Weekly Implementation Calls
2) Implementation Portfolio (Minutes, Action Items, Contact List)

Workstreams*		Approximate Timeline**
1) Data	• Eligibility • Medical • Rx • Disability • UR/UM • Other	10 – 12 weeks
2) Contracts	• CA • BAA • Contract	Signed Before Launch
3) Wellness Program	• Brand • Lifestyle coaching • Activities, Goals & Incentives	10 weeks
4) Communication	• Member - intro letters, brochures, consent forms, unable to contact, etc. • Provider – notification & status letters, etc.	12 weeks
5) Integration	• Health Plan, UM, Behavioral Health, EAP, PBM, Disability, DM, other • Program Referrals & Care Coordination	6-8 weeks
6) Technology	• Health Plan, CM/UM, EAP • Web Portal (DM & Wellness) • Program Referrals & Care Coordination	6-8 weeks
7) Reporting	• Identification and Enrollment, Activity • Clinical and Financial Outcomes • Operational Performance	8-10 weeks

* Key Points: Simultaneous, Dedicated Lead in Each Workstream
** Average for standard implementation. Varies based on program complexity.

3.15.2 Is your organization prepared to assign an exclusive team to assist with the implementation process? How many exclusive service representatives would be assigned for the initial implementation?

KEPRO RESPONSE:

We assign a dedicated/exclusive implementation team led by our Account Manager. The team is comprised of representatives from IT and IT service support, HR, Operations, Reporting/Analytics, corporate communications, account management.

Our experienced project team will lead efficient and effective implementations, within the required timeframes. Collectively, this team, in addition to corporate KEPRO staff, brings unparalleled depth and breadth of experience to the implementation. The Team will organize initial and subsequent planning meetings, coordinate the implementation activities, facilitate communications between PEBP administrators, meeting with providers, and actively participate in contract negotiations and the initial account operations post-implementation. Team Participants and senior executives will be onsite at PEBP offices and remain following program start-up to serve as mentors to newly hired staff and as program consultants, as needed.

3.15.3 Describe the most frequent problems your organization has encountered during previous transitions for plans of this size. How were these resolved?

KEPRO RESPONSE:

KEPRO has successfully implemented five commercial clients in the past 18 months. Historically, the variables that have impacted time frames have been:

- ***Acquiring eligibility data, and medical and pharmacy claims at least 60 days prior to implementation.***
- ***Systems integration (i.e., secure file transfers)***
- ***Identifying and defining key systems requirements.***
- ***Transfer of provider network data and benefits plan design information.***
- ***Client customization and unique identifiers***

Risk Management
Our assessment of challenges includes using our experience with the implementation and operation of several statewide contracts. A solid risk management process helps to make a project run smoothly. By identifying and addressing a list of project risks as part of a larger project management system, many surprises and roadblocks can be eliminated. KEPRO assesses project risks using a seven-step process:

Step 1: Each implementation team Participant individually lists potential risk items.
Step 2: All team Participant items are compiled into a single list, and duplicates are removed.
Step 3: Assess the probability (likelihood), the impact (consequence), and the testability of each item on the master list. We assign a low, medium or high risk level for each.
Step 4: Identify triggers (warning signs) for each risk item.
Step 5: Identify possible preventive actions for the threats and enhancement actions for the opportunities
Step 6 Create a contingency plan for each risk – a plan that includes the actions we will take should a trigger or a risk was to occur.
Step 7 Assign an owner to each risk. The owner is responsible for watching for triggers and then responding with the established contingency plan.
Upon completion of this assessment, we complete a risk matrix. This matrix is in a format that is easily reviewed by the Project Manager. The format of this matrix is included in the following illustrative in the below figure:

Figure 22 – Sample Risk Matrix

Risk	*Probability*	*Impact*	*Test-ability*	*Triggers*	*Preventive actions*	*Contingency plan*
Example: Data Mapping issues (i.e.: unique identifier)	***High***	***High***	***High***	***File format does not match files received***	***Identify appropriate IT leads and implement members; review documents and sample files***	***Obtain file in alternative layout***
Plan Design information	***Moderate***	***Mod-erate***	***High***	***Lack of documents received; unable to be loaded into system***	***Review necessary information during implementation***	***Determine alternative resources for verifying plan information***

The above items are examples and not items currently identified. It is our experience that most delays occur in establishing the regular transmission of data files from multiple parties. Ensuring that the files obtain complete, accurate and up to date contract information are among the top challenges in a new implementation.

We are very experienced at complex implementations and believe we possess the experience to overcome any potential challenges. Our commitment to ongoing communications with the Department will result in achievement of objectives as we focus our solution on the desired outcomes. Our sample Implementation Work Plan begins on the following page.

3.15.4 Please confirm that your cost proposal includes all costs associated with implementation services. You must provide a detailed description of any implementation service and/or fee charge not specifically included in your cost proposal.

KEPRO RESPONSE:

Confirmed. Our cost proposal includes all fees, including those associated with implementation services. We have included a detailed cost breakdown in Part II, Cost Proposal to supplement the Cost Matrix (Attachment E).

3.15.5 What is the minimum amount of time recommended to ensure a clean transition into the proposed program?

KEPRO RESPONSE:
90 days is the minimum amount of time required for implementation.

3.16 DISASTER RECOVERY PLAN

3.16.1 Your organization is required to submit with the proposal a disaster recovery plan in the event of a major disaster that disables most or all of your processing capabilities for the PEBP. A major disaster includes, but is not limited to:

3.16.1.1 A hardware system failure/collapse;
3.16.1.2 A software system failure/collapse;
3.16.1.3 Any natural disaster or Act of God; and
3.16.1.4 Total loss of electrical/backup power.

KEPRO RESPONSE:

KEPRO's Business Continuity Plan (Attachment 1) is a comprehensive plan designed to address all levels of disaster and potential service disruptions. It includes scenarios related to partial and complete hardware or software failure, loss of power for any extended period of time, and natural disasters. As further described in this response, it is revised and tested on a regular basis.

3.16.2 Please explain the anticipated time frames to restore normal operations once the disaster situation has been resolved.

KEPRO RESPONSE:

In the event KEPRO declares a disaster event our primary enterprise applications will be restored to normal operations within <u>24 hours</u>.

3.16.3 How often is your disaster recovery plan reviewed and/or updated?

KEPRO RESPONSE:

KEPRO performs a full systems failover test and plan review on an annual basis.

3.16.4 Describe in detail how the plan will be customized to meet the needs of PEBP.

KEPRO RESPONSE:

KEPRO has developed a Contingency and Business Continuity framework that will easily scale to meet the needs of PEBP. KEPRO's systems are hosted in a virtual private cloud with virtually unlimited compute and storage resources available to them. In addition, multiple internet pathways and power grids ensure full redundancy of the systems. In addition to this, the systems are protected by full VMware capabilities, clustered SQL server technologies, web and citrix farms and full systems replication to a geographically dispersed business continuity center. When KEPRO establishes a new contract all client configuration is automatically part of this Business Continuity framework from day one. All client data is protected, secured and replicated to the business continuity center and assures recovery in the event of a disaster.

3.16.5 Please provide with your proposal your plan for regularly scheduled backups for PEBP data for the day-to-day computer-related processing operations and where the backups will be stored.

KEPRO RESPONSE:

KEPRO has invested in state of the art disk based backup technologies with de-duplication technologies to ensure the integrity and availability of its client's data. Full system backups are performed each night and replicated to the alternate business continuity center for offsite storage and recovery. System recoveries are not only performed by our disk-based backup system but due to the full system VMware site recovery technologies our systems have recovery rollback points to within approximately 15 minutes of a designated time. These two technologies give KEPRO the capabilities to ensure a versatile, scalable and an industry best solution to our clients.

3.17 PRIVACY AND SECURITY

3.17.1 Is all data contained in the proposed system (active and "at rest") stored in an encrypted format?

KEPRO RESPONSE:

KEPRO recognizes that fully encrypting PHI and clinical review data is the next step in protecting members personal information. KEPRO is in the process of converting all Atrezzo file data to be encrypted and will have the process completed during the first quarter of 2014 - before the implementation of the Nevada PEPB contract is started.

