Ohio Department of Medicaid, Office of Contracts and Procurement

Clinical Utilization Management and Prior Authorization Program

RFP Number: ODMR-2223-0006

Technical Proposal

October 26, 2022
2:00 PM Columbus Local Time

Permedion, Inc. (a Gainwell Technologies company)

gainwell

gainwell

October 26, 2022

Office of Contracts and Procurement, RFP/RLB Unit
Ohio Department of Medicaid
ODMR-2223-0006
50 West Town Street
Columbus, OH 43215

Re: Request for Proposal ODMR-2223-0006
Clinical Utilization Management and Prior Authorization Program

Dear Sir or Madame,

Permedion, Inc., a Gainwell Technologies company, welcomes the opportunity to serve as a partner to Ohio Department of Medicaid (ODM) and support your statewide clinical utilization management and prior authorization program for hospital and other services for State Medicaid consumers. We have unmatched experience and a history of success in providing medical peer review and quality assurance (QA) services. Based on this experience, and to support the ODM Bureau of Program Integrity's (BPI) quality efforts, Permedion brings proven processes, approaches, and technological advancements for measuring the quality of our services and the resulting quality of care ODM provides to Ohio's Medicaid consumers. Permedion has received designation by the Centers for Medicare and Medicaid Services (CMS) as a quality improvement organization (QIO)-like entity.

As a partner to ODM for more than 35 years, Permedion has successfully supported quality healthcare for Ohio Medicaid and other underserved populations in the State. Our organization has a long and distinguished history of commitment to making sure the healthcare needs of Ohio Medicaid consumers are appropriately met. We have dedicated ourselves to the pursuit of improvements in medical quality and healthcare resource utilization. We will take the knowledge we have gained in evaluating the quality, appropriateness, necessity, and utilization of medical care for Ohio and for other clients and apply this knowledge with the same care, compassion, and sense of fiscal responsibility to ODM's program.

Our proposed UM/PA solution supports ODM objectives in the following ways:

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- **Safeguard against unnecessary or inappropriate use of Medicaid services and against excess payments.** We know ODM and have successfully overseen ODM's UM/PA operations for more than 35 years, and our proposed key staff bring extensive clinical experience and deep knowledge of ODM operations. Our proposed solution includes provider education, and we will continue to emphasize the importance of professional interactions and positive working relationships with providers. Permedion's solution includes effective technical and clinical support for focused reviews, prior authorizations, special reviews, retrospective reviews, and medical record reviews of denied Managed Care prior authorizations.
- **Assess service quality.** In support of the importance of service quality, Permedion screens every retrospective clinical review for quality of care. Concerns of a higher level are reported to the Department of Health to determine if additional investigation is necessary.
- **Provide for control and utilization of all services provided under a state plan.** The Permedion solution includes the use of nationally accepted, evidence-based clinical guidelines along with the Ohio Revised Code and Ohio Administrative Code Rules to confirm that the care proposed or provided is 1) medically necessary, 2) provided in the most appropriate setting, and 3) was properly billed.
- **Provide for the control of the utilization of inpatient services for both medical and psychiatric services.** Permedion's solution includes experienced licensed clinical professionals and Ohio-licensed physicians with expertise in both medical and psychiatric inpatient admissions.

Permedion is the most experienced and highest performing state government UM firm in the industry and has a proven record of quality results and service delivery in Ohio. Our team is comprised of healthcare professionals with expertise in all aspects of the scope of work (SOW) defined in the Department's RFP. Permedion offers dedicated experts who understand the Ohio Medicaid environment and who have been integral to the success of the State's UM/PA efforts today. We understand the evolving needs of the provider community as modular systems are deployed in Ohio, and we look forward to the opportunity to continue supporting ODM in its goal of integrated and transparent solutioning. Lauren Rizzo, Vice President, Government Services, will serve as the Accountable Executive for this project. Please contact her via telephone at 973.285.5478 or via email at lauren.rizzo@gainwelltechnologies.com with any questions about Permedion and/or our proposal to provide the service needs outlined in this RFP.

We look forward to continuing our partnership with ODM and to moving your program forward with increased efficiency, ongoing quality, continuous improvement, and proactive innovation.

Sincerely,

Paul Saleh
President and Chief Executive Officer

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RFP Requirement Reference Table

To support the evaluation process, HMS provides the following reference table that identifies the location of our responses to each RFP requirement. The organizational structure of Permedion's Technical Proposal complies with RFP Section 6.2.

Criterion identified in RFP Attachment B Technical Proposal Score Sheet is indicated in **bold**.

Table 1. Permedion Proposal Response Compliance with RFP Requirements

RFP Section Reference	RFP Requirement	Permedion Proposal Section
A. Mandatory Offeror Requirements		
3.1	Offerors MUST meet and provide proof of, at minimum, ALL of the following qualifications. Offerors who do not meet ALL the below requirements will be disqualified from further consideration for contract award.	A.3.1
3.1.A	The selected vendor must have received designation by the Centers for Medicare and Medicaid Services (CMS) as a Quality Improvement Organization (QIO) or QIO-like entity. Proposals from vendors who do not demonstrate that the organization is a Medicare QIO or QIO-like entity will not be considered.	A.1
3.1.B	Complete and return all requirements and forms in Attachment A upon submission of Proposal.	A.2
3.1.C	Submission with Proposal of a selected Ohio certified Minority Business Enterprise (MBE) subcontractor assigned, at a minimum, job duties that will equate to a minimum of 15 percent of the total dollar amount of the contract per state fiscal year (SFY). This requirement is further described in MBE (EDGE) Subcontracting Requirements. a. If the submitting organization is a State of Ohio Minority Business Enterprise (MBE), Encouraging Diversity, Growth and Equity (EDGE) Offeror, or Veteran Business Enterprise (VBE), provide copy of current certification from DAS.	A.3
C. Organizational Experience and Capabilities		
3.2	Proposals should demonstrate significant organizational expertise of the prime Offeror. Proposals must include, at a minimum, the following demonstrated experience as detailed below; and as part of the evaluation process, this information will be scored by ODM: The Offeror information provided for all the [below] topics should include summary descriptions of all successfully completed projects, any notable accomplishments and outcomes, and contact information for an Offeror's customers that received the services provided—if not already included as a reference. Offeror experience and knowledge should be demonstrated by providing key samples, excerpts, or copies representative of the quality of relevant work.	C.3.2
3.2.A	Demonstrated experience relevant to completing the work identified in the Scope of Work and Specification of Deliverables Sections of this RFP. Include information on the background of the firm, including any subcontractors who would perform work under any contract resulting from this RFP.	C.A. 3.2.A
3.2.B	Samples (excerpts and/or Executive Summaries acceptable) of at least two, but no more than four, similar sized projects completed or begun in the past five (5)	C.B 3.2.B

RFP Section Reference	RFP Requirement	Permedion Proposal Section
	years that demonstrate expertise and experience in providing expert assistance in the strategies and objectives listed in section 1.3.	
3.2.C	Demonstrated knowledge of and experience in Medicaid, include Ohio-specific knowledge and experience.	C.C 3.2.C
3.2.D	Demonstrated familiarity with and experience in the practical application of the laws and regulations impacting Medicaid operations. Include Ohio-specific knowledge and experience.	C.D 3.2.D
3.2.E	Names and contact information for at least three entities for which the Offeror has performed similar large-scale projects in the past five (5) years.	C.E 3.2.E
B. Staff Experience and Capabilities		
3.3	Offeror must have staff proposed for the program with demonstrated quality improvement experience and knowledge of Medicaid programs and delivery systems. This means that the proposed staff must have experience with the following: A. Medicaid consumers, policies, data systems. Utilization review programs. C. Quality assessment and improvement methods. D. Evidence-based clinical guidelines. E. Research designs, methods, and statistical analysis. F. Claim submission and correct coding requirements, both professional and institutional (inpatient and outpatient) G. HIPAA billing requirements and guidelines. H. National Uniform Billing Committee (NUBC) manual. I. Electronic Data Interchange (EDI) guidelines and companion guides. J. All Patient Refined Diagnosis Related Groups (APR-DRG) reimbursement. K. Enhanced Ambulatory Patient Groups (EAPG) reimbursement. L. Ohio Revised Code and Ohio Administrative Code Rules - 5160 Medicaid. M. Centers for Medicare and Medicaid Services (CMS) rules and regulations or other pertinent federal guidelines.	B. 3.3
3.3.A	Offeror must have the specified number of executive and professional personnel, management analysts, system analysts, programmers, consultants, etc., who will be involved in providing the Deliverables, and indicate where these personnel will be physically located during the time that they are involved in the work. Offeror must identify, by position and by name, those staff they consider key to the program's success. Additionally, the Offeror should provide resumes, education, experience and a list of related published works for key personnel that will be assigned to this program. Key personnel should include, at a minimum, at least one of the following personnel, unless otherwise specified below: A. Medical Director, located and licensed in Ohio; B. Project Leader; C. Project Managers (2); D. Director of Quality Studies; E. Database Administrator; and F. Biostatistician.	B.14: 3.3.A

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3.3.A	The Medical Director will act as both Medical Director and Principal Clinical Coordinator for the program. The Medical Director will provide clinical direction for the Utilization Management program. Responsibilities of the Medical Director include: A. Oversight of all physician reviewer activities (recruiting, training, and supervising). B. Oversight of medical record reviews and appeals. C. Provide medical and technical expertise and guidance on criteria interpretation and other professional issues. D. Respond to calls or correspondence from physicians and providers. E. Manage quality assurance procedures to ensure consistent and appropriate application of criteria. The Medical Director is expected to provide medical oversight and clinical leadership in the development and execution of health care quality improvement efforts involving physicians, hospitals, and managed care organizations. The Medical Director must be a licensed and Ohio board certified Doctor of Medicine (MD) or Doctor of Osteopathic Medicine (DO). A minimum of five (5) years prior medical director or administrative experience is required.	B.14.a 3.3.A
3.3.A	The Project Leader will oversee the start-up and ongoing operations of the proposed program. The Project Leader will be expected to: A. Establish action plans, budgets, timetables, and performance measurements. B. Obtain and allocate resources. C. Review progress of the contract to accomplish established objectives. The Project Leader must have the ability to operate independently; a proven track record in planning, conducting and overseeing programs of major significance; experience with Utilization Review and Quality Assurance; and prior fiscal management responsibilities. A Bachelor's Degree in business, health administration, management, or public health is required. Minimum qualifications include five (5) years of experience in a lead position in a quality and utilization management program, including the two (2) most recent years being in health care management.	B.14.b 3.3.A
3.3.A	At least two (2) Project Managers are required, one Project Manager will be assigned to the Quality and Hospital Utilization Management Program and one Project Manager will be assigned to the Behavioral Health special review prior authorization of services program. The Project Managers' responsibilities include the following: A. Management of the implementation and operation of the utilization management plan, which encompasses prospective pre-admission reviews and retrospective review of services provided in a hospital setting. B. Management of the program's Quality of Care Studies, which involves collaboration with ODM in the development of study design and methodology, coordination of study analysis, and dissemination of study findings. C. Management of the implementation and operation of the special review of prior authorization services, which encompasses prospective review of Assertive Community Treatment (ACT) and other mental health and substance use services and level of care. These positions are expected to be assigned to persons who have a background in medicine and clinical care and are licensed, Registered Nurses in Ohio. At a minimum, Project Managers must have five (5) years of experience in the management of activities in a quality and utilization management program, of which at least two (2) years of experience were in Medicaid programs.	B.14.c 3.3.A

RFP Section Reference	RFP Requirement	Permedion Proposal Section
3.3.A	A Director of Quality Studies is needed to serve as principal investigator of quality studies. The Director of Quality Studies will be responsible for: A. Research and sampling design of studies, including clinical measurement. B. Assuring that studies take into account existing clinical practice guidelines, as well as other previous clinical studies using the same research techniques or performed in the same clinical areas. C. Assuring that studies are designed to meet the objectives and answer the research questions agreed upon with ODM. D. Overseeing implementation of the study, analysis and report production. E. Presenting results of the study to ODM and other forums upon reasonable request. The Director of Quality Studies must have an M.D., D.O., or clinical Ph.D., with at least five (5) years of experience in clinical research, including at least three (3) studies (please describe) serving as the principal investigator. Identify authored articles in professional journals, if applicable.	B.14.d 3.3.A
3.3.A	A Database (IT) Administrator for the program. Responsibilities of this position will include the following: A. Create, maintain and update ODM and other databases that will be used to perform contract activities. B. Assure that the Offeror receives data in a timely fashion. C. Maintain reasonable access to data for analytical purposes. The Database Administrator must have at least a Bachelor's Degree in computer science with at least five (5) years' experience including programming, systems analysis and database management. The Database Administrator must possess the technological skills necessary to adequately perform duties utilizing healthcare claims from ODM's current Medicaid Information Technology System (MITS) or any new Medicaid Information Technology System (MITS), or both.	B.14.e 3.3.A
3.3.A	As needed, assign and specify a Biostatistician for the Quality and Hospital Utilization Management Program. Responsibilities include the following: A. Assure that the sampling design meets agreed upon confidence intervals and that sampling weights are constructed consistently with the complexity of the sampling design. B. Determine which statistical tests are used in analysis of the data and assuring that they are used appropriately. C. Participate in the development of abstracting and survey tools, train abstractors and surveyors and oversee tests of inter-rater reliability. The Biostatistician must have a Master's Degree in statistics, biostatistics, or mathematics, or a Ph.D. in a related subject. In addition, the Biostatistician must have at least three (3) years of experience, including at least two studies (please describe) serving as a biostatistician.	B.14.f 3.3.A
3.3.A	In addition, the Offeror must submit general job descriptions/requirements of other staff positions to be assigned to this program, including: A. Medical record extractors; B. Review nurses; C. Physician reviewers; D. Data processors; E. Data analysts; F. Registered Health Information Administrator (certified medical coder); and G. Information Systems Manager.	B.14.g 3.3.A

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3.2	Proposals should demonstrate significant organizational expertise of the prime Offeror. Proposals must include, at a minimum, the following demonstrated experience as detailed below; and as part of the evaluation process, this information will be scored by ODM: The Offeror information provided for all the [below] topics should include summary descriptions of all successfully completed projects, any notable accomplishments and outcomes, and contact information for an Offeror's customers that received the services provided—if not already included as a reference. Offeror experience and knowledge should be demonstrated by providing key samples, excerpts, or copies representative of the quality of relevant work.	C. 3.2
3.2.A	A. Demonstrated experience relevant to completing the work identified in the Scope of Work and Specification of Deliverables Sections of this RFP. Include information on the background of the firm, including any subcontractors who would perform work under any contract resulting from this RFP.	C.A 3.2.A
3.2.B	Samples (excerpts and/or Executive Summaries acceptable) of at least two, but no more than four, similar sized projects completed or begun in the past five (5) years that demonstrate expertise and experience in providing expert assistance in the strategies and objectives listed in section 1.3.	C.B 3.2.B
3.2.C	Demonstrated knowledge of and experience in Medicaid, include Ohio-specific knowledge and experience.	C.C 3.2.C
3.2.D	Demonstrated familiarity with and experience in the practical application of the laws and regulations impacting Medicaid operations. Include Ohio-specific knowledge and experience.	C.D 3.2.D
3.2.E	Names and contact information for at least three entities for which the Offeror has performed similar large-scale projects in the past five (5) years.	C.E 3.2.E
D. Subcontractor Identification and Participation Information		
3.5	Offerors must clearly identify the subcontractor(s) and their tasks in their Proposals. The Proposal must include a letter from the proposed subcontractor(s), signed by a person authorized to legally bind the subcontractor, indicating the following: A. Subcontractor's legal status, federal tax ID number, and principal business address; B. Name, phone number, and email address of a person who is authorized to legally bind the subcontractor to contractual obligations; C. A complete description of the work the subcontractor will do; D. A commitment to do the work, if the Offeror is selected; E. A statement that the subcontractor has read and understands the RFP, the nature of the work, and the requirements of the RFP; and F. The MBE certification number, if applicable, a copy of their current MBE Certification letter must be included.	D. 3.5
E. Scope of Work		
4.1	The selected Offeror will be responsible for the Deliverables as described in Section 1, including all preparatory and intervening steps, whether or not ODM has explicitly specified or delineated them within the RFP. In developing their Proposals, all Offerors must fully and appropriately plan and cost out their proposed projects, including all necessary preparatory and intervening steps.	E. 4.1

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	The selected Offeror will be required to implement and manage a statewide quality and utilization control program. Specifically, the selected Offeror will be responsible for utilization reviews, including focused reviews, prior authorizations, special reviews, retrospective reviews, pre-certification reviews, and medical record reviews of Managed Care prior authorizations and/or claims denied based on medical necessity criteria as requested, conduct provider education, and provide technical assistance to ODM. The selected Offeror will demonstrate an expertise regarding Medicaid populations, developing a comprehensive plan for utilization control, and claims data management and reporting. Additionally, Offeror Proposals submitted in response to this RFP must reflect the Offeror's understanding of, and commitment to, performing the Scope of Work fully.	
F. Deliverables and Proposed Work Plan		
4.2.A	A. Special Reviews: The selected Offeror will conduct all reviews in accordance with the OAC 5160- 2-03 Conditions and Limitations and OAC 5160-1-31, which describes the Special Review/Prior Authorization Program. All reviews must include the use of Ohio-based physicians to ensure practice patterns within Ohio are taken into consideration. To implement and manage the Special Review Program, the selected Offeror will be required to: 1. Develop the methodology and criteria that will be used when a provider requests prior authorization. 2. Select the medical criteria used to determine appropriateness and medical necessity of the request. 3. Train Medicaid providers, ODM staff, and the selected Offeror/subcontractor staff on the prior authorization program. 4. Maintain a reporting mechanism that meets notification requirements described in OAC 5160-1-31 and 5160-2-03. 5. Develop and implement procedures for all prior authorization review denials, including specific documentation of all the reasons for denials. 6. Develop a plan for and participate in hearings when prior authorizations are appealed.	F.1 4.2.A
4.2.B	All reviews must be conducted in accordance with OAC 5160-2-13, which describes utilization control policies for hospital services. Reviews should also meet applicable federal guidelines and should support ODM's program integrity initiatives to ensure appropriate utilization of hospital services. All reviews must include the use of Ohio-based physicians to ensure practice patterns within Ohio are taken into consideration, where determined appropriate. Ohio Medicaid utilizes Milliman Care Guidelines for retrospective review determinations. The 19 retrospective reviews must consist of at least 1,700 inpatient and outpatient claims being reviewed on a monthly basis. The claims will be reviewed for proper coding, level of care, medical necessity and quality of care. The time period for the selection of claims will be determined by, and coordinated with, ODM. Selected Offeror will be required to develop a plan for utilization management that includes post- payment reviews for services and/or admissions provided in the hospital (inpatient and outpatient) setting. The claims are selected based upon the following examples of current target areas: 1. Billing Errors: This target consists of inpatient admissions which have either the admission source or the patient disposition (discharge status) coded incorrectly. 2. Readmissions: This target looks at claims that include readmissions within one day, and within 30 days of the initial admission.	F.2 4.2.B

RFP Section Reference	RFP Requirement	Permedion Proposal Section
	3. Target Diagnostic Related Groups (DRG): This target consists of looking at DRGs that represent a potential for upcoding or other billing errors, or higher than expected utilization. 4. Medical Necessity and Short Lengths of Stay: This target consists of claims with significantly short lengths of stay based on the DRG and/or primary diagnosis for any diagnosis or procedure; claims for procedures which have significantly higher denial rates due to medical necessity concerns and have short lengths of stay; and selected claims with short lengths of stay. 5. Compliance: This target consists of comparing the diagnostic and procedural information reported on the claim against the medical record documentation for consistency. 6. Outpatient/Ambulatory: This target consists of incorrect coding/number of units, billing issues and inappropriate hospital setting. 7. Bill audit: This target reviews DRG-exempt facility claims once a year for accuracy of billing itemized charges. 8. Transfers: This target reviews the documented reasons for and the appropriateness of the transfer. 9. Outliers: This target reviews claims with outliers to determine if days or services were covered and medically necessary. In addition to the target areas listed above, the selection methodology for retrospective reviews is continuously monitored by ODM and updated based on provider utilization trends and national trends in public and private insurance markets.	
4.2.B	To implement and manage the Retrospective Review Program, the selected Offeror will be required to: 1. Develop the methodology and criteria used to select procedures and/or admissions. (Note: selection criteria must address provider incentives likely under a prospective payments system, such as, medical necessity of admission, discharge/transfer decisions, and accuracy of coding.) 2. Include in the program a mechanism that verifies that the services were performed in the most appropriate location. 3. Include in the program a mechanism to verify that information given during the pre- certification process was accurate if pre-certification is applicable. 4. Select the medical criteria used to determine appropriateness of the procedure and/or admission. 5. Provide (number) license(s) granting ODM staff access to Milliman Care Guidelines. 6. Incorporate participation in the provider appeal process as described in OAC 5160-2-12. 7. Train Medicaid providers, ODM staff, and the selected Offeror/subcontractor staff on the retrospective review program. 8. Maintain a reporting mechanism that meets the notification requirements of ORC § 164.57 9. Develop a process for referring quality of care findings to ODM. 10. Monitor and provide suggested updates to the program to ensure that appropriate procedures and/or admissions are reviewed. 11. Ensure that reviews support quality of care studies and the pre-certification program plan described in this Section. Claims To Be Excluded from Fee-for-Service Retrospective Review: 1. Crossover claims where Medicare is the primary payer. 2. Claims where the consumer had a retroactive eligibility change from fee-for-service to managed care.	F.2.A

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	3. Claims for inpatient services rendered to incarcerated individuals participating in the Inpatient Hospital Services Benefit program. 4. Claims for inpatient services rendered under the Presumptive Eligibility program. 5. Claims for Inpatient and Outpatient services subjected to mass adjustment by ODM. Retrospective reviews will primarily be focused on inpatient care, and the sampling methodology will need to be updated to take into account changes in trends in the insurance market and in utilization trends.	
4.2.C	The selected Offeror shall be responsible for performing special reviews. The selected Offeror shall assist with reimbursement for noncovered items and services which may be available contingent upon an approved prior authorization. Prior authorization must be obtained from ODM, or its designee, by the provider before services are rendered or the items are delivered.	F.3 4.2.C
4.2.D	The selected Offeror will conduct focused reviews on an as-needed basis for specific provider's claims as determined by ODM. Focused reviews allow ODM the opportunity to take a closer look at issues that may arise out of the retrospective review program, quality of health care studies, or issues that come to the attention of ODM through any number of sources (e.g. consumer complaint, legislative inquiry, ODM Surveillance and Utilization Review Section (SURS), or other program integrity initiatives). Focused reviews may identify service and procedure targets for pre-certification review. As an example of a focused review, the selected Offeror would analyze the claims data of selected providers that rebill a large number of claims with codes that have been upgraded, to determine if a problem exists with that provider. A "bill audit" may be performed to compare a provider's medical records to the services and charges submitted on their claims. The methodology used for focused reviews must fulfill the agency's Medicaid utilization management objectives and permit focused reviews of either a physician or an institution. The selected Offeror will be required to participate in designing focused review projects through data analysis, targeting, sampling and reporting. The size and scope of the focused reviews will vary depending on the nature of the issue necessitating the review.	F.4 4.2.D
4.2.E	The selected Offeror shall be responsible for performing Community Behavioral Health Service Reviews. Reimbursement for some behavioral health services covered under the Medicaid program is available only upon obtaining prior authorization; prior authorization must be obtained from ODM, or its designee, by the provider before services are rendered. All reviews must be conducted in accordance with OAC Chapter 5160-27 and OAC rule 5160-8-05 as applicable. All reviews must include the use of Ohio-based physicians and medical staff to ensure practice patterns within Ohio are taken within consideration, where appropriate. The selected Offeror must perform the following tasks: 1. Develop the methodology and criteria used to determine the appropriateness of the behavioral health service. Criteria must align with the aforementioned OAC rules. 2. Conduct retrospective reviews of an agreed upon number of claims, if requested by ODM. 3. Conduct provider education as needed. 4. Provide activity and other types of reports as requested by ODM.	F.5 4.2.E

RFP Section Reference	RFP Requirement	Permedion Proposal Section
	5. Participate, with ODM, in an agreed upon appeal process and participate in appeal hearings, as required. The selected Offeror may be required, on a case-by-case basis, to review a prior authorization request for a behavioral health service not currently covered by Ohio Medicaid. The number of these types of reviews is expected to be low. The selected Offeror will be required to support and respond to provider PA requests: 1. For Assertive Community Treatment (ACT), substance use disorder residential, and substance use disorder partial hospitalization services, the selected Offeror will respond by either approving or denying a PA within 48 hours of receiving a provider's request. 2. For all other PA requests, the selected Offeror will respond by either approving or denying a PA within 72 hours of the provider's request.	
4.2.F	The selected Offeror will be required to develop a plan for utilization management that emphasizes prospective reviews for prior authorization of services across all mental health and substance abuse settings. The plan should include a mechanism to review services that can be performed for non-medically necessary purposes to determine that the procedure is medically necessary. The plan should also include a mechanism to determine the most appropriate location of care. The goal of the pre-certification program is to use prospective solutions to avoid inappropriate patterns of utilization and levels of care. All reviews must be conducted in accordance with the OAC 5160:2-40, which describes the pre- certification review process for hospital services. The reviews must also meet applicable federal guidelines, and should reflect ODM's program integrity initiatives by ensuring appropriate utilization of hospital services. All reviews must include the use of Ohio-based physicians to ensure practice patterns within Ohio are taken into consideration, where determined appropriate ODM expects the selected Offeror to conduct continuous data analysis to monitor and update the pre-certification program. To implement and manage the Pre-certification Review Program, the selected Offeror will be required to: 1. Develop the methodology and criteria that will be used to select psychiatric admissions. 2. Select the medical criteria used to determine appropriateness of the admission. 3. Train Medicaid providers, ODM staff, and the selected Offeror/subcontractor staff on the pre-certification review program. 4. Maintain a reporting mechanism that meets notification requirements described in OAC 5160-2-40. 5. Monitor and provide suggested updates to the program to ensure that appropriate admissions are reviewed. 6. Develop and implement procedures for all pre-certification review denials in accordance with OAC 5160-2-40, including documentation of all reasons for denials or subsequent reversals of determinations. 7. Develop a plan for and participate in hearings when pre-certification denials are appealed.	F.6 4.2.F
4.2.G	The selected Offeror must monitor practices to ensure consistent application of the ODM Service authorization criteria. The selected Offeror should ensure that an inter-rater reliability process is in place and should report the inter-rater reliability data to ODM upon request. When issuing a denial of service, the selected Offeror must clearly state all the	F.7 4.2.G

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	clinical rationale for the denial per approved clinical guidelines and standards of care and note whether a denial was reviewed by a nurse, physician, or other agreed upon practitioner type. The selected Offeror must prior authorize some HCPCS code S9482 for the provision of stabilization services as a component of the mobile response and stabilization service in the fee-for-service system. The selected Offeror must do the following: 1. Develop the methodology and criteria used to determine the appropriateness of stabilization services rendered more than six weeks after the completion of mobile response. Criteria must align with OAC rules 5122-29-14, 5160-27-13, and 5160-1-01. 2. Conduct retrospective reviews of an agreed upon number of claims, if requested by ODM. 3. Conduct provider education as needed. 4. Provide activity reports, and other types of reports as requested by ODM. Once the requirement of prior authorization is met, the appropriateness of stabilization services will be determined based on medical necessity. Upon receipt of a prior authorization request, the prior authorization request must be reviewed and a decision rendered within 48 hours, including weekends. However, the decision may be pended if more information is needed and will restart when the additional information is received. This process applies to all prior authorization requests. Selected Offeror shall comply with the following terms, or requirements, for this service; 1. Type of clinicians expected to perform the reviews will be determined by ODM during discussions with the selected Offeror. 2. All the selected Offeror's medical review policies should be available to ODM for review. 3. The selected Offeror must participate, with ODM, in an agreed upon appeal process and participate in appeal hearings as required. 4. The selected Offeror must meet with ODM staff regularly and upon request to discuss coverage policies and clinical needs. 5. The ODM clinical and policy teams will create a training that provides an overview of the current MRSS rule and any needed intricacies about interpretation. In addition, the clinical and policy teams will remain accessible to the selected Offeror for ongoing conversation and questions.	
4.2.H	The selected Offeror must have internal monitoring practices to ensure consistent application of the ODM Service authorization criteria. The selected Offeror should ensure that an inter-rater reliability process is in place and should report the inter-rater reliability data to ODM upon request. When issuing a denial of service, the selected Offeror must clearly state all the clinical rationale for the denial per approved clinical guidelines and standards of care and note whether a denial was reviewed by a nurse and/or a physician. The selected Offeror will be responsible for development and presentation of appeal summaries in state hearings as part of member's due process rights. The selected Offeror is expected to prior authorize some CPT/HCPCS Level II codes for types of services including but not limited to transportation, outpatient dental procedures, durable medical equipment, skilled therapies, hearing/vision, acupuncture, laboratory and chiropractor services and temporary procedure codes will require medical necessity reviews by the selected Offeror. Some CPT/HCPCS codes always require prior authorization while other procedures codes have limit-based edits in place. When there are limit-based edits in place, a	F.8 4.2.H

RFP Section Reference	RFP Requirement	Permedion Proposal Section
	PA review for medical necessity may be needed to either approve or deny the additional supplies or service. For limit-based edits that pay and post, a PA review would not be required Regardless of a request's technical merits, all prior authorizations must be reviewed for medical necessity. The selected Offeror must provide notice to the provider and individual as expeditiously as the individual's health condition requires, but no later than ten (10) calendar days following receipt of the request for service. If a provider indicates or the selected Offeror (or ODM) determines that following the standard authorization timeframe could seriously jeopardize the individual's life or health or ability to attain, maintain, or regain maximum function, the selected Offeror must make an expedited authorization decision and provide notice of the authorization decision as expeditiously as the individual's health condition requires but no later than forty-eight (48) hours after receipt of the request for service. All pediatric PA requests are to be reviewed for medical necessity according to federal EPSDT requirements and are time sensitive. Types of clinicians expected to perform the review: 1. Prior authorization approvals may be processed by Registered Nurses (RN) 2. Prior authorization denials for medical necessity must be reviewed/approved by a physician under the direction of the Medical Director. All selected Offeror medical review policies should be available to ODM for review. The selected Offeror will meet with Clinical staff regularly and upon request to discuss coverage policies and clinical needs. Additional reports as requested based on VUE360/FI system functionality and data access.	
4.2.I	The selected Offeror will perform provider appeals of Managed Care Entity denials in accordance with OAC 5160-1-31. The selected Offeror will make a standard reconsideration determination within ten calendar days of receipt of a valid request. If an expedited review is requested because the service or item qualifies as urgent care services, the reconsideration determination will be made no later than forty-eight hours after receipt of a valid reconsideration. 1. Selected Offeror shall perform external medical reviews at the request of a provider for disputes resulting from an MCE's denial, limitation, reduction, suspension, or termination of a service due to a lack of medical necessity. a. Selected Offeror must assign a reference number to each request for external medical review, which is available for the provider, MCE, and ODM for tracking and reporting purposes. b. The request for external medical review from provider may be submitted in writing to the Selected Offeror. c. If the MCE and provider disagree that the reduction, limitation, denial, suspension, or termination of a service is subject to external medical review, ODM or its designee will determine if the EMR will be conducted. d. Selected Offeror shall review requests for EMRs to determine if they are valid requests by verifying: i. The denial, limitation, reduction, suspension, or termination was based on medical necessity. ii. Provider has exhausted the MCE internal appeals process or provider claim dispute resolution process; or provider has attempted to complete MCE internal appeals process or provider claim dispute resolution process but has not received a timely response from the MCE.	F.9 4.2.I

RFP Section Reference	RFP Requirement	Permedion Proposal Section
	e. Selected Offeror will track requests for external medical reviews that are determined to be invalid requests. If selected Offeror determines a request for an external medical review is not valid due to a denial reason other than medical necessity, selected Offeror will notify ODM using an ODM approved established process. f. The determination regarding whether or not a request is valid will be made by appropriately qualified staff. 2. Selected Offeror shall conduct the review and render a determination as to whether or not the MCE's denial, limitation, reduction, suspension, or termination of a service due to a lack of medical necessity was appropriate and in accordance with Ohio's rules and laws. a. Selected Offeror will request all appropriate documentation from the MCE to make its determination. b. For external medical record requests that are associated with expedited service authorization decisions, the determination must be issued as expeditiously as the member's health condition requires, but no later than 3 business days from the selected Offeror's receipt of the valid external medical review. c. For external medical review requests that are associated with standard service authorization decisions or claim denials, the determination must be issued within 30 calendar days from the selected Offeror's receipt of the valid request for an external medical review. d. Selected Offeror will share the outcome of its determination with MCE and provider. 3. Selected Offeror shall allow for external medical review requests to be submitted by providers electronically. This portal must include at least the following: a. Ability for MCE providers to request EMR. b. Ability to send and receive narrative and any attachments as accompanying documentation to support request for EMR. c. Any other information identified by ODM. 4. Selected Offeror shall provide ODM role-based access to routine and ad hoc reports with information both for individual and aggregate EMR data as specified by ODM. ODM may perform audits or make other requests for information and documentation. Selected Offeror shall provide all information requested by ODM in a timely manner. 5. Selected Offeror shall permit ODM-contracted MCEs with role-based access to information about EMRs requested from the MCE. a. This access will ensure the MCE can: i. Receive notification of a requested EMR. ii. Receive notification of the outcome of an external medical review and any associated documentation. iii. Permit the MCE to upload any attachments or other documentation to support their decision to reduce, deny, or suspend a service due to lack of medical necessity. 6. Selected Offeror shall assign as a clinical peer a health care professional who meets the following minimum qualifications: a. Is an expert in the treatment of the covered person's medical condition that is the subject of the review; b. Has knowledge of all relevant Ohio laws and rules specific to the service(s) subject to the external medical review; c. Is knowledgeable about the recommended health care service or treatment through recent or current actual clinical experience treating patients with the same	