3.17.2 Do all of your organization's current systems, policies and procedures currently comply with the following (including any systems storing or processing PEBP data):

3.17.2.1 Title 45 of the Codified Federal Regulations (CFR) HITECH Breach Rule - 45 CFR §160 and §164;

KEPRO RESPONSE:

KEPRO Information systems are already subject to and comply with the HITECH Breach Rule - 45 CFR §160 and §164;

3.17.2.2 HIPAA Privacy and Security Rules – 45 CFR §160, §162, and §164; and

KEPRO RESPONSE:

KEPRO is required to implement Technical, Administrative and Physical safeguards specified in the HIPPA Privacy and Security Rules for several of its client contracts and is compliant.

3.17.2.3 Audited for compliance with the HITECH Breach Rule and HIPAA Privacy and Security Rules.

KEPRO RESPONSE:

KEPRO has been audited for HIPPA Privacy and Security Rules for its TRICARE contract and is in compliance. No compliance audit has been performed for the HITECH Breach Rule but will be performed in 2014.

3.17.2.4 Are corrective actions implemented by your organization for issues identified in the audit?

KEPRO RESPONSE:

Corrective Action Plans (CAP)
Should an issue be identified through our HITECH Breach Rule and HIPAA Privacy and Security Rules compliance monitoring audits, a Corrective Action Plan (CAP) will be developed, monitored, and adjusted, if necessary, and followed through until completion. KEPRO's Business Associate Agreement (BAA) spells out the safeguards, policies and procedures (P&P's) in place to prevent negative events. In the event that such an event occurs, a Corrective Action Plan (CAP) is developed to address the issue. CAPs are monitored weekly, adjusted, and followed through completion. Focused monitoring is conducted until results prove there is no longer a problem. P&Ps are then revised/updated. All corrective action plans are captured in the tracking system.

Figure 23. KEPRO Process for Categorizing and Escalating Issues Ensures Quick Resolution

Problem Category	*Responsibility*	*Escalation*	*Timeframe*
Minor: no or minor impact	*Supervisors, Coordinators*	*Task Lead*	*1 week for resolution*
Major: measurable impact	*Task Lead*	*Program Manager*	*Corrective action plan w/in 3 bus days, resolution schedule in plan*
Critical: significant impact	*Program Manager*	*VP, Ops; COO, CIO*	*Corrective action plan w/in 1 bus day; resolution schedule in plan*

The corrective action process includes the development and implementation of both a short-term containment plan and a long-term process improvement plan. The short-term and long-term processes are outlined below.

KEPRO's Short-Term CAP includes the following:
- ***Clearly define problem***
- ***Notify appropriate personnel***
- ***Develop an immediate action/containment plan***
- ***Document variance in corporate corrective & preventive action tracking system***
- ***Put the short-term plan into effect as quickly as possiple***
- ***Report generation to monitor for trends.***

KEPRO's Long-Term CAP development includes the following:

- ***Organization of the appropriate team members, experts, and management needed to develop an optimal plan - A cross-functional team is required to work on all Long-Term CAPs***
- ***Investigation and verification of the problem, including historical data***
- ***Brainstorming and research consensus on potential causes***
- ***Performing an analysis of the investigation***
- ***Clearly defining the suspect root causes***
- ***Determining actions to correct the root cause problem***

Corrective actions may include additional training, modifications to policies/procedures, disciplinary action, and/or additional auditing practices.

Internal corrective action plans are designed to eliminate the cause of the problem, not just the symptoms. Key to this process is conducting a root cause analysis. Investigation of the root cause of noncompliance may be specific or system-wide. The root cause provides the basis for solutions that eliminate or prevent the problem. After corrective actions are implemented, these actions are monitored to ensure that the problem does not reoccur. Outcomes are reported to the staff and to corporate management.

3.17.3 Vendor and all of the vendor's subcontractors must comply with all PEBP privacy and security policies and procedures. A copy of PEBP's privacy and security policies and procedures is provided under Attachment M – Privacy Security Policies and Procedures. Please indicate that your organization would agree to these conditions.

KEPRO RESPONSE:

KEePRO agrees and will comply with all Policies and Procedures listed in Attachment M – Privacy Security Policies and Procedures.

3.17.4 Vendor must sign and agree to the terms of PEBP's Business Associates Agreement (BAA). A copy of PEBP's BAA is provided under Attachment N – Business Associate Agreement. Please indicate that your organization would agree to this condition.

KEPRO RESPONSE:

KEPRO agrees and will comply with the terms of the PEBP's Business Associates Agreement (BAA) provided under Attachment N – Business Associate Agreement.

3.18 ELECTRONIC DATA INTERCHANGE (EDI)

3.18.1 All exchange of PEBP electronic formatted data, as well as data exchange between PEBP and vendors, shall be approved in advance by PEBP's Information Technology Officer or designated staff.

KEPRO RESPONSE:

KEPRO has extensive experience in mapping data to match inbound and outbound file requirements of every contract we hold. Our current interfaces for major Medicaid contracts in Virginia, South Carolina, Minnesota, New Hampshire, and Wyoming as well as numerous commercial contracts all required that KEPRO map data fields and create interface programs to properly format data for submission to fiscal agents and other entities and files received from those entities. We will use whatever file format and specifications PEBP prefers or requires for data exchange.

KEPRO Information Technology staff will work with the PEBP to ensure that our interfaces are not only compatible with existing systems, but to ensure the format, protocol and encryption methods meet the PEBP requirements. All transaction plans will be approved by PEBP's Technology Officer or designee.

3.18.2 The file format for eligibility data exchange is fixed field, flat file. Exact file specifications will be determined by PEBP. All EDI will require file level encryption. All files exchanged between PEBP and its vendors are accomplished via FTP. Please confirm your ability to comply with this requirement.

KEPRO RESPONSE:

Transferring the data to and from the previously identified entities is being done in several ways. KEPRO is primarily using FTPS in several different configurations to meet the needs and requirements of each contract. We employ both "push" and "pull" methodologies and automate those processes wherever possible by using scheduling software to facilitate the transfer. File level encryption and FTP transfers can easily be employed to facilitate the transfers. Whatever the final methodology employed, KEPRO will ensure that all data transfers and the processes and equipment used for those transfers will meet or exceed the requirements for security compliance that are identified by PEBP.

3.18.3 All data is the property of PEBP. Data cannot be shared, distributed, or used outside contract specification without permission from PEBP. All data must be made available upon PEBP's request.

KEPRO RESPONSE:

Our current processes support all of our government and commercial clients, typically exceeding required security standards, and will protect PEBP data from distribution or use outside of the specifications of this contract. KEPRO agrees that all data is the property of PEBP and any and all data will be furnished upon request.

3.19 PERFORMANCE STANDARDS, GUARANTEES, PENALTIES

Please confirm that your organization will agree to the following performance standards, guarantees, and financial penalties. Compliance will be determined by PEBP and PEBP's health plan auditor. PEBP reserves the right to revise the performance standards, guarantees, and financial penalties as needed. PEBP's health plan auditor will audit the UM Vendor every odd numbered year of the existing vendor contract.

July 1, 2014- June 30, 2019

Service Performance Standard	Guarantee	Method of Measurement	Performance Guarantee Penalty Amount
I. Quarterly and annual management reports	100.0%	Delivery of Quarterly reports within 45 days of end of reporting period as established by PEBP	1% of annual administration fees per report per day greater than 10 days.
II. Notification of potential high expense cases. High expense case is defined as a single claim or treatment plan expected to exceed $100,000.00.	95.0%	Designated PEBP staff will be notified within 5 business days of the UM vendors initial notification of the requested service	For each percentage point, or a fraction thereof below the annual guarantee, 1% of annual administration fees.
III. Pre-certification information shall be provided to PEBP's third party administrator	98%	Pre-certification requests from healthcare providers shall be communicated to PEBP's Third Party Administrator using an approved method e.g. electronically, within 5 business days of UM completing Precertification determination	For each percentage point, or a fraction thereof below the annual guarantee, 1% of annual administration fees.
IV. Concurrent hospital review	98%	Concurrent hospital reviews shall be completed and communicated using an approved method e.g. electronically within 5 business days of determination decision	For each percentage point, or a fraction thereof below the annual guarantee, 1% of annual administration fees.