RFP Section Reference	RFP Requirement	Permedion Proposal Section
	or similar medical condition of the covered person; and d. Has no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit or regulatory body that raise a substantial question as to the clinical peer's physical, mental or professional competence or moral character. 7. Selected Offeror shall assure the clinical peer health care professional performing the review: a. Is not under contract to provide the disputed service with the MCE at any time while considering the dispute b. Is not rendering care and services to the member. c. Does not have or acquire any personal or professional interest in connection with the review, direct or indirect, that could present a conflict or perceived conflict of interest, or that otherwise could compromise the impartiality of the review. Reviews shall be performed by a physician Medical Director who holds a current and non-restricted Ohio license and is certified by the American Board of Medical Specialties. All review determinations will be authorized by an Ohio licensed physician. Potential Offeror, or their proposed subcontractor, shall be nationally accredited in independent review. PLEASE NOTE: It is at ODM's discretion to determine if services described in this Section I will be needed during the term of the contract. Additionally, during the term of the contract, ODM may determine that the Services in this Section I may be removed from this Contract and be procured separately.	
4.2.J	The selected Offeror will act as a designee on behalf of ODM, to receive and prior authorize (or deny) requests for additional home health nursing and home health aide services, when the request is for additional units of service beyond fourteen hours per week, and if ordered by an individual's treating clinician. Upon receipt from a Medicare Home Health Agencies (MCHHA) provider, the selected Offeror will review and consider all documentation submitted to support the request and ensure compliance with OAC Chapter 5160-12-01 prior to approving or denying the request. Prior authorization approvals must be processed by Registered Nurses (RN). The selected Offeror must have an internal form and monitoring practices to ensure consistent application of the ODM Service authorization criteria. The selected Offeror should ensure that an inter-rater reliability process is in place and should report the inter-rater reliability data to ODM upon request. The selected Offeror will meet with Clinical staff regularly and upon request to discuss coverage policies and clinical needs. All selected Offeror medical review policies must be available to ODM for review. The selected Offeror must provide notice to the MCHHA provider and individual as expeditiously as the individual's health condition requires, but no later than five (5) calendar days following receipt of the request for service, unless the MCHHA provider, or ODM determines that following the standard authorization timeframe could seriously jeopardize the individual's life or health or ability to attain, maintain, or regain maximum function. In such cases, the selected Offeror must adjust to provide an authorization decision and provide notice of the authorization decision as expeditiously as the individual's health condition requires but no later than forty-eight (48) hours after receipt of the request for additional service.	F.10 4.2.J

RFP Section Reference	RFP Requirement	Permedion Proposal Section
4.2.K	The selected Offeror will act as a designee on behalf of ODM, to receive, review and adjudicate prior authorization requests for private duty nursing upon request from a Medicare certified home health agency (MCHHA) that meets the requirements in accordance with rule 5160-12-03 of the Administrative Code, an otherwise accredited agency that meets the requirements in accordance with rule 5160-12-03.1 of the Administrative Code, and a non-agency nurse that meets the requirements in accordance with rule 5160-12-03.1 of the Administrative Code, or a case manager from one of the following care coordination entities: Ohio Home Care Waiver Agency, PASSPORT Administrative Agencies, County Boards of Developmental Disabilities. The requestor must submit the following form https://medicaid.ohio.gov/static/Resources/Publications/Forms/ODM02374fillx.pdf and supporting documentation including a plan of care (e.g., https://www.cdc.gov/wtc/pdfs/policies/CMS-485-P.pdf). Prior authorization denials for medical necessity must be reviewed/approved by a physician under the direction of the Medical Director. When issuing a denial of service, the selected Offeror must clearly state all rationale for the denial per approved clinical and procedural guidelines, and standards of care, and note whether a denial was reviewed by a nurse and/or a physician. The selected Offeror will be responsible for development and presentation of appeal summaries in state hearings as part of member's due process rights. Upon receipt, the selected Offeror, specifically a Registered Nurse, will review and consider all documentation submitted to support the request and ensure compliance with OAC Chapter 5160-12-02 prior to approving or denying the request. A Registered Nurse must also complete an ODM-standardized assessment and acuity tool https://medicaid.ohio.gov/static/Resources/Publications/Forms/ODM02376.pdf. The assessment must be completed and documented no later than 10 business days following the initial request. Expedited requests must be completed the same day or within 24 hours. The selected Offeror must have the capacity to complete the assessments in-person as directed by ODM. After the assessment is completed, the selected Offeror will determine the outcome of the referral request including notification of outcome and issuance of due process rights https://medicaid.ohio.gov/static/Resources/Publications/Forms/ODM02373fillx.pdf. The selected Offeror will notify the referral source (if authority exists to do so), individual, provider, and case manager, if applicable, of the determination (denial, modification, or approval) including authorized amount, scope and duration of services). The selected Offeror shall represent ODM at any hearing filed resulting from the prior authorization requested.	F.11 4.2.K
4.2.L	The selected Offeror will perform provider appeals when designated by ODM. The selected Offeror will make a standard reconsideration determination within ten calendar days of receipt of a valid request. If an expedited review is requested because the service or item qualifies as urgent care services, the reconsideration determination will be made no later than forty-eight hours after receipt of a valid reconsideration. The request for reconsideration may be reviewed by a nurse, and if the newly submitted documentation does not substantiate the request, a review would be conducted by a clinical peer.	F.12 4.2.L
4.2.M	In order to monitor and evaluate utilization of medical services in the Medicaid population, various reports will be required from the selected Offeror. These include, but are not limited to, activity reports related to the pre-certification, prior	F.13 4.2.M

RFP Section Reference	RFP Requirement	Permedion Proposal Section
	authorization, and special review program and the retrospective and quality review program. The accuracy of all reports must be verified by the selected Offeror prior to submission to ODM. The selected Offeror is responsible for developing and implementing all reports in accordance with ODM's specifications. All reports must be submitted within thirty days of the end of the reporting period unless an alternate time frame has been established by ODM in writing. Reports must be submitted electronically, but also be available in hard copy form. Reports should be accurate and complete. The following mandatory reports are required for the Pre-certification and Special Review Program: 1. A monthly report summarizing work completed. The source of the report will be mutually agreed upon by both parties. At a minimum, the report must include the total number of cases completed, the number of cases recommended, the number of cases referred to physician advisors, and the outcome of pre-certification/special review. 2. A monthly report detailing work completed including specific information related to individual cases. 3. A monthly report documenting reconsiderations of initial adverse decisions and the reconsideration outcomes. The selected Offeror is encouraged to identify and develop additional reports needed to monitor utilization of medical services by the Ohio Medicaid population. The following mandatory reports are required for the Retrospective Review Program: 1. A monthly retrospective review schedule and a frequency report. 2. A quarterly report summarizing work completed including the total number of cases denied by review category and the net dollar savings associated with these categories. 3. A monthly report detailing work completed, including specific information related to individual cases. 4. A monthly report finalizing all review activity for a specific review month after the appeal deadline has been reached. 5. A monthly report that details sample selection methodology. Reports of quality concerns, using processes established by Medicare for quality screens and levels include: 1. Initial and final quality concerns issued on a monthly basis. 2. Quarterly report demonstrating trends. The selected Offeror is encouraged to identify and develop additional reports needed to monitor utilization of medical services by the Ohio Medicaid population. Other reports may be requested by ODM as needed. The following reports are required for Non-Institutional Services Prior Authorization: Monthly reports of number of finalized reviews by category sorted by approvals and denials and also sorted by adult and pediatric (under age 21).	
4.2.N	In each fiscal year of the contract, the selected Offeror is responsible for production of up to four (4) studies which support efforts towards increasing quality of care, improving beneficiary access, and reducing costs. Specific study topics will be assigned to the selected Offeror by ODM. The number of studies in a given year is negotiable depending on the scope of each study and may be modified through a joint agreement between the selected Offeror and ODM depending on research needs and scope. The selected Offeror may be required to conduct studies, share tools, or coordinate analysis with other ODM contractors. Clinical outcome-based studies are used to evaluate the quality of care delivered to Medicaid managed care	F.14 4.2.N

RFP Section Reference	RFP Requirement	Permedion Proposal Section
	organization (MCO) enrollees and to compare outcomes by MCO may be developed and performed. The selected Offeror may work with current and historical FFS claims, as well as, managed care encounter data. The selected Offeror is expected, where necessary, to retrieve medical records for analysis, or survey individual patients about their outcomes. ODM will compare the results of quality reviews and coordinate improvement activities across delivery systems (managed care and fee-for-service). The studies will be supportive of ODM's overall health care quality improvement strategy. For each of the health care studies, the selected Offeror is expected to make recommendations to ODM which include: 1. Prospective solutions to identified patterns of inappropriate utilization of Medicaid services. 2. Methods to identify/screen appropriate and inappropriate utilization of health care services through the use of provider profiling measures of claims data. 3. Suggestions for effectively incorporating study findings into ODM's quality improvement strategy, thereby furthering ODM's efforts as prudent purchasers of health care services. 4. Recommendations for defining and measuring improvement in utilization, clinical decision making, and clinical outcomes as a result of implementing these solutions. These solutions must proactively involve the education and cooperation of the provider community. The selected Offeror is responsible for developing a plan for health care studies and necessary follow-up.	
4.2.N	Data Collection and Sampling The source of data for the health care studies will be medical records, administrative data, surveys, or a combination of the three. Eligibility data, FFS claims data, and managed care encounter data will be provided by ODM to the selected Offeror. Offeror will be responsible for transferring necessary data to its own systems for data analysis. Offeror will sample the administrative data for the health care studies to determine which medical records to request, will request the records from institutional and physician providers, and then will extract the data needed to complete the study from the records. Depending on the number of records requested from a provider, the Offeror will either review the records at the provider's site or will review copies of the records sent by mail (secure mail, fax, or other secure electronic transfer). The data collection and sampling performance standards are: 1. Obtaining from providers no less than 80% of the medical records that were selected as part of the sample. 2. Achieving an inter-rater reliability score, as measured by Cohen's Kappa or another measure appropriate to the data, of no less than 0.7 (95% confidence interval). 3. Submitting a final report for each study area to ODM on dates that are established by ODM in conjunction with the selected Offeror. 4. Submitting a complete report for each study area to ODM which addresses each of the topics identified by ODM for inclusion in the report and each other topic that is important to understanding the background, methods, results, and limitations of the study. The selected Offeror is required to use qualified surveyors, provide training to the surveyors in data abstraction, and measure inter-rater reliability. The selected Offeror is responsible for selecting a sufficient sample of medical records and	F.14 4.2.N

RFP Section Reference	RFP Requirement	Permedion Proposal Section
	provider sites to assure valid studies. The expected statewide and sampling subgroup confidence interval for the studies is 95 percent.	
4.2.O	The selected Offeror will be required to develop educational materials and conduct provider education seminars at various times during the contract period. The selected Offeror will be: 1. Providing any necessary clinical criteria in support of changes made to the current program, in addition to communicating the changes to the provider community through educational seminars and mailing educational materials to providers. 2. Educating the provider community regarding prospective changes to the utilization review program resulting from the identification of inappropriate utilization of Medicaid services through the post payment and focused review processes. This educational opportunity may be through a seminar or through the development and dissemination of an Ohio Medicaid institutional utilization review program provider electronic newsletter. 3. Developing and regularly producing provider e-newsletters throughout the contract period with input and final content approval from the ODM team. The selected Offeror will be expected to provide ongoing updates regarding the operations of the Institutional Utilization Review program and communicate to the provider community through these periodic provider newsletters. Development will include: 1) a detailed concept for the newsletter (including frequency, length, focus, etc.); and 2) a plan to address provider education that incorporates utilization management activities and quality of care studies, and documented impact from provider education.	F.15 4.2.O
4.2.P	ODM is structured to operate as a matrix organization to provide flexibility needed to respond to and act in an external environment that remains highly volatile, both at the level of federal policy and within the health care marketplace. ODM conducts much if its program development and reform activities through teams made up of staff from both policy and operational bureaus. The pace of change in health care, social services and in state/federal and state/local relationships makes organizational flexibility and “out of the box” thinking a critical success factor. This flexibility and creativity is enhanced through teamwork. The selected Offeror may provide up to 600 hours of technical assistance to policy and operational units within ODM. This work will primarily involve clinical expertise and guidance, as needed, in support of policy development and operational functions. Examples of technical assistance work may include, review of new or existing procedure codes for a recommendation on the appropriate setting (inpatient or outpatient), guidance on medical coding questions, or assistance in developing clinical screens to be used by ODM to make coverage determinations for services that require hospitalization (e.g. procedures related to the treatment of obesity).	F.16 4.2.P
4.2.Q	ODM will provide data to the selected Offeror to carry out the functions of the contract. The cost of this Deliverable will be incorporated into the proposed fee of the project. Data to be provided may include: a. FFS claims data; b. MCO encounter data; c. Medicaid eligibility data; d. Long term care Minimum Data Set (MDS) data; e. Medicaid provider files; f. MCO primary care provider (PCP) database; and	F.17 4.2.Q

RFP Section Reference	RFP Requirement	Permedion Proposal Section
	g. Medicaid procedure, drug, and diagnosis reference files. The selected Offeror will be responsible for maintaining reasonable access to data at all times and for receiving this data in a timely fashion. The following standards apply: A. Reasonable access means the ability to retrieve all data in a batch processing mode so that analytical processing can be completed within 24 hours. Note that this is a minimum standard which should be applied to complicated analytical processes involving multiple large data sets over multiple years. Less complicated processes using smaller data sets should be able to be completed in less time. B. Receiving data in a timely fashion means being able to provide reasonable access to monthly updates within 48 hours of receipt of the data. To ensure successful data management, the selected Offeror must develop a plan and timetable for initial data base design and set-up of historical and initial reference files, and provide a description of how the data bases will be set up and accessed for use by the selected Offeror in carrying out the contract.	
4.2.R	The selected Offeror may be required to perform prior authorizations in order to continue the provision of various services after an allowed amount of services has been rendered. This may include additional behavioral health prior authorizations, as well as others that may be required through changes to policies ODM is not currently aware of, but may come up through the life cycle of a contract resulting from this RFP.	F.18 4.2.R
G. Business Continuity Plan		
V	A. Offeror recognizes that certain services covered in this RFP are vital to ODM and must be continued without interruption. Offeror shall be prepared to continue providing such services identified by ODM, during periods of disaster, crisis, or other unexpected break in services based upon a Business Continuity Plan (Plan). Offeror is required to implement and maintain a sustainable Plan throughout the term of the Contract resulting from this RFP and provide a summary of the Plan to ODM upon request. The Plan will, at a minimum address the following: 1. How the Offeror will enable continued performance under this Contract in the event of a disaster or other unexpected break in services; 2. How the Offeror will ensure the continuity for identified vital services and supporting facilities; 3. Disaster recovery plans for critical technology and systems infrastructure; and 4. Proper risk controls (collectively, the "Contingency Plans") to enable continued performance under the Contract in the event of a disaster or other unexpected break in services. B. For purposes of this Section, the term “Disaster” means an unanticipated incident or event, including, without limitation, force majeure events, technological accidents or human-caused events that (i) may cause a material service or critical application to be unavailable without any reasonable prediction for resumption, or (ii) causes data loss, property damage, or other business interruption without any reasonable prediction for recovery within a commercially reasonable time period. C. The awarded Offeror will update and test the operability of any applicable Plan at least annually and will implement such Plan upon the occurrence of a Disaster.	G. V.
H. MBE Documentation		
9.11	This RFP contains a sheltered solicitation subcontracting requirement which requires the Offeror to seek and set aside at least 15 percent of the work to be	H. 9.11

RFP Section Reference	RFP Requirement	Permedion Proposal Section
	exclusively performed by Ohio certified Minority Business Enterprise (MBE) businesses. Proposal must include the selected subcontractor's name, MBE certification number, and the stated percentage of the cost of work to be performed. Proposal must also include a letter from the selected MBE subcontractor, on company letterhead and signed by an individual authorized to commit the business to performing the work outlined in the Proposal.	
Appendix A		
6.2.1	Offerors are to review Attachment A and complete and sign each of the provided signature blocks to note the Offeror's acknowledgment and intent of compliance. All original signatures must be in blue ink.	Appendix A
Appendix B		
6.2.2	Offerors are to review Attachment F – Terms and Conditions, and sign each of the provided signature blocks to note the Offeror's acknowledgment and intent of compliance. All original signatures must be in blue ink.	Appendix B

A. 3.1 Mandatory Offeror Requirements

RFP Reference: Section 3.1

Offerors MUST meet and provide proof of, at minimum, ALL of the following qualifications. Offerors who do not meet ALL the below requirements will be disqualified from further consideration for contract award.

As described in detail herein, our proposal addresses how Permedion, a Gainwell Technologies company, (referred to as "Permedion" hereafter in this proposal) exceeds all of the minimum utilization management and prior authorization (UM/PA) service qualifications described by the Ohio Department of Medicaid (ODM) in its RFP. Also, we describe how we have provided a comprehensive response to RFP Attachment A and have submitted information regarding our proposed Ohio-certified Minority Business Enterprise (MBE) subcontractors, Ardent Technologies, Inc. and Diversified.

Permedion Exceeds ODM UM/PA Objectives

We have proven ability to fulfill all the objectives described in the ODM RFP:

- More than 35 years' experience providing services in Ohio
- CMS-certified as a QIO-like entity for the State of Ohio
- URAC accredited for providing UM services
- Support for Medicaid UM programs in 17 states
- 100,000 clinical reviews annually

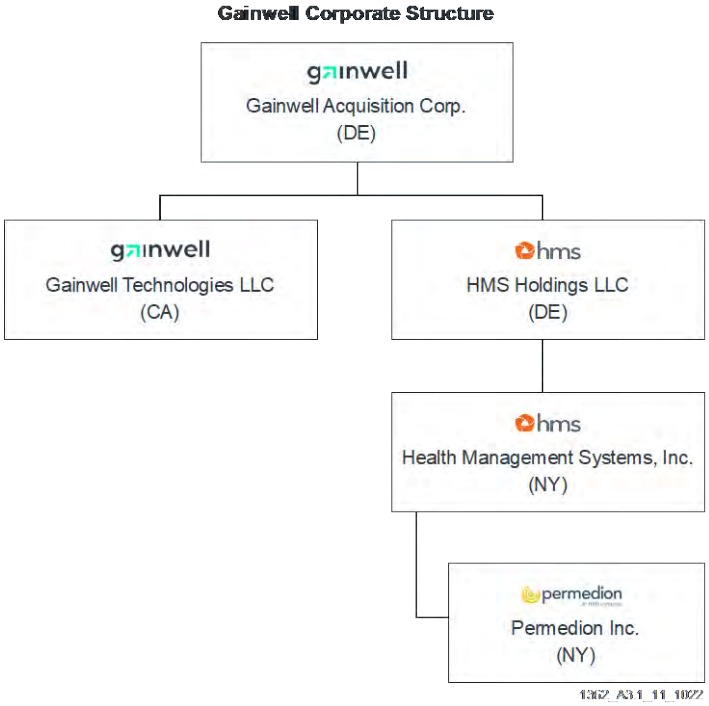
Company Overview

Permedion was founded in Ohio in 1974 as a corporation providing medical peer review and quality assurance (QA) services within the Medicare program. In 1985, Permedion engaged in our first state Medicaid contract with the Ohio Department of Human Services, which to perform post-payment review of hospital admissions.

Effective October 5, 2007, Permedion became a wholly owned subsidiary of HMS. HMS was founded in 1974 and provides expertise in Medicaid cost containment, program policy, data, program analysis, data analytics, and recovery.

On April 1, 2021, Gainwell Acquisition Corp. acquired HMS Holdings Corp. (including its subsidiary, HMS and the HMS subsidiary, Permedion, Inc.). Gainwell Technologies LLC and Health Management Systems, Inc. are the operating entities of Gainwell Acquisition Corp. and will continue to operate as independent businesses. We utilize the full resources and qualifications of Gainwell's more than 11,000 healthcare professionals and technologies to better serve Ohio. The following figure shows Gainwell's legal entity structure.

Figure 1. Gainwell Legal Entities



With more than 35 years of experience in Ohio, including 25 years providing UM/PA services ODM, Permedion exceeds the minimum three-year qualification described in ODM's RFP. To augment our solution, we propose subcontractor partnerships with Ardent Technologies, Inc. and Diversified Systems, Inc., Ohio-certified MBEs, to support our services for the State. As described in proposal Section 3, Permedion offers the UM/PA qualifications and experience as well as staff expertise needed by ODM to best support the financial viability of its healthcare programs.

A.1 Designation by CMS as a QIO-like Entity

RFP Reference: Section 3.1.A

A. The selected vendor must have received designation by the Centers for Medicare and Medicaid Services (CMS) as a Quality Improvement Organization (QIO) or QIO-like entity. Proposals from vendors who do not demonstrate that the organization is a Medicare QIO or QIO-like entity will not be considered.

Gainwell Technologies, parent company, and Health Management Systems, Inc., prime vendor (a Gainwell Technologies company, under its wholly owned clinical review subsidiary, Permedion) are both currently designated by the Centers for Medicare & Medicaid Services (CMS) as Quality Improvement Organization-like (QIO-like) entities. Permedion has had QIO-like certification since 1999, and parent company Gainwell has had QIO-like certification since 2011.This designation allows our team to support state Medicaid Agencies' requirements to provide methods and procedures to safeguard against unnecessary utilization of care and services and to assure efficiency, economy, and quality of care. As proof of our QIO-like designation, we have included the current certification letters from CMS in proposal Appendix C.

Permedion meets all of the requirements in 42 CFR § 475 related to CMS-contracted QIOs and CMS-certified QIO-like companies. As a certified QIO-like company, Permedion has attested to

CMS that we meet the eligibility and contracting requirements in 42 CFR § 475.101 and 42 CFR § 475.105. Specifically, we:

- Have a governing body that includes at least one individual who is a representative of health care providers and at least one individual who is a representative of consumers
- Perform case reviews and quality improvement initiatives
- Actively engage beneficiaries, families, and consumers, as applicable, in case reviews and/or quality improvement initiatives
- Perform the functions of a QIO with objectivity and impartiality and in a fair and neutral manner
- Are not a health care facility
- Are not a health care facility affiliate
- Are not a payor organization
- Do not subcontract with a health care facility to perform case review activities

Permedion's proven track record of adhering to quality processes and providing service excellence has also resulted in accreditation by the Utilization Review Accreditation Commission (URAC). HMS, including wholly owned subsidiary Permedion, is accredited by the URAC in Health Utilization Management (HUM) and as an External Independent Review Organization (EIRO). This accreditation provides our state Medicaid agency customers with the confidence that our team understands the structures and processes that promote high quality care while preserving patient rights.

A.2 Submission of Attachment A Requirements and Forms

RFP Reference: Section 3.1.B

B. Complete and return all requirements and forms in Attachment A upon submission of Proposal.

Permedion has completed all requirements and forms in Attachment A. The signed documents are included in proposal Attachment A.

A.3 Ohio-Certified MBE Subcontractor

RFP Reference: Section 3.1.C

C. Submission with Proposal of a selected Ohio certified Minority Business Enterprise (MBE) subcontractor assigned, at a minimum, job duties that will equate to a minimum of 15 percent of the total dollar amount of the contract per state fiscal year (SFY). This requirement is further described in MBE (EDGE) Subcontracting Requirements.
   a. If the submitting organization is a State of Ohio Minority Business Enterprise (MBE), Encouraging Diversity, Growth and Equity (EDGE) Offeror, or Veteran Business Enterprise (VBE), provide copy of current certification from DAS.

Permedion fully supports the State of Ohio's commitment to making business opportunities available to MBEs certified by the Ohio Department of Administrative Services in accordance with the applicable State rules and regulations. This effort aligns with our initiatives and goals.

Our decades of service experience and success makes us ideally suited to support the development of other businesses on how best to serve the cost containment needs of organizations such as ODM.

Permedion proposes to fulfil the services described in the RFP in partnership with Ardent Technologies, Inc., and Diversified Systems, Inc., Ohio-certified MBEs that will support our delivery of industry-best UR services to the State. The job duties for both subcontractors will equate to a minimum of 15 percent of the total dollar amount of the contract per state fiscal year (SFY) as described in proposal Section D.

Ardent

Ardent Technologies, Inc. (Ardent) offers more than 18 years of experience in staffing augmentation for IT consulting services, including infrastructure support, cybersecurity, mobile application development, website development and cloud computing. Since its inception, Ardent has provided services to more than 1,000 state and local agencies, and currently provides services to more than 60 entities nationwide. Ardent is an established player in providing software and technology solutions and services to state-level government agencies, as well as to cities, counties, and school districts. Ardent team members are experts in developing digital assets for federal and state agencies, optimizing business processes, and developing software applications to address key performance areas. Their applicable certifications include International Organization for Standardization (ISO) 9001:2015, 14001:2015, and AS9100D and Capability Maturity Model Integration Development Level 3 (CMMI DEV L3).

Ardent currently serves as a subcontractor to Permedion, supporting our delivery of comprehensive Third-Party Liability identification and recovery services to the State. As part of the subcontract agreement, we require Ardent to maintain its Ohio-specific MBE certification throughout the term of the contract, including any renewals. We are confident that Ardent is ideally suited to support the UR scope of work for ODM.

Diversified Systems

Diversified Systems, Inc. (Diversified) has 32 years of experience providing quality IT consulting services that enable its clients to increase market share, improve profits, and increase productivity while reducing costs and turnaround time. Their comprehensive range of services includes project management, system integration, application development, Web development, mainframe support, network support, and staff augmentation. Diversified’s nationwide client base includes State and Local Governments, the Federal Government, and Fortune 1000 commercial enterprises.

Diversified currently serves as a subcontractor to Permedion, augmenting our resources with Ohio-based dentists supporting our review of dental prior authorization requests. As part of the subcontract agreement, we require Diversified to maintain its Ohio-specific MBE certification throughout the term of the contract, including any renewals. We are confident that Diversified is ideally suited to support the UR scope of work for ODM.

B. 3.3 Staff Experience and Capabilities

RFP Reference: Section 3.3

Offeror must have staff proposed for the program with demonstrated quality improvement experience and knowledge of Medicaid programs and delivery systems. This means that the proposed staff must have experience with the following:

A. Medicaid consumers, policies, data systems.
B. Utilization review programs.
C. Quality assessment and improvement methods.
D. Evidence-based clinical guidelines.
E. Research designs, methods, and statistical analysis.
F. Claim submission and correct coding requirements, both professional and institutional (inpatient and outpatient).
G. HIPAA billing requirements and guidelines.
H. National Uniform Billing Committee (NUBC) manual.
I. Electronic Data Interchange (EDI) guidelines and companion guides.
J. All Patient Refined Diagnosis Related Groups (APR-DRG) reimbursement.
K. Enhanced Ambulatory Patient Groups (EAPG) reimbursement.
L. Ohio Revised Code and Ohio Administrative Code Rules - 5160 Medicaid.
M. Centers for Medicare and Medicaid Services (CMS) rules and regulations or other pertinent federal guidelines.

Permedion has supported a variety of Medicaid programs across the United States attaining decades of clinical review, cost containment, and payment integrity experience. As a current provider of Utilization Management and Prior Authorization (UM/PA) services, our team has developed significant understanding and capabilities related to supporting Medicaid programs, including Ohio Medicaid. We have a deep understanding of the Ohio Medicaid programs (below) and their eligibility and enrollment requirements, coverage of benefits, and rules related to UM/PA:

- Fee-for-service and managed care delivery systems
- Age Blind and Disabled program
- Covered Families and Children program
- Various waiver programs (PASSPORT, MyCare Ohio, Assisted Living, etc.)

We also bring a broad set of experience and perspective gained through our corporate-wide service to more than 45 state Medicaid programs and more than 200 Medicaid managed care plans (MCPs), and over 10,000 team members are experienced and focused on Medicaid technology, payment methodologies, and regulations, etc.

Our proposed project team have the requisite skillset necessary to continue to deliver to ODM a compliant and secure UM/PA program, as we have done for 25 years. Unlike the competition, our proposed team already possesses a significant level of Ohio-specific project management, clinical, data analytics, quality assurance, technology, provider education, and member services experience; therefore, ODM won't experience a decrease in service levels as you would if you transitioned to a new vendor.

Unlike other vendors that need to hire specialists to fulfill the key roles and additional support functions listed in the RFP, Permedion already has experts on staff who are ready to start work for ODM beginning on Day One of the contract term. Our in-house project team members apply decades of Medicaid and Ohio-specific UM/PA experience to deliver the results ODM expects.

Unparalleled Program Support

93 individuals support the ODM UM/PA contract today, of which 57 are Ohio residents. Should Permedion be selected as the vendor for the new contract, these knowledgeable and local team members will continue their support of the project. This will make sure UM/PA services are continued uninterrupted for ODM, providers, and members.

This team will leverage their Ohio-specific and overall Medicaid expertise to effectively manage a compliant UM/PA program that meets local, state, and federal requirements and maximizes results for ODM. We bring the following areas of expertise to the UM/PA project:

- Ohio Medicaid program and policies
- Big five initiatives that are the pillars of the Next Generation of Ohio Medicaid
- Partnering with ODM, providers and vendors in support of the MMIS transformation from Prior Authorization in MITS towards modularity including PNM and FI
- Cost containment methodologies
- Managed care expertise and the evolution to Ohio Managed Care Entities
- Value-based payment methodology
- Clinical review practices and clinical guidelines
- Quality-assessment and quality improvement methods
- Health Insurance Portability and Accountability Act (HIPAA) billing, security, and privacy practices and standards

The following table describes the scope-specific areas of experience of the proposed Permedion staff on our UM/PA project team for ODM.

Table 2. Permedion's UM/PA-Specific Staff Experience

Service Area	Description of Permedion's Staff Experience/Knowledge
A. Medicaid consumers, policies, data systems.	We provide UM/PA and cost containment services to more than 45 state Medicaid programs, including Ohio Medicaid. This experience has produced in-depth knowledge of Medicaid programs and policies, an understanding of Medicaid consumers and providers, and extensive capabilities of working with Medicaid data, Medicaid Management Information Systems (MMISs), PA systems, and other systems that support the Medicaid infrastructure. Our team members maintain a comprehensive understanding of Medicaid (federal and Ohio-specific) including its resources and the people it serves.