Compliance with service category I is determined by PEBP's Executive Officer. Compliance with service categories II, III & IV is determined by audits performed by PEBP's health plan auditor conducted in odd numbered years. Annual is typically defined as the time period starting July 1 and ending June 30 of each year of the contract.

- Public Employees' Benefits Program will collect performance guarantee amount by withholding the appropriate amount from vendor's annual administration fees. If no further administrative fees are due, PEBP will send an invoice for the penalty amount to the vendor. Payment is due within 30 days. Failure to pay within 30 days will result in a penalty of 1.5% of the penalty amount per month, compounded monthly.
- Upon contract termination, PEBP may withhold payment of a portion of the last invoice until after all audits have been accepted by the PEBP Board. The portion of payment withheld will be not more than the lesser of:
  1. The last invoice received by PEBP; or
  2. An amount equal to 100% of the largest quarterly penalty assessed during the last two years of the contract.

3.19.1 Selected vendor will be required to have an independent financial audit performed annually and a copy of the audit shall be provided to the State within 30 days of its completion. The date of the audit shall be mutually agreed upon.

3.19.2 Exceptions to the requirements of this Scope of Work must be clearly stated in Attachment B – Technical Proposal Certification of Compliance with Terms and Conditions of RFP, noting a) the RFP section to which vendor is taking exception, and b) future expectations for meeting the requirement, a projected timetable, and detailed plans for meet the requirement, along with the vendor staff and qualifications assigned.

3.19.3 Vendors are encouraged to include any additional information in their proposals that would be considered useful to PEBP.

KEPRO RESPONSE:

KEPRO confirms and agrees to the performance standards, guarantees, and financial penalties as outlined above. We confirm that compliance will be determined by PEBP and PEBP's health plan auditor. We confirm that PEBP reserves the right to revise the performance standards, guarantees, and financial penalties as needed that the PEBP's health plan auditor will audit the selected utilization management vendor annually.

SECTION 4 – COMPANY BACKGROUND AND REFERENCES

4.1 VENDOR INFORMATION

4.1.1 Vendors must provide a company profile in the table format below.

Question	Response
Company name:	***KEPRO Acquisitions, Inc.***
Ownership (sole proprietor, partnership, etc.):	***PAMED***
State of incorporation:	***Pennsylvania***
Date of incorporation:	***July 1985***
# of years in business:	***27 years***
List of top officers:	***Joseph A. Dougher, President and CEO Meghan Harris, Chief Operations Officer Joseph Koury, Chief Financial Officer Chris Bouvier, Chief Information Officer***
Location of company headquarters:	***777 East Park Drive, Harrisburg, PA, 17111***
Location(s) of the company offices:	***Harrisburg, PA***
Location(s) of the office that will provide the services described in this RFP:	***Nevada locally based staff with support from Orlando, Florida office.***
Number of employees locally with the expertise to support the requirements identified in this RFP:	***4.5 FTE's locally based staff with support of 26 FTE's in the Orlando, Florida office.***
Number of employees nationally with the expertise to support the requirements in this RFP:	***246***
Location(s) from which employees will be assigned for this project:	***Nevada and Orlando, Florida***

4.1.2 Please be advised, pursuant to NRS 80.010, a corporation organized pursuant to the laws of another state must register with the State of Nevada, Secretary of State's Office as a foreign corporation before a contract can be executed between the State of Nevada and the awarded vendor, unless specifically exempted by NRS 80.015.

4.1.3 The selected vendor, prior to doing business in the State of Nevada, must be appropriately licensed by the State of Nevada, Secretary of State's Office pursuant to NRS 76. Information regarding the Nevada Business License can be located at http://sos.state.nv.us.

Question	Response
Nevada Business License Number:	20091
Legal Entity Name:	KEPRO Acquisitions, Inc. (KEPRO)

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

Yes	X	No	

If "No", provide explanation.

4.1.4 Vendors are cautioned that some services may contain licensing requirement(s). Vendors shall be proactive in verification of these requirements prior to proposal submittal. Proposals that do not contain the requisite licensure may be deemed non-responsive.

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

Yes		No	X

If "Yes", complete the following table for each State agency for whom the work was performed. Table can be duplicated for each contract being identified.

Question	Response
Name of State agency:	
State agency contact name:	
Dates when services were performed:	
Type of duties performed:	
Total dollar value of the contract:	

4.1.6 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

If "Yes", please explain when the employee is planning to render services, while on annual leave, compensatory time, or on their own time?

If you employ (a) any person who is a current employee of an agency of the State of Nevada, or (b) any person who has been an employee of an agency of the State of Nevada within the past two (2) years, and if such person will be performing or producing the services which you will be contracted to provide under this contract, you must disclose the identity of each such person in your response to this RFP, and specify the services that each person will be expected to perform.

4.1.7 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 must 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:		

4.1.8 Vendors must review the insurance requirements specified in Attachment E, Insurance Schedule for RFP 3084. Does your organization currently have or will your organization be able to provide the insurance requirements as specified in Attachment E.

Yes	***X***	No	

Any exceptions and/or assumptions to the insurance requirements ***must*** be identified on ***Attachment B, Technical Proposal Certification of Compliance with Terms and Conditions of RFP.*** Exceptions and/or assumptions will be taken into consideration as part of the evaluation process; however, vendors must be specific. If vendors do not specify any exceptions and/or assumptions at time of proposal submission, the State will not consider any additional exceptions and/or assumptions during negotiations.

Upon contract award, the successful vendor ***must*** provide the Certificate of Insurance identifying the coverages as specified in ***Attachment E, Insurance Schedule for RFP 3084.***

KEPRO RESPONSE:

KEPRO understands and will comply with all requirements outlined in section 4.1.8 and will provide the Certificate of Insurance (identifying the coverage's as specified in Attachment E of the RFP).

4.1.9 Company background/history and why vendor is qualified to provide the services described in this RFP. Limit response to no more than five (5) pages.

KEPRO RESPONSE:

KEPRO, a leading quality improvement and care management organization, offers integrated, outcomes-focused solutions to reduce health care utilization, help members better manage their health, and optimize quality of care. From our origins as a QIO in 1985, we've expanded our reach to include national, state, and local government; commercial contract oversight was added in 1996. We expanded our scope of services in 2006 to include case, chronic, maternity, and specialty condition management. We have been a trusted partner to 13 state Medicaid agencies, several Federal agencies, and numerous commercial healthcare entities with similar scope and complexity to the responsibilities governed by this opportunity.

KEPRO is URAC accredited in health utilization, case, and disease management. Our most recent audit indicated 100 percent compliance with the highest standards established by this prestigious organization. We also received Department of Defense's accounting (DCAA) and IT security agencies (DIACAP) certification. We are also licensed to perform review in all 27 states requiring such licensure.

We offer an integrated suite of care management solutions:

- ***Utilization management/Management, including standard of care review***
- ***Independent Review Organization (IRO) Appeals Review***
- ***Claims Review and Risk Management***
- ***Case Management (including specialty services such as Maternity, Oncology, and Advanced Illness)***
- ***Chronic Care Management***
- ***Wellness and Lifestyle Management.***

Throughout our 28 year history, KEPRO has demonstrated our ability to perform utilization management and care management functions. We have developed standard operating procedures that efficiently and effectively enable us to review more than 500,000 medical records annually for prior authorization, retrospective and/or concurrent review, and claims review. We have significant experience in the review of medical claims, including quality of care, standard of care, medical malpractice, medical necessity, continued stay, appropriateness of setting, quality of care screening, DRG/coding validation, readmission and transfers, Hospital-Issued Notices of Noncoverage (HINNs), and Notices of Discharge & Medicare Appeal Rights and preadmissions. An average of 250,000 –

300,000 members annually are screened for potential enrollment in our care management programs. Figure 3 in section 3.3 demonstrates the breadth of our UM experience.