Service Area	Description of Permedion's Staff Experience/Knowledge
B. Utilization review (UR) programs.	Many of the existing project team will remain in place, which allows each team member to apply their expertise to begin fulfilling the program goals of the State beginning on Day One of the contract term. We continue to partner with ODM through the implementation of the "Big 5" Initiative for the Next Generation of Medicaid. We leverage the expertise of our UR colleagues that support the other 17 UM/PA Medicaid contracts. Our Project Leader and other key staff regularly communicate with these staff regarding best practices on selection methodology, clinical criteria, services/providers that should be auto-authorized, process improvements, analytics (utilization trends), quality of care findings, approaches to provider education and communication, new technologies, and policies/regulations. They also review and discuss possible resolutions to issues related to data and systems.
C. Quality assessment and improvement methods.	Our staff remains committed to customer satisfaction as defined by our clients, which we understand is delivered by the highest quality UR services and results. Our project team members work to assess, monitor, measure, and improve key processes associated with their work on behalf of clients, including ODM. We implement quality reviews and monitor contract compliance to make continuous improvements across our clinical and non-clinical operational areas.
D. Evidence-based clinical guidelines.	Evidence-based criteria and/or nationally recognized guidelines inform our team's review decisions. Our personnel are highly experienced in using national criteria, including MCG, InterQual Care Planning, and InterQual Level of Care Criteria, ASAM, along with specialized criteria, such as guidelines supplemented or modified by our state Medicaid clients. We review and update our selected criteria annually and have the criteria evaluated and approved by our Chief Medical Officer and our Medical Director. This is a requirement to receive URAC accreditation, which we hold in Utilization Management and Independent Medical Review.
E. Research designs, methods, and statistical analysis.	Our project team members, specifically our clinicians, biostatisticians, and data analysts, have knowledge of and experience conducting quality improvement studies within a range of health care settings. We perform these activities for several other Medicaid programs. We understand how topics are selected, how studies should be designed, effective sampling methodologies' data-collection processes, data analysis techniques, and valuable reporting. In addition to developing and implementing health care studies and other data analytics, we have experience examining the results and delivering them to our clients so that we can help them improve their delivery of health care services.
F. Claim submission and correct coding requirements, both professional and institutional (inpatient and outpatient	Each year, Permedion analyzes millions of claims on behalf of Medicaid state agencies including ODM, to identify inappropriate utilization, improper billing, coding errors (including National Correct Coding Initiative [NCCI] errors), fraud, waste, and abuse. This experience has provided our team with extensive knowledge of claims, claim submission and coding requirements, and claim formats for inpatient, outpatient, and other specialties. Our established team of clinical reviewers, coding specialists, Ohio-licensed physicians, data analysts, and data processors have decades of Ohio Medicaid-specific claim submission and correct coding experience because they support the review processes today. Our UM/PA team includes the following valuable features: • Hospital/APR-DRG and EAPG clinical coding and utilization experts • Certified Professional Coder® personnel, Certified Coding Specialists, Registered Health Information Technicians, and Registered Health Information Administrators

Service Area	Description of Permedion's Staff Experience/Knowledge
	• Clinical review specialists, including board-certified physicians, RNs, licensed independent social workers, and long-term care specialists with experience in the review of claims against clinical and coding criteria to identify utilization, coding, and quality issues • Experience and knowledge of the NCCI related to procedure-to-procedure and medically unlikely event claims that are reimbursed on the basis of HCPCS/CPT codes • Familiarity with various bill types including UB-04 and CMS-1500 and knowledge of HIPP-standard claim transactions • Knowledge of various institutional (hospital, SNF, nursing home, residential, etc.), professional (outpatient, physician, clinic, DME, home health, diagnostics, therapies, transportation, etc.) and dental billing requirements and reimbursement methodologies • Access to qualified coding and clinical personnel with a deep knowledge of federal and state regulations relating to the provision, coverage, claiming, reimbursement, and review/audit of Medicaid services; policy, criteria, requirements, and areas of risk/vulnerability for each service type being audited; and state requirements and policies relating to review, reconsideration, and appeal • Web-based audit tools and sophisticated claims data tracking and case management system, which make certain that Bill Auditors use consistent processes in the abstraction and review of medical records, review of claims, and application of testing criteria to the services being reviewed
G. HIPAA billing requirements and guidelines.	As the nation's leading provider of cost containment, program integrity, and third-party liability (TPL) services for Medicaid agencies such as ODM, Permedion's staff have extensive experience applying billing requirements, guidelines, and controls throughout phases of contract operations. As TPL contractor in Ohio and several other states, we bill third party insurers and clearinghouses using HIPAA-required standards, criteria, and transactions. We also receive and process data in established HIPAA standards. We have established processes and tools in place to make certain that we comply with required security and privacy standards including, but not limited to, the following: HIPAA Security and Privacy Rules, and the Family Educational Rights and Privacy Act of 1974 (FERPA), SSA, IRS (as applicable), other applicable state and federal privacy laws. Sensitive information, including PII, PHI, and Federal Tax Information (FTI) will be restricted to vetted U.S. support personnel only. Data, including backups and archives, will be maintained within the contiguous United States. Sensitive data, as defined by CMS, will be encrypted during in-transit and at rest.
H. National Uniform Billing Committee (NUBC) manual.	Our project team members maintain a comprehensive understanding of Medicaid and other healthcare billing processes including those associated with institutional bills—both inpatient and outpatient. We leverage the NUBC manual to support our billing efforts since it enables a single billing form and standard dataset to be used nationwide by institutional, private, and public providers and payers for handling healthcare claims. Our medical bill audit functionality works to identify unnecessary spending of healthcare dollars through the comparison of the UB-04, an itemized bill, against the medical record, coding validation, and/or review for appropriateness of setting. We measure savings through the difference between services originally billed and the payment that would have been received had the provider billed correctly.
I. Electronic Data Interchange	Because we send and receive more than 10,000 electronic data files each month, our project team specialists maintain EDI expertise regarding the secure transmission and receipt of files in both standard and non-standard formats. Most of

Service Area	Description of Permedion's Staff Experience/Knowledge
(EDI) guidelines and companion guides.	these project-related files transmitted or received via EDI leverage business-to-business standards; many of them are in standard American National Standards Institute formats driven by standards guidelines as outlined in companion guides. Unlike other vendors, our Ohio-specific service experience has enabled Permedion to establish the interfaces and protocols required to support ODM's current hospital UM/PA program and other cost containment programs that we support for the State.
J. All Patient Refined Diagnosis Related Groups (APR-DRG) reimbursement.	Permedion supported many of our state Medicaid clients, including ODM, as they transitioned to the APR-DRG reimbursement system. We assisted the Commonwealth of Massachusetts in developing policies to support the impact of the change specific to readmission for the adult and pediatric populations. Our coders and nurses currently review claims that use APR-DRG in eight states including Ohio. Our nurses review the medical record(s) to affirm that there is specific documentation to support the diagnosis and procedures. They also review the chart to make certain that there is clear rationale behind an admission and that the secondary diagnosis, that affect the care provided for the primary diagnosis, is well documented within the medical record. Severity of illness is also evaluated to determine if services meet specific qualifications. Our coding team members use the 3M™ encoder to determine if the correct APR-DRG has been billed. They continue to study the Official Coding Guidelines and coding Clinic publications that provide them with guidance and examples that can be applied to the Medicaid patient population. Our staff is familiar with APR-DRG reimbursement methodologies including base (operations) payment, and payment for hospital transfers and inpatient outliers.
K. Enhanced Ambulatory Patient Groups (EAPG) reimbursement.	The EAPG system is designed to classify services into groups that utilize similar resources and have similar costs. These groupings were developed to encompass the full range of ambulatory settings, including same day surgery units, hospital emergency rooms and outpatient clinics Today, we review EAPG claims for ODM as part of our retrospective Hospital Outpatient reviews. Our staff is knowledgeable of the components that drive EAPG groupings and reimbursement.
L. Ohio Revised Code and Ohio Administrative Code Rules - 5160 Medicaid.	Our team currently conducts the scope of work required in the RFP in accordance with the guidelines described in OAC rule 5160 and other rules, and we will continue to do so. We are very familiar with the OAC, and its availability on the ODM website located in the Medicaid Provider Handbook. We build the requirements and OAC 5160 criteria into our standard operating procedures, and our reviewers refer to them during the interpretation of the rules that govern UM/PA, as necessary. We receive frequent inquiries from providers looking for the source of the regulation, and we refer them to this specific OAC rule. Our reviewers and other team members have a strong working knowledge of OAC, and commonly refer to the following subsections in OAC during the course of their reviews and other work activities: • 5160-1 General Provision, including: – Member and provider eligibility requirements – Medical Necessity definitions and principles – Prior authorization for fee-for-service and managed care programs – Review of Provider Records (pre and post payment) – Notification to providers (approvals, denials, right to appeal/hearing) • 5160-2 Hospital Services, including: – General provisions – Service requirements, conditions, and limitations – Utilization Review

Service Area	Description of Permedion's Staff Experience/Knowledge
	– Medical necessary hospital level of services – Psychiatric admission precertification – Potentially Preventable Readmissions – Billing requirements and ODM reimbursement (APR-DRG, EAPG, other) – Bill audits – Appeals and reconsiderations • 5160-8 Skilled therapies for behavioral health services • 5160-10 DME supplies and services • 5160-12 Home Health and Private Duty Nursing services • 5160-26 Managed Care Plan • 5160-27 and 5122-29 Procedures and requirements for community mental health agency and behavioral health services including Mobile Response and Stabilization • 5101:6 State hearing procedures While 5160 contains the majority of the code regulating the UR/PA work, other sections of the code including We have provided additional details on several of these requirements throughout our proposal response.
M. Centers for Medicare and Medicaid Services (CMS) rules and regulations or other pertinent federal guidelines.	Through our nationwide clinical review experience, Permedion has a deep understanding of the applicable federal laws, regulations, and guidance that impact Medicaid UM/PA programs. Below is a listing of some of the CMS/federal rules and regulations: • 42 CFR 456 Utilization Control of Inpatient and Other Services: – Requirements for a statewide utilization control program – Criteria for evaluating the appropriateness and quality of Medicaid services – Processes for pre-admission, continued stay and retrospective admissions – Contents for a written plan of care – Review timelines and notification • 42 CFR 482 Conditions of Participation for Hospitals – Hospital administration, functions, and staffing – Quality assessment and performance improvement program – Medical record content • 42 CFR 484 Conditions of Participation for Home Health Providers – Care planning, coordination of services, and quality of care – Patient assessments – Personnel qualifications including skilled nursing and therapy professionals, and home health aides • USC § 1320-d, 45 CFR 160 and 164 (HIPAA regulations) * – Privacy and confidentiality of protected health information (electronic and hard copy) – Uses and disclosures of protected health information – Notification of breaches – Security safeguards and standards – Fraud and abuse protection – Compliance, investigations, and penalties **See additional information on our organizations' and team members' knowledge of HIPAA, billing, security, and confidentiality requirements above*

Staff Training

Our newly hired employees and sub-contracted staff receive training on subjects affecting the UM/PA program including but not limited to:

- Federal and state guidelines, criteria, and rules including those established in 42 CFR 456 and OAG Chapter 5160
- Standard operating procedures for the UM/PA program including intake, review, appeal processes (applicable to role and responsibilities)
- ODM eligibility, coverage, and billing policies and rules, and reimbursement methodologies
- Clinical review standards and criteria (URAC, MCG, ASAM, etc.)
- Use of state and Permedion systems
- Security, privacy, and confidentiality policies (federal, HIPAA, state, and corporate)
- Identifying and reporting fraud, waste, and abuse
- Quality assurance, including inter-rater reliability
- Effective customer relations

Existing staff receive routine refresher training on the above topics as well.

B.14: 3.3.A Key Personnel

RFP Reference: Section 3.3.A

Offeror must have the specified number of executive and professional personnel, management analysts, system analysts, programmers, consultants, etc., who will be involved in providing the Deliverables, and indicate where these personnel will be physically located during the time that they are involved in the work.

Offeror must identify, by position and by name, those staff they consider key to the program's success. Additionally, the Offeror should provide resumes, education, experience and a list of related published works for key personnel that will be assigned to this program. Key personnel should include, at a minimum, at least one of the following personnel, unless otherwise specified below:

A. Medical Director, located and licensed in Ohio;

B. Project Leader;

C. Project Managers (2);

D. Director of Quality Studies;

E. Database Administrator; and

F. Biostatistician.

As presented in this proposal section and the resumes in proposal Appendix D, the personnel assigned to ODM's UM/PA project have the necessary education, experience, and licensure requirements. They are uniquely knowledgeable regarding what it takes to make this contract successful because they perform these tasks for the current UM/PA contract with ODM.

The highly qualified key personnel proposed for the new contract with the Department, including their name, contract title, physical location, and years of experience are shown in the following table. Combined, these seven individuals possess more than 172 years of applicable experience (UM/PA, direct patient care, data analysis, IT/data processing, etc.).

Our key clinical personnel include Ohio-licensed and Ohio-domiciled Medical Director Anthony "AJ" Beisler MD, FACS, CHCQM, along with our Director of Quality Studies, Mathew George, MD, and project managers Merrily Sable, RN, and Lisa Thompson, RN, are experienced clinicians with strong knowledge of UM/PA processes, acute hospital, non-institutional services, and psychiatric and community behavioral health services in Ohio and across the country. This clinical leadership team guides our nurse reviewers, Ohio-licensed physician reviewers, and Certified Coding Specialists. The clinical team partners with our highly qualified, and knowledgeable Ohio-based project leader, Seana Ferris, who is responsible for the overall service delivery and success of the contract. Ms. Ferris brings insight from other State Medicaid Utilization Management contracts she oversees and is supported by our proposed biostatistician, Caroline Black, PhD, RN who works with the health care data analysts, and our experienced IT Director, William Walo who will serve as the Database Administrator.

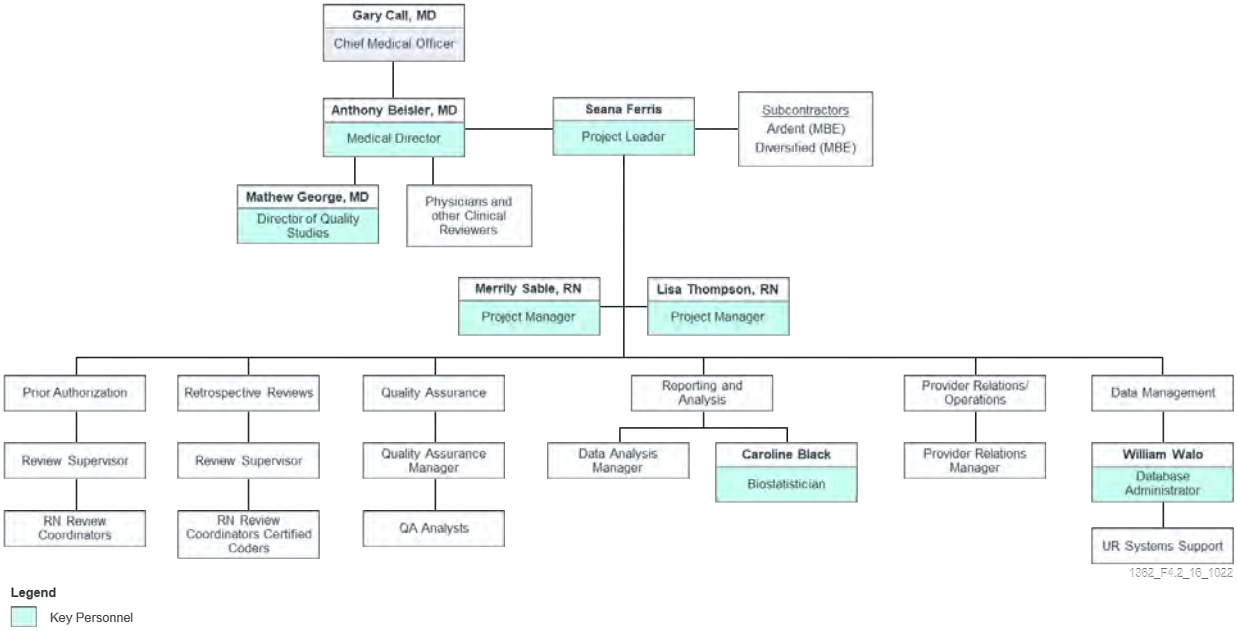
Table 3. Key Personnel Experience

Name	Position	Physical Location	Years of Applicable Experience
Anthony Beisler, MD	Medical Director	Dublin, OH	20
Mathew George, MD	Director of Quality Studies	Tappan, NY	17
Seana Ferris	Project Leader	Dublin, OH	30
Merrily Sable, RN	Project Manager, Quality and Hospital UM	Raleigh, NC	31
Lisa Thompson, RN	Project Manager, Behavioral Health	Dublin, OH	32
William Walo	Database Administrator	Georgetown, TX	33
Caroline Black, PhD, RN	Biostatistician	Huntsville, AL	9
Total Years' Experience			**172**

We provide detailed information associated with each of our key project team personnel in the following pages. Proposal Appendix D contains the resumes of the key personnel.

The following figure represents the Project Team Organizational Chart who will lead the ODM UM/PA program.

Figure 2. Project Team Organizational Chart



B.14.a 3.3.A Medical Director

RFP Reference: Section 3.3.A

The Medical Director will act as both Medical Director and Principal Clinical Coordinator for the program. The Medical Director will provide clinical direction for the Utilization Management program. Responsibilities of the Medical Director include:

A. Oversight of all physician reviewer activities (recruiting, training, and supervising).

B. Oversight of medical record reviews and appeals.

C. Provide medical and technical expertise and guidance on criteria interpretation and other professional issues.

D. Respond to calls or correspondence from physicians and providers.

E. Manage quality assurance procedures to ensure consistent and appropriate application of criteria.

The Medical Director is expected to provide medical oversight and clinical leadership in the development and execution of health care quality improvement efforts involving physicians, hospitals, and managed care organizations. The Medical Director must be a licensed and Ohio board certified Doctor of Medicine (MD) or Doctor of Osteopathic Medicine (DO). A minimum of five (5) years prior medical director or administrative experience is required.

Since 2008, Anthony “AJ” Beisler, MD, FACS, CHCQM has been the Medical Director of Permedion where he has gained broad experience on utilization and clinical review activities across Medicaid and other payers. Dr. Beisler will continue to fulfill the role of Medical Director and Principal Clinical Coordinator on the Ohio UM/PA project program and is responsible for the clinical oversight via the following tasks:

- Maintaining a current and unrestricted Ohio clinical license and holding board certification
- Sustaining qualifications to perform clinical oversight for the services provided, including oversight of physician reviewer oversight activities (recruiting, training, and supervising), medical records reviews, and appeals activities
- Communicating with physicians/providers as related to clinical reviews

- Provide medical and technical expertise and guidance on criteria interpretation and other professional issues
- Respond to calls or correspondence from physicians and providers
- Overseeing Quality Assurance procedures, including inter-rater reliability process to confirm appropriate application of criteria
- Accomplishing post-graduate work in direct patient care

Dr. Beisler is an Ohio-licensed Doctor of Medicine board certified in general surgery who received certification in healthcare quality management from the American Board of Quality Assurance and Utilization Review Physicians (ABQAURP). With more than 20 years of professional experience in the administration of healthcare and UM/PA review programs, Dr. Beisler exceeds the required minimum of five years of experience and is well-qualified to provide the value-added services that only Permedion can bring to ODM.

Dr. Beisler's resume includes a list of his published works and is included in proposal Appendix D.

B.14.b 3.3.A Project Leader

RFP Reference: Section 3.3.A

> The Project Leader will oversee the start-up and ongoing operations of the proposed program. The Project Leader will be expected to:
>
> A. Establish action plans, budgets, timetables, and performance measurements.
>
> B. Obtain and allocate resources.
>
> C. Review progress of the contract to accomplish established objectives.
>
> The Project Leader must have the ability to operate independently; a proven track record in planning, conducting and overseeing programs of major significance; experience with Utilization Review and Quality Assurance; and prior fiscal management responsibilities. A Bachelor's Degree in business, health administration, management, or public health is required. Minimum qualifications include five (5) years of experience in a lead position in a quality and utilization management program, including the two (2) most recent years being in health care management.

Our proposed project leader, Seana Ferris will continue to serve as project leader. She will work closely with the clinical, data analytics, operations, and data management teams to make certain the contract requirements and ODM's objectives are fulfilled. Ms. Ferris is responsible for overall contract compliance, proper allocation of resources, development and execution of project plans, and monitoring performance measurements.

Seana Ferris is uniquely qualified to serve in this capacity given her more than 30 years of experience in the healthcare industry, including hospital administration, program integrity, service development, and client support. She will continue to meet regularly with ODM to discuss the project status. She will also coordinate with ODM's contractors and other project stakeholders, as needed.

Ms. Ferris is based in our Dublin, OH office and is available for in-person meetings. She also meets the education requirements of the RFP with a Bachelor of Science degree in Business from Miami University. Her project-scope experience includes the following:

- 30+ years of healthcare industry experience
- 20 years of experience with Program Integrity for state Medicaid program integrity

- 10 years of experience as a hospital and health care system administrator
- Five years of experience as a healthcare consultant
- Working knowledge of medical terminology, legal terminology, and managed care policies, as demonstrated through performance of contract services

Ms. Ferris' resume is included in proposal Appendix D.

B.14.c 3.3.A Project Manager

RFP Reference: Section 3.3.A

At least two (2) Project Managers are required, one Project Manager will be assigned to the Quality and Hospital Utilization Management Program and one Project Manager will be assigned to the Behavioral Health special review prior authorization of services program. The Project Managers' responsibilities include the following:

A. Management of the implementation and operation of the utilization management plan, which encompasses prospective pre-admission reviews and retrospective review of services provided in a hospital setting.

B. Management of the program's Quality of Care Studies, which involves collaboration with ODM in the development of study design and methodology, coordination of study analysis, and dissemination of study findings.

C. Management of the implementation and operation of the special review of prior authorization services, which encompasses prospective review of Assertive Community Treatment (ACT) and other mental health and substance use services and level of care.

These positions are expected to be assigned to persons who have a background in medicine and clinical care and are licensed, Registered Nurses in Ohio. At a minimum, Project Managers must have five (5) years of experience in the management of activities in a quality and utilization management program, of which at least two (2) years of experience were in Medicaid programs.

The Department requires two project managers to support the UM/PA contract, each with duties specific to certain aspects of the project. In addition to performing the duties described in the RFP for each position, our proposed project managers will lend their knowledge and expertise to the Medical Director and Director of Quality Studies to support the successful completion of focused reviews and health care studies that we perform during the contract period.

Our proposed project managers meet the required qualifications and have experience in performing their roles, as follows:

Merrily Sable, RN, Project Manager, Quality and Hospital Utilization Management Program. Merrily Sable is an Ohio-licensed RN with 31 years of experience in healthcare as a Nurse, Clinical Reviewer, Clinical Project Manager, and Clinical Supervisor. As a clinical supervisor and project manager, Ms. Sable has experience with leading the monitoring and oversight of review activities across multiple Medicaid programs and making sure that compliance requirements and deliverables are met. She has also served as a clinical supervisor for the ODM UM/PA contract for two years.

Ms. Sable has managed the review process, including quality measures for prepay and post-pay retrospective reviews across multiple service types. Her experience encompasses inpatient and outpatient hospital, Long-Term Care, behavioral health, pediatrics, DME, home health care, rehabilitation therapy (speech, occupational, physical), and dental services.

Additionally, Ms. Sable has 26 years of experience with utilization review practices, medical necessity, level of care reviews, coding, quality, and billing compliance reviews, and informal and formal appeal proceedings. She supervises 20 nurse reviewers and affirms that reviews are

completed accurately and timely. She collaborates with state representatives as well as internal team members (clinical leadership, provider services, project management, and data analytics) to make certain contract deliverables are met.

Lisa Thompson, RN, Project Manager, Behavioral Health. Lisa Thompson is an Ohio-based, Ohio-licensed RN with over 32 years of healthcare experience. She has direct experience in providing clinical reviews at each level of mental health and chemical dependency, including precertification, concurrent and retrospective reviews for medical necessity, aftercare planning and identification of appropriate discharge plan resulting in cost containment. Ms. Thompson is uniquely qualified because of her experience managing Permedion's previous UM/PA contract with ODMHAS for the inpatient psychiatric program.

Since Ms. Thompson started as a nurse reviewer, she has a detailed knowledge base of interpreting and applying the Ohio Administrative codes and Medical Necessity Criteria to prior authorization and understands the importance of a timely and accurate prior authorization processes. She has worked on the ODMHAS and ODM contracts since 2014, which includes five years as a nurse reviewer and three years as Project Manager. Ms. Thompson was involved in implementing the Behavioral Health expansion in 2018 and the Prior Authorization expansion in 2021. She also collaborated with ODM to develop the Spinraza study and the SUD Prior Authorization Pilot. Ms. Thompson also responded timely to focused reviews, requests for technical assistance, and special case study requests, including: the MCO SUD PA review comparison, annual reviews of inpatient, outpatient, and ambulatory procedure code review, review of MCO denial of Private Duty Nursing services, and behavioral health diagnosis list review. She also has performed prior authorization reviews of Assertive Community Treatment and other mental health and substance use services and levels of care.

Both of our proposed project managers more than exceed the 5 years' experience requirement for management of activities in a quality and utilization management program, of which at least two (2) years of experience were in Medicaid programs. Merrily Sable's and Lisa Thompson's resumes are included in proposal Appendix D.

B.14.d 3.3.A Director of Quality Studies

RFP Reference: Section 3.3.A

A Director of Quality Studies is needed to serve as principal investigator of quality studies. The Director of Quality Studies will be responsible for:

A. Research and sampling design of studies, including clinical measurement.

B. Assuring that studies take into account existing clinical practice guidelines, as well as other previous clinical studies using the same research techniques or performed in the same clinical areas.

C. Assuring that studies are designed to meet the objectives and answer the research questions agreed upon with ODM.

D. Overseeing implementation of the study, analysis and report production.

E. Presenting results of the study to ODM and other forums upon reasonable request.

The Director of Quality Studies must have an M.D., D.O., or clinical Ph.D., with at least five (5) years of experience in clinical research, including at least three (3) studies (please describe) serving as the principal investigator. Identify authored articles in professional journals, if applicable.

In this role, he will be responsible for the design and methodology of health care studies, including sampling, metrics, research techniques, and study questions. Dr. George's responsibilities will also include:

- Overseeing research and sampling study designs that incorporate clinical measurement, are consistent with existing clinical practice guidelines, and that meet the objectives and research requirements of ODM
- Overseeing implementation activities associated with study development
- Presenting studies to ODM and other forums upon request from the Department

Dr. George will collaborate with Dr. Beisler, the proposed Medical Director, to incorporate relevant clinical findings from other studies, as well as make certain the study accounts for adheres to clinical practice guidelines. He will provide oversight of study implementation and activities, as well as study results, evaluation, and reporting. Dr. George is located in Tappan, NY, and will be available to present study findings and recommendations to ODM and other forums, as requested.

Director of Quality Studies

Our proposed director of quality studies, Dr. Mathew George, MD has more than 17 years' experience in leadership and national experience in researching, designing, conducting, analyzing, and reporting complex studies to support healthcare quality and improved outcomes.

Dr. George received a Medical Degree in India and conducted ten years of Post Grad training in various specialties in the United States. He is an Assistant Professor of Psychiatry in the Neuroscience Institute at Geisinger Commonwealth School of Medicine in Pennsylvania. He is also a core faculty in the Psychiatry residency program for the AtlantiCare Health System in New Jersey. Dr. George is actively board certified in five specialties: General Pediatrics, Pediatric Pulmonology, Medical Toxicology, Sleep Medicine, and Addiction Medicine. He also is a Certified Medical Review Officer and Certified Workers Compensation Analyst.

In his current role as Medical Director of Division of Addiction Services, Dr. George oversees the largest addiction services program in New Jersey. He makes certain that the ever-evolving treatment of addiction is carried out with respect and courtesy to the often-ignored patient population suffering from substance use disorder (SUD). He keeps abreast with current evidence-based practice for addictions in different divisions of AtlantiCare Health System, community SUD data, available resources, and local healthcare trends. Dr. George works closely with AtlantiCare's Accountable Care Organization (ACO) managed care program to deliver addiction services to the community with help of local resources/public health agencies. In this role he often leverages the data from different federal/state agencies and to reduce the cost and improve the delivery and quality of addiction care.

Dr. George advised both physicians and nurses in the AtlantiCare health system and the New York City health system where he held the post of Pediatric Emergency Department (ED) Director. His involvement in clinical research focused on ED workflow management and reducing the costly lab work up in various clinical settings. He was successful in securing multiple grants in the ED to improve workflow. Dr. George was the resident education director for pediatric residency and emergency medicine residency while he was the Director of Pediatric ED. He is currently the education lead in the AtlantiCare psychiatric residency addiction program. He has served on several hospital committees including Code Committee and Pharmacy and Therapeutics Committee.

Dr. George has published and presented dozens of leading industry health care studies including several with quality improvement topics such as "*Trends in Publication of Mental Health*" published in the Journal of Pediatrics. Abstracts from three published studies for which Dr. George served as principal investigator are described below.

- **Will switching to Metered Dose Inhalers (MDI)/Spacers from Nebulization improve the Length of Stay (LOS) of patients with mild asthma exacerbation in the Pediatric Emergency Department (PED): A Quality Improvement (QI) Project in an inner-city hospital. (to be published in November 2022)**
  George M, Pereda Alejandra M, Noorudin T, Wadowski S.

  Background: Asthma is the most commonly encountered chronic disease in children. As per the NY State Asthma Surveillance Report 2013, asthma prevalence in age group 0-17 years was 10.3%. Between 2005 to 2010 there was 13.5 asthma emergency room visits each year per 100 children with current asthma in NY State. There are previous reports that emphasized the positive impact of MDI/spacers in reducing the length of stay (LOS) in the Pediatric Emergency Department (PED) and healthcare utilization cost in PED.

  Methods and Results: The aim of the QI was to improve the length of stay in PED for patients who present with mild asthma exacerbation. We identified and targeted the factors that contributed to prolonged LOS of patients with mild asthma exacerbation in PED. We identified that PED use of MDI/spacer was nil, and our QI team developed and applied a plan/schedule to implement the MDI/spacer in PED in patients with mild asthma exacerbation. The QI investigators applied the PDSA cycle (Plan, Do, Study, Act) over a period of 3 months. The MDI/spacer rate of use improved from nil to 10% of patients with asthma exacerbation presenting to PED.

  Conclusions: The QI project showed that in mild acute asthma exacerbation, changing the mode of administration of albuterol from nebulization to MDI/Spacer decreased the LOS from 236 minutes to 168 minutes. We also demonstrated in our 3rd PDSA cycle that re-enforcement of education increases the acceptability of MDI/spacer by the PED providers with further reduction in LOS.

- ***"Serum Osmolality Changes After Intravenous Contrast Administration: A Pilot Study."* Peds Emerg Care. 25(9): 555-557(2009).**
  George M, Shannon M, et al.

  Background: Anecdotal data suggest that intravenous contrast agents given to enhance the sensitivity of computed tomography (CT) can produce increases in serum osmolality, producing an osmolal gap. An unexplained osmolal gap often prompts extensive evaluation for the presence of unidentified toxins, particularly the toxic alcohols (methanol, ethanol, isopropyl alcohol, and ethylene glycol). The ability of intravenous contrast media to raise serum osmolality with a resulting osmolal gap has not been systematically investigated.

  Methods and Results: We evaluated changes in serum osmolality and osmolal gap in a cohort of patients presenting to a pediatric emergency department with abdominal pain who necessitated a contrast-enhanced CT scan as part of their diagnostic evaluation. Inclusion criteria were age of 10 to 18 years and the ability to obtain blood samples 30 minutes after contrast administration. Before and 30 minutes after contrast administration, serum osmolality and Na, glucose, and serum urea nitrogen levels were obtained. Osmolal gap was calculated using the formula 2(Na) + serum urea nitrogen/2.8 + glucose/18. The contrast agent Optiray 320 (Tyco healthcare, Mallinkrodt, Hazelwood, Mo) (ioversol, 68%) was administered at a dose of 2 mL/kg (1.36 g/kg). The main outcomes of interest were pre-contrast versus post-contrast osmolality and osmolar gap.

  Fourteen subjects were enrolled. The mean pre-contrast and post-contrast serum osmolalities were 292.75 and 292.875 mOsm/L (P = 0.93), respectively. The corresponding mean values for the pre-contrast and post-contrast osmolal gaps were 9.17 and 12.15 mOsm/L, respectively (P = 0.133). The mean difference between the pre-contrast and the

post-contrast osmolal gaps was 0.125 mOsm/L. There was no statistically significant correlation between the dose of the contrast agent administered and the post-contrast osmolality or osmolal gap.

Conclusions: These data suggest that intravenous contrast agents, when administered at conventional doses, do not significantly increase serum osmolality or produce an osmolal gap. Patients who are found to have an osmolal gap after the performance of a contrast-enhanced CT scan should undergo thorough evaluation to identify its etiology rather than attributing the gap to contrast administration.

- ***"Incidence, Recurrence and Long-Term Outcome of Steven Johnson Syndrome and Toxic Epidermal Necrolysis in Children: A Retrospective study."* Pediatrics. 2011 Oct;128(4):723-8**
  George M, Finkelstein Y, Soon G, Acuna P, Pope E, Ito S, Shear N, Koren G, Shannon M, Garcia-Bournisse F.

  Objectives: To report clinical course, etiology, management, and long-term outcomes of children suffering from Stevens-Johnson syndrome (SJS) or toxic epidermal necrolysis (TEN).

  Methods and Results: We conducted a study of pediatric patients with SJS or TEN admitted between 2000 and 2007 to the Hospital for Sick Children and Children's Hospital Boston, and particular attention was paid to clinical manifestations, etiology, mortality, and long-term outcomes.

  We identified 55 cases of SJS (n = 47), TEN (n = 5), or SJS/TEN overlap syndrome (n = 3). Drugs were identified as the most likely etiologic agent in 29 children (53%); antiepileptic drugs were the most common agents (n = 16), followed by sulfonamide antibiotics (n = 7) and chemotherapy drugs (n = 2). Acute Mycoplasma pneumoniae infection was confirmed in 12 children (22%), and herpes simplex virus was confirmed in 5 children (9%). Treatment regimens differed significantly between participating sites and included systemic antimicrobial agents (67%), systemic corticosteroids (40%), and antiviral drugs (31%). Intravenous immunoglobulin was administered to 21 children (38%), of whom 8 received concomitant systemic corticosteroids. Ten children (18%) had recurrence of SJS up to 7 years after the index episode, and 3 experienced multiple recurrences. Twenty-six children (47%) suffered long-term sequelae that mostly involved the skin and eyes.

  Conclusions: Mortality rate in children was lower than that reported in adults, but half of affected children suffered long-term complications. The recurrence rate of SJS was high (1 in 5), which suggests vulnerability and potential genetic predisposition. In the absence of standardized management guidelines for these conditions, treatment regimens differed significantly between participating institutions.

Additional studies Dr. George led or participated in are described in his resume in proposal Appendix D.

B.14.e 3.3.A Database Administrator

RFP Reference: Section 3.3.A

A Database (IT) Administrator for the program. Responsibilities of this position will include the following:

A. Create, maintain and update ODM and other databases that will be used to perform contract activities.

B. Assure that the Offeror receives data in a timely fashion.

C. Maintain reasonable access to data for analytical purposes.

The Database Administrator must have at least a Bachelor's Degree in computer science with at least five (5) years' experience including programming, systems analysis and database management. The Database Administrator must possess the technological skills necessary to adequately perform duties utilizing healthcare claims from ODM's current Medicaid Information Technology System (MITS) or any new Medicaid Information Technology System (MITS), or both.

Our proposed database administrator, William Walo brings 33 years of extensive experience in leading information technology organizations. Mr. Walo has a strong technical background in application development, database design and administration, and planning and analysis of infrastructure and applications. Our experienced database administrators and programmers will support William, providing the necessary IT services under the contract.

Mr. Walo holds a bachelor's degree in Computer Science and is specifically responsible for phases of the system development and implementation process including system analysis, design, development, testing and ongoing support of a custom in-house application portfolio consisting of an environment of diverse development platforms, computing environments (e.g., host-based, distributed systems, client-server), software, technology, and tools.

In addition, he will be responsible for the timely delivery of ODM data. As a database administrator, Mr. Walo will perform a variety of tasks including:

- Creating, maintaining, and updating ODM and other databases used to perform contract activities
- Making certain that Permedion and ODM receive data in a timely fashion
- Maintaining reasonable access to systems and data for analytical purposes

Mr. Walo will lead our continuing efforts to support ongoing regular data loads to the system, troubleshoot issues, and work to maximize efficiency and user experience for the benefit of ODM's UM/PA program. William Walo's resume is included in proposal Appendix D.