In 2012, KEPRO reviewed over <u>one million</u> records and screened 250,000 – 300,000 members for care management programs.

Physician Driven Oversight

As one of the most experienced federal, state and local government review vendors in the nation, we understand the need for expert clinical knowledge, impartiality, quality, and integrity in every component of the utilization management process; we manage it through our staff medical directors and national review panel. We employ xx full time and xx part time medical directors in various specialties. Medical directors are intimately involved in our product development and oversee the day to day clinical operations.

We offer a national review panel of more than 3,200 board-certified physician specialists in all 50 states, providing care management consultation and specialty-matched peer review to assess and monitor care. Our specialists are either full time practitioners or in academia. Other health care practitioners are available to support utilization management programs. These include, but are not limited to: physician assistants, nurse practitioners, nurse midwives, nurse anesthetists, registered nurses, physical therapists, pharmacists, occupational therapists, speech and language pathologists, psychologists, social workers.

Federal Programs Experience; Standard of Care Review

KEPRO was created in 1985 as a peer review organization (QIO) to protect the rights of Pennsylvania's Medicare beneficiaries. We became the QIO for Ohio in 1999. QIOs work to improve the quality of health care by increasing the likelihood of desired health outcomes and ensuring they are consistent with current professional knowledge. We evaluate whether the quality of services provided is consistent with professionally recognized standards of care.

Our medical claims review experience includes Federal Tort Claims Act (FTCA) medical claims reviews, Medicare quality of care case reviews, and TRICARE Department of Defense (DoD) Standard of Care reviews. We perform external medical malpractice review for the DoD as TRICARE's National Quality Monitoring Contractor. Expert medical reviewers determine if services followed standard medical care or fell below an acceptable standard of care for the patient's condition, based on what a competent peer would have done under the same or similar circumstances. We partner with HRSA to provide malpractice claims review and risk mitigation for 7,500 federally funded health centers and 125 free clinics. We have recommended reduced payments and decreased the awarding of malpractice claims. We also provide risk mitigation education and provider improvement training.

Utilization management Experience with State Medicaid and Commercial Programs

Since 1992, we have helped 13 Medicaid agencies and numerous commercial entities such as employers, Third Party Administrators, Health Plans, and State Employee Benefit Programs administer utilization management programs by making timely, evidence-based medical necessity determinations across all health care settings. We currently provide utilization management and

quality management services to Virginia, Tennessee, South Carolina, Wyoming, Minnesota, and New Hampshire.

Of note is our Tennessee Medicaid contract. Since 2007, we have provided expert witness testimony for almost 5,000 hearings and over 16,000 expert medical reviews/findings. These medical reviews include evaluating medical care to determine if it was consistent with evidenced based practice, and identifying quality concerns or evidence of fraud or abuse.

We have completed independent physician reviews for a number of commercial health plans. Members and providers who appeal the health plan's non-certification of requested medical care are offered the opportunity to have their care and requested services reviewed by an independent third party. Our physician reviewers determine medical necessity of the requested service, consistent with evidenced based practice; they report on quality concerns that may be evident.

KEPRO's Value: Quality, Measureable Outcomes

As a quality based company, we understand the value of measuring results! We monitor/audit for quality as described in section 3.6 and while process outcomes are important, the greater value is measured in customer service and program outcomes. The table below lists KEPRO's UM outcomes for 2013 to date.

Outcome	Benchmark/Goal	KEPRO Outcome
Call Center Abandonment Rate	5%	1.47%
Call Center Average Speed to Answer	30 seconds	20.14 seconds
Average LOS	Milliman Moderately Managed 4.28 Days	3.84 Days
Days/1000 covered lives	Milliman Moderately Managed 237.36 Days	195.30 Days
Admits/1000 covered lives	Milliman Moderately Managed 55.51 Admissions	50.16 Admissions
Cost Savings		$256,057,473
ROI	5:1	16:1

Case Management Experience

KEPRO has been offering URAC accredited/NCQA compliant case and chronic care management since 2006. The scope of our case management program includes care coordination, care transition management, short term/general case management, complex/large case management, and specialty case management such as maternity, heart failure, oncology, or Advanced Illness (End of Life and Palliative Care) Management.

Our programs are designed with the ability to adapt to the specific needs of each client's population. We use all mechanisms available to identify potential participants – referrals from multiple sources (including member self-referrals) and utilization management. Through extensive claims analysis and predictive modeling, we are able to not only identify members with high cost conditions but our sophisticated algorithms identify those who have the probability of having high cost conditions in the future. We incorporate medical, behavioral health, and pharmacy claims as well as results of Health

Risk Assessments and biometric screenings to develop a composite health profile for not only the population but each individual. This profile identifies utilization trends, quality of care concerns, compliance with evidenced based practice guidelines and gaps in care. We then work with our clients to adapt our core programs to meet the challenges offered by each unique population.

As stated in section 3.11.1.7, our case management philosophy is one of member self-care and management. Our case managers empower members to work more collaboratively with their physicians to take a more proactive role in managing their health; we facilitate the removal of barriers to treatment plan compliance to reduce avoidable use of health care resources. Why:

- ***Industry knowledge shows that up to 75 percent of readmissions occur as a result of medication non-compliance.***
- ***A study reported in the Annals of Emergency Medicine found that a quarter of discharges resulted in at least one emergency department visit within a month after the patients left the hospital; 46 percent of these visits lead to a readmission.***

Case Management Outcomes

We show our program value by reporting on three metrics – clinical (behavioral change that results in desired outcomes), financial (cost savings/avoidance), and member satisfaction (perception of the program's ability to assist in realizing their health goals). The table below lists the outcomes that reflect the success of our program.

Outcome	Benchmark/Goal	KEPRO Outcome
Medical Treatment Plan Compliance	>90%	100%
Effective Self-Management Plan	>90%	100%
Optimize Quality of Life /Behavioral Health	>85%	100%
Reduced hospital admissions	>90%	83%
Recognize risk factors/prevent complications	>90%	99%
Work more collaboratively with physician	>90%	100%
Member Satisfaction with the Program	>90%	95%

Our case management program has reduced the frequency of admissions, readmissions, and emergency department visits resulting in a 5:1 ROI.

Cancer management

Avoidable cancer-related complications are significant cost drivers; malnutrition as an example, is a major cause of morbidity and mortality. KEPRO's Cancer Management Program is founded on the basic principles of our case management program and employs nurses and physicians with extensive oncology management experience. Our program helps improve quality of life in cancer patients, and reduce cost associated with morbidities and mortality. The following table shows the cost avoidance for a sampling of cases managed in our program.

Oncology Goal	*# of Members Meeting Goal*	*Avg Cost/Goal*	*Total Savings*
Healthy Lifestyle	*49*	*$3,762.50*	*$184,362.50*
Medication Compliance	*9*	*$2,000.00*	*$18,000*
Treatment Compliance	*17*	*$2,000.00*	*$34,000*
Preventing Infection	*220*	*$8,832.00*	*$1,943,040.00*

These are just a few examples that reflect KEPRO's experience and ability to deliver successful, results oriented case management programs for our clients. They reflect how our program can significantly improve the health outcomes of PEBP employees and reduce your health cost trends.

4.1.10 Length of time vendor has been providing services described in this RFP to the public and/or private sector. Please provide a brief description.

KEPRO RESPONSE:

The following identifies the length of time KEPRO has been providing services described in this RFP to both the public and private sector and a brief description of our services.

<u>Utilization Management</u>: Public Sector – 21 years (1992); Private Sector – 7 years (2006)
KEPRO's URAC accredited utilization management program evaluates the medical necessity, quality, and efficiently of health care services using evidenced based practice guidelines and nationally recognized criteria (such as InterQual or MCG – formally Milliman Care Guidelines). UM actions are conducted under the provisions of applicable benefits/Master Plan Document for all members deemed to be eligible under the plan.

UM activities help ensure that patients receive the "right care at the right time and in the right place" across the care continuum to improve clinical outcomes and lower costs. UM's goal is not meant to merely "limit or restrict" care, but to assure that "appropriate" care is received. Actions are also designed to reduce or eliminate inappropriate/avoidable use of health care resources that may result from provider/member actions or inactions. Utilization management components include but are not limited to:

- ***Pre-certification/prior authorization***
- ***Concurrent review***
- ***Discharge planning***
- ***Appeals***
- ***Retrospective reviews (including medical necessity, quality of care, and usual and customary fee review)***
- ***Determining alternate level of care***
- ***Steering to network providers***
- ***Negotiating out of network discounts***
- ***Monitoring for quality of care concerns***
- ***Collaborating with member, families, and providers to ensure appropriate use of health care resources (through prior authorization, concurrent review, and case management)***

KEPRO's UM program also includes management reports that allow all concerned parties to monitor programs both from a quality, efficient process standpoint as well as desired outcomes. Data is used to identify areas that need further study or improvement and to validate what is working.

General and Large Case Management: Public and Private Sector: 7 years (2006)
KEPRO incorporates the CMSA's definition of case management: Case management is a collaborative process of assessing, planning, facilitating, coordinating (care), evaluating, and advocating for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes.

Our case management program includes care coordination, care transition, general/short term case management, large/complex case management, and specialty management for members with Cancer, Heart Failure, or Advanced Illness (End of Life/Palliative Care). We also offer Maternity Management.

Our philosophy is one of self-care. Our certified case managers work with members, families, and physician/providers to empower members to work collaboratively with their physician and take a more proactive role in managing their health. We consider ourselves an "extension" of the member's physician and work collaboratively to assist the member in realizing health care goals. We assist the member in developing effective self-management plans and removing barriers to compliance with prescribed treatment plans.

We identify members for participation through any and all available sources: HRA/biometric screening results, member self-referrals, referrals from providers, other programs, clients, claims administrators, stop loss carriers, and from the utilization management process. Our system has triggers embedded that auto-generate a referral to case management when data entered into a UM case matches one of the triggers. Review nurses can also refer members at any time when their condition warrants.

We also analyze medical, behavioral health, and pharmacy claims to identify members who have or are at risk of having high cost claims using our sophisticated, proprietary predictive models.

Triggers for general or large case management include but are not limited to conditions such as:

- ***Discharge planning and education***
- ***Care Transition to avoid readmissions***
- ***Long term rehabilitation***
- ***Extensive DME/Home Health needs***
- ***SNF/Inpatient rehab admissions***
- ***Serious injury/illness***
- ***High cost diagnoses***
- ***Multiple providers (uncoordinated care)***
- ***Poly-pharmacy***
- ***Gaps in care as a result of physician non-compliance with evidenced based care and/or member non-compliance***
- ***Multiple use of health care resources (especially those that appear to be avoidable or inappropriate)***

- ***Little/no family support/care givers***

As a URAC accredited program, members must consent to participate in the program. Our outreach and enrollment process consists of a series of phone calls and letters to introduce the program and obtain consent to participate.

Our proprietary medical management system allows us to assess and manage members with multiple comorbidities by completing multiple condition specific assessments. Results of the assessments feed into a consolidated, member centric case management plan of care. Frequency, intensity, and duration of interventions are dependent on the member's risk. Interventions are primarily telephonic and also include web portal, secure email/text, mailings, and in rare instances, on-site evaluation. Members are managed in the program until their health care goals are met. Enrollment may be short term (30 days) or up to 6 months on an average.

We measure our success by reporting financial, clinical, and member satisfaction outcomes.

<u>Pre-certification of specified medical services to determine medical necessity</u>: Public Sector – 21 years (1992); Private Sector – 7 years (2006)

KEPRO's pre-certification program includes medical necessity review of all scheduled/unscheduled inpatient admissions (acute, SNF, rehab, behavioral health, etc.), outpatient procedures, diagnostic testing, radiology, high cost pharmaceuticals, DME, Home Health, and therapies. We customize this list to meet client/benefit plan requirements.

Members may submit requests by phone, fax, or mail. Providers may do the same however also may submit via the secure provider portal. Reviews encompass medical/surgical, behavioral health, and substance abuse. The rationale for what should/should not require pre-certification includes:

- ***High cost/high risk procedures or diagnoses***
- ***Potential abuse of services***
- ***Identify members for potential case management***
- ***Ensure compliance with benefit plan coverage***
- ***Steer to network providers – to include COE***

We embed InterQual criteria in our systems to facilitate the medical necessity review process. We also incorporate MCG (formally Milliman Care Guidelines) to augment InterQual and/or based on client preference. The review evaluates the "right care at the right time and in the right place". It includes:

- ***Medical necessity***
- ***Alternate level of care evaluation***
- ***Compliance with evidenced based practice***
- ***Steerage to network providers***
- ***Fee negotiations for out of network services***
- ***Quality of care monitoring to include HAC and avoidable days***
- ***Efficient, timely discharge planning***
- ***Referral to case management***

Review of inpatient admissions includes assigning a length of stay and scheduling continued stay reviews to ensure timely discharge (see concurrent review).

Any quality of care concerns or requests that do not meet medical necessity are referred to our staff medical director for review and determination. He/she may opt for a peer to peer discussion before rendering a determination.

Members are notified of the determination by mail; providers are notified by phone, fax, portal, or mail based on the method the request was submitted. Denial notices include appeal rights and comply with all regulatory and accreditation requirements.

All pre-certification determinations are sent to the Claims Administrator via a nightly file extract. We coordinate with the Administrator during implementation to establish a layout that meets their claims processing requirements.

<u>Concurrent Review</u>: Public Sector - 21 years (1992); Private Sector - 7 years (2006)

Inpatient admissions are assigned an initial length of stay when the request is initially certified. We assign up to three days unless the member's condition indicates an extended length of stay (such as serious injury or a premature infant admitted to the NICU). In this case we assign up to five days. While it's evident that the stay will exceed 5 days, it is important to monitor for quality and the member's progress to allow for timely alternate level of care and discharge planning decisions.

We contact the facility at least one day before the last certified day to obtain clinical information required to support medical necessity. The medical necessity review at this point is consistent with that used in the pre-certification process – to include criteria, medical director referral, and notification of members and providers, and sending determination results to the claims administrator.

Concurrent reviews also consider whether the member is progressing along the care continuum. If the answer is no, we consult with our medical director who may conduct a peer to peer with the treating physician to determine plan of care.

Concurrent reviews continue until the member's status no longer supports medical necessity of an inpatient stay. In this cause the medical director denies continued stay but we continue to monitor the member until discharge. If inpatient stay remains medically necessary, we follow the member through discharge. In both scenarios, we document the discharge date which allows us to capture average length of stay and bed days per 1,000 covered lives.

We may also conduct concurrent review for certain outpatient services such as home health, therapies, or continued use of certain rented DME. In these instances, the provider notifies us of the need for continued services.

<u>Retrospective Review</u>: Public Sector - 21 years (1992); Private Sector - 7 years (2006)

Retrospective Review is performed after services have been delivered but prior to claims payment. We may get a request from the client or the Claims Administrator.

We request complete medical records from the provider and review to determine medical necessity of the initial treatment and any/all continuation of services. Essentially, medical necessity review mirrors that of the pre-certification process – medical necessity, level of care, length of stay/services, quality of care concerns, HAC, and avoidable days.

In addition, retrospective reviews include a review of charges to compare against usual and customary rates.

Results of the determination are normally communicated back to the client or Claims Administrator in writing. We establish a secure, efficient mechanism to seamlessly transfer data from one entity to the other. Our notices are such that appropriate content may be "copied/pasted" into the client's or Claims Administrator's notice to the member or provider.

If preferred, we can communicate directly with the member or provider. We coordinate with the client during implementation to develop a retrospective review letter template for both members and providers.

<u>Appeals</u>: Public Sector - 21 years (1992); Private Sector - 17 years (1996)

There are two levels to our Appeals process: first level appeal as part of the pre-certification/concurrent review process and independent review (IRO) appeal requested by our Health Plan clients. In both instances, the core processes are the same. We process both standard and expedited appeals; our processes comply with accreditation and regulatory requirements.