B.14.f 3.3.A Biostatistician

RFP Reference: Section 3.3.A

As needed, assign and specify a Biostatistician for the Quality and Hospital Utilization Management Program. Responsibilities include the following:

A. Assure that the sampling design meets agreed upon confidence intervals and that sampling weights are constructed consistently with the complexity of the sampling design.

B. Determine which statistical tests are used in analysis of the data and assuring that they are used appropriately.

C. Participate in the development of abstracting and survey tools, train abstractors and surveyors and oversee tests of inter-rater reliability.

The Biostatistician must have a Master's Degree in statistics, biostatistics, or mathematics, or a Ph.D. in a related subject. In addition, the Biostatistician must have at least three (3) years of experience, including at least two studies (please describe) serving as a biostatistician.

We propose that Caroline Black, RN, PhD, continue in her role as biostatistician for the ODM UR/PA project. She has nine years of applied experience in analysis and data visualization. Dr. Black has a Doctor of Philosophy in Biomedical Engineering and specializes in mathematical modeling, and programming. With nine years of experience, Dr. Black utilizes her analytical problem-solving skills, and quantitative and qualitative information to provide informed data to

assist in the research efforts for the medical, biology and public health industries. As an applied biostatistician, Dr. Black is responsible for planning and conducting statistical and epidemiological analysis of health care data, designing, and conducting analysis of health care databases and providing statistical input to study design, sampling methodology and reporting to assure statistical integrity of a project. Dr. Black is skilled at analyzing large, complex data sets to provide insight on performance improvement, cost reduction, and utilizing clinical decision support tools in an agile development environment for clinical process improvement.

Dr. Black also is experienced in leading conceptual-framework development and statistical modeling efforts across multiple markets. She has created multiple reports centered around review target effectiveness, recoupment statistics, and provider rebilling practices for the Ohio UM/PA contract. She has also conducted multiple project scoping reports for studies centered around sepsis patients leaving AMA, cost analysis of drug testing procedures and substance abuse.

Caroline Black's resume is included in proposal Appendix D.

B.14.g 3.3.A Other Necessary Positions

RFP Reference: Section 3.3.A

> In addition, the Offeror must submit general job descriptions/requirements of other staff positions to be assigned to this program, including:
>
> A. Medical record extractors;
>
> B. Review nurses;
>
> C. Physician reviewers;
>
> D. Data processors;
>
> E. Data analysts;
>
> F. Registered Health Information Administrator (certified medical coder); and
>
> G. Information Systems Manager.

Our proposed project team includes experienced healthcare program–service specialists with expertise in delivering hospital UM/PA solutions and fulfilling complex contract requirements. Permedion has demonstrated our ability to assemble and manage a diverse, talented team with expertise in each program service area. Our in-place resources and relationships with stakeholders guarantee that we can provide reliable and immediate results on Day 1 of the contract and throughout the contract term.

We have the capability of staffing our project service teams for our contracts with qualified hospital UM/PA specialists, and our new contract term with ODM will be no exception. To provide the highest level of service the Department has come to expect from us, we have assigned healthcare professionals to work interactively to support the SOW requirements set forth in ODM's RFP. Each member knows the nuances of our services and the procedures imperative to exceeding the State's expectations. They are not disparate individuals cobbled together to fulfill the obligations of this procurement. The proposed team has the breadth of experience and depth of Ohio Medicaid knowledge to support the continuation of the success of our services.

The following table provides the position name and primary functions and requirements for each of these non-key personnel/project team members. We have also provided the names of the

Permedion team members who work on the current ODM UM/PA contract and will continue to under a new contract. In Appendix E, we provide full job descriptions for these positions.

Table 4. Non-Key Project Team Positions for ODM

Project Position and Current Team Members	Project Position Functions	Project Position Requirements
Medical Record Extractors	• Collects demographic, clinical, and statistical information from medical records • Supports bill audits, health care studies, and other projects/reviews requiring medical record extraction	• RN, LPN, RHIT, CCS, or CPC with at least three years of clinical experience • Expert knowledge of data collection of medical record elements and understanding physician terminology and documentation • Experience in performing line-item bill auditing, health care studies, focused reviews, and other activities
Medical Record Extractors currently supporting the ODM UM/PA Contract: Elizabeth Halley Dease and others listed below		
Review Nurses	• Perform retrospective medical chart review to collect data, evaluate quality of care, and validate the accuracy of diagnostic data • Perform Prior authorizations • Uses nationally recognized criteria to perform clinical review of medical information and conduct QI activities	• Active and unrestricted nursing license required • 5+ years of related clinical experience • 2+ years utilization review experience or claims auditing required • Experience using MCG and other nationally recognized criteria
Review Nurses currently supporting the ODM UM/PA Contract: Kathryn Simpson (Manager); Leanne Piniones (Supervisor); **RNs:** Christine Kitson, Dara Billeaud, Jennifer Seif, Linda Hetson, Lindsay Fisher, Tanya Yoder, Yasmine Jaafer, Deborah Herres, Jennifer Day, Judy Bertz, Sanjeev Bedasee, Niz Hassan, Renata Grinshpun, Sandra Heckler, Sara Grissom, Stacey Mathis; **LPNs**: Christina McGee, Juris Torres, Lindsay Cabras, Michele Diaz, Rosalyn Martin; **LSW:** Jennifer Rosette		
Physician Reviewers	• Performs review of retrospective and prior authorization requests and appeals regarding issues of medical necessity, resource utilization, standard of care, and overall quality, and provides a reasoned opinion as well as responses to specific questions posed • Conducts peer-to-peer discussions • Participates in hearings, pre-hearings, and other meetings as necessary	• Current unrestricted Ohio medical license • Current board certification in specialty • Experience in stated specialty for 5+ years • Practicing in stated specialty for a minimum of 12 months • No history of sanctions or disciplinary actions • No loss of personnel privileges or restrictions on participation
Physician Reviewers currently supporting the ODM UM/PA Contract*: Kevin Alten MD, Jacinto Beard, DDS, Danielle Clemmer DO, Justin Crivelli, DO, Richard Fikes DO, Mathew George MD, James		

Project Position and Current Team Members	Project Position Functions	Project Position Requirements
Gilsdorf, DDS, Neal Goldenberg MD, Sara Goldman MD, Joan King DO, Christopher Linscott, DDS, Ryan Longstreth MD, John Pressler MD, Ravi Ramachandran MD, Tanvir Singh MD, Curtis Taylor MD, Peter Wiest MD, Susan Wilson, DDS, Laurel Zulliger MD* **Note this is only a sample of the 39 Ohio-licensed physicians/dentists assigned to the Ohio UM/PA contract today. Please see additional information on our Ohio physician network following this table.*		
Data Processors	• Plans, writes, develops, modifies, and adapts existing and new computer programs using standard procedures and techniques • Leads efforts in establishing protocols for and testing of data transmission to and from the MITS	• Associates degree or equivalent work experience • Bachelor's degree in Computer and Information Sciences or a related field preferred • Minimum of three years' experience or an equivalent combination of education and experience
Data Processors currently supporting the ODM UM/PA Contract: Barry Isenbarger, Praveen Kamisetty		
Data Analysts	• Responsible for planning and conducting statistical and epidemiological analysis of healthcare data • Coordinates with the Medical Director, clinical team, and others to define/refine, write/program, and produce analysis of utilization patterns and trends of Medicaid services to evaluate efficiency of health care delivery, appropriate use of health services and opportunities to improve quality of care	• Master's degree in statistics, preventive medicine, or related field with two years' relevant experience; Bachelor's degree in statistics, preventive medicine, or related field with at least five years' relevant experience; or equivalent combination of education and experience • Demonstrated experience in the use of statistical analysis software • Demonstrated basic level of familiarity with spreadsheet, graphics, and database software
Data Analysts currently supporting the ODM UM/PA Contract: Wendy Wescott (Director), Kilian Wells (Manager), Walshe Izumigawa		
Registered Health Information Administrator	• Reviews medical records to collect data and confirm appropriate billing of and compliance with coding guidelines and rules • Responds to questions or concerns raised by nurse reviewers, physician reviewers, or healthcare providers	• Current RHIA, RHIT, CCS, CPC, or other coding-related licensed/accredited healthcare professional • Minimum of three years' clinical-coding experience • Demonstrated experience with APR-DRG and EAPG groupers, MITS • Demonstrated experienced in International Statistical Classifications of Diseases and Related Health Problems, Ninth Revision, Clinical Modification, and Current Procedural Terminology coding for the clinical area under evaluation

Project Position and Current Team Members	Project Position Functions	Project Position Requirements
		• Demonstrated ability to analyze and evaluate medical information and collect specific healthcare information • Demonstrated experience in medical review, chart audits, and quality improvement processes preferred
Registered Health Information Administrators currently supporting the ODM UM/PA Contract: Deb Baudo (Supervisor), Bobbie Frost, Charolette Brown, Donna Hollaway, Fikisha Jones, Jennifer Fouty, Kathalene LaCroix, Rebecca Doming		
Information Systems Manager	• Manages information technology field-support personnel in Ohio and other offices • Makes sure that the technical-support function is meeting user needs in an effective, timely fashion • Maintains, administers, and troubleshoots technical systems, as required	• Bachelor's degree in Computer Science, Information Sciences or equivalent experience • Minimum of four years' technical-support experience
Information Systems Manager Currently supporting the ODM UM/PA Contract: David Jones		
Client Services Analysts	• Conducts non-clinical contract operations, workflow management, and system user acceptance testing • Receives, triages, and enters PA requests into MITS • Responds to provider and other stakeholder calls • Routes calls to appropriate parties as needed • Conducts provider education and training • Conducts quality steps to confirm the accuracy of letters, reports and other deliverables	• Minimum of three years' operational support experience • High school diploma or GED and at least 1 to 2 years of experience in health care environment within customer service, provider relations, admissions or call center. • Experience with call center telephony and computer equipment
Client Services Analysts currently supporting the ODM UM/PA Contract: Yalonda Harper (Director), Angel Tucker (Manager), Kimberly Walker, Terrell Peterson, Linsey Armstrong, Hiran Thouti Reddy, Lesley Ward, Lauren Devereaux		

Anthony "AJ" Beisler, MD, our Ohio Medical Director, will routinely assess the strength of our physician panel and will proactively recruit additional reviewers in areas where needs are greatest. Upon contract award, we will begin recruiting

Physician/Dental Review Staff

We have a credentialed Ohio-licensed panel of 39 clinical peers, which 37 reside in Ohio.

additional Ohio-licensed specialists. We use various sources to assist in our recruiting efforts including:

- Current panel member referrals
- Professional societies
- Hospitals and university medical programs
- Local, state, and national medical societies
- Professional colleagues
- Ongoing solicitations posted on our website and transmitted through other channels

Our high standards can assure ODM that only appropriately trained, qualified clinical personnel will continue to conduct and oversee our UM/PA review process.

Permedion employs a rigorous credentialing process that makes certain the physicians conducting reviews have the required professional qualifications and are appropriately licensed, registered, or certified. This process is conducted when the reviewer applies to become a member of our network and once credentialed, repeated every two years thereafter. The credentials verified as part of this process include:

- Current unencumbered U.S. Medical License (full, unrestricted licensed; not on probation, supervision, or regularly reports to the State Board)
- Current board certification in specialty, if applicable
- Actively practicing with a minimum of five years' experience in the stated specialty
- List of Excluded Individuals and Entities (LEIE) check*
- Report from National Practitioner Data Bank query*
- History of sanctions and/or disciplinary actions*
- Professional experience
- Potential conflicts of interest

**Reviewers excluded from participation in a government-funded health care program, with significant entries in the NPDB, or with history of sanctions and disciplinary actions are not credentialed by Permedion.*

Additional Team Members: Subcontractors

The Permedion project team for ODM includes qualified and experienced subcontractors that will support our industry-best delivery of UM/PA services:

- **Ardent Technologies, Inc. (Ardent)** will provide provider authorization request review support services. Ardent is an Ohio-certified Minority Business Enterprise. Please see proposal Section H for a Letter of Commitment from Ardent.
- **Diversified Systems, Inc. (Diversified)** will provide provider authorization request review support services. Diversified is an Ohio-certified Minority Business Enterprise. Please see proposal Section H for a Letter of Commitment from Diversified.

Additional information on our subcontractors can be found in Section D.3.5 of our proposal.

C. 3.2 Organizational Experience and Capabilities

RFP Reference: Section 3.2

Proposals should demonstrate significant organizational expertise of the prime Offeror. Proposals must include, at a minimum, the following demonstrated experience as detailed below; and as part of the evaluation process, this information will be scored by ODM:

The Offeror information provided for all the [below] topics should include summary descriptions of all successfully completed projects, any notable accomplishments and outcomes, and contact information for an Offeror's customers that received the services provided—if not already included as a reference. Offeror experience and knowledge should be demonstrated by providing key samples, excerpts, or copies representative of the quality of relevant work.

Permedion was founded in Ohio in 1974 as a Peer Review Organization providing medical peer review and quality assurance (QA) services within the Medicare program. On October 5, 2007, Permedion became a wholly owned subsidiary of Health Management Systems, Inc. (HMS). HMS was founded in 1974 and provides expertise in Medicaid cost containment, program policy, data, program analysis, data analytics, and recovery. On April 1, 2021, Gainwell, a leading provider of solutions vital to the administration and operations of health and human services programs, purchased HMS Holdings LLC and its wholly owned subsidiaries, including HMS and Permedion, Inc. Gainwell, is an independent private company, founded on October 1, 2020. Gainwell Technologies, LLC, was created through the sale of DXC Technology's State & Local Health and Human Services business, creating a standalone company with a primary focus on providing our customers with state-of-the-art Health and Human Services solutions.

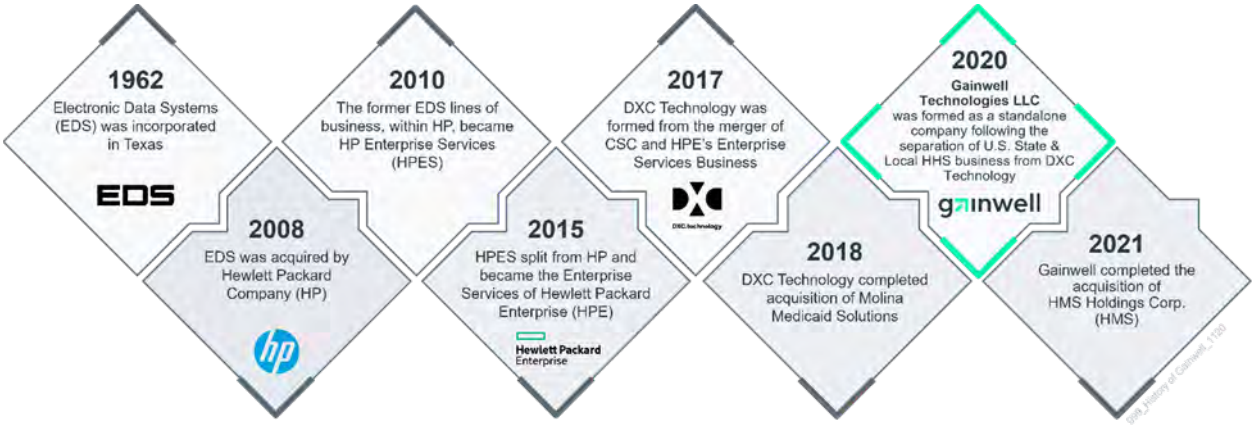
The Gainwell name is new, but they have been building their reputation as a valued partner to state and local governments for more than 50 years. As a new company, Gainwell combines the best practices and service excellence of our predecessor companies, a strong focus on HHS, and the innovation and flexibility of a start-up to enable government agencies to achieve great health and human service outcomes.

Notable Medicaid industry leaders in our predecessor companies are:

- EDS, the company that built the first Medicaid claims processing system. Many of the people who were a part of EDS remain in Gainwell, bringing thought leadership to build even better solutions for our clients.
- Molina Medicaid Solutions, a Medicaid Management Information Systems (MMIS) business, from Molina Healthcare, Inc.
- HMS Holdings Corp. (HMS), an industry-leading healthcare technology, analytics, and engagement solutions provider with capabilities in coordination of benefits (COB) and payment integrity solutions delivered to states.

The following figure depicts Gainwell's history.

Figure 3. History of Gainwell



Our Ohio Medicaid Footprint

Our Dublin, Ohio office is home to the collective Gainwell team supporting Ohio Medicaid to improve health outcomes for Ohioans under various contracts including:

- **Utilization Management.** Permedion performs Utilization Management of Hospitals and Specified Behavioral Health Care Services as well as Prior Authorization for institutional, non-institutional, behavioral health, and other services offered to Ohio Medicaid consumers.
- **Third Party Liability.** HMS provides Third Party Liability services to Ohio Department of Medicaid since 1999. We work closely with Ohio hospitals and individual practitioners. In support of our Casualty recovery scope of work, we have also established effective working relationships with the legal community and attorneys throughout the State that enable case identifications and settlements.
- **Medicaid Management Information System.** Gainwell has been providing technology services to ODM since 2007 as the Medicaid Management Information System (MMIS) vendor. As ODM transitions to the next generation modular model, Gainwell will provide systems and business services as the Fiscal Intermediary providing claims processing, call center functions, financial management and support for coordination between ODM and its managed care partners.
- **Single Pharmacy Benefit Manager.** Recently implemented, Gainwell serves as the (SPBM) with ODM to administer Ohio Medicaid's prescription drug program. Gainwell operates as a pre-paid ambulatory health plan (PAHP), a first-of-its-kind approach to pharmacy care in Medicaid.

The collective Gainwell—Permedion, HMS, and Gainwell—brings decades of experience and knowledge of Ohio Medicaid partnering for over 35 years. Our extensive staff of clinical professionals and the backing of Gainwell, which is greater than 10,000 employees strong, allow us to effectively handle growth and volume demands with ease. Our vast corporate resources and expertise, both in Ohio and nationally, can provide ODM with continued UM/PA program operations with no disruption in services to members and providers, and ensure we meet the requirements and goals of this RFP.

In this section we provide:

- Our experience relevant to completing the work identified in the Scope of Work and Specification of Deliverables Sections of this RFP including HMS's corporate background, and the MBE subcontractors we propose to use
- Summaries of four similar sized projects that demonstrate our expertise and experience in the strategies and objectives listed in RFP Section 1.3
- Our knowledge of and experience in Medicaid, including our deep Ohio-specific knowledge and experience
- Our familiarity with and experience in the practical application of the laws and regulations impacting Medicaid operations, including Ohio-specific expertise
- Names and contact information for three entities for which we have performed similar large-scale projects in the past five (5) years

C.A 3.2.A Experience Relevant to the SOW

RFP Reference: Section 3.2.A

A. Demonstrated experience relevant to completing the work identified in the Scope of Work and Specification of Deliverables Sections of this RFP. Include information on the background of the firm, including any subcontractors who would perform work under any contract resulting from this RFP.

Background and Relevant Experience

Permedion has 35 years' experience performing UM/PA services and currently provides these services for 18 Medicaid programs.

Permedion has years of experience providing the clinical utilization management and prior authorization (UM/PA) services described in this RFP not only nationally, but directly with Ohio. Beginning in 1985 when Permedion engaged in its first contract with the Ohio Department of Human Services to conduct post payment clinical review of hospital claims. Permedion partnered with the Ohio Department of Rehabilitation and Correction (ODRC) to develop and manage a prior authorization program, beginning with outpatient services, and growing to include prior authorization of admissions as well as post-payment review. We successfully leveraged our knowledge, experience, and capabilities regarding healthcare utilization management, providing ODRC with a 95:1 Return on Investment over the duration of our contracts.

The Ohio Department of Mental Health and Addiction Services contracted with Permedion to provide Statewide Utilization Management/Utilization Review for Specified Behavioral Health Care Services for Medicaid Recipients from 2013–2018, until services of the contract were incorporated into and amended to our current Hospital Utilization Management contract with ODM.

Permedion Inc. (Permedion), a certified, quality improvement organization (QIO)-like firm with a 24-year background in utilization management, was founded in Ohio in 1974 as a corporation providing medical peer review and quality assurance (QA) services within the Medicare program. Permedion engaged in its first state Medicaid contract with the Ohio Department of Human Services in 1985 conducting post payment clinical review of hospital claims.

HMS, including wholly owned subsidiary Permedion, is accredited by the URAC (Utilization Review Accreditation Commission) in Health Utilization Management (HUM) and as an External Independent Review Organization (EIRO). The following figure shows our accreditation certificates.

URAC accreditation provides our state Medicaid agency customers with the confidence that our team understands the structures and processes that promote high quality care while preserving patient rights. The URAC-accreditation process applies nationally recognized standards and guidelines to verify the following:

- Only appropriately trained and qualified clinical personnel conduct and oversee the clinical review (prior authorization) process
- Valid clinical criteria provide the bases for all medical decisions
- Case determinations are evaluated for accuracy and timeliness through an internal quality control process
- A reasonable and timely appeals process is in place

Figure 4. URAC Health Utilization Management and Independent Review Organization Accreditation

urac®

CERTIFICATE OF AWARD

in recognition of

Health Management Systems, Inc.
5615 High Point Drive, Suite 100
Irving, Texas 75038

for compliance with

Health Utilization Management, 7.4 Accreditation Program

is awarded

Full Accreditation

Effective from May 01, 2021 through May 01, 2024

Shawn Griffin MD

Shawn Griffin, M.D.
President & Chief Executive Officer

Certificate Number: HUM007567 - 118833

urac®

ACCREDITED

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 AWARD

in recognition of

Health Management Systems, Inc.
5615 High Point Drive, Suite 100
Irving, Texas 75038

for compliance with

Independent Review Organization: External Review, 5.2 Accreditation Program

is awarded

Full Accreditation

Effective from May 01, 2021 through May 01, 2024

Shawn Griffin MD

Shawn Griffin, M.D.
President & Chief Executive Officer

Certificate Number: IRE007568 - 120102

urac®

ACCREDITED

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.

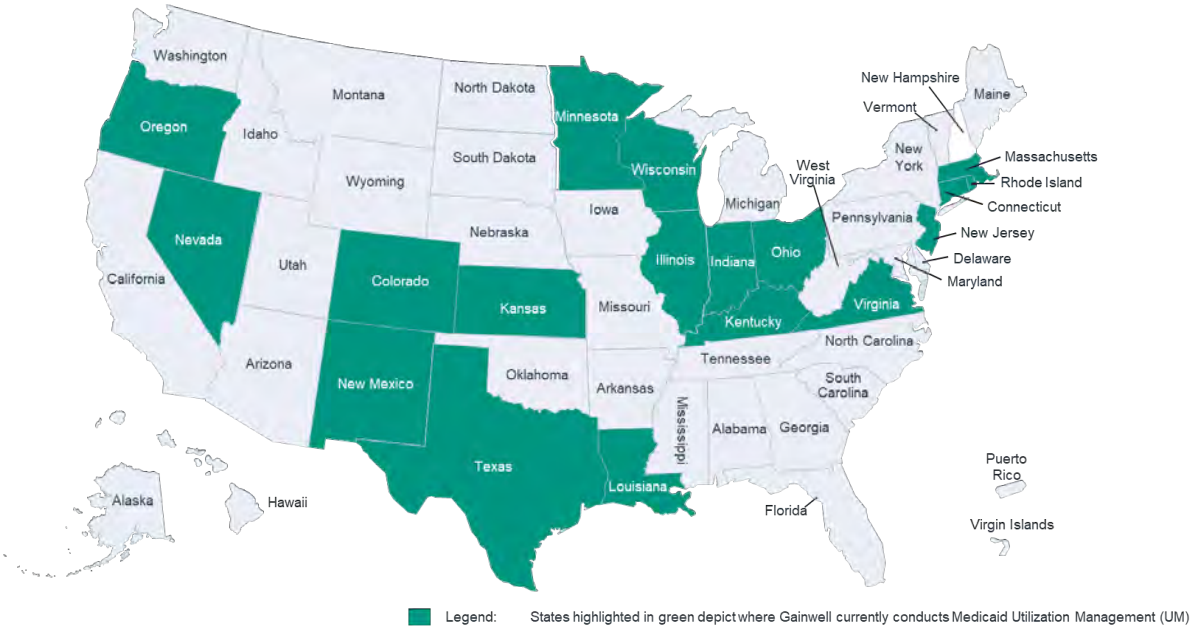
This certificate is the property of URAC and shall be returned upon request.

Relevant Experience

Permedion and the Gainwell affiliates have extensive Utilization Management and Prior Authorization program experience in both Medicaid FFS and managed care populations. We have over 35 years of experience in the design and implementation of UM/PA programs and strategies for large Medicaid programs, such as the programs in Ohio.

As shown in the following figure, we currently perform UM/PA reviews for 18 state Medicaid programs—including Ohio—consisting of prior authorization, pre-certification, concurrent/continuing stay, and retrospective reviews (pre- and post- payment). We perform over 1.2 million UM/PA reviews annually across these states.

Figure 5. Permedion UM/PA Footprint



The table in upcoming subsection 3.2.B Samples of Similar Projects lists the states where we conduct services similar to those defined in this RFP, categorized by the Scope of Work/Deliverables defined in Section IV of the RFP.

Nationally, we perform UM/PA reviews across all the provider/service types covered under this RFP, as well as other Medicaid provider/service types:

- Inpatient and outpatient hospital (acute, psychiatric, residential, rehabilitation)
- Clinic (emergency and urgent care)
- Ambulatory Care/Surgery Center
- Physician/professional including hearing/vision, acupuncture, and chiropractor services
- Behavioral health
- Waiver/Home and Community Based Services
- Long Term Care and Nursing facilities
- Radiology/Imaging
- Laboratory
- Therapies (respiratory, physical, speech, occupational)
- DME supplies and equipment
- Home health

- Private duty nursing
- Personal care
- Hospice
- Ambulance/transportation
- Pharmacy
- Dental/Orthodontia

Subcontractors

Permedion proposes to use two qualified and experienced subcontractors to support our delivery of industry-best UR/UM services to the State of Ohio: Ardent Technologies, Inc. (Ardent) and Diversified Systems, Inc. (Diversified). Ardent and Diversified are both certified by the State of Ohio as Minority Business Enterprises (MBEs).

> Permedion proposes two experienced Ohio-certified MBE subcontractors to support our delivery of services: **Ardent Technologies, Inc. and Diversified Systems, Inc.**

Ardent, who currently serves as a subcontractor for Permedion in multiple state contracts, including the ODM UM/PA contract, will provide staffing augmentation for programming and quality assurance positions. Ardent is an MBE headquartered in Dayton, Ohio.

Diversified will provide provider authorization request review support to Permedion to support our delivery of UM/PA services to ODM. We have subcontracted with Diversified under the current UM/PA contract to provide the services of four dentists. Diversified is an MBE headquartered in Westerville, Ohio.

As in our current contract with ODM, Permedion will set aside at least 15% of the payments generated under the UM/PA contract for the services provided by these subcontractors. Additional information on our MBE subcontractors is included in proposal Section D.

Project Office in Dublin, Ohio

The Gainwell office in Dublin, Ohio, is home to all contracts with ODM including the UM/PA, TPL, MITS/FI, and SPBM. We have office space to host meetings and accommodate site visits from ODM and/or project stakeholders. We recognize the value of maintaining and performing project work and project management out of a local office.

C.B 3.2.B Samples of Similar Projects

RFP Reference: Section 3.2.B

B. Samples (excerpts and/or Executive Summaries acceptable) of at least two, but no more than four, similar sized projects completed or begun in the past five (5) years that demonstrate expertise and experience in providing expert assistance in the strategies and objectives listed in section 1.3.

The upcoming table lists our state experience in providing similar services as those described in ODM's UM/PA Program RFP. The objectives for many of these state contracts include those listed in RFP Section 1.3:

- Safeguarding against unnecessary or inappropriate use of Medicaid services and against excess payments

- Assessing the quality of those services
- Providing for the control of the utilization of all services provided under a state plan
- Providing for the control of the utilization of inpatient services for both medical and psychiatric services

Table 5. Relevant UM/PA Experience

Scope of Work/Deliverables in ODM RFP (Section IV)	States Permedion Conducts
A. Special Reviews	IN, KY, MA, LA, NV, OH (6)
B. Retrospective Reviews	CO, CT, IL, IN, KY, MA, MN, NJ, NM, NV, OH, TX, VA (13)
C. Special Reviews	NJ, OH (2)
D. Focused Case Reviews	OH, MA, NJ (3)
E. Community Behavioral Health Services (Prior Authorization)	IN, KY, NV, OH, VA, WI (6)
F. Psychiatric Hospital Admission Reviews (Prior Authorization)	IN, KY, NV, OH (4)
G. Mobile Response and Stabilization Services (Prior Authorization)	OH
H. Non-Institutional Services (Prior Authorization)	IN, KS, KY, LA, NV, OH, WI (7)
I. Provider Prior Authorization Appeal Requests	OH, NJ (2)
J. Home Health Services (Prior Authorization)	IN, KY, LA, NV, OH, WI (6)
K. Private Duty Nursing (Prior Authorization)	KY, LA, NV, OH, WI (5)
L. Prior Authorization Appeal Requests (Reconsiderations)	IN, KS, KY, LA, MA, NJ, NV, OH, WI (9)
M. Reporting and Analysis	All states (18)
N. Health Care Studies	MA, OH, VA (3)
O. Provider Education	All states (18)
P. Technical Assistance	All states (18)
Q. Data Management	All states (18)
R. Other Prior Authorizations	CT, IN, KS, KY, LA, MA, NV, OH, OR, RI, WI (11)

In the following table, we provide summaries of four of these contracts of similar size as the ODM UM/PA contract that we have completed in the past five years.

Table 6. Summaries of Similar Sized UM/PA Projects

Medicaid State Agency and Contract Term*	UM/PA Scope Summary	Notable Accomplishments and Outcomes
Kentucky Department for Medicaid Services	• Prior Authorization and concurrent reviews (Inpatient, Outpatient, Physician, Radiology, DME, Home Health, Private Duty Nursing, Dental/Orthodontic, Hospice, EPSDT,	• Annual UM/PA Reviews: 183,000 • Partnered with the Commonwealth to develop,

Medicaid State Agency and Contract Term*	UM/PA Scope Summary	Notable Accomplishments and Outcomes
April 2006 – November 2023	Therapies, Psychiatric/PRTF, Behavioral Health, LTC, and Waiver services) • Retrospective hospital APR-DRG reviews (medical necessity, claim coding, and readmission) • Resource Utilization Group (RUGS) reviews (on-site and virtual) • Billing Audits (on-site and desktop) of home health agencies and EPSDT providers • Clinical Claim Suspense reviews • Reconsiderations, Appeals, and Hearings support • Reporting and analysis • Provider education • Technical assistance • Data management	test and implement the Medicaid Waiver Management Application to process waiver program prior authorizations • Partnered with the Commonwealth to develop, test and implement the Kentucky Level of Care System (KLOCS) that processes UM/PA reviews • Implemented a desktop review process for nursing facility ancillaries when COVID was introduced • Inpatient hospital DRG Retro Review process moved from a paper-based process to electronic submission • Partnered with the Commonwealth to develop, test and implement a telehealth review process for nursing facility reassessments
Massachusetts Executive Office of Health and Human Services January 2010 – February 2025	• Prior authorization/pre-admission screening and concurrent reviews of inpatient hospital services • Pre and Post Payment retrospective hospital reviews (medical necessity, APR-DRG claim coding, and readmission) • Focused reviews • Health Care studies • Reconsiderations, Appeals, and Hearings support • Reporting and analysis • Provider education • Technical assistance • Data management	• Annual UM/PA Reviews: 46,000 • Conducted 5 health care studies resulting in follow up tasks to improve processes, communications, and patient quality • Focused reviews on hospital/hospital systems and specific services/procedures • Annual analysis of review selection targets and provider utilization and denial rates • Robust provider education program including meetings with hospital association • 95% success rate (Permedion decision upheld) supporting state hearings
New Jersey Department of	• Pre and Post Payment retrospective inpatient hospital reviews (medical necessity,	• Annual UM/PA Reviews: 40,000 (managed

Medicaid State Agency and Contract Term*	UM/PA Scope Summary	Notable Accomplishments and Outcomes
Health and Human Services August 2008 – July 2025	APR-DRG claim coding, quality of care) for both FFS claims and encounter data • Special Reviews • Focused Reviews • Hospital bill audits • Reconsiderations, Appeals, and Hearings support • Reporting and analysis • Provider education • Technical assistance • Data management	care/encounter and fee-for-service) • Annual savings to state: $15 million • Conduct quality of care reviews for all selected inpatient hospital claims • Focused reviews assisted State with needed data regarding review targets • Conducted bill audits for hospital acquired conditions to remove charges post event • Readmission review identified coding issue in the state's clam system • Made policy changes to NJ Medicaid Managed Care Organization contract based on review results • Completed 65 formal provider education series to date, including two presentations with the NJ Hospital Association
Wisconsin Department of Health Services July 1976 – November 2023	• Prior Authorization and concurrent reviews (Physician, DME, Home Health, Private Duty Nursing, Dental/Orthodontic, Therapies, Psychiatric/PRTF, Behavioral Health, Personal Care Services, and RX) • Reconsiderations, Appeals, and Hearings support • Reporting and analysis • Provider education • Technical assistance • Data management	• Annual UM/PA Reviews: 208,000 • Currently using InRule for automated Prior Authorization and working weekly with the state to add Process Types and sub-categories for each process type. • Deliver daily PA aging reports by process type, of which there are roughly 35. • Deliver quarterly reports to the state that breaks down submissions by media type as well as an advanced aging report related to service levels.