IRO Appeals: Health Plans submit appeal requests from members/providers who have requested a review from an independent third party. We receive the request – which includes all medical records – and identify a specialty reviewer on our panel for specialty match review – meaning, their specialty is the same as that of the treating physician. All clinical documents and benefit plan information is forwarded electronically to the physician reviewer who will then review and make a determination using InterQual/MCG criteria – but most importantly, his/her expertise related to quality evidenced based practice. The physician reviewer may uphold the denial or overturn it in whole or part. The reviewer documents his/her determination, along with rationale in the appeal case and electronically returns the case to KEPRO. KEPRO prepares a determination letter that is forward to the Client who is responsible for notifying the provider and/or member.

Appeals as part of the URAC accredited utilization management process: Members, or family/providers on behalf of the member, may appeal an adverse determination within the timeframe specified in their non-certification letter. If additional clinical information accompanies the request, the appeal and clinical documents are forwarded to a nurse reviewer. The nurse reviewer will evaluate the new clinical information and determine if it supports medical necessity. If it does, the nurse overturns the denial and notified the member and provider of the determination.

If the clinical information does not support medical necessity, the appeal is forwarded to a like-specialty reviewer who was not involved in the initial determination. As with IRO reviews, the specialty reviewer may uphold the denial or overturn it in whole or part. His/her decision and rationale is pulled into an Appeal Determination Letter that contains second level appeal rights if the member's Master Plan Document allows for second level appeal.

<u>Management Reporting</u>: Public Sector - 28 years (1985); Private Sector - 7 years (2006)

Management reports are vital to the success of any program. As a QIO, KEPRO has been gathering and analyzing data and preparing management reports for over 28 years. Management reports are designed specifically for each opportunity/program therefore may be as simple as "transactional" that purely shoe the number of something such as review volumes, enrolled members, top 25 diagnoses/procedures, etc. They can be extremely complex such as cause and effect reports, program analysis/recommendations, or provider profile reports.

As a QIO, quality is our foundation; which means we build processes with the end in mind. We first determine desired outcomes and how we are going to measure them. We then design processes that will drive success and allow us to collect the prerequisite data. Since our systems are proprietary, we have designed it to capture just about all data components in reportable fields. And, we have the ability to customize to some extent to capture client specific data.

Management reports may include but are not limited to:

- ***Results of quality audits***
- ***Compliance with regulatory standards***
- ***Timeliness Reports***
- ***Customer Service reports such as call center performance***
- ***Complaints and grievance reports***
- ***Tranactional/volume reports (number of reviews/cases; number of appeals, number of cases managed, number of case management participants who met goals, etc.)***
- ***Outcomes reports***
- ***Performance guarantee reports***
- ***Program evaluation and analysis with recommendations***
- ***Ad Hoc reports***

Reports are available on-line, many in real time, which allows our clients to easily access data when they need it. We also produce standard report packages that allow us to review our contributions and the effectiveness of the programs during face-to-face quarterly meetings.

Given the importance of data, we review data requirements in depth with our clients during implementation to ensure we make the modifications required to capture client appropriate data.

4.1.11 Financial information and documentation to be included in Part III, Confidential Financial Information of vendor's response in accordance with Section 9.5, Part III – Confidential Financial Information.

Dun and Bradstreet Number:

4.1.11.2 Federal Tax Identification Number:

4.1.11.3 The last two (2) years and current year interim:

A. Profit and Loss Statement
B. Balance Statement

KEPRO RESPONSE:

In accordance with the RFP please review the information for 4.1.11 in Part III, Confidential Financial Information.

4.2 SUBCONTRACTOR INFORMATION

4.2.1 Does this proposal include the use of subcontractors?

Yes		No	***X***

If "Yes", vendor must:

Identify specific subcontractors and the specific requirements of this RFP for which each proposed subcontractor will perform services.

If any tasks are to be completed by subcontractor(s), vendors must:

A. Describe the relevant contractual arrangements;

B. Describe how the work of any subcontractor(s) will be supervised, channels of communication will be maintained and compliance with contract terms assured; and

C. Describe your previous experience with subcontractor(s).

Vendors must describe the methodology, processes and tools utilized for:

D. Selecting and qualifying appropriate subcontractors for the project/contract;

E. Ensuring subcontractor compliance with the overall performance objectives for the project;

F. Ensuring that subcontractor deliverables meet the quality objectives of the project/contract; and

G. Providing proof of payment to any subcontractor(s) used for this project/contract, if requested by the State. Proposal should include a plan by which, at the State's request, the State will be notified of such payments.

Provide the same information for any proposed subcontractors as requested in ***Section 4.1, Vendor Information***.

Business references as specified in ***Section 4.3, Business References*** must be provided for any proposed subcontractors.

Vendor shall not allow any subcontractor to commence work until all insurance required of the subcontractor is provided to the vendor.

Vendor must notify the using agency of the intended use of any subcontractors not identified within their original proposal and provide the information originally requested in the RFP in ***Section 4.2, Subcontractor Information***. The vendor must receive agency approval prior to subcontractor commencing work.

4.3 BUSINESS REFERENCES

4.3.1 Vendors should provide a minimum of three (3) business references from similar projects performed for private, state and/or large local government clients within the last ten (10) years.

4.3.2 Vendors must provide the following information for every business reference provided by the vendor and/or subcontractor:

The "Company Name" must be the name of the proposing vendor or the vendor's proposed subcontractor.

Reference #:	***1***		
Company Name:	***Hillsborough County Government Department of Family and Aging Services Health Care Services Division***		
Identify role company will have for this RFP project (Check appropriate role below):			
X	***VENDOR***		***SUBCONTRACTOR***
Project Name:	***Florida Hillsborough County Health Care Plan (HCHCP)***		
Primary Contact Information			
Name:	***Gene E. Earley, Jr., Director***		
Street Address:	***601 E. Kennedy Blvd.***		
City, State, Zip	***Tampa, FL, 33602***		
Phone, including area code:	***(813) 301-7356***		
Facsimile, including area code:	***(813) 276-2865***		
Email address:	***earleyg@hillsboroughcounty.org***		
Alternate Contact Information			
Name:	***Debbie DeWitt***		
Street Address:	***601 E. Kennedy Blvd.***		
City, State, Zip	***Tampa, FL, 33602***		
Phone, including area code:	***(813) 301-7337***		
Facsimile, including area code:	***(813) 276-2865***		
Email address:	***DewittD@hillsboroughcounty.org***		
Project Information			
Brief description of the project/contract and description of services performed, including technical environment (i.e., software applications, data communications, etc.) if applicable:	***Perform utilization management for inpatient and outpatient services, durable medical equipment (DME), home health and skilled nursing facilities services and specialty physician referrals.***		
Original Project/Contract Start Date:	***10/18/2004***		
Original Project/Contract End Date:	***12/31/2012***		
Original Project/Contract Value:	***$3,627,175.14***		
Final Project/Contract Date:	***6/30/2014***		
Was project/contract completed in time originally allotted, and if not, why not?	***Awarded contract renewal of services***		
Was project/contract completed within or under the original budget/ cost proposal, and if not, why not?	***Contract continues to be maintained within original budget allotted.***		

Reference #:	***2***		
Company Name:	***State of Louisiana Office of Group Benefits***		
Identify role company will have for this RFP project (Check appropriate role below):			
X	***VENDOR***		***SUBCONTRACTOR***
Project Name:			
Primary Contact Information			
Name:	***Rusti White, Contract Manager***		
Street Address:	***7389 Florida Blvd. Suite 400***		
City, State, Zip	***Baton Rouge, LA, 70806***		
Phone, including area code:	***(225) 925-3936***		
Facsimile, including area code:	***(225) 248-4497***		
Email address:	***rwhite@ogb.state.la.us***		
Alternate Contact Information			
Name:	***Patty Rahl, Contract Reviewer***		
Street Address:	***7389 Florida Blvd. Suite 400***		
City, State, Zip	***Baton Rouge, LA, 70806***		
Phone, including area code:	***(225) 925-4207***		
Facsimile, including area code:	***(225) 248-4497***		
Email address:	***Patty.Rahl@LA.gov***		
Project Information			
Brief description of the project/contract and description of services performed, including technical environment (i.e., software applications, data communications, etc.) if applicable:	***Utilization management for inpatient and some outpatient services, and case management for state employees, dependents and retirees.***		
Original Project/Contract Start Date:	***4/1/2010***		
Original Project/Contract End Date:	***6/30/12***		
Original Project/Contract Value:	***$1.4 Million***		
Final Project/Contract Date:	***12/31/12***		
Was project/contract completed in time originally allotted, and if not, why not?	***Yes***		
Was project/contract completed within or under the original budget/ cost proposal, and if not, why not?	***Yes***		

Reference #:	***3***		
Company Name:	***Pittman & Associates, Inc.***		
Identify role company will have for this RFP project (Check appropriate role below):			
X	***VENDOR***		***SUBCONTRACTOR***
Project Name:	***Commercial Services***		
Primary Contact Information			
Name:	***Jane E. Hogan, President***		
Street Address:	***1 S. Prescott Street***		
City, State, Zip	***Memphis, TN, 38111***		
Phone, including area code:	***(901) 473-3316***		
Facsimile, including area code:	***(901) 473-3255***		
Email address:	***jhogan@pa-tpa.com***		
Alternate Contact Information			
Name:	***Debbie Faulkner***		
Street Address:	***1 S. Prescott Street***		
City, State, Zip	***Memphis, TN, 38111***		
Phone, including area code:	***(901) 473-3308***		
Facsimile, including area code:	***(901) 473-3255***		
Email address:	***dfaulkner@pa-tpa.com***		
Project Information			
Brief description of the project/contract and description of services performed, including technical environment (i.e., software applications, data communications, etc.) if applicable:	***Provide Utilization, Case and Disease Management***		
Original Project/Contract Start Date:	***7/16/2001***		
Original Project/Contract End Date:	***7/15/2002***		
Original Project/Contract Value:	***$329,455.00 – 2012 Annual Amount***		
Final Project/Contract Date:	***7/15/2014***		
Was project/contract completed in time originally allotted, and if not, why not?	***Yes, with automatic renewal.***		
Was project/contract completed within or under the original budget/ cost proposal, and if not, why not?	***Yes, with automatic renewal.***		

4.3.3 Vendors must also submit Attachment F, Reference Questionnaire to the business references that are identified in Section 4.3.2.

KEPRO RESPONSE:

We have submitted Attachment F to the business references that are identified in Section 4.3.2.

4.3.4 The company identified as the business references must submit the Reference Questionnaire directly to the Purchasing Division.

KEPRO RESPONSE:

We have requested that each of our references submit the Reference Questionnaire directly to the Purchasing Division.

4.3.5 It is the vendor's responsibility to ensure that completed forms are received by the Purchasing Division on or before the deadline as specified in Section 8, RFP Timeline, for inclusion in the evaluation process. Reference Questionnaires not received, or not complete, may adversely affect the vendor's score in the evaluation process.

4.3.6 The State reserves the right to contact and verify any and all references listed regarding the quality and degree of satisfaction for such performance.

KEPRO RESPONSE:

KEPRO has read, understands and agrees to comply with all requirements outlined in section 3.21.1 through 3.21.4.

ATTACHMENT G – PROPOSED STAFF RESUME

VENDOR STAFF RESUMES

A resume must be completed for each proposed key personnel responsible for performance under any contract resulting from this RFP per ***Attachment G, Proposed Staff Resume.***

PROPOSED STAFF RESUME

A resume must be completed for all proposed contractor staff and proposed subcontractor staff.

COMPANY NAME:	**KEPRO ACQUISITIONS, INC.**		
☒ **Contractor**		☐ **Subcontractor**	
Name:	**Meghan Harris, MS**		**X Key Personnel**
Classification:	Chief Operating Officer	**16 Years in Classification:**	
Brief Summary: of Experience:	***More than 16 years of using data to make strategic decisions to improve operational efficiencies and fuel revenue growth. More than 15+ years of experience in health service research, data acquisition, warehousing and analysis. Adept at sampling design, models of analysis and at chi-square testing and regression analysis among other analytical techniques. Responsibilities have included contract performance management, project design, acquisition of data, data reliability, analysis, reporting and presentation.***		
# of Years with Firm:	**14**		

RELEVANT PROFESSIONAL EXPERIENCE	
Required Information:	
MMYYYY to Present:	***01/2011 to present***
Vendor Name:	
Client Name:	***KEPRO***
Client Contact Name:	***Rose Ungaro-Ciullo***
Client Address, Phone Number, Email:	***777 East Park Drive, Harrisburg, PA 17111 (717) 564-8288***
Role in Contract/Project:	***Chief Operating Officer***
Details and Duration of Contract/Project:	***A vital member of the senior management team who has responsibility for operational leadership to achieve company-wide goals and objectives, particularly in the areas of growth and profitability. Develops and implements strategy for the company. Accountable for the effective management and profitable growth of all operating units and supports the CEO in the development and realization of overall company objectives. Primary focus is day-to-day operations, achievement of long and short-term financial goals, customer relations and driving a culture that is focused on quality and service excellence.***

Required Information: ***MMYYYY to MMYYYY:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	 ***01/2009 to 12/2010*** ***KEPRO*** ***Rose Ungaro-Ciullo*** ***777 East Park Drive, Harrisburg, PA 17111 (717) 564-8288*** ***Vice President, Public Operations*** ***Concurrently oversees several public program contracts by driving innovation, creativity, and strategic comprehension.*** ***Responsible for meeting customer expectations and company financial goals. Productivity expectations to ensure commercial programs achieve financial and contract targets. Identify opportunities for further operational effectiveness through process improvement, re-design, automation, etc.***
Required Information: ***MMYYYY to MMYYYY:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	 ***01/2008-12/2009*** ***KEPRO*** ***Rose Ungaro-Ciullo*** ***777 East Park Drive, Harrisburg, PA 17111 (717) 564-8288*** ***Vice President of Informatics and Reporting*** ***Overall responsibility for informatics and data analytic programs across organizational operational locations. Provide visible and strong leadership in formulating data analysis to improve quality outcomes and reduce costs. Define business needs and requirements for data acquisition, reporting services and performance management. Responsible for planning and directing the development and implementation of reports and data analysis.***

EDUCATION	
Institution Name: ***City:*** ***State:*** ***Degree/Achievement:*** ***Certifications:***	***University of Akron*** ***Akron*** ***Ohio*** ***M.S. of Statistics*** ***Project Management certification, Villanova University***

REFERENCES

Minimum of three (3) required, including name, title, organization, phone number, fax number and email address	**#1 Rose Ungaro-Ciullo** **777 East Park Drive, Harrisburg, PA 17111 (717) 564-8288** **#2 Joseph Dougher, President and CEO** **777 East Park Drive, Harrisburg, PA 17111 (717) 564-8288** **#3 Karen Eaton, Vice President** **777 East Park Drive, Harrisburg, PA 17111 (717) 564-8288**

PROPOSED STAFF RESUME

A resume must be completed for all proposed contractor staff and proposed subcontractor staff.