**Contract term includes successive contracts.*

C.C 3.2.C Knowledge of and Experience with Medicaid

RFP Reference: Section 3.2.C

C. Demonstrated knowledge of and experience in Medicaid, include Ohio-specific knowledge and experience.

As the incumbent contractor, Permedion possesses a deep understanding of the work required by this RFP and the specific services that are requested by ODM. We are committed to continuing our comprehensive, successful UM/PA program in Ohio, and we look forward to implementing new methods to meet and exceed the program objectives established by ODM.

Through our extensive Medicaid clinical review experience in Ohio and other states, Permedion has gained a deep understanding of the policies, procedures, and systems that produce a successful PA/UM program. We recognize the primary goals of these programs are to:

- Control Medicaid program costs and utilization by reviewing requests for services and supplies and allowing payment only for those that are medically necessary, appropriate, and meet program rules.
- Make certain Medicaid members can access healthcare providers and high-quality care and services in the most cost-effective manner and appropriate setting.

Our company works with hundreds of providers daily and has effective, user-friendly processes in place to accommodate state agencies, providers, members, and members' representatives. We have experience using multiple UM/PA systems, both state-owned and our own, to receive, track, and respond to provider and member requests and communicate effectively to obtain additional information and present our review decisions and rational. For instance, in Ohio we interface with ODM's systems and applications (MITS portal) for prior authorization requests.

We develop our clinical review processes to meet state program requirements, minimize provider and member abrasion, and where applicable, identify and refer provider fraud and abuse. We offer all of our Medicaid state clients the option to implement best practices used in other states to improve program quality, operational efficiency, and stakeholder communications.

The starting point for designing a successful UM/PA program is having a thorough understanding of each Medicaid program's coverage policies, reimbursement methods, member population, provider population, and trends and patterns at work within the healthcare delivery system. To achieve that understanding, we leverage our experienced program team members, our proven processes and information systems, and robust data analytics. Permedion is among the industry leaders in combining Medicaid program understanding with the analysis of clinical and claims data to deliver highly effective product improvement and cost containment solutions.

Over the years, we have acquired and developed unique resources that enable our Medicaid state clients to preserve the integrity of their offerings while improving quality of health care services and reducing costs. Our qualified and experienced UM/PA specialists — including more than 700 clinical reviewers — apply an in-depth understanding of Medicaid UM/PA programs on behalf of the ODM and our other state agencies. Our team members also bring a competitive understanding of the following areas:

- How Medicaid programs vary in structure (services, eligibility, benefits, etc.) from state to state

- How coverage, authorization, and medical review policies differ between individual programs
- How clinical review regulations and practices differ between programs
- State-specific challenges and sensitivities, including modular system changes, claims payment guidelines, and provider PA submission timelines and issues

Ohio-Specific Knowledge and Experience

Our team members have demonstrated our ability to assemble and manage a diverse, talented team with expertise in each program service area described in ODM's RFP. Our in-place resources and relationships with ODM and its contractors, Ohio providers, and other stakeholders guarantee that we can provide reliable and immediate results on Day One of the contract and throughout the contract term.

Our team members have a thorough understanding and working knowledge of Ohio's Medicaid program including:

- Managed care program
- Enrollment and eligibility processes
- Benefits and coverage limitations
- Claims adjudication and other systems
- Data/file structures and exchange protocols
- Provider billing processes and requirements
- Reimbursement methodologies (APR-DRG, EAPG, etc.)
- Adjustment/Recovery/recoupment processes
- Appeals guidelines, timelines and requirements

Our internal education and training sessions includes discussion of these areas to ensure employees, subcontractors, and independent contractors are knowledgeable of the topics that apply to their role and responsibilities.

C.D 3.2.D Knowledge of Medicaid Laws and Regulations

RFP Reference: Section 3.2.D

D. Demonstrated familiarity with and experience in the practical application of the laws and regulations impacting Medicaid operations. Include Ohio-specific knowledge and experience.

Through our extensive clinical review experience in Ohio and other states, Permedion has gained a deep understanding of the applicable federal and state laws, regulations, rules, policies, and requirements that impact Medicaid UM/PA programs. Our staff have demonstrated their expertise in providing UM/PA program bestpractices throughout the country. Our project team members for the ODM contract, along with our legal, medical advisory, and government relations teams, stay abreast of the current laws and regulations (state and federal) governing utilization management, prior authorization, medical necessity, admission guidelines, billing rules, hearings/appeals, and other related topics on the state and federal levels. These individuals regularly advise state Medicaid agencies in best practices as well as clinical and practice research and guidelines.

Our Ohio UM/PA project team members (employees, subcontractors, and independent contractors) are currently knowledgeable of and will continue to be updated and trained on all laws, regulations, policies, and rules that effect Medicaid operations and the UM/PA contract. These include but are not limited to those shown in the following table.

Table 7. Staff Familiarity with Laws and Regulations Impacting Medicaid Operations

Applicable Laws, Regulations, Policies
OAC 5160-1 General Provisions
OAC 5160-2 – Hospital Services
OAC 5160-8 – Skilled therapies for behavioral health services
OAC 5160-10 – DME supplies and services
OAC 5160-12 – Home Health and Private Duty Nursing services
OAC 5160-26 – Managed health care programs
OAC 5160-27 and 5122-29 – Community mental health agency and behavioral health services
42 CFR § 456 – Utilization Control of Inpatient and Other Services
42 CFR § 482 – Participation for hospitals
42 CFR § 484 – Participation for home health providers
USC § 1320-d, 45 CFR § 160 and § 164 – HIPAA privacy, confidentiality and security regulations

Our organization’s and team members’ knowledge and application of these laws and regulations is detailed in proposal Section B.3.3.

C.E 3.2.E Client References

RFP Reference: Section 3.2.E

E. Names and contact information for at least three entities for which the Offeror has performed similar large-scale projects in the past five (5) years.

Below are the names and contact information for three Medicaid UM/PA contracts for which Permedion performs similar services (see summary of scope for these contracts in Table 6 earlier in this document). These state contacts can attest to our ability to provide effective, large-scale PA/UM services.

Table 8. Client References

Permedion UM/PA Contracts	Contact Information
Kentucky Department of Medicaid Services	**Name:** Cheryl Hanna **Title:** Project Manager, KY Utilization Management **Email:** Cheryl.hanna@ky.gov **Telephone:** 502-320-3976
Massachusetts Executive Office of Health and Human Services	**Name:** Clara Filice, MD, MPH, MHS **Title:** Deputy Chief Medical Officer MassHealth, Executive Office of Health and Human Services, Commonwealth Medicine, Office of Clinical Affairs **Email:** clara.filice@mass.gov **Telephone:** 508-340-0815
New Jersey Department of Health and Human Services	**Name:** Anna M. Morrison **Title:** Program Manager Office of the Medical Director - Utilization Management Unit **Email:** Anna.M.Morrison@dhs.nj.gov **Telephone:** 609-588-3061

D. 3.5 Subcontractor Identification and Participation Information

RFP Reference: Section 3.5

Offerors must clearly identify the subcontractor(s) and their tasks in their Proposals. The Proposal must include a letter from the proposed subcontractor(s), signed by a person authorized to legally bind the subcontractor, indicating the following:

A. Subcontractor's legal status, federal tax ID number, and principal business address;

B. Name, phone number, and email address of a person who is authorized to legally bind the subcontractor to contractual obligations;

C. A complete description of the work the subcontractor will do;

D. A commitment to do the work, if the Offeror is selected;

E. A statement that the subcontractor has read and understands the RFP, the nature of the work, and the requirements of the RFP; and

F. The MBE certification number, if applicable, a copy of their current MBE Certification letter must be included.

To best serve the UR service needs of ODM, Permedion proposes the following qualified and experienced entities to serve as subcontractors, providing the following tasks under the PA/UM contract:

- **Ardent Technologies, Inc.** (Minority Business Enterprise): Staffing augmentation for programming and quality assurance positions
- **Diversified Systems, Inc.** (Minority Business Enterprise): Provider Authorization request review support

Ardent Technologies, Inc. (Ardent)

Ardent Technologies, Inc. (Ardent) offers more than 18 years of experience in staffing augmentation for IT consulting services, including infrastructure support, cybersecurity, mobile application development, website development and cloud computing. Since its inception, Ardent has provided services to more than 1,000 state and local agencies, and currently provides services to more than 60 entities nationwide. Ardent is an established player in providing software and technology solutions and services to state-level government agencies, as well as to cities, counties, and school districts. Ardent team members are experts in developing digital assets for federal and state agencies, optimizing business processes, and developing software applications to address key performance areas. Their applicable certifications include International Organization for Standardization (ISO) 9001:2015, 14001:2015, and AS9100D and Capability Maturity Model Integration Development Level 3 (CMMI DEV L3).

Ardent currently serves as a subcontractor to Permedion, supporting our delivery of comprehensive Third-Party Liability identification and recovery services to ODM. As part of the subcontract agreement, we require Ardent to maintain its Ohio-specific MBE certification throughout the term of the contract, including any renewals. We are confident that Ardent is ideally suited to support the UR/PA scope of work for ODM.

Please see proposal Section H for a signed commitment letter from Ardent. The letter provides responses to ODM RFP Items 3.5.A through 3.5.F. Please also see proposal Section H for a copy of the MBE Certification for Ardent.

Diversified Systems, Inc. (Diversified)

Diversified Systems, Inc. (Diversified) has 32 years of experience providing quality IT consulting services that enable its clients to increase market share, improve profits, and increase productivity while reducing costs and turnaround time. Their comprehensive range of services includes project management, system integration, application development, Web development, mainframe support, network support, and staff augmentation. Diversified's nationwide client base includes State and Local Governments, the Federal Government, and Fortune 1000 commercial enterprises.

Diversified currently serves as a subcontractor to Permedion, augmenting our resources with Ohio-based dentists supporting our review of dental prior authorization requests. As part of the subcontract agreement, we require Diversified to maintain its Ohio-specific MBE certification throughout the term of the contract, including any renewals. We are confident that Diversified is ideally suited to support the UR/PA scope of work for ODM.

Please see proposal Section H for a signed commitment letter from Diversified. The letter provides responses to ODM RFP Items 3.5.A through 3.5.F. Please also see proposal Section for a copy of the MBE Certification for Diversified.

E. 4.1 Scope of Work

RFP Reference: Section 4.1

The selected Offeror will be responsible for the Deliverables as described in Section 4.2, including all preparatory and intervening steps, whether or not ODM has explicitly specified or delineated them within the RFP. In developing their Proposals, all Offerors must fully and appropriately plan and cost out their proposed projects, including all necessary preparatory and intervening steps.

The selected Offeror will be required to implement and manage a statewide quality and utilization control program. Specifically, the selected Offeror will be responsible for utilization reviews, including focused reviews, prior authorizations, special reviews, retrospective reviews, pre-certification reviews, and medical record reviews of Managed Care prior authorizations and/or claims denied based on medical necessity criteria as requested, conduct provider education, and provide technical assistance to ODM. The selected Offeror will demonstrate an expertise regarding Medicaid populations, developing a comprehensive plan for utilization control, and claims data management and reporting. Additionally, Offeror Proposals submitted in response to this RFP must reflect the Offeror's understanding of, and commitment to, performing the Scope of Work fully.

Experienced Incumbent

As the incumbent dedicated to advancing ODM's success, Permedion has the experience, knowledge, processes, systems, and relationships to fully and effectively continue the services requested in the RFP.

ODM is committed to excellence in administering a high-quality UM/PA program for Ohio consumers. As the current statewide quality and utilization control program vendor for ODM, Permedion welcomes the opportunity to continue to support ODM in this mission. We propose a proven, comprehensive solution for the deliverables detailed in the RFP Scope of Work (SOW). In this Work Plan, we will summarize our plan to deliver the services grouped into the major process components including prior authorization/precertification, retrospective review, outlined. We will highlight the that encompasses prior authorization and precertification; special, retrospective, and focused reviews; provider reconsideration for prior authorization; appeals and hearings support; health care studies; data analysis and reporting; conducting provider education; providing technical assistance to ODM; and data management.

For the past 35 years, Permedion has provided a variety of UM/PA and external medical review services for both state government agencies and private clients. We have thousands of team members nationwide engaged in projects that contain the SOW included in the ODM PA/UM RFP. These experienced personnel include nurses, coding specialists, bill auditors, data analysts, and a panel of more than 500 physicians and other licensed medical professionals.

Our Ohio PA/UM project team members, many of them Ohio residents, possess an in-depth understanding of Ohio Medicaid's fee-for-service (FFS) and managed care entities (MCE), operations, processes, systems, data, applicable laws, and regulations (Ohio and federal), and stakeholders. UM/PA touches many areas within the Ohio Department of Medicaid. Permedion has well established working relationships not only with the Program Integrity section, not only with the Surveillance and Utilization Review team, but also the Policy teams including Behavioral Health, Hospital Services and Non-Institutional, the Managed Care section, and the Health Innovation and Quality section lead by the ODM Medical Director including the Prior Authorization team. Representatives from the various teams attend our monthly meeting reviewing the UM/PA contract. This includes requirements specifically related to implementing and managing the statewide UM/PA program.

Additional details on our company and project teams' knowledge and experience, both in UM/PA and Ohio-specific, is provided in Sections B.3.3, C.3.2, and D.3.5 of our proposal response.

A major enhancement we will implement with the award of this contract is enhanced transparency for ODM and the providers. In support of the single-entry point for providers, we will partner with ODM's Provider Network Management vendor Maximus to include access to the UM/PA portal and functions via the PNM portal. Our proposed portal makes it easy for providers to manage the UM review lifecycle. Features include:

- **Review Status.** Providers can see in real-time where in the process a retrospective reviews claim is, including service line specific details. The application allows flexibility to search and filter in a variety of ways, such as ICN, batch, or consumer name. This information can be downloaded for reporting, transactional, or analytical purposes by providers. Dashboarding capabilities allow for both providers and ODM staff to review activities through multiple filters, as exhibited below
- **Documentation Management.** Providers are able to both submit and receive documentation related to retrospective reviews. This includes submission of supporting clinical documentation required to meet medical necessity criteria, eliminating the need to fax supporting materials.

Ohio Medicaid
Medical Necessity Guidelines

Permedion reviews cases to make certain medical necessity is met according to 5160-1-01, which states:

- It meets generally accepted standards of medical practice.
- It is clinically appropriate in its type, frequency, extent, duration, and delivery setting.
- It is appropriate to the adverse health condition for which it is provided and is expected to produce the desired outcome.
- It is the lowest cost alternative that effectively addresses and treats the medical problem.
- It provides unique, essential, and appropriate information if it is used for diagnostic purposes; and
- It is not provided primarily for the economic benefit of the provider nor for the sole convenience of the provider or anyone other than the recipient.

- **Notification and Communication.** Providers can communicate with Permedion staff regarding a specific review through the portal, eliminating the need to call in. Providers can also subscribe to various notifications (case status updates, case decisions, etc.) to stay informed about their reviews throughout the process.
- **Appeals.** Providers can submit a request for reconsideration, associated with the specific claim and upload additional documentation via the portal. Leveraging this capability as opposed to faxing requests verifies timely receipt and processing. Providers can track the appeal status through the online portal.
- **Many Transactions in One Place.** In addition to retrospective reviews, providers will have access to other transactions, such as External Medical Review without the need to log-in to multiple applications.
- **Simplified User Access Management.** After initial setup, providers will be able to add and manage authenticated users in real time to access review information in portal.

Permedion provides ODM with a holistic solution that addresses the end-to-end needs of an effective UM/PA program. ODM can rely on Permedion to deliver. By selecting Permedion as its ongoing UM/PA partner, ODM will realize the benefits outlined in the following figure.

Figure 6. Benefits of the ODM/Permedion Partnership

In the upcoming subsections, we provide a high-level review of our experience and processes regarding the SOW. In subsequent proposal sections, we dive into the details of the methodology, criteria, analytics, processes, policies and procedures already in place.

Permedion's URAC accreditation validates we have well established policies and procedures for Health Utilization Management and Independent External Review work. Accreditation verifies that our organization has policies in place for maintaining regulatory compliance, standards for information management, risk management and business continuity, operations and infrastructure including policy and procedure maintenance, delegation management, clinical staff credentialing, staff training including ethical conduct, employee diversity, equity and inclusion, and qualified senior leadership.

urac® ACCREDITED
Independent Review Organization: External Review
Expires 05/01/2024

urac® ACCREDITED
Health Utilization Management
Expires 05/01/2024

Each step of the review process from program management, reviewer qualifications, initial review, clinical review, physician peer review, timeliness of notifications and the appeals process is detailed. Rigorous standards for a comprehensive Quality Management Program exists incorporating our program for inter-rater reliability between our reviewers for the consistency of the review and decisions made. It also lets us quickly identify and implement additional coaching or training needs so standards are maintained.

Prior Authorization and Precertification

Permedion is prepared to manage prior authorization and precertification requests including:

- Special Review/Prior Authorization for institutional services
- Special Reviews as requested for noncovered items and services
- Community Behavioral Health Services, including services such as ACT Enrollment, Hospital OP-Behavioral Health, IHBT Enrollment, SUD Partial Hosp Services, and SUD Residential Services
- Psychiatric Hospital Admissions
- Mobile Response and Stabilization Services

Utilization Review Benefits

The Permedion utilization review program prevents losses due to misuse, but also makes certain that the member is getting the right treatment, at the right time, optimizing health, healing, and ensuring cost containment-review staff.

- Non-Institutional Services including outpatient/clinic, durable medical equipment, skilled therapies, laboratory, radiology/imaging, and dental services
- Home Health Services
- Private duty nursing is a service type not currently included on our contract. We will be prepared to process PDN requests including the patient assessment.
- Other Prior Authorizations

In state fiscal year 2022, Permedion reviewed over 46,000 prior authorization and pre-certification requests from Ohio Medicaid providers. As part of the Next Generation of Ohio Medicaid the new Provider Network Module (PNM) portal was deployed and the new PA system that is part of the FI module will go live December 1, 2022. Permedion's review team has been involved in trainings and has partnered with ODM to support the providers through this transition. Day 1 of this contract we will have established access and experience with the new systems.

Prior Authorization Benefits

Prior authorization helps to make certain that only medically necessary hospitalizations, procedures, services, supplies, and equipment are approved. This reduces unnecessary costs allowing more consumers to receive medically necessary care.

When a prior authorization or pre-certification request is received, the reviewer, trained and experienced in the service type requested processes the request. During the initial review, the request is evaluated for completeness, to make certain the information to make a well-informed determination has been submitted. If the request is not complete, the reviewer pends the request back to the provider, and requests additional information. In most cases, the provider has 30 business days to submit the requested information. In some review types, such as precertification for psychiatric admissions or substance abuse residential treatment, information may be needed sooner due to the urgent need of the request. If the provider does not respond within the required timeframe, a system generated denial is issued.

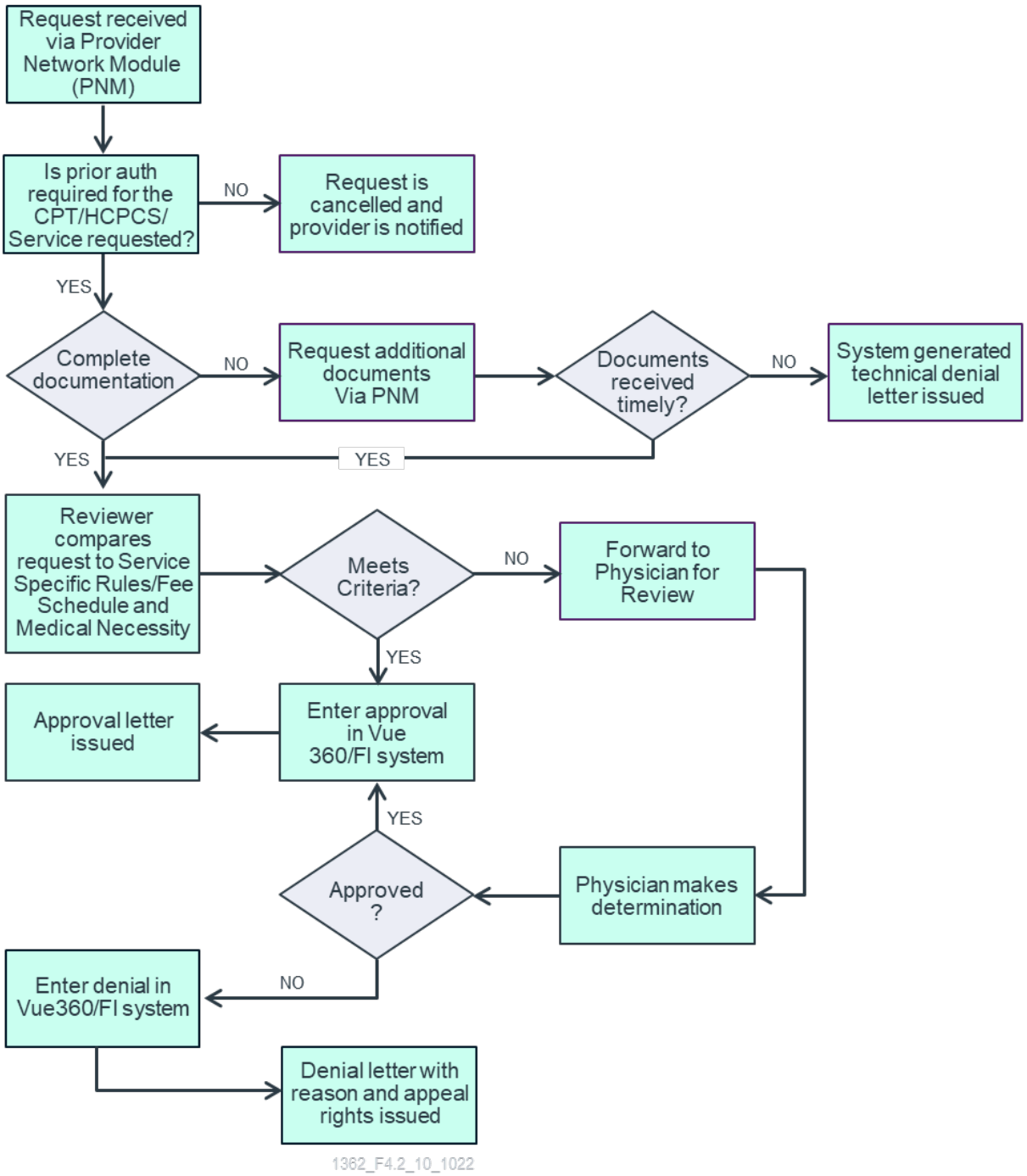
Once information is received, the clinical review begins. Requests are assessed for medical necessity as defined in OAC 5160-1-01 Medicaid Medical Necessity. The appropriate OAC for the request under review is supplemented by ODM approved MCG evidence-based guidelines to facilitate consistent decisions. For service types such as Non-Institutional (DMEOS) fee schedules and pricing methodologies are also applied to calculate the proper fee to approve.

If medical necessity cannot be affirmed by the reviewer, the request is forwarded to an Ohio licensed physician who has the qualifications and experience to apply medical necessity rules as well as current evidenced-based guidelines and local Ohio practices.

Standard determinations for prior authorizations are made within 10 calendar days of receipt. If the standard timeframe could jeopardize the individual's life, or health or ability attain, maintain, or regain maximum function, the timeline is adjusted to provide a decision expeditiously, but no later than 48 hours after the receipt of the request. For precertification of inpatient hospital care, such as psychiatric admissions, requests are completed within three business days. For both prior authorization and precertification, adherence to determination timeframes is strictly applied.

Providers and members receive notification of the determination through system generated notifications and letters. If a request is denied, the letter includes appeal rights for Providers and Members in accordance with 5160-2-40 for precertification of psychiatric admissions and 5160.34 of the revised code for prior authorizations.

Figure 7. Process for Prior Authorizations and Pre-Certifications



Retrospective Reviews

Another significant component of the UM/PA contract is retrospective clinical review. Permedion has performed retrospective reviews for Ohio since 1985. The SOW includes postpayment reviews of inpatient hospital services, both medical and psychiatric, as well as outpatient

hsoptial services. We currently have 21 licensed reviewers (registered nurses, licensed practical nurses, social workers, and coders), 39 Ohio-lciensed doctoers, a biostatistician and data analysts, client services representatives supported by multiple corporate functions such as security, data management and informaiton technology, compliance, human resources, etc.

An enhancement we will implement with the award of this contract is an enhanced portal to allow ODM and providers to not only access letters and reports, allow end-to-end status tracking and lookup for claims selected for retrospective review. We will deploy portal functionality across SOW, Retrospective Reviews, service types for Prior Authorization and External Medical Review to allow end-to-end updates.

In support of the single-entry point for providers, we will partner with ODM's Provider Network Management vendor Maximus to include access to the UM/PA portal and functions via the PNM portal. Our proposed portal makes it easy for providers to manage retrospective reviews throughout the review lifecycle.

The following paragraphs provide an overview of key activities in our Retrospective Review Process. Reviews are conducted in accordance with OAC 5160-2-13, meet applicable federal guidelines, and support ODM's program integrity initiatives to verify appropriate utilization of hospital services.

1. **Claims selection.** Before embarking on the retrospective review, Permedion performs a thorough review of applicable contracts, rules, and regulations, with particular emphasis on updates and changes. In conjunction with ODM, we determine and agree on the claims selection methodology that we will use for this process.

   Our biostatistician, Caroline Black, RN, PhD, uses a combination of machine learning algorithms, and targets to identify claims most likely to have a finding. The specific targets are listed in proposal Section 4.2.B Retrospective Reviews. At least 1,700 inpatient (medical and psychiatric) and outpatient claims will be selected for review on a monthly basis.

2. **Request for medical records.** A medical record request letter is sent to each provider through our provider portal, (or mailed if necessary to accommodate a provider). Providers are required to submit medical records within 30 calendar days of the date of the medical record request. As a courtesy to the providers, if we do not receive the medical records within seven days of the due date, members of our client services team will call and/or send an email to the designated hospital contact as a reminder. If the provider does not submit records, we issue a technical denial (meaning, a denial for non-response).

   Permedion has established Ohio protocols to receive medical documentation submissions including USPS mail, fax, CD/USB drive, and HIPAA-compliant Electronic Data Interchange (EDI) transmission. We have also established relationships and protocols with third-party vendors such as Ciox and MRO to receive medical records from their participating providers securely and electronically. With this new contract, we will also be accepting medical records through our provider portal.

   99% Compliance

   Working closely with the hospital community, Permedion received medical records on 99% of requested cases in the last two SFYs.

3. **Medical record/claim review.** Cases are reviewed to confirm requirements for reimbursement were met, including medical necessity as defined in OAC 5160-1-01, compliance with billing rules and to verify proper quality of care as defined in federal regulation 42 C.F.R 456.3 (b). MCG criteria is utilized to supplement regulations and validate evidence-based decisions.

A nurse reviewer will refer a case to an Ohio-licensed clinical peer if they cannot approve a case and/or if there is a quality of care finding. For some billing questions the nurse may refer the case to a certified coder.

4. **Determination.** If the nurse reviewer, certified coder, or physician reviewer approves the case, the approval is recorded in our Utilization Management system and available via the portal. If Permedion cannot approve the case, we will issue a Denial Letter with the specific findings via the portal within 30 business days.
5. **Appeal.** Appeals can be submitted within 60 days. OAC 5160-2-12 outlines rules for appeals and reconsiderations regarding hospital inpatient and outpatient services. The preferred method is for the provider to submit the appeal and supporting documentation via the provider portal associated with the original claim.

   Our appeal RN will review the reconsideration and additional information submitted. If the additional information is sufficient, the nurse will overturn the denial. If the appeal RN cannot establish medical necessity, the appeal will be referred to an Ohio-licensed clinical peer. The case will be upheld, modified, or overturned. An appeal determination will be issued within 30 business days via the provider portal. In addition, we will provide monthly reports indicating hospitals reviewed to ODM.
6. **Recoupment.** After the review and appeal process is completed, Permedion prepares an adjustment report for ODM of claims that are in a final denied status for payment recoupment. The denial reasons are mapped to the ODM adjustment reason codes specifying for each claim if the provider can re-submit for same type of bill, cannot re-submit, or if the provider is allowed to re-submit as outpatient only.

Focused Reviews

Permedion responds to ODM's request for focused reviews when they have identified an issue or opportunity that they would like to review in detail. Our experienced team has the skillset to perform focused reviews:

- Excellent working relationships with Ohio providers that facilitate acceptance and cooperation with special review activities
- Clinical analysts who are very responsive to requests for investigation of potential topics and can provide quick responses to initial inquiries
- Trained nurse reviewers, physician reviewers, and data analysts to look for and report aberrant patterns in service delivery or billing processes
- Experience performing bill audits for Ohio providers including influencing providers to implement corrective action for inappropriate unbundling of charges and billing for charges not substantiated in the medical record

The following are examples of focused reviews conducted by Permedion for ODM during the current contract period:

- We received a referral to perform a focused review to assess the quality of care for a patient with multiple hospital readmissions. The results of the focused review determined that there was a Severity Level 3 (actual harm to patient) quality of care issue with the patient's care due to serious safety concerns, and failure to recognize and investigate probable neglect.
- In response to a referral submitted to us from another State Agency, Permedion conducted a focused review of an Ohio Medicaid member in an institutional setting that had an acute

incident and subsequently died. The assessment found that while the outcome of this patient's course was unfortunate, the care received was within the expected standards of care, and no deviations nor quality concerns were identified.

- Permedion performed a focused review involving several cases from an individual provider with a high number of patient deaths, to review the quality of care provided

Permedion will continue to work closely with ODM staff to identify the need for and the performance of focused reviews as we have done throughout the current and previous contracts with ODM.

Health Care Studies

The goal of developing and implementing a successful health care study is to provide measurable impact for ODM and health care consumers. The findings offer the insight needed to effect change in practice or policy. The study results and recommendations, when disseminated to stakeholders of Ohio Medicaid, can prompt the creation of a new policy or program, a change in what clinicians or patients do, improved access to care, and changes in health outcomes.

To assist ODM in increasing the quality of health care and improving beneficiary access while endeavoring to reduce overall costs for the Medicaid program, Permedion will provide ODM with up to four health care studies each fiscal year of a new contract. We understand that ODM will assign specific study topics to us, and that the number and scope of these studies is negotiable and may be modified by joint agreement between Permedion and ODM. We are prepared to discuss with ODM similar studies we conduct for other Medicaid programs to determine if similar reviews are beneficial in Ohio.

Our proposed Director of Quality Studies Director, Mathew George, MD, will lead the development and execution of Health Care Studies for the Permedion Team with input from our Medical Director, Anthony Beisler IV, MD, FACS, CHCQM. Dr. George has participated in or led the development of several health care studies across many healthcare settings while Dr. Beisler has led the production of several previous health care studies for ODM and other Medicaid programs. Our nurses, coding specialists, biostatistican, and data analysts will assist Dr. George in the design, data collection, analysis and clinical review needed to draft the final report develop reports and pertinent analysis derived from the data collected during the study.

Data Analysis and Reporting

Permedion will provide ODM-required and supplemental (non-required) reports to monitor and evaluate the utilization of medical services in the Medicaid population. Reports will include activity reports related to the pre-certification, prior authorization, special review program, and the retrospective and quality review program. We will provide a variety of reports that measure the utilization and outcomes of our reviews and identify areas to adjust or add new review targets. Permedion will be responsible for developing and implementing reports in accordance with ODM specifications, and we will verify report accuracy prior to submission to ODM.

Permedion will identify and develop additional reports needed to monitor utilization of medical services by the Ohio Medicaid population, and recognize that ODM may request other reports as needed. Proposed utilization reports include:

- **Pattern Analysis Report**. This report identifies areas of utilization that are "out of control" as determined by using Statistical Process Control. It profiles specific information relevant to

healthcare trends and obtained through analysis of current claims. The report uses statistical process p-chart concepts to examine characteristics of claims submitted over a selected period of time to identify providers significantly above or below statewide or peer-group averages.

- **Utilization/Trend Reports.** These reports show key utilization, trending, and spend metrics by service category and/or provider and offers retrospective utilization insights such as a breakdown of admissions by inpatient vs. outpatient, length of stay distribution, top patient conditions, and targeted procedures/diagnoses. Further examination will be provided when appropriate that examines changes in areas such as patient demographic mix, service mix, condition mix, or catastrophic claim incidence

Our experienced data analytics team has in-depth understanding of and experience in coverage, billing, coding, clinical, and reimbursement policies and overpayment issues in Medicaid. The team members can analyze data and develop algorithms to recognize improper Medicaid payments. Our data analysts have the Medicaid and ODM-specific claim experience, analytic capabilities, and tools necessary to incorporate medical-review claims into our processes efficiently and accurately.

Provider Education

Communication with hospitals, physicians, and other healthcare providers is most important in maintaining strong working relationships. At the heart of our approach is a focus on customer service, including delivering high-quality service to the providers with whom we interact in the course of ongoing projects. We understand and respect the complex relationship that ODM has with providers. When interacting with providers as an agent of ODM, we are always professional. Our personnel are respectful of providers' time and the services that they provide to the community—especially to Medicaid members.

Experienced Collaborative Partner

ODJFS and Permedion collaborated on the SHARE site for improved navigation.

"Thank you all for agreeing to assist us. BSH (Bureau of State Hearings) wants to make the SHARE Portal as user-friendly as possible. We appreciate your suggestions and look forward to improving the SHARE Portal to assist you."

Performing many provider review and recovery projects has allowed us to gain a deep appreciation for the importance of establishing and maintaining effective provider relations and provider communication processes. Our provider relations plan includes the following key components:

- Effective communications
- Relevant educational events
- Pertinent educational materials
- Informative publications

Our training plan includes multiple education and communication methods such as Provider Seminars, Permedion Website, Utilization Review Newsletter, Webinars, Determination letters, Dissemination of clinical criteria, and education during the prior authorization process.

Data Management

Permedion will carry out the functions of the UM/PA contract utilizing ODM-provided data. As the incumbent, we have responsibility today for maintaining reasonable access to data and for receiving data in a timely fashion. We are responsible for transferring necessary data to our own systems for data analysis, and we already have established data exchange mechanisms and protocols.

Our data processing team is fully capable of handling the data requirements of the ODM's UM/PA contract in the established timelines. They are familiar with the intake of ODM's source data sets - including the FFS and MCO encounter claim data, Medicaid eligibility data, MDS data, provider files (including MCO PCP) and reference files. We have established high quality data mapping requirements so that necessary data elements are appropriately captured for UM/PA analytical processes to complete. Additionally, we have worked iteratively with the ODM and MMIS teams over time to address data element updates, file layout changes, historical version controls, and ongoing data linking, furthering the ability to effectively analyze ODM data sets.

We have extensive EDI and data transfer experience through our work via UM/PA, third-party liability, reporting, and other contracts with a variety of state MMISs, including serving as the current Ohio MMIS vendor. Additionally, Permedion has worked extensively to provide data transfer and processing utilizing the Ohio MITS portal. Such data activities include multiple file format changes, the addition of encounter data, and confirmation of high data quality in received files.

Technical Assistance

Permedion understands that ODM is structured to operate as a matrix organization to provide flexibility needed to respond to and act in an external environment that remains highly volatile, both at the level of federal policy and within the health care marketplace. To that effort, we partner with ODM to provide technical assistance to researching and gathering data as a part of the team supporting program development and reform activities.

Permedion's knowledgeble team has the experience to research ODMs technical assistance requests:

- Physicians across multiple specialties in active practice knowledgable of current practices, concerns and trends
- Clinicians with a variety of backgrounds and experiences, including behavioral health
- Team of professional coders
- Data and analytics specialists
- Operations staff working with providers

Permedion and ODM have developed a partnership when it comes to technical assistance requests, including discussing the purpose of request, responding within established timeframes, and discussing and providing documentation on the findings of the research or assistance request.

We look forward to continuing to provide ODM with a wide spectrum of technical assistance. Our services will include the following:

- Review of procedure codes requiring prior authorization
- Opinions on experimental and investigational services
- Coding review based on Coding Official Guidelines and ODM requirements
- Research regarding Behavioral Health and Substance abuse
- Assistance with MITS
- Other consulting

We commit to providing 600 hours of technical assistance to continue to meet ODM's needs during a new contract term. Throughout our current contract with ODM, Permedion has taken on a variety of technical requests ranging from how to code lactation consultation to comparing ASAM, InterQual and MCG criteria for substance disorder level of care consistency. These technical assistance projects were completed accurately, timely, and provided valuable information to ODM.

Medical Record Reviews of Managed Care Denials

Permedion provides independent external medical review services on issues of quality of care, medical necessity, appropriateness of setting, and experimental/investigational treatment to both state government and private clients across the country. We work with various state agencies, including Medicaid and departments of insurance, medical licensure, and corrections, to help make certain that healthcare services are billed appropriately and that the care provided is of the highest quality.

Being URAC accredited in External Independent Review Organization, we have strict policies and procedures in place to address provider appeals of Managed Care Entity denials. These policies apply to both prior authorization and retrospective review of services. Permedion will make a standard reconsideration determination within ten calendar days of receipt of a valid request. If an expedited review is requested because the service or item qualifies as urgent care services, the reconsideration determination will be made no later than 48 hours after receipt of a valid reconsideration.

Permedion has been partnering with ODM to implement the new MCE External Review Program over the past several months. On July 1, 2022, the program went live with the OhioRISE Managed Care Entity. On December 1, 2022, we will be going live with the seven other MCEs. Under OAC 5160-1-31 providers may request an external medical review for prior authorization denials made by a Managed Care Entity.

Our Understanding of and Commitment to Provide the Full Scope of Work

Permedion has a thorough understanding of the SOW requirements defined in the RFP and how to manage them. As the incumbent contractor, we will have a minimal amount of development and implementation required prior to starting operations on a new contract. This will be limited to establishing procedures for the service types we do not review under the current contract - private duty nursing.

Our team offers a tested approach to UM/PA operations that will secure the continued success of the ODM program. Our robust set of qualifications position us to continue to deliver and augment our current work for the State. These qualifications include the following:

- National UM/PA and Medicaid experience
- Extensive knowledge of Ohio's policies, regulations, hospital billing rules, and payment methodologies
- Subject matter experts in clinical, analytical, administrative, and information systems areas
- A project team made up of Ohio residents
- Sophisticated clinical-review applications
- Customized electronic solutions for the transmission and review of medical records
- Comprehensive quality control procedures
- A comprehensive provider education and outreach program
- Consistently favorable hearing results

Permedion's project team, a few of which have been in place since the first review utilization review contract with ODM, are dedicated to the UM/PA work they perform. The entire team, including project management, clinical reviewers, data analysts, client services, and other support services are passionate about the services we provide to ODM and the Ohio healthcare community.

Permedion is committed to fully performing the SOW requirements under a new contract with ODM and partnering with ODM to achieve and exceed the UM/PA program goals. Our tried and true processes are put in place to make certain the SOW and individual requirements of each component are met. We are also always looking for ways to improve our program in collaboration with ODM, identifying new targets, new processes efficiencies and automation.

The following proposal sections describe our approach to performing the SOW. They also highlight Permedion's UM/PA Medicaid program experience and the wide-ranging qualifications of the key personnel and other project team members we propose to support ODM's project.

F. 4.2 Deliverables and Proposed Work Plan

RFP Reference: Section 4.2

Permedion will implement and manage a statewide quality and utilization control program for ODM that fully meets the utilization management, prior authorization, and quality/reporting requirements stated in the RFP. We will be fully responsible for the deliverables as described in Section 4.2 of the RFP. In developing our proposed solution, we have accounted for the preparatory and intervening steps required for successful implementation.

As the incumbent provider, Permedion is delivering UM/PA services today to ODM, and we are committed to successfully and fully performing the Scope of Work described in the RFP. We have a successful 35-year partnership with the Ohio Medicaid program and have provided UM services to Ohio Medicaid for 25 years. In the following sections, we describe not only the UM/PA processes and services already in place for ODM today but also the solution enhancements we bring to a new contract.

F.1 4.2.A Special Reviews/Prior Authorization Program

RFP Reference: Section 4.2.A

A. Special Reviews: The selected Offeror will conduct all reviews in accordance with the OAC 5160- 2-03 Conditions and Limitations and OAC 5160-1-31, which describes the Special Review/Prior Authorization Program. All reviews must include the use of Ohio-based physicians to ensure practice patterns within Ohio are taken into consideration. To implement and manage the Special Review Program, the selected Offeror will be required to:
    1. Develop the methodology and criteria that will be used when a provider requests prior authorization.
    2. Select the medical criteria used to determine appropriateness and medical necessity of the request.
    3. Train Medicaid providers, ODM staff, and the selected Offeror/subcontractor staff on the prior authorization program.
    4. Maintain a reporting mechanism that meets notification requirements described in OAC 5160-1-31 and 5160-2-03.
    5. Develop and implement procedures for all prior authorization review denials, including specific documentation of all the reasons for denials.
    6. Develop a plan for and participate in hearings when prior authorizations are appealed.

Permedion currently conducts special prior authorization reviews for institutional services, hospital inpatient and hospital outpatient, for eight different Medicaid programs including ODM. In Ohio we perform these reviews in accordance with OAC 5160-2-03, that describes the conditions and limitations applicable to both inpatient and outpatient hospital, and OAC 5160-1-31, which describes the prior authorization reimbursement requirements for certain items or services covered under the Medicaid program. Certain procedure codes must be evaluated via the prior authorization process to confirm they are medically necessary and covered by Medicaid.

1. Methodology

As of October 1, 2022, Providers submit all prior authorization requests through the PNM portal. ODM policy maintains and publishes HCPCS/Procedure codes that require special review / prior authorization. The upcoming figures provide examples of the information posted for institutional codes that require prior authorization.

Figure 8. Codes Requiring Prior Authorization (Institutional)

List of CPT and HCPCS codes covered for Enhanced Ambulatory Patient Groups (EAPG) - revised 10/1/2022

		Outpatient Hospital					Ambulatory Surgery Centers				
Procedure Code	Procedure Description	OPH Covered Code	OPH PA Required	OPH VFC Code	OPH Coverage Effective Date	OPH Coverage End Date	ASC Covered Code	ASC PA Required	ASC Coverage Effective Date	ASC Coverage End Date	Note
11971	REMOVE TISSUE EXPANDER(S)	Yes			8/1/2017	OPEN	Yes		8/1/2017	OPEN	
11976	REMOVE CONTRACEPTIVE CAPSULE	Yes			8/1/2017	OPEN	Yes		8/1/2017	OPEN	
11980	IMPLANT HORMONE PELLET(S)	Yes			8/1/2017	OPEN	Yes		8/1/2017	OPEN	
11981	INSERT DRUG IMPLANT DEVICE	Yes			8/1/2017	OPEN	Yes		8/1/2017	OPEN	
11982	REMOVE DRUG IMPLANT DEVICE	Yes			8/1/2017	OPEN	Yes		8/1/2017	OPEN	
11983	REMOVE/INSERT DRUG IMPLANT	Yes			8/1/2017	OPEN	Yes		8/1/2017	OPEN	
12001	RPR S/N/AX/GEN/TRNK 2.5CM/<	Yes			8/1/2017	OPEN	Yes		8/1/2017	OPEN	
12002	RPR S/N/AX/GEN/TRNK2.6-7.5CM	Yes			8/1/2017	OPEN	Yes		8/1/2017	OPEN	
12004	RPR S/N/AX/GEN/TRK7.6-12.5CM	Yes			8/1/2017	OPEN	Yes		8/1/2017	OPEN	
12005	RPR S/N/A/GEN/TRK12.6-20.0CM	Yes			8/1/2017	OPEN	Yes		8/1/2017	OPEN	
12006	RPR S/N/A/GEN/TRK20.1-30.0CM	Yes			8/1/2017	OPEN	Yes		8/1/2017	OPEN	
12007	RPR S/N/AX/GEN/TRNK >30.0 CM	Yes			8/1/2017	OPEN	Yes		8/1/2017	OPEN	
12011	RPR F/E/E/N/L/M 2.5 CM/<	Yes			8/1/2017	OPEN	Yes		8/1/2017	OPEN	
12013	RPR F/E/E/N/L/M 2.6-5.0 CM	Yes			8/1/2017	OPEN	Yes		8/1/2017	OPEN	
12014	RPR F/E/E/N/L/M 5.1-7.5 CM	Yes			8/1/2017	OPEN	Yes		8/1/2017	OPEN	
12015	RPR F/E/E/N/L/M 7.6-12.5 CM	Yes			8/1/2017	OPEN	Yes		8/1/2017	OPEN	
12016	RPR FE/E/EN/L/M 12.6-20.0 CM	Yes			8/1/2017	OPEN	Yes		8/1/2017	OPEN	
12017	RPR FE/E/EN/L/M 20.1-30.0 CM	Yes			8/1/2017	OPEN	Yes		8/1/2017	OPEN	
12018	RPR F/E/E/N/L/M >30.0 CM	Yes			8/1/2017	OPEN	Yes		8/1/2017	OPEN	

Figure 9. Inpatient Hospital: Fee Schedule & Rates | Medicaid (ohio.gov)

Ohio | Department of Medicaid

Inpatient Procedures Normally Non-Covered (per OAC 5160-2-03 because considered cosmetic, experimental, etc.) and Require Prior Authorization

09QM0ZZ	09S10ZZ	09UM0KZ	0B5G3Z3	0CQ10ZZ	0CU437Z	0D5C3Z3	0F510Z3	0G504Z3
09QM3ZZ	09S14ZZ	09UM37Z	0B5G4Z3	0CQ13ZZ	0CU43JZ	0D5C4Z3	0F513Z3	0G510Z3
09QM4ZZ	09S1XZZ	09UM3JZ	0B5H0Z3	0CQ1XZZ	0CU43KZ	0D5E0Z3	0F514Z3	0G513Z3
09QM8ZZ	09S20ZZ	09UM3KZ	0B5H3Z3	0CQ40ZZ	0CU4X7Z	0D5E3Z3	0F520Z3	0G514Z3
09R007Z	09S24ZZ	09UM47Z	0B5H4Z3	0CQ43ZZ	0CU4XJZ	0D5E4Z3	0F523Z3	0G520Z3
09R00JZ	09S2XZZ	09UM4JZ	0B5J0Z3	0CQ4XZZ	0CU4XKZ	0D5F0Z3	0F524Z3	0G523Z3

Registered nurses apply OAC 5160-2-02, OAC 5160-2-03 and OAC 5160-2-04 in addition to MCG criteria and medical necessity rule OAC 5160-1-01 to be sure requests meet requirements for Medicaid reimbursement.

If the prior authorization request is incomplete and additional information is needed, the review is pended for additional documentation and returned to the Provider via the PNM portal. If the Provider does not respond within 30 days, the request will be denied by the prior authorization system.

The nurse reviewer will review every line item and come to one of the following conclusions:

- **Cancel.** In certain instances, a request may be cancelled if, for example, more than one hospital inpatient prior authorization request is submitted for the same dates of services, or a

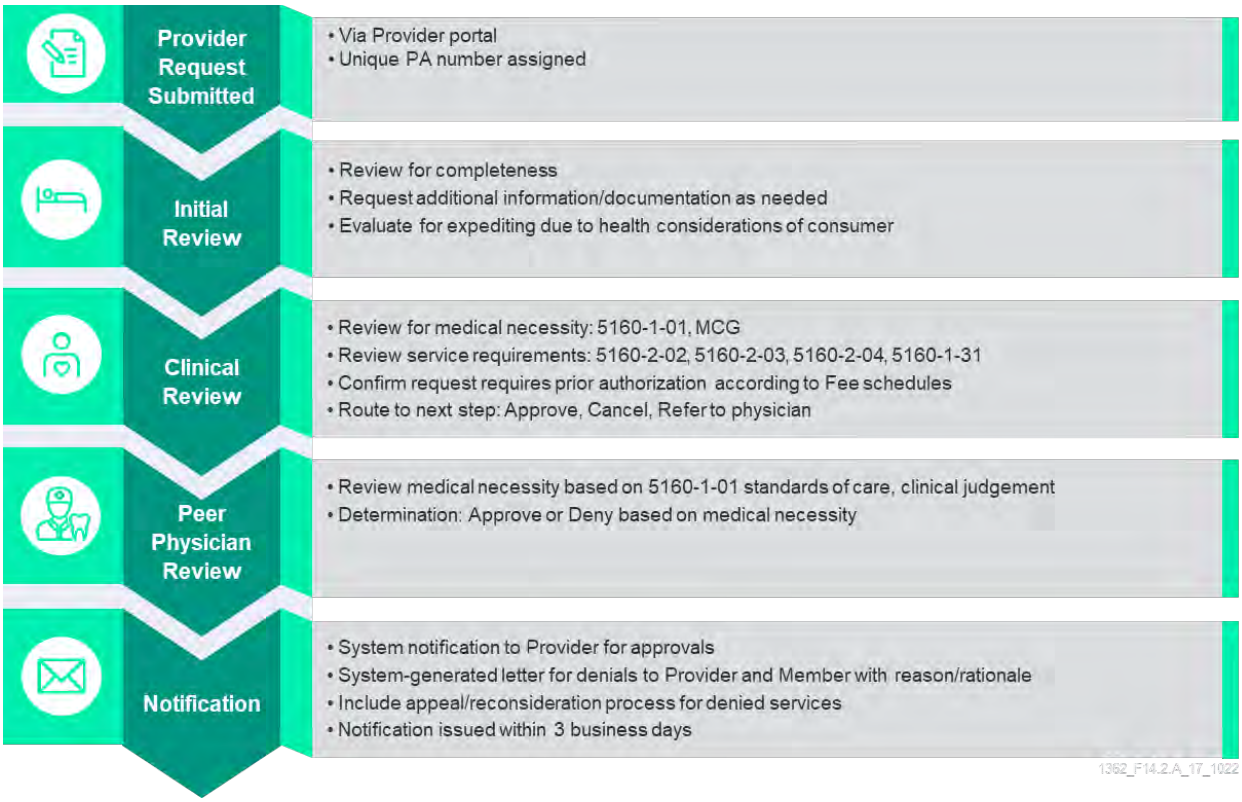
request for prior authorization is not required based on the mandated procedure codes and fee schedules. The review nurse communicates with the Provider to make sure they understand the next steps for submitting a revised request.

- **Approve**. After review, if all requirements are met, the reviewer will approve the request. Each service requested (CPT/HCPCS or procedure code) within the PA is addressed at the line level.
- **Refer.** However, if the reviewer cannot affirm that the service or procedure requested meets medical necessity, the request is referred to an Ohio-licensed physician along with supporting documentation.

The physician makes a determination based on medical necessity rules as well as considers practice patterns within Ohio, and then the physician will approve or deny as follows:

- **Approve.** After review, if all requirements are met, the physician will approve, at the line level, the service(s) or procedure(s) requested.
- **Deny.** If the requested service(s) does not meet medical necessity, the physician denies the request and documents the reasons/rationale that medical necessity was not met. This denial may be for a specific HCPCS/Procedure line within a request or the entire request, depending on the documentation submitted.

Figure 10. Prior Authorization for Special Reviews Process



2. Medical Criteria

Prior Authorization requests must be assessed for medical necessity as defined by the Ohio Administrative Code 5160-1-01.

Medical necessity for a procedure, item, or service are met if all the following apply:

- It meets generally accepted standards of medical practice.
- It is clinically appropriate in its type, frequency, extent, duration, and delivery setting.
- It is appropriate to the adverse health condition for which it is provided and is expected to produce the desired outcome.
- It is the lowest cost alternative that effectively addresses and treats the medical problem.
- It provides unique, essential, and appropriate information if it is used for diagnostic purposes.
- It is not provided primarily for the economic benefit of the Provider nor for the sole convenience of the Provider or anyone else other than the Member.

To support consistent, accurate medical necessity assessments, Permedion utilizes MCG, or evidence-based care guidelines as applicable when there is no detailed regulatory guidelines. In the absence of both Ohio regulatory and MCG criteria, Permedion will work with ODM policy to make sure the assessment and decision are consistent with the intent of ODM.

MCG publishes nationally recognized guidelines based on peer-reviewed papers and research studies. Criteria including MCG and other medical necessity criteria are reviewed, updated and approved annually.

The following figure shows an example of MCG criteria for Heart Failure.

Figure 11. MCG Criteria Information

If a PA request does not meet criteria, an Ohio-based physician uses his/her clinical judgment and knowledge of Ohio practice patterns to make a determination.

We partner with ODM Policy to develop criteria guidance as needed for certain conditions or services. For example, the Dr. AJ Beisler, Permedion Medical Director, worked with ODM policy to develop guidelines including specific documentation needed from the requesting Provider, to assess medical necessity for procedures related to gender dysphoria. With this documented guidance, nurse reviewers are able to evaluate a request and make certain that sufficient documentation has been provided for a determination.

3. Train Medicaid Providers, ODM Staff, and Others

Permedion will continue to collaborate with ODM to identify training opportunities for the Medicaid Provider community, ODM personnel, and other stakeholders regarding the precertification and PA process. A recent example of this collaboration and training opportunity was gathering information regarding Spinraza for ODM. Prior authorization protocols were developed, and Providers requesting Spinraza were subsequently trained on what was needed to be addressed in the prior authorization request.

> As the incumbent vendor, we have developed and implemented a dynamic and robust training program that keeps Ohio Providers up to date on ODM's UM/PA processes and how Providers are to participate in them.

We use a variety of methods to conduct training (webinars coordinated with the Ohio Hospital Association, teleconferences). We are routine presenters at the quarterly Ohio Medicaid Large Provider Group meeting and utilize that forum to cover topics.

Training may include but not be limited to the following topics:

- Process overview
- Procedures requiring precertification
- Review and appeal process
- Description of criteria used to support the review determinations
- Exempt categories
- Listing of resources, definitions, and frequently asked questions & answers
- OAC guidelines and ODM rules
- Best practices, logic and applying common sense

Our review team members use the opportunities presented during phone conversations related to precertification and PA requests to identify areas of the process that are unclear to the caller and will provide clarity and greater understanding while communicating with the caller. We place a high priority on providing clear explanations of the reasons for denials in the letter sent to Providers, physicians, and Members. When Permedion needs to cancel a request, such as when a HPCS that does not need prior authorization is submitted, we use this as an opportunity for Provider education. For example, the Provider is given feedback on prior authorization submission resources, including the Fee Schedule & Rates and provided the Medicaid link so that they can identify if the code they are requesting needs prior authorization.

We also provide written correspondence to Providers with notification updates and process changes and are proud of the quarterly newsletter we publish in Ohio, covering a number of key issues with clarity and responsiveness. As we are working with ODM under the current contract, we understand the ebbs and flows in training requests and requirements and are available throughout the duration of the contract to support educational needs on a regular or ad hoc basis.

In addition, we thoroughly train our own employees, independent contractors, and subcontractors on all aspects of the UM/PA program. Information on this training and our team's knowledge and experience is detailed in Section B.3.3 of our proposal.

4. Maintain a Reporting Mechanism

Permedion will continue to submit Prior Authorization reports to ODM detailing all of the review activity for the previous month, based on the accessible data. We understand that reporting requirements and mechanisms have changed for precertification activities performed within MITS and will continue to work with ODM to be sure that all reporting needs continue to be met in the required timeframe(s).

A summary and detailed reports of all PA requests completed for the month are reported in the following table.

Table 9. Summary and Detailed Reports

	Approved		**Denied**		**Cancelled**	
Assignment Category	Adult	Ped	Adult	Ped	Adult	Ped
ACT Enrollment	7	0	3	0	0	0
Compression Garments	118	1	9	1	0	0
Decubitus Care Equipment	12	1	1	0	0	0
Dental	768	4	343	1	0	0
Dressings, Surgical	43	10	11	2	0	0
Enteral Nutrition and Supplies	308	194	38	28	7	4
Hearing Aids	175	4	17	0	2	0
Hospital Beds	57	5	39	1	0	0
Hospital Inpatient	47	1	4	0	7	1
Hospital OP-Behavioral Health	2	0	0	0	0	0
Hospital Outpatient	77	1	10	0	54	10
Incontinence Supplies	62	13	20	1	0	1
Increased State Home Health	154	0	0	0	8	0
Miscellaneous Equipment	57	41	30	21	5	1
Orthodontics	0	7	0	0	0	0
Orthotics (MTA)	93	29	12	5	1	4
Orthotics/Prosthetics (Nurses)	19	5	3	0	0	0
Psychiatric Inpatient	366	2	17	8	16	0
Repairs	350	48	16	5	2	2
Respiratory (MTA)	60	28	20	1	4	0
Respiratory (Nurses)	33	54	11	11	0	2
Speech Generating Devices	19	18	0	0	0	0
SUD Partial Hosp Services	236	0	55	0	11	0
SUD Residential Services	107	0	8	0	18	0
Supplies (Miscellaneous)	21	12	4	2	5	0

	Approved		Denied		Cancelled	
Therapies	8	6	0	0	1	0
Vision	59	1	0	0	0	0
Wheelchairs	340	30	137	13	15	1
Grand Total	3598	515	808	100	156	26

In addition, a detailed listing of each PA completed is generated- including:

- Prior Authorization Number
- Header Status (Approved, Denied, Cancelled)
- Assignment Category
- Invoice Grouping
- Clerk ID (Reviewer ID)
- Date Request was Received
- Date Review was Completed
- Patient Age Category (Adult, Ped)
- PA Line-Item Number
- Codes for Service Type
- Description of Service Type
- Line-Item Decision Status

Please see Section 4.2.M Reporting and Analysis in our proposal for a listing of Permedion-provided reporting.

5. Procedures for PA Review Denials

Permedion processes are in compliance with OAC 5160-1-31. When a request for prior authorization is denied, Permedion enters the reason codes and rationale into the MITS system within three days of a complete request. The notice of medical determination includes a right to a state hearing to the consumer. Providers will also be notified of the denial. Permedion is aware that 5160-1-31 is under review and that changes to the Provider reconsideration process are anticipated to be implemented in December 2022. When filed, the updated rule will afford Providers the right to reconsideration. Providers will have 60 calendar days to file for reconsideration. Permedion will make standard determinations within 10 days of receipt. If the request qualifies for urgent care services, a determination will be made no later than 48 hours after receipt.

6. Member Hearings and Provider Appeals

Member/Recipient Appeals

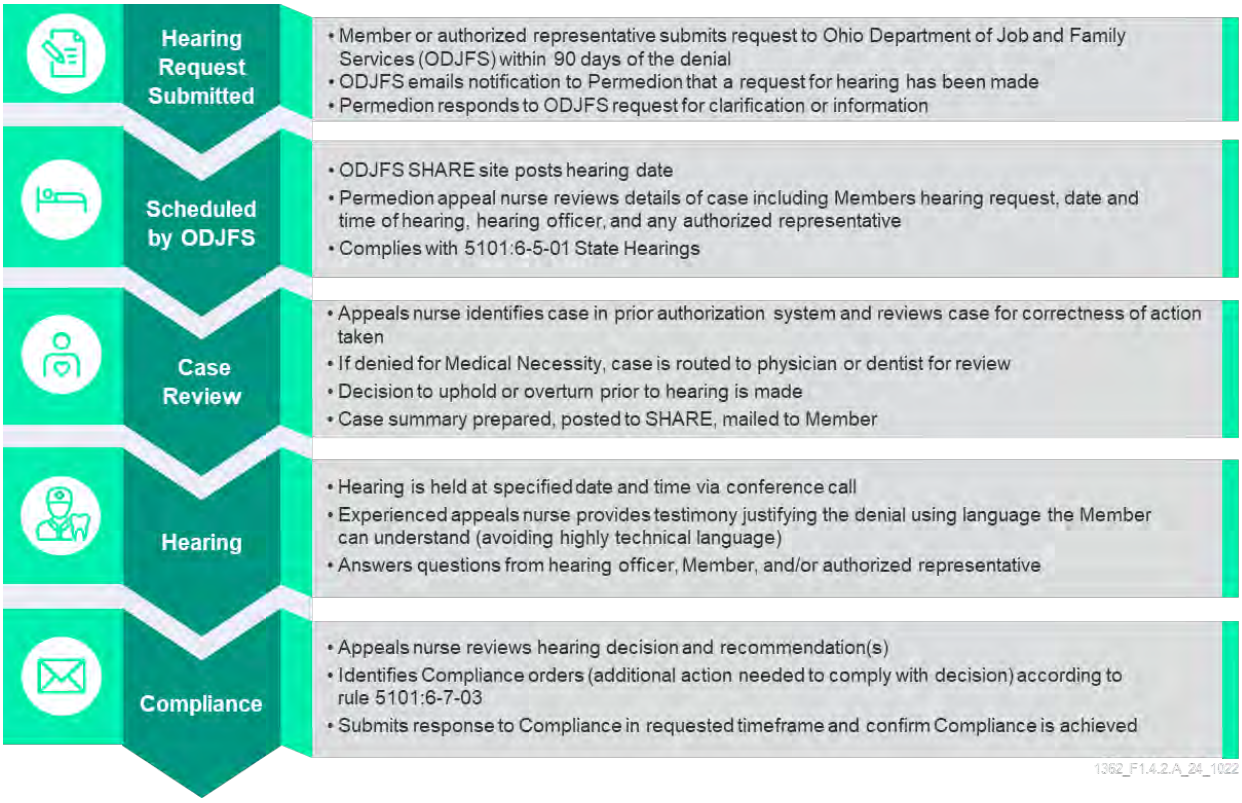
Permedion has been representing ODM in hearings related to fee-for-service denials and is experienced in composing an appeal summary, as well as providing testimony to uphold determinations that do not meet medical necessity or other rules required to be met in order to receive services.

When an adverse decision is made, under OAC 5101:6 “Hearings” a Member of a denied service has the right to a state hearing. The Members are notified of their hearing rights, and the process on how to request a hearing in the adverse determination letter.

On average, Permedion prepares 15-20 appeal summaries and attends appeal hearings each month on behalf of ODM. This includes making certain that case summaries are completed and distributed to the hearing officers and Members prior to the hearing, and identified trained personnel attend the hearings to provide testimony regarding the rationale of the decision.

The Ohio Department of Job and Family Services (ODJFS) is responsible for managing recipient hearing requests. Permedion is notified of a hearing request via email. We access ODJFS’s State hearing Access to Records Electronically (SHARE) site which assists Members guiding them through their appeal process as well as where appeal summaries and compliance actions are submitted. Permedion logs into SHARE for information on Member demographics, the service being appealed, any authorized representatives and the hearing date and time.

Figure 12. Member Recipient Hearings Process



Provider Appeals

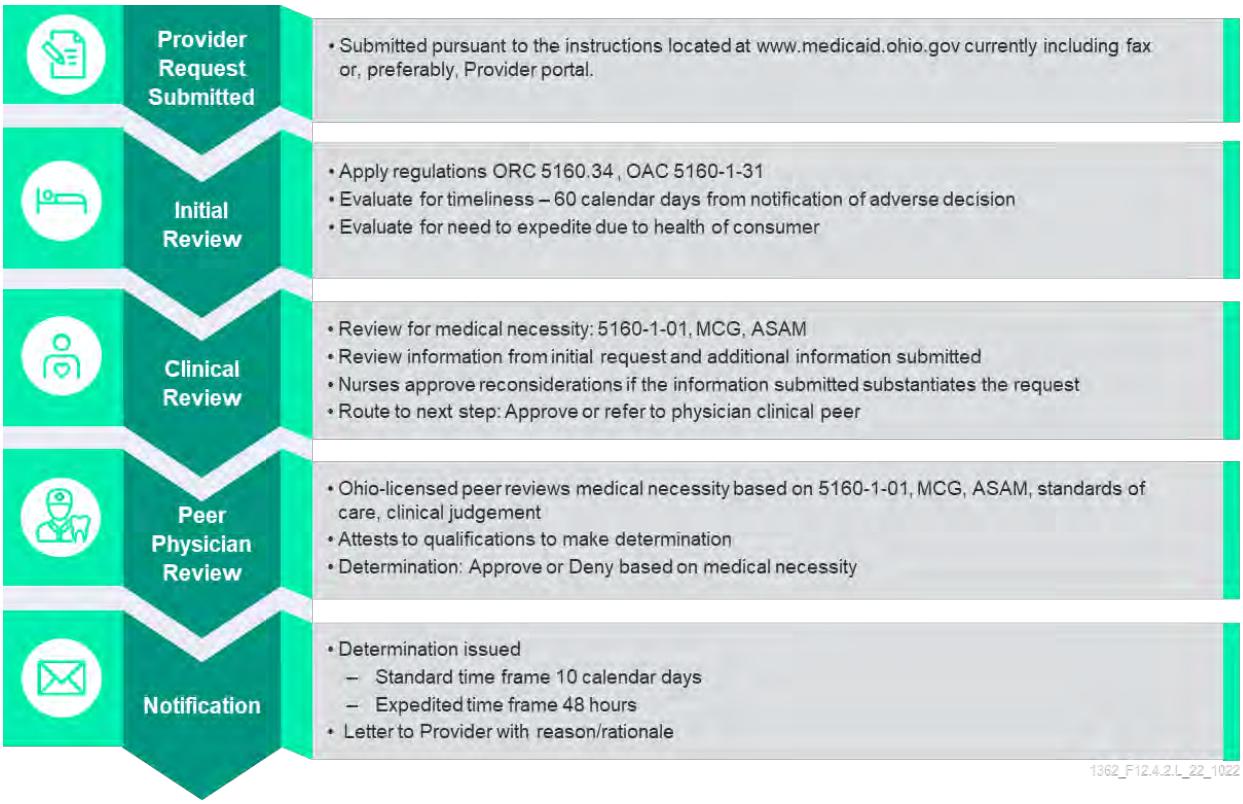
Permedion has been processing Provider appeals (reconsiderations) for other service types and are prepared when this starts for Providers of special reviews. For adverse determinations regarding prior authorizations, the Provider may appeal in accordance with 5160-1-31(E), which regulates the Provider’s right to a reconsideration. Providers may request reconsiderations of an adverse prior authorization in accordance with section 5160.34 of the revised code. Providers may submit reconsiderations by mail or Provider portal. Providers may request a reconsideration within 60 days from the date on the adverse prior authorization determination. For a valid request, the Provider should submit the following information:

- Medicaid recipient's name and Medicaid number;
- Name of requested service or item and billing code;
- Date of service or item request;
- Clinical documentation supporting medical necessity for the service or item;
- A reference to any relevant federal or state law or regulation, if applicable;
- An explanation outlining the reason for reconsideration, including supportive information not previously submitted as necessary; and
- If applicable, an indication of whether the service or item qualifies as “urgent care services” as defined in section 5160.34 of the Revised Code.

In accordance with 5160.34(B12), Permedion will consider standard requests for reconsideration within 10 days of receipt. For urgent care services, the appeals shall be considered withing 48 hours after the appeal is received.

The clinical reviewer will review and consider all information during the appeals process, without regard as to whether information was submitted in the initial consideration of the case. If after review, the reviewer cannot approve the reconsideration request, the request is forwarded to a physician who is knowledgeable of the issue under review and has the clinical expertise that permits them to manage the medical or behavioral health condition or disease under review.

Figure 13. Reconsiderations/Provider Appeals Process



The Provider and Member are notified of the determination, along with any other reconsideration rights. The Provider reconsideration process afforded under 5106-1-31 does not interfere with the Medicaid recipient’s right to appeal in accordance with OAC 5101:6 Hearings.