COMPANY NAME:	**KEPRO ACQUISITIONS, INC.**		
☒ **Contractor**		☐ **Subcontractor**	
Name:	**Julie Wright, B.S., M.B.A.**		**X Key Personnel**
Classification:	**Implementation Manager Account Management**	**15 Years in Classification:**	
Brief Summary: of Experience:	**Over 15 years Account Management experience in health care services for Federal, State, County, and private sector clients. Dedicated, hard working, and self-motivated with a solid track record of consistently meeting and exceeding corporate goals, objectives, and deliverables. Successful project implementation and management. SME in developing project plans, tracking deliverables, and analyzing data. Key member of implementation team for successful start-up of six major state contracts. Project lead for statewide outcome task force and quality improvement procedure manual. Effective communicator able to interact with diverse cultural backgrounds; strong written and oral communication skills. Highly proficient in Microsoft Windows and the following software applications: Microsoft Office (Word, Excel, Project, Visio, Access, and PowerPoint), CRM Dynamics, and SharePoint.**		
# of Years with Firm:	**6**		
RELEVANT PROFESSIONAL EXPERIENCE			

Required Information: ***MMYYYY to Present:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	 ***07/2011 to present*** ***KEPRO*** ***KEPRO*** ***Rose Ungaro-Ciullo*** ***777 East Park Drive, Harrisburg, PA 17111 (717) 564-8288*** ***Strategic Account Executive/Implementation Manager*** ***Responsible for providing overall planning, direction and control to assigned lines of business to achieve operating and financial goals. Ensures that contractual service standards and customer expectations are satisfied. Build strong relationships with customers' senior management and account management staff. Develop a business partnership that promotes opportunities for growth and revenue while supporting the customer's growth objectives.***
Required Information: ***MMYYYY to MMYYYY:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	 ***06/2010 to 07/2011*** ***KEPRO*** ***Rose Ungaro-Ciullo*** ***777 East Park Drive, Harrisburg, PA 17111 (717) 564-8288*** ***Operations Manage/Implementation Manager*** ***Responsible for providing overall planning, direction and control to assigned lines of business to achieve operating and financial goals. Ensures that contractual service standards and customer expectations are satisfied.***

Required Information: ***MMYYYY to MMYYYY:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	 **07/2008-06/2010** **KEPRO** ***Rose Ungaro-Ciullo*** ***777 East Park Drive, Harrisburg, PA 17111 (717) 564-8288*** ***Manager of Corporate Compliance/Implementation Manager*** ***Key member of transition teams for successful start-up of three state contracts. Responsible for directing the development, implementation, and maintenance of a Quality Management System for operational units in seven states.*** ***Responsibilities included interpreting contractual requirements and developing procedures to ensure customer requirements are met, establishing and monitoring performance metrics, and working with contract administrators to develop appropriate corrective action plans when needed. Provided independent and objective review and evaluation of compliance issues/concerns within the organization to ensure meeting/exceeding contract deliverables and customer expectations for all contracts.***

EDUCATION	
Institution Name: ***City:*** ***State:*** ***Degree/Achievement:*** ***Certifications:***	***Columbia Southern University*** ***Orange Beach*** ***Alabama*** ***Masters in Business Administration, Concentration in Project Management***

REFERENCES	
Minimum of three (3) required, including name, title, organization, phone number, fax number and email address	**# 1 Rose Ungaro-Ciullo** **777 East Park Drive, Harrisburg, PA 17111 (717) 564-8288** **#2 Karen Eaton, VP** **777 East Park Drive, Harrisburg, PA 17111 (717) 564-8288** **#3 Meghan Harris , COO** **777 East Park Drive, Harrisburg, PA 17111 (717) 564-8288**

PROPOSED STAFF RESUME

A resume must be completed for all proposed contractor staff and proposed subcontractor staff.

COMPANY NAME:	**KEPRO ACQUISITIONS, INC.**		
☒ **Contractor Account Manager**		☐ **Subcontractor**	
Name:	**Chandra E. Tucker, R.N., B.S.N. , CMM**		**X Key Personnel**
Classification:	**Program Manager**	**20 Years in Classification:**	
Brief Summary: of Experience:	***Accomplished and motivated leader with a proven track record of critical thinking skills and expertise in resolving complicated healthcare, social, interpersonal and financial patient situations. Proficient in applying problem-solving techniques to articulate medical requirements to patients, families, care givers, medical and support staff. Effective rapport building, resourceful problem solving and excellent verbal and written communication skills. Committed to professionalism, highly organized, able to work under strict deadline schedules with attention to detail, and abiding in accordance with the Department of Labor, Health Insurance Portability and Accountability Act (HIPPA), The Joint Commission (TJC), and other regulatory boards. Proficient in Clinical Practice Guidelines (CPGs), the use of McKesson (InterQual) and Milliman Care Guidelines. Excellent conceptual and analytical skills. Exceptional project management skills, able to develop presentations, proposals, protocols, and review guideline documents.***		
# of Years with Firm:			

RELEVANT PROFESSIONAL EXPERIENCE	
Required Information:	
MMYYYY to Present:	***01/2013 to present***
Vendor Name:	
Client Name:	***United Healthcare***
Client Contact Name:	***Kathy Morreale, HR Director***
Client Address, Phone Number, Email:	***6285 Rock Dove Ave, Las Vegas, NV 702-463-3385***
Role in Contract/Project:	***Program Manager***
Details and Duration of Contract/Project:	***Reviewed and integrated medical information from diverse sources including medical records, immunization registries, member documents, and provider offices. Requested and abstracted appropriate medical records, assessing for assigned categories as needed. Reviewed assigned medical records in order to abstract specified and required clinical data elements for HEDIS reporting. Participated in medical record collection and inter-rater reliability process. Scheduled and performed on-site medical record reviews. Complied with appropriate procedures for scheduling, requesting, and reviewing records on-site at provider hospitals and facilities. Documented abstraction findings as required and prepared additional reports as needed. Communicated all project issues including scheduling, assignment, fax/mail correspondence, and supervisor alerts in a timely manner.***

Required Information: ***MMYYYY to MMYYYY:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	 ***02/2009 to 01/2013*** ***Amerigroup Community Care*** ***Suzanne M. Scott, HR Director*** ***7251 W. Lake Mead Blvd. Ste 104, Las Vegas, NV 800-454-3730*** ***Utilization Review /Case Manager*** ***Performed prospective, concurrent, retrospective reviews and case management services. Performed Prior Authorization services for requested medical services. Collaborated with multiple insurance carriers regarding discharge planning needs of hospitalized, acute inpatients.*** ***Collaborated with the Medical Director on cases involving continued stay criteria. Acted as liaison between providers of care (i.e. Hospitalists) and the Medical Director and care facilities. Conducted inpatient care unit rounds for clinical data collection; provided documentation for appeals and grievance resolution. Collaboration on Healthcare Effectiveness Data and Information Set (HEDIS) initiatives. Quality Management and Case Management.***
Required Information: ***MMYYYY to MMYYYY:*** ***Vendor Name:*** ***Client Name:*** ***Client Contact Name:*** ***Client Address, Phone Number, Email:*** ***Role in Contract/Project:*** ***Details and Duration of Contract/Project:***	 ***01/2008-02/2009*** ***Encompass Healthcare Management*** ***Linda Stephens, HR Director*** ***1945 Las Vegas Blvd. S, Las Vegas, NV, 89104 702-223-2900*** ***Managed Care Specialist*** ***Responsible for the Utilization review and case management services for a Commercial Insurance population - inpatient and outpatient. Collaborated with multiple insurance carriers regarding discharge planning needs of hospitalized, acute inpatients. Acted as liaison between providers of care (i.e. Hospitalists) and the Medical Director and care facilities. Medical Necessity claims review. Discharge planning in the acute care setting, within a managed care organization.***

EDUCATION	
Institution Name: ***City:*** ***State:*** ***Degree/Achievement:*** ***Certifications:***	***University of Arizona*** ***Tuscon, Arizona*** ***Arizona*** ***Masters in Nursing with Emphasis in Public Health (Graduation 2014)*** ***Bachelor of Science in Nursing*** ***Registered Nurse, Illinois***

REFERENCES

Minimum of three (3) required, including name, title, organization, phone number, fax number and email address	***#1 Linda Stephens, HR Director*** ***lindastephens@encompasshealth.com*** ***1945 Las Vegas Blvd. S, Las Vegas, NV, 89104*** ***702-223-2900 Fax: (717) 223-2901*** ***#2 Suzanne M. Scott, HR Director*** ***lscott@amerigroup.com*** ***7251 W. Lake Mead Blvd. Ste 104, Las Vegas, NV*** ***800-454-3704 Fax: (702) 245-1234*** ***#3 Kathy Morreale, HR Director*** ***kmorreale@unitedhealthcare.com*** ***6285 Rock Dove Ave, Las Vegas, NV*** ***702-463-3385 fax: (702) 463-3333***