F.2 4.2.B Retrospective Reviews

RFP Reference: Section 4.2.B

All reviews must be conducted in accordance with OAC 5160-2-13, which describes utilization control policies for hospital services. Reviews should also meet applicable federal guidelines and should support ODM's program integrity initiatives to ensure appropriate utilization of hospital services. All reviews must include the use of Ohio-based physicians to ensure practice patterns within Ohio are taken into consideration, where determined appropriate. Ohio Medicaid utilizes Milliman Care Guidelines for retrospective review determinations.

The 19 retrospective reviews must consist of at least 1,700 inpatient and outpatient claims being reviewed on a monthly basis. The claims will be reviewed for proper coding, level of care, medical necessity and quality of care. The time period for the selection of claims will be determined by, and coordinated with, ODM. Selected Offeror will be required to develop a plan for utilization management that includes post- payment reviews for services and/or admissions provided in the hospital (inpatient and outpatient) setting.

The claims are selected based upon the following examples of current target areas:

1. Billing Errors: This target consists of inpatient admissions which have either the admission source or the patient disposition (discharge status) coded incorrectly.
2. Readmissions: This target looks at claims that include readmissions within one day, and within 30 days of the initial admission.
3. Target Diagnostic Related Groups (DRG): This target consists of looking at DRGs that represent a potential for upcoding or other billing errors, or higher than expected utilization.
4. Medical Necessity and Short Lengths of Stay: This target consists of claims with significantly short lengths of stay based on the DRG and/or primary diagnosis for any diagnosis or procedure; claims for procedures which have significantly higher denial rates due to medical necessity concerns and have short lengths of stay; and selected claims with short lengths of stay.
5. Compliance: This target consists of comparing the diagnostic and procedural information reported on the claim against the medical record documentation for consistency.
6. Outpatient/Ambulatory: This target consists of incorrect coding/number of units, billing issues and inappropriate hospital setting.
7. Bill audit: This target reviews DRG-exempt facility claims once a year for accuracy of billing itemized charges.
8. Transfers: This target reviews the documented reasons for and the appropriateness of the transfer.
9. Outliers: This target reviews claims with outliers to determine if days or services were covered and medically necessary.

In addition to the target areas listed above, the selection methodology for retrospective reviews is continuously monitored by ODM and updated based on provider utilization trends and national trends in public and private insurance markets.

Permedion has unparalleled experience, knowledgeable staff, established relationships within ODM and with external stakeholders. We acknowledge that a collaborative relationship between all parties is empowered by technology. To further the value we bring, as part of this new contract we will deploy enhanced provider (and client) portal functionality that delivers a robust modern user experience with ease and transparency throughout the entire review process. This deployment will allow tracking and searching of claim status throughout the entire review process from claim selection

Experience Counts

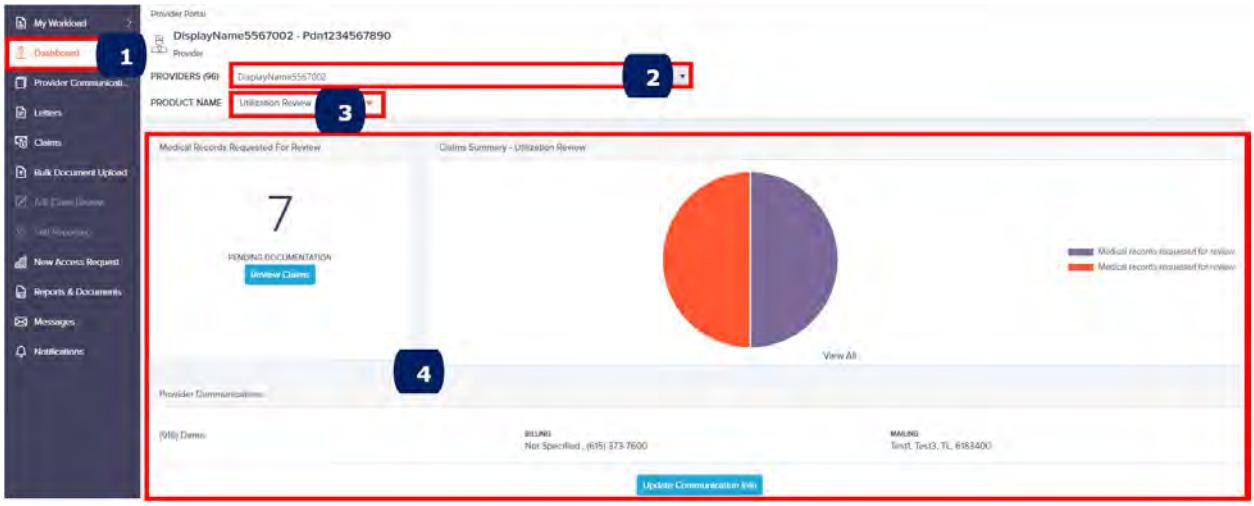
For over 35 years, Permedion has worked with ODM to develop and continuously improve our retrospective review program with significant tangible results. In 2021 we reviewed 23K claims and produced a net savings of $60M.

through appeals. This portal is already deployed to Ohio Medicaid hospitals and practitioners for HMS Third-Party Liability requests and interactions with over 350 users enrolled. Leveraging this familiar portal will reduce training and administrative burden across the program while improving the transparency for UM.

We understand that an effective retrospective review program supports improved member health outcomes, reduces health disparities, addresses provider training needs, corrects claims processing issues, and strengthens ODMs program policies, rules, and regulations. Our Project managers are already in place and knowledgeable of the requirements for retrospective review. Mary Sable, RN our project manager for Hospital Utilization Management Program will manage the operation of the utilization management plan and Lisa Thompson, RN our other Project Manager, will assist with a focus on Behavioral Health. Our proven plans and core processes are in place, and we are in an excellent position to continue performing this scope of work. The Permedion advantage includes:

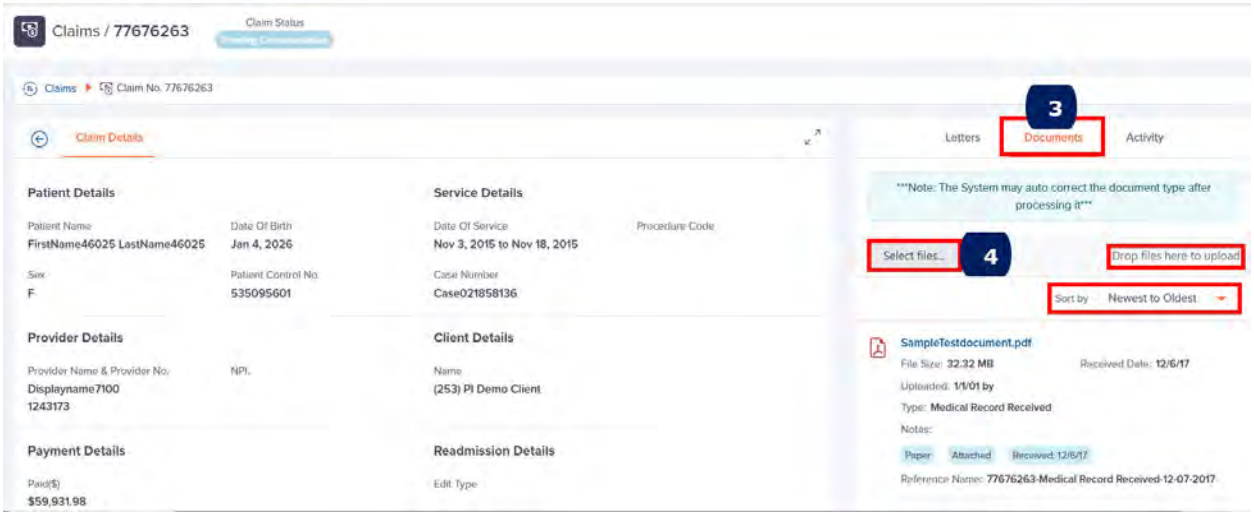
- **Established, knowledgeable clinical reviewer staff.** Along with named highly qualified key personnel who currently support the ODM PA/UM contract, Permedion has an established team of 21 clinical reviewers including nurses and coding specialists, and 39 Ohio-licensed physicians who have decades of Ohio Medicaid experience because they support the review processes today.
- **Proven selection methodology and retrospective review program.** Our selection methodology and retrospective review program have been developed and fine-tuned for many years, specifically for state Medicaid populations. This is evidenced by the extraordinary average return on investment (ROI) of 19:1.
- **Ongoing Analysis and Improvements.** Our continued analysis of the retrospective review data and results have yielded focused reviews and studies that support provider education efforts, changes in billing practices, and additional financial recoveries for the State, where applicable.
- **Strong Relationships with Providers.** The proactive efforts incorporated into our retrospective review processes create and foster professional and collegial relationships with the provider community, resulting in low rates of appeal and administrative burden for ODM.
- **Status Tracking and Electronic Capabilities.** Our proposed portal for this contract will be an enhancement over the DOTS portal currently deployed. It will allow providers to manage retrospective reviews throughout the review lifecycle. Features include:
  - **Review Status.** Providers can see in real-time where in the process a retrospective reviews claim is, including service line specific details. The application allows flexibility to search and filter in a variety of ways, such as ICN, batch, or consumer name. This information can be downloaded for reporting, transactional, or analytical purposes by providers. Dashboarding capabilities allow for both providers and ODM staff to review activities through multiple filters, as exhibited below:

Figure 14. Review Activities on Dashboard



– **Documentation Management.** Providers can both submit and receive documentation related to retrospective reviews. This includes submission of supporting clinical documentation required to meet medical necessity criteria, eliminating the need to fax supporting materials. The following figure shows the screen that providers would utilize to review a claim and upload related documents for their response.

Figure 15. Review a Claim and Upload Related Documents

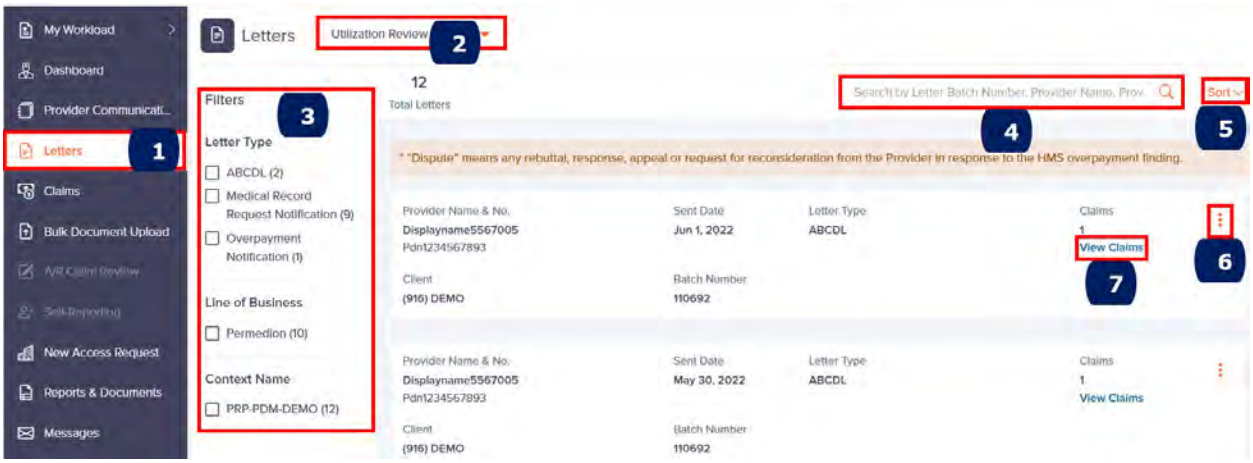


– **Notification and Communication.** Providers can communicate with Permedion staff regarding a specific review through the portal, eliminating the need to call in. Providers can also subscribe to various notifications (case status updates, case decisions, etc.) to stay informed about their reviews throughout the process. There is also the ability to review letters and communications related to a provider, allowing better transparency and accurate status updates.

To search and view “Letters” from left navigation menu, the following steps are followed in our portal:

1. Select “Letters” from left navigation menu to view “Letters” screen shown below.

Figure 16. Notification and Communication for Specific Review



2. Letters: Use the dropdown to select the Product Name – Utilization Review.
3. Filters: Use filters under “Letter Type”, “Line of Business” and “Context Name” to narrow your search results. Once you select a check box, the application refreshes the screen and displays only Letter cards based on the selection.
4. Search: Enter one of the options below and click **Search**.
   A. Enter Provider Name to search all the Letters posted to respective Providers.
   B. Enter Provider Number to search all Letters posted to respective Providers.

– **Appeals.** Providers can submit a request for reconsideration, associated with the specific claim and upload additional documentation via the portal. Leveraging this capability as opposed to faxing requests verifies timely receipt and processing. Providers can track the appeal status through the online portal.

– **Many Transactions in One Place.** In addition to retrospective reviews, providers will have access to other transactions, such as External Medical Review and Third-Party Liability related requests without the need to log-in to multiple applications.

– **Simplified User Access Management.** After initial setup, providers will be able to add and manage authenticated users in real time to access review information in portal.

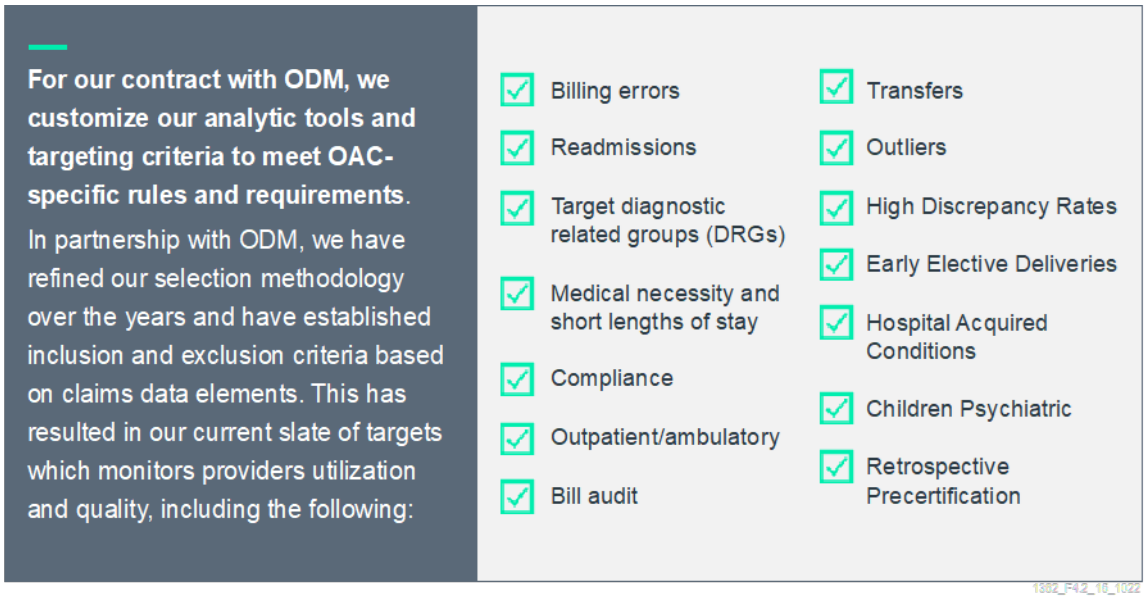
Retrospective Review Process

The following paragraphs provide an overview of key activities in our Retrospective Review Process. Following the overview, details are provided for the activities as requested in the RFP. All reviews are conducted in accordance with OAC 5160-2-13, meet applicable federal guidelines, and support ODM’s program integrity initiatives to verify appropriate utilization of hospital services.

1. **Claims selection.** Before embarking on the retrospective review, Permedion performs a thorough review of all applicable contracts, rules, and regulations, with particular emphasis on updates and changes. In conjunction with ODM, we determine and agree on the claims selection methodology that we will use for this process.

   Our biostatistician, Caroline Black, RN, PhD, uses a combination of machine learning algorithms, and targets to identify claims most likely to have a finding. The specific targets are listed below. At least 1,700 inpatient (medical and psychiatric) and outpatient claims will be selected for review on a monthly basis.

Figure 17. Selection Criteria



2. **Request for medical records.** A medical record request letter is sent to each provider through our provider portal, (or mailed if necessary to accommodate a provider). Providers are required to submit medical records within 30 calendar days of the date of the medical record request. As a courtesy to the providers, if we do not receive the medical records within seven days of the due date, members of our client services team will call and/or send an email to the designated hospital contact as a reminder. If the provider does not submit records, we issue a technical denial (meaning, a denial for non-response).

   99% Compliance
   Working closely with the hospital community, Permedion received medical records on 99% of requested cases in the last two SFYs.

   Permedion has established Ohio protocols to receive medical documentation submissions including USPS mail, fax, CD/USB drive, and HIPAA-compliant Electronic Data Interchange (EDI) transmission. We have also established relationships and protocols with third-party vendors such as Ciox and MRO to receive medical records from their participating providers securely and electronically. With this new contract, we will also be accepting medical records through our provider portal.

3. **Medical record/claim review.** Each case is reviewed to confirm requirements for reimbursement were met, including medical necessity as defined in OAC 5160-1-01, compliance with billing rules and to verify proper quality of care as defined in federal regulation 42 C.F.R 456.3 (b). MCG criteria is utilized to supplement regulations and validate evidence-based decisions. Other references include the Coding ICD-10 CM Official Coding Guidelines for Coding and Reporting applicable for the dates of service reviewed and relevant ODM Billing Guidelines, and 3M APR-DRG Grouper.

   A nurse reviewer will refer a case to an Ohio-licensed clinical peer if they cannot approve a case and/or if there is a quality of care finding. For some billing questions the nurse may refer the case to a certified coder.

4. **Determination.** If the nurse reviewer, certified coder, or physician reviewer approves the case, the approval is recorded in our Utilization Management system and available via the portal. If Permedion cannot approve the case, we will issue a Denial Letter with the specific findings via the portal within 30 business days. A case can include multiple findings.

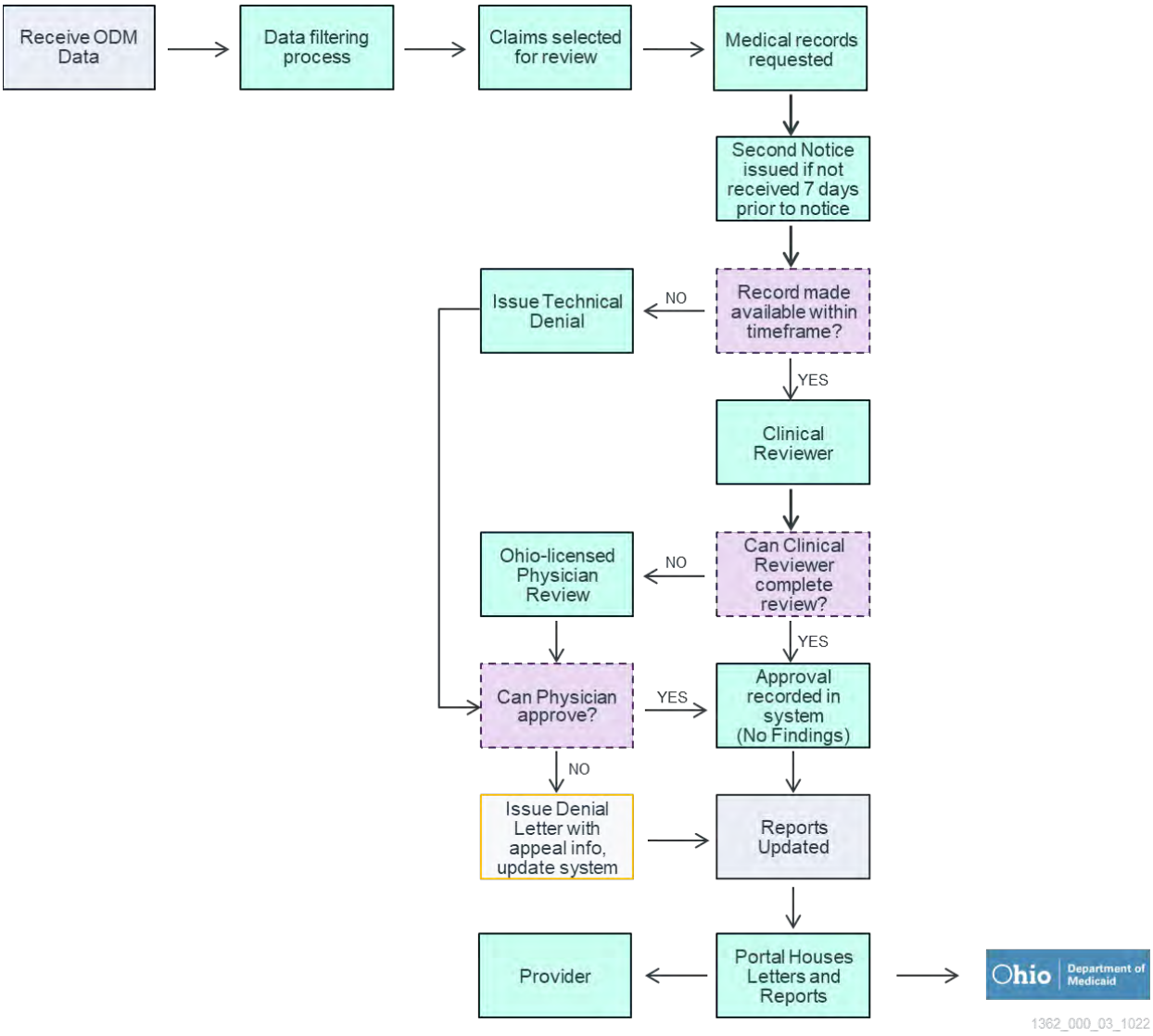
5. **Appeal.** Appeals can be submitted within 60 days. OAC 5160-2-12 outlines rules for appeals and reconsiderations regarding hospital inpatient and outpatient services. The preferred method is for the provider to submit the appeal and supporting documentation via the provider portal associated with the original claim.

   Our appeal RN will review the reconsideration and additional information submitted. If the additional information is sufficient, the nurse will overturn the denial. If the appeal RN cannot establish medical necessity, the appeal will be referred to an Ohio-licensed clinical peer. The case will be upheld, modified or overturned. An appeal determination will be issued within 30 business days via the provider portal.

   In addition, we will provide monthly reports indicating all hospitals reviewed to ODM.

6. **Recoupment.** After the review and appeal process is completed, Permedion prepares an adjustment report for ODM of all claims that are in a final denied status for payment recoupment. The denial reasons are mapped to the ODM adjustment reason codes specifying for each claim if the provider can re-submit for same type of bill, cannot re-submit, or if the provider is allowed to resubmit as outpatient only.

Figure 18. Retrospective Review Process



Permedion acknowledges and currently meets the requirements for:

- **Physician Reviewers.** All reviews will include the use of Ohio-licensed physicians across multiple specialties, including psychiatry, to make sure Ohio practice patterns are taken into consideration as appropriate. We have 39 Ohio-licensed physicians/dentists currently assigned to the Ohio UM/PA program. Additional information on our physician and clinical review team is detailed in B.14.g.3.3.A Other Necessary Positions.
- **Clinical Review Criteria**. When conducting clinical reviews, evidence-based criteria and/or nationally recognized guidelines predicate the Permedion team's decisions. We will continue to use MCG for retrospective review determinations in Ohio. We have extensive experience using various national criteria, including MCG and InterQual Criteria, as well as guidelines supplemented or modified by individual state programs.
- **Time Period and Plan for Retrospective Reviews.** Currently, each month, Permedion selects claims for review covering payment dates over the previous five state fiscal

years. Under a new contract, we will discuss with and confirm the selection time period with ODM. We will also develop for ODM's review, an updated plan for utilization management that includes post-payment reviews for services and/or admissions provided in the hospital (inpatient and outpatient) setting.

F.2.A Implementation and Management of the Retrospective Review Program

RFP Reference: Section 4.2.B

To implement and manage the Retrospective Review Program, the selected Offeror will be required to:

1. Develop the methodology and criteria used to select procedures and/or admissions. (Note: selection criteria must address provider incentives likely under a prospective payments system, such as, medical necessity of admission, discharge/transfer decisions, and accuracy of coding.)
2. Include in the program a mechanism that verifies that the services were performed in the most appropriate location.
3. Include in the program a mechanism to verify that information given during the pre- certification process was accurate if pre-certification is applicable.
4. Select the medical criteria used to determine appropriateness of the procedure and/or admission.
5. Provide (number) license(s) granting ODM staff access to Milliman Care Guidelines.
6. Incorporate participation in the provider appeal process as described in OAC 5160-2-12.
7. Train Medicaid providers, ODM staff, and the selected Offeror/subcontractor staff on the retrospective review program.
8. Maintain a reporting mechanism that meets the notification requirements of ORC § 164.57
9. Develop a process for referring quality of care findings to ODM.
10. Monitor and provide suggested updates to the program to ensure that appropriate procedures and/or admissions are reviewed.
11. Ensure that reviews support quality of care studies and the pre-certification program plan described in this Section.

Claims To Be Excluded from Fee-for-Service Retrospective Review:

1. Crossover claims where Medicare is the primary payer.
2. Claims where the consumer had a retroactive eligibility change from fee-for-service to managed care.
3. Claims for inpatient services rendered to incarcerated individuals participating in the Inpatient Hospital Services Benefit program.
4. Claims for inpatient services rendered under the Presumptive Eligibility program.
5. Claims for Inpatient and Outpatient services subjected to mass adjustment by ODM.

Retrospective reviews will primarily be focused on inpatient care, and the sampling methodology will need to be updated to take into account changes in trends in the insurance market and in utilization trends.

We value the long-standing relationship we have fostered with ODM, and Permedion will continue to meet and exceed ODM's requirements for retrospective reviews. The following paragraphs address the numbered requirements from Section 4.2.B of the RFP.

Overall, medical records received for inpatient admissions is reviewed by a nurse reviewer to determine whether care was medically necessary on an inpatient hospital basis; to determine if the care was medically necessary as defined in

> Permedion performs over 140,000 inpatient hospital retrospective reviews for Medicaid programs each year.

rule 5160-1-01 of the Administrative Code; to determine whether the discharge occurred at a medically appropriate time; and to assess the quality of care rendered as mandated in 42 C.F.R. 456.3(b). Outpatient hospital services may also be reviewed by ODM to determine whether the care or services were medically necessary as defined in rule 5160-1-01 of the Administrative Code, to determine whether the services were appropriately billed, and to assess the quality of care rendered as mandated in 42 C.F.R. 456.3(b).

1. Methodology to select procedures and/or admissions

Each year Permedion conducts over 140,000 retrospective clinical reviews for various Medicaid programs, including Ohio. The core analytics processes we employ under our retrospective review program with ODM have been developed and perfected specifically for the Ohio Medicaid fee-for-service population.

For our OH UM/PA program, our selection methodology and process is led by our biostatistician, Caroline Black, RN, PhD. We leverage machine learning algorithms using cutting edge analytics and historical clinical expertise to target claims for inaccurate billing of the correct place of service/level of care. We utilize results based on a large data set of claims have completed a full, clinical, medical record review. This automated approach identifies claims with the highest likelihood of a finding.

Exclusions

Before selecting claims for review, we first exclude claims not eligible for review as approved by ODM. Some examples (not inclusive) of the exclusion criteria applied includes:

- Claims falling outside the Medicaid overpayment recovery period. The timeframe is defined per ORC 5164.57 as a claim selected will be within the five-year period immediately following the end of the state fiscal year in which the overpayment was made and will allow a lag for a one-year period that applies to the state fiscal year in which the payment was made.
- DRG 580 or 581 - neonates, died or transferred to another acute care facility
- Crossover claims where Medicare is the primary payer
- Claims where the consumer had a retroactive eligibility change from fee-for-service to managed care
- Claims for inpatient services rendered to incarcerated individuals participating in the Inpatient Hospital Services Benefit program
- Claims for inpatient services rendered under the Presumptive Eligibility program
- Claims for Inpatient and Outpatient services subjected to mass adjustment by ODM

Targeting

Once claims are excluded, we leverage our machine learning algorithms and targets to select the claims with the highest likelihood of a finding. The following table provides a description of current target areas. This is not complete documentation of the inclusion/exclusions that are part of our process.

Table 10. ODM's Current Target Areas

Target	Selection Methodology
Billing errors	Our analyses include potential transfers that have either an incorrect admit source or patient-discharge/disposition code. This error can also occur when there is a delay in claim submission.
Readmissions	Our team selects claims for review (after omitting transfers) if the second stay is within 1 day and within 30 days of the first stay's discharge. We have developed the model to calculate the likelihood of often-related readmissions pairs that should be paid as one diagnosis-related group (DRG) instead of two. Our readmissions analysis also includes review of such codes as patient status (e.g., discharge status) and source of admission codes relative to the claims history to verify that each claim was properly coded.
Target diagnostic related groups (DRGs)	We target specific, higher-paying DRGs that represent a potential for overpayment because they used slightly different diagnosis/ procedure codes instead of more-accurate, lower-paying codes. Our analysis identifies overpayments for non DRG-based services that should have been paid on a per diem basis rather than a DRG methodology.
Medical necessity and short lengths of stay (LOSs)	Our selection methodology in this category includes the following: • **Inappropriate admission**. Our review for inappropriate admissions includes claims for procedures that have short LOSs or significantly higher denial rates due to medical necessity concerns. • **One-day stays**. Stays lasting fewer than 23 hours often indicate an unnecessary admission for medical services that could have been provided on an outpatient basis or during an observation stay. • **Significantly short LOS**. This target consists of claims with a short length of stay based on DRG and/or primary diagnosis for diagnosis or procedure.
Compliance	We select claims with targeted principal diagnosis and procedure codes that have a high rate of being mis-coded resulting in a higher reimbursement rate to the hospital. To achieve the highest success rate, we continuously update the codes we select based on the results of similar targets we use in other states.
Outpatient/ambulatory	Targets in this category focus on outpatient claims with the potential for denial of payment. These outpatient claims include those for which the member was admitted for an inpatient setting no more than three days after being admitted for outpatient services for the same provider. This target consists of unlisted CPT codes for outpatient claims, both surgical and dental. It also includes claims related to physical therapy, high dollar procedures, endomyocardial biopsies, debridement, shoulder debridement, neurostimulator implantation, lysis of adhesions, modifiers 25, 50 and 59, observations, vascular procedures and infusions. We also identify inpatient ambulatory procedures that could be performed in an outpatient setting based on current guidelines.
Bill audit	We review excessive cost or day thresholds resulting in additional payments. Our focus is on determining medical need for the extended stay, congruence of billed and delivered services, physician involvement in treatment orders, and potential duplications in billing.
Transfers	This target consists of transfers that appear to have either the admit source and/or the patient disposition coded incorrectly. This target identifies "TransferTo" claims that has subsequent claim ("TransferFrom") admitted on the same day under a different facility.

Target	Selection Methodology
Outliers	We use data modeling techniques to identify outlier coding or utilization patterns that could signal error or abusive coding/utilization practices. We compile and analyze standard utilization measures relative to its peer group through cluster and statistical analysis. These measures include cost outlier and day outlier rates.

The targets below are additional targets that have been developed in partnership with ODM and are used within Permedion's current selection methodology.

Target	Selection Methodology
High Discrepancy Rate	This target looks at claims where there is a great difference between the reimbursement amount (paid amount) and the total charged amount, subject to length of stay restrictions.
Early Elective Deliveries	This target identifies delivery (medical induction and C-section) claims where the gestational age of the fetus 37-38 weeks. OAC 5160-1-10 states cesarean sections, labor inductions, or deliveries following labor induction that occur prior to thirty-nine weeks gestation that are not considered medically necessary are not eligible for payment.
Hospital Acquired Conditions	This target identifies claims with a diagnosis that was not present on admission (POA) and meets the requirements for a HAC diagnosis (HAC category 1-14) as defined by CMS.
Children Psychiatric	This target specific to inpatient psychiatric claims where the recipient is nine (9) years old or younger at the time of admission.
Retrospective Precertification	This target is specific to inpatient psychiatric stays/discharges that did not get a pre-certification medical necessity review due to retrospective eligibility. Medical necessity is evaluated during the post-payment review

Permedion will adjust inclusion or exclusion of populations based on ODM feedback. Permedion will select a minimum of 1,700 claims each month.

2. Verify services were performed in the most appropriate location

One of the components of Permedion's retrospective review program involves verifying that the services provided were performed in the most appropriate location. To determine appropriateness of location, our medical record review will include, but is not limited to, the following:

- An evaluation of the need for medical services and the services received
- A physician certification and recertification of the need for inpatient care
- Medical, psychiatric, and social evaluations
- A daily written plan of care note or notation that plan follows the standard of care
- A continuous program of UR under which the admission, continued stay, and discharge of the patient is reviewed or screened as per State and federal regulations
- Admit order dated and signed by physician

- Laboratory results and radiology services support the working diagnosis
- Appropriateness of the prescribed medications
- Types of quality of concern issue in the medical record
- The chart is reviewed for day of care for each day the patient is in the hospital
- The patient's discharge plan started on day of admission

Our nurses leverage MCG and other state-approved criteria to evaluate cases to determine if the care was delivered in the most appropriate setting. If the nurse reviewer determines that the information in the medical record does not meet the MCG for an inpatient admission, the case will be referred to a peer-matched Ohio-licensed physician for review. If the physician reviewer denies the case for inappropriate location, the provider will receive a Denial Letter. When the appeals period is complete, Permedion provides a report of claims in a denied status to support ODM in recover inappropriately paid claims.

3. Verify that information given during the precertification process was accurate

Another component of Permedion's retrospective review program involves the validation of information given during the precertification process. Permedion includes in its selection methodology targets that identify claims that fall under the precertification process. These cases are added to the regular monthly reviews that are audited. Our nurse reviewers compare information from the hospital medical records with the medical information provided at the time of the precertification request.

To determine compliance, information given at precertification and the information included in the medical record need to match and indicate medical necessity. If the nurse reviewer determines that the information in the medical record does not meet the MCG for medical necessity or if the information presented at the time of precertification does not match the information in the medical record, the case will be referred to an Ohio-licensed physician for review. If the physician reviewer denies the case for medical necessity, the provider will receive a Denial Letter. The data is then analyzed and reported. When the appeals period is complete, ODM can recoup the payment from the denied cases.

The purpose of the precertification compliance review is to determine if there are trends identified by a provider for cases that were referred as a result of the compliance review and to recoup payment for the cases that were denied in this process. This review component is extremely important because it holds providers accountable for the information provided at the time of a precertification request and it enforces with hospital providers that accurate medical information is vital for the precertification program to be effective.

4. Medical criteria to determine appropriateness

Ohio Administrative Code 5160-1-01 describes that medical necessity for a procedure, item, or service is met if the following apply:

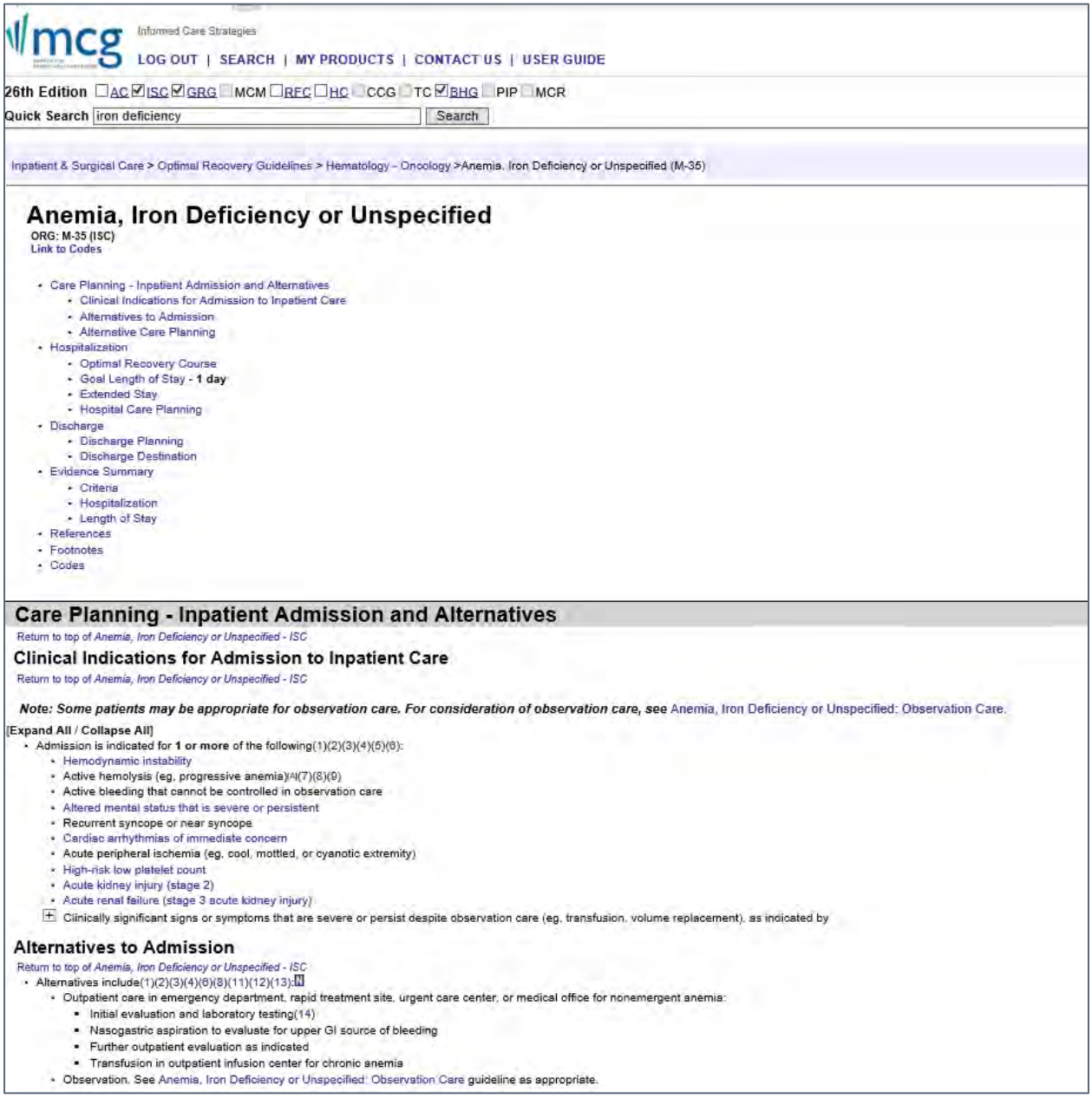
- It meets generally accepted standards of medical practice.
- It is clinically appropriate in its type, frequency, extent, duration, and delivery setting.
- It is appropriate to the adverse health condition for which it is provided and is expected to produce the desired outcome.

- It is the lowest cost alternative that effectively addresses and treats the medical problem.
- It provides unique, essential, and appropriate information if it is used for diagnostic purposes.
- It is not provided primarily for the economic benefit of the Provider nor for the sole convenience of the Provider or anyone else other than the Member.

To support consistent, accurate medical necessity assessments, Permedion utilizes MCG, evidence-based care guidelines as applicable when there is no detailed regulatory guidelines. In the absence of both Ohio regulatory and MCG criteria, Permedion will work with ODM policy to make sure the assessment and decision are consistent with the intent of ODM.

Permedion utilizes MCG evidence-based healthcare guidelines. MCG provides a focused summary of the current best medical evidence and is updated annually (see the following figure). The guidelines' clinical criteria were developed with input from healthcare providers in active clinical practice; they are designed for use in conjunction with a healthcare professional's clinical judgment, enabling more informed and consistent decisions. Sources of information for MCG include peer-reviewed medical literature and textbooks, nationally recognized guidelines published in medical fields, practice observation, and database analyses. The MCG is an excellent reference for determining the medical necessity of an inpatient stay and the optimal length of that stay. It provides clear indicators for and alternatives to admission as well as information on optimal treatment guidelines, goal length-of-stay, quality measures, and observation care guidelines. The guidelines also provide guidance when reviewing a request for outpatient and ambulatory services.

Figure 19. Milliman Care Guidelines Sample



5. Provide (number) license(s) granting ODM staff access to Milliman Care Guidelines

We will continue to use MCG guidelines, to supplement Ohio regulations and federal guidelines to conduct review activities. Permedion will allow access to ODM staff as permissible based on the contract with MCG.

6. Incorporate the provider appeal process as described in OAC 5160-2-12

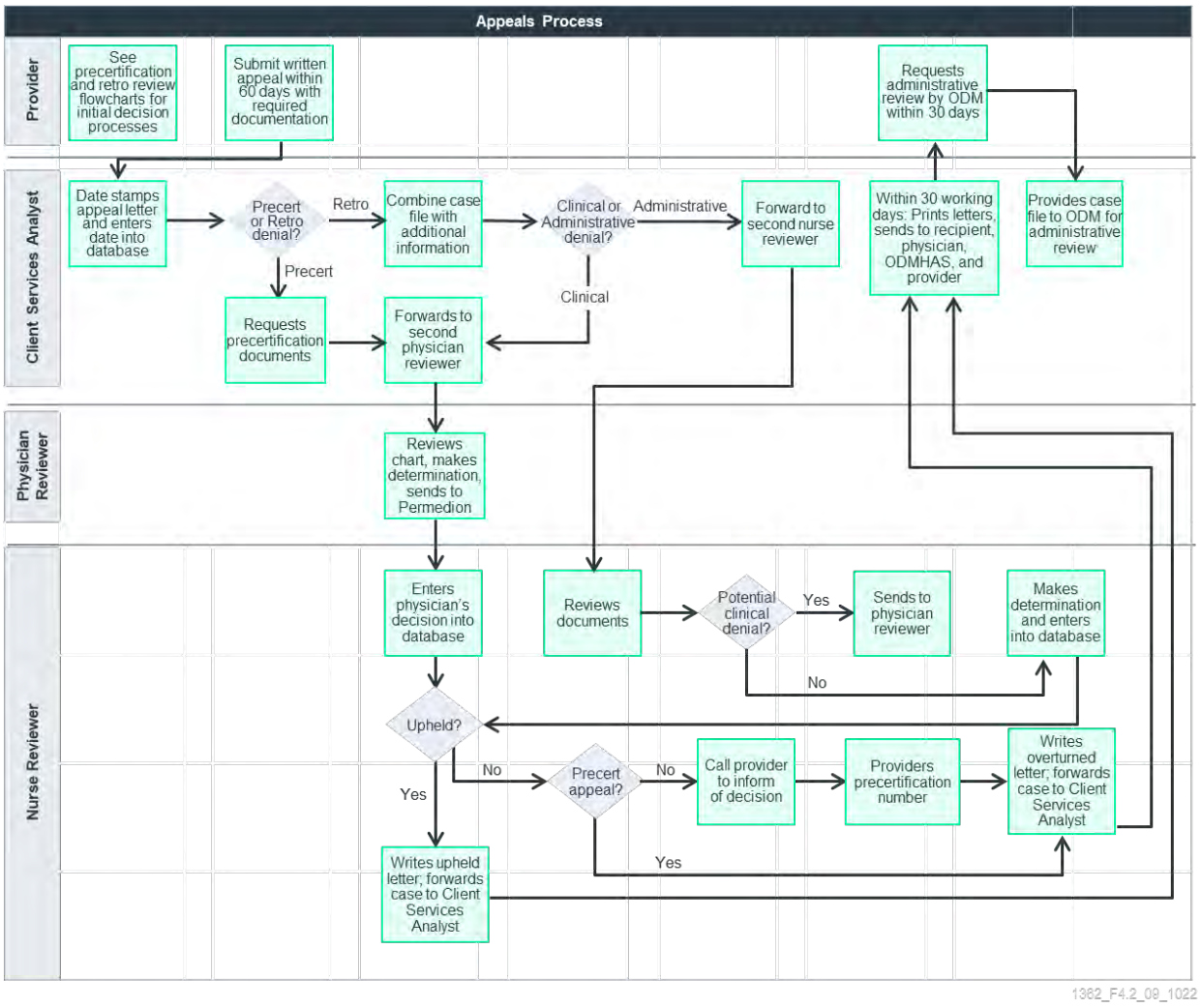
We have strict policies and procedures regarding appeal processes. Permedion processes appeals within appropriate timelines and if a denial will be upheld, it is reviewed by a second (not the same reviewer that made the initial denial) Ohio-licensed clinical peer.

The steps required in the provider appeals process are as follows:

1. **Request for Reconsideration.** Providers will submit the reconsideration request via the provider portal associated with the original claim denial. A request must be in writing and submitted within 60 days of the date of the determination unless extenuating circumstances exist.
2. **Clinical Review.** An appeal registered nurse will review the appeal. If the nurse cannot overturn the decision, the appeal will be referred to an Ohio-licensed clinical peer not involved with the initial denial. The physician reviewer will review the case in its entirety and make a determination.
3. **Determination.** The determination will be posted to the provider portal within 30 business days of receipt of appeal request, unless otherwise required to issue via mail. If the physician reviewer upholds the denial, the denial letter sent to the provider will contain instructions for an administrative review.

Upon receipt of an administrative review request, the review will be conducted by ODM to evaluate the medical record and additional submitted information. ODM has 30 business days from the receipt of the request to issue a final and binding decision. This final decision will be mailed to the provider upon completion of the second-level appeal. The following figure shows the appeals process for both precertification and retrospective review.

Figure 20. Appeals Process



7. Train Medicaid providers, ODM staff, and the selected Offeror/subcontractor staff

Permedion brings expertise in training- covering topics ranging from technical program requirements to state and federal compliance, to clinical training, and to evidence-based practices for hard-to-treat populations. The Permedion solution for ODM includes training for Medicaid providers, ODM staff, and selected Permedion/subcontractor staff.

Provider Training

Permedion has facilitated countless provider training conferences and workshops. Our Provider Training Process incorporates joint experiences and expertise, including the key components of effective communications, relevant educational events, and informative publications. With our clients, we have developed collaborative provider education, conducted large-scale seminars and workshops, provided consulting sessions with individual providers to develop quality improvement plans, and convened early quality conferences.

Our production of educational materials runs the gamut from topic-specific clinical educational reference manuals and teaching guides to web-based program information and from newsletters to one-on-one consultations. Provider education and program improvement is an important component of Permedion's' clinical review projects, and it occurs in several ways. The purpose of the Provider Education program is to update providers on policies and procedures and to educate them regarding appropriate utilization of healthcare services, medical necessity, quality of care, clinical criteria, current patterns (for example aberrant practice patterns), and trends identified in utilization and focused studies.

With ODM's permission, we will make the results of our utilization review work available to individual providers and, if indicated, provide information that gives statewide and peer group comparisons and current national trends. These educational programs provide an excellent opportunity for us to share with the provider community results and recommendations from our recent analyses. Continuous improvement in the provision of healthcare comes through widely disseminated and shared results of utilization and quality improvement projects.

Training provided to Medicaid providers includes one-on-one telephone consultations, on average to approximately 75 providers per month in Ohio. Our personnel share information regarding the retrospective review process, which includes information on the medical record request process, submission of medical records through the EDI protocol, timely submission of medical records and reconsideration requests, explanation of denial letters, ODM contact information, and the ODM website where the OAC rules and the Ohio Medicaid Provider Handbook may be obtained. Medicaid providers are supplied with current information concerning the MCG. We also hold teleconferences and in-person conferences with provider personnel to address concerns and provide information about application of the OAC rules to the retrospective review process. Conferences have included a webinar with ODM and the OHA community on utilization management, precertification, and prior authorization.

We deliver training in a variety of ways, including one-on-one sessions, computer-based training, webinars, website materials, town hall sessions. We also share information via the online Provider Portal, the primary contact with Permedion.

Building strong relationships with Ohio providers is integral to the success of our utilization management review efforts. Our ability to provide education about the program helps providers gain a better understanding of State rules and regulations, identifies common ground for improvement, strengthens our credibility, and enables us to cultivate an environment of mutual trust and respect.

ODM Staff Training

Permedion will provide training to ODM personnel as requested and as the need arises. This training could include education regarding data, our processes, use of the Provider Portal, MCG, completed reporting, and targets and samples used in the retrospective review program. Much of this transfer of information occurs virtually during our regular monthly meetings. However, there are times when special training is requested by ODM to understand the retrospective review process. Led by our Medical Director, Dr. Anthony Beisler, Permedion will develop training sessions as required to meet ODM's needs.

An example of a recent education session held by Dr. Anthony Beisler was the July 2022 session for the ODM SURS unit on sepsis and the sequential organ failure assessment (SOFA) score.

Permedion/Subcontractor Staff Training

Permedion has an established, experienced team supporting the ODM retrospective review process today. We support them with a robust training program, geared toward assuring that personnel are equipped to continue to deliver high-quality service to ODM. Throughout the contract, our corporate-level QA programs provide feedback on the effectiveness of our personnel and our activities, allowing us to identify opportunities for refinement and possible additional cost savings.

Our current personnel have completed the necessary training for this contract. Our training employs a combination of online lectures, hands-on practice, skill strengthening exercises, and one-on-one mentoring so that project team members:

> Our two Project Managers, Lisa Thompson RN and Merrily Sable RN, along with designated clinical trainers, provide review training specific to the retrospective review tool for reviewers assigned to the project.

- Understand privacy and confidentiality, including HIPAA regulations as they relate to the utilization control process
- Understand and adhere to ODM requirements
- Follow applicable State and federal laws without exception
- Understand the responsibilities of their position within the ODM retrospective review program
- Are knowledgeable regarding operations of the ODM retrospective review program

Additionally, Permedion, our independent clinical reviewers and subcontractors are trained to safeguard systems and data integrity as well as to comply with State and federal regulations and our clients' requirements. We mandate and track initial and ongoing training of the workforce. Our Corporate Risk Management Training program emphasizes the importance of security and compliance issues to employees throughout their tenure at our company—beginning with initial employee orientation and training. Upon accepting employment, employees must:

- Affirm that they have read the Corporate Compliance Handbook (including the formal policies and Corporate Compliance Statement)
- Undergo initial Corporate Compliance program and HIPAA privacy training
- Sign an agreement that they understand the statement and policies and will abide by and conform to the rules within those documents

An integral part of our organizational philosophy is striving for continuous quality improvement. Permedion maintains a QA program that makes sure that validity, reliability, and the technical integrity of the contract are maintained through frequent communication with ODM regarding changes to the approved work plan and measurement of the quality and timeliness of contract deliverables. We take steps to verify the following:

- Retrospective review activities are consistent with ODM's objectives and training needs through measurement of review results (denial rates, appeal rates, ROI, etc.) and with identifying opportunities for training/educational topics
- Activities are performed within a permissible range of deviation from standards that have been approved by ODM through tracking and measuring key contract activities
- Nurse and physician reviewer performance is accurate, consistent, and timely through interval performance measurement

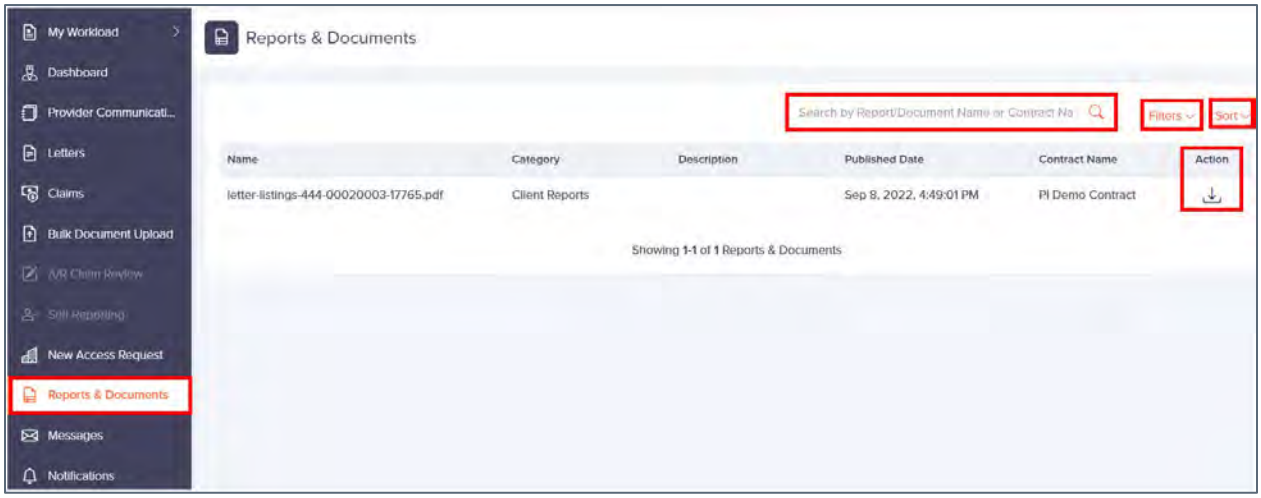
Our QA program, including the inter-rater reliability process, enables us to accurately identify training needs for Permedion employees and subcontractors working on this contract. The quality data that the program generates often exceeds what is required per our contractual obligations, and it may identify educational topics that should be addressed. In addition to our QA results, we use several assessment tools to verify that we are proactively identifying gaps and needs for training. We will use task assessments to compile information about a particular job function to determine whether there are gaps between existing competencies and those required for improved performance. Our individual assessments will look at employees to discover their level of performance. This analysis identifies the existing skills and qualifications, as well as capacity for learning. Individual assessment will show who needs training and what kind of training is needed most.

8. Maintain reporting mechanism that meets the notification requirements of Ohio Revised Code (ORC) § 164.57

Permedion maintains and will continue to maintain a timely and informative reporting mechanism in accordance with ORC § 164.57 for notification of determinations to providers, including the hospital community. Our letters and reports are critical to verify providers understand the review process and findings, and next steps they must take. Based on feedback from ODM and providers, we continuously fine-tune the content of these documents to make sure that we are communicating clearly and effectively.

As the current vendor for the ODM UR program, Permedion has established ODM-approved regulations, compliant reporting, and letters that communicate the results of the retrospective review program to providers. The results of our determinations are sent to providers (either uploaded to our Provider Portal or provided by mail) and include a Monthly Approval Report, a Monthly summary of denials, and denial letters. The following figure depicts our reports dashboard in Portal, which will provide ODM staff a centralized and on demand reporting library.

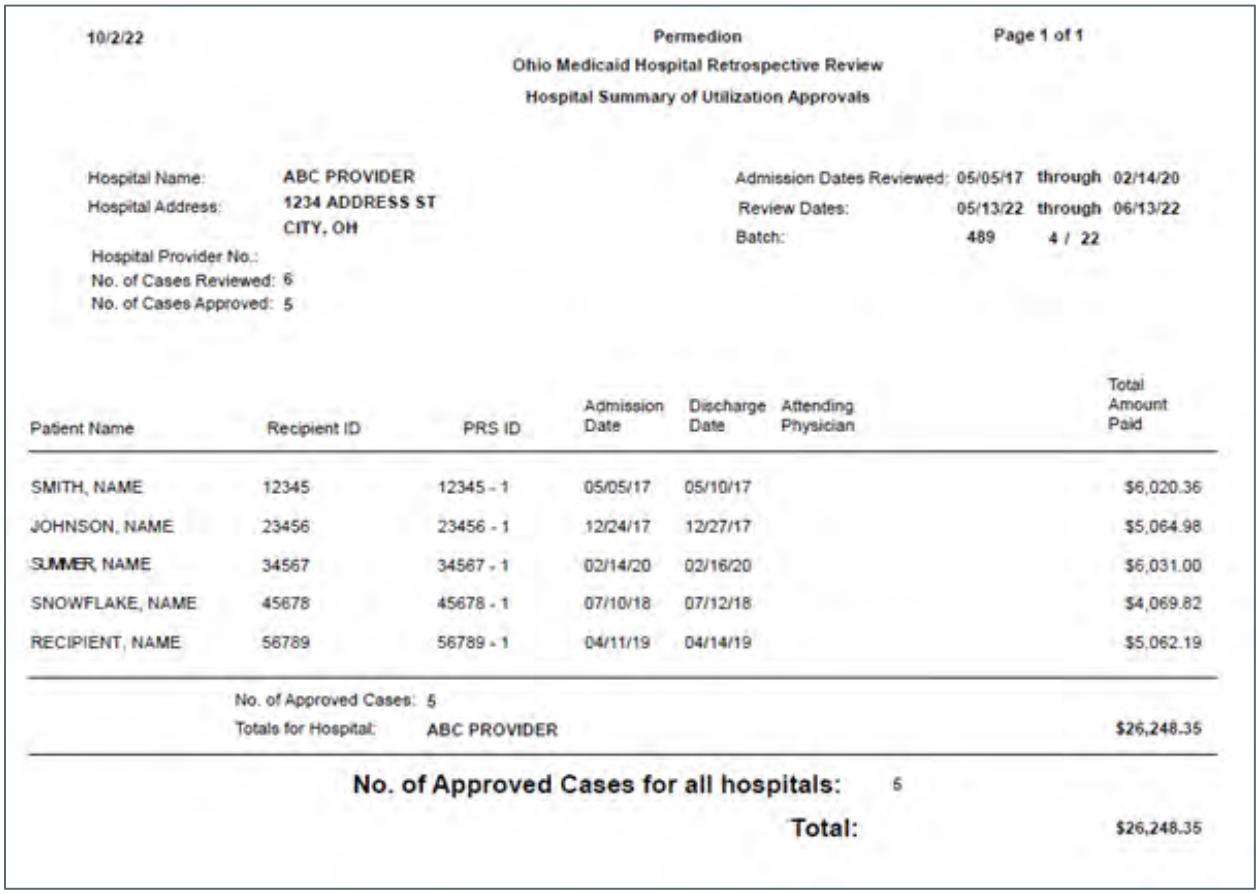
Figure 21. Portal Reports Dashboard



Monthly Approval Report

This report lists the cases that were retrospectively reviewed and resulted in an “approved” decision. The approval report includes the hospital demographic information and case level summary of claims that were approved during the retrospective review process.

Figure 22. Example Monthly Approval Report



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Ohio Medicaid Hospital Retrospective Review

Hospital Summary of Utilization Approvals

Hospital Name: ABC PROVIDER
Hospital Address: 1234 ADDRESS ST
CITY, OH
Hospital Provider No.:
No. of Cases Reviewed: 6
No. of Cases Approved: 5

Admission Dates Reviewed: 05/05/17 through 02/14/20
Review Dates: 05/13/22 through 06/13/22
Batch: 489 4 / 22

Patient Name	Recipient ID	PRS ID	Admission Date	Discharge Date	Attending Physician	Total Amount Paid
SMITH, NAME	12345	12345 - 1	05/05/17	05/10/17		$6,020.36
JOHNSON, NAME	23456	23456 - 1	12/24/17	12/27/17		$5,064.98
SUMMER, NAME	34567	34567 - 1	02/14/20	02/16/20		$6,031.00
SNOWFLAKE, NAME	45678	45678 - 1	07/10/18	07/12/18		$4,069.82
RECIPIENT, NAME	56789	56789 - 1	04/11/19	04/14/19		$5,062.19

No. of Approved Cases: 5
Totals for Hospital: ABC PROVIDER $26,248.35

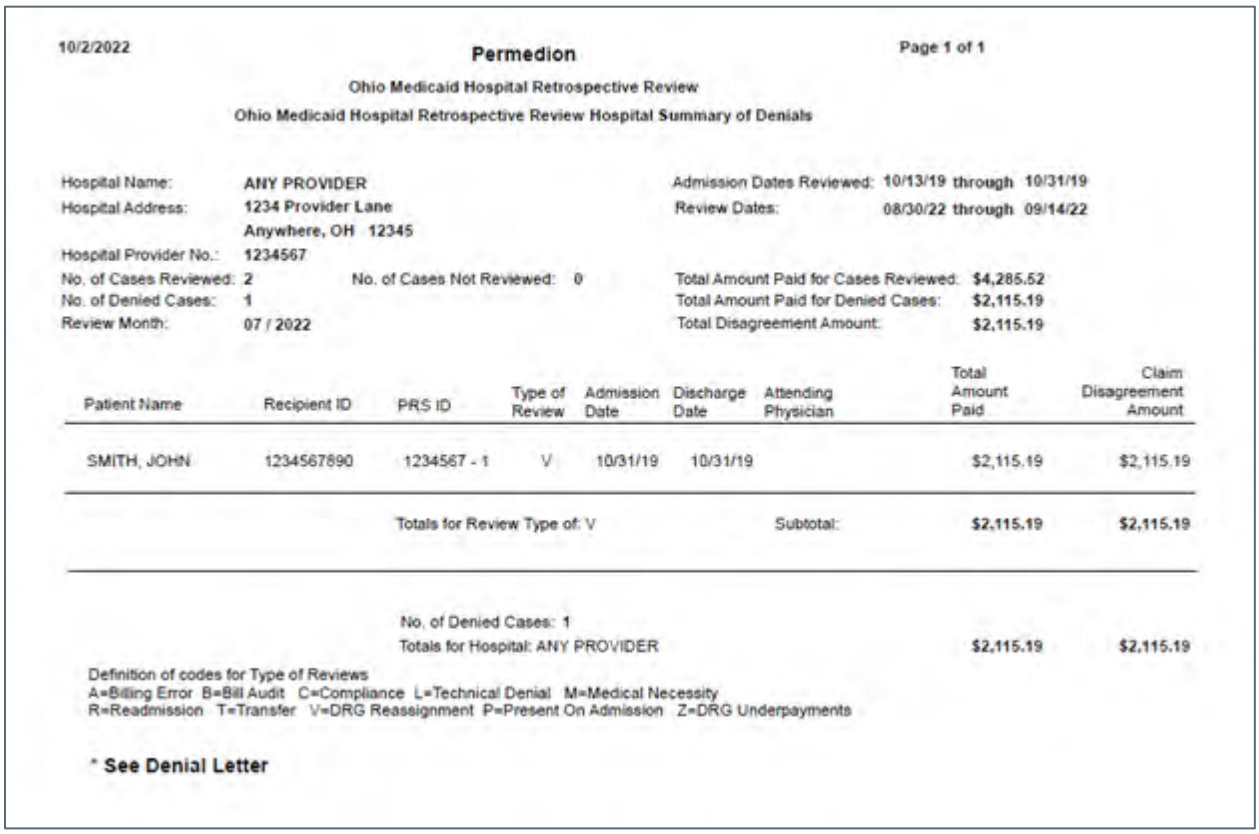
No. of Approved Cases for all hospitals: 5

Total: $26,248.35

Monthly Summary of Denials

This report lists the cases that were retrospectively reviewed where a finding was noted resulting in a denial. This summary report includes the hospital demographic information and case level detail of claims that were denied during the retrospective review process, along with category of denial (i.e., type of review) by case.

Figure 23. Example Monthly Summary of Details



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Ohio Medicaid Hospital Retrospective Review

Ohio Medicaid Hospital Retrospective Review Hospital Summary of Denials

Hospital Name: **ANY PROVIDER**
Hospital Address: **1234 Provider Lane**
Anywhere, OH 12345
Hospital Provider No.: **1234567**
No. of Cases Reviewed: **2** No. of Cases Not Reviewed: **0**
No. of Denied Cases: **1**
Review Month: **07 / 2022**

Admission Dates Reviewed: **10/13/19 through 10/31/19**
Review Dates: **08/30/22 through 09/14/22**
Total Amount Paid for Cases Reviewed: **$4,285.52**
Total Amount Paid for Denied Cases: **$2,115.19**
Total Disagreement Amount: **$2,115.19**

Patient Name	Recipient ID	PRS ID	Type of Review	Admission Date	Discharge Date	Attending Physician	Total Amount Paid	Claim Disagreement Amount
SMITH, JOHN	1234567890	1234567 - 1	V	10/31/19	10/31/19		$2,115.19	$2,115.19
		Totals for Review Type of: V				Subtotal:	**$2,115.19**	**$2,115.19**
		No. of Denied Cases: 1						
		Totals for Hospital: ANY PROVIDER					**$2,115.19**	**$2,115.19**

Definition of codes for Type of Reviews
A=Billing Error B=Bill Audit C=Compliance L=Technical Denial M=Medical Necessity
R=Readmission T=Transfer V=DRG Reassignment P=Present On Admission Z=DRG Underpayments

*** See Denial Letter**

Denial Letter

For each claim that is denied (i.e., a finding determined in the retrospective review process), a detailed denial letter is created for the provider which includes the following information:

- Enrollee demographics
- Principal reason for the denial
- Synopsis of record review
- Enrollee's clinical information including presentation on admission, comorbidities, and evaluation and treatment
- Disagreement date ranges (dates of service)
- Disagreement amount in dollars (recoupment amount)
- Appeal instructions
- Relevant OAC regulations citations
- Rebilling instructions

Figure 24. Example Denial Letter

Ohio Medicaid **Utilization Review Program**

permedion
A Gainwell Technologies Company

Date: **10/2/2022**

To: **Provider Contact, RN, Director Utilization Review**
ANY PROVIDER

From: **Anthony J. Beisler, MD, MBA, FACS, CHCQM**
Medical Director
Permedion Inc.

Re: **MEDICAL NECESSITY DENIAL**

PATIENT NAME:		RECIPIENT ID:	
PATIENT DOB:		MED. RECORD NO.:	
PERMEDION ID:		HOSPITAL NAME:	
PATIENT STATUS:	01	HOSPITAL PROVIDER NO.:	
ADMISSION DATE:	2/3/2021	ATTENDING PHYSICIAN:	
ADMISSION SOURCE:	2	PHYSICIAN PROVIDER NO.:	
ADMISSION TYPE:	3	TCN:	
LOS:	1	DRG:	2542
DISCHARGE DATE:	2/4/2021	DATE PAID:	2/25/2021
TYPE OF REVIEW:	MEDICAL NECESSITY	TOTAL AMOUNT PAID:	$11,523.66
REVIEW MONTH:	07/22	ADJ TCN:	

Permedion has been selected by the plan administrator, Ohio Department of Medicaid (ODM), to review the necessity and appropriateness of health care services. The information in this letter is CONFIDENTIAL and contains Protected Health Information that may only be redisclosed in accordance with the 45 CFR Parts 160, 162, and 164 (Standards for Privacy of Individually Identifiable Health Information).

The following case has been reviewed by a peer-matched, Ohio physician and the following decision has been rendered:

Figure 25. Example Denial Letter (page 2)

REVIEW SUMMARY:

DISAGREEMENT DATE RANGES: **DISAGREEMENT AMOUNT: $11,523.66**
2/3/2021 - 2/4/2021

TOTAL DAYS: 1

PRESENTATION ON ADMISSION
This 37 year old female presented as a direct admit for iron infusion and esophageal dilatation. Vital signs were T 37.2, BP 148/89, P85, and R 18, with a pulse oximetry of 98% on room air.

COMORBIDITIES/COEXISTING MEDICAL CONDITIONS
IV drug use abuse, recessive dystrophic epidermolysis bullosa

EVALUATION/TREATMENT PERIOD
Physical examination revealed all within normal limits. Pre-medicated with Benadryl and Tylenol for IV iron infusion. Patient underwent pg. 6 – 7 of operative, esophageal balloon dilation and esophagogastroduodenoscopy that revealed mild luminal narrowing was noted. The patient's vital signs remained hemodynamically stable. The patient was discharged to home with instructions for outpatient follow-up.

ADMISSION DENIAL
Review of the medical record does not justify medical necessity for an inpatient admission to an acute care hospital. An outpatient or observation setting would have been appropriate for the evaluation and/or treatment of this patient.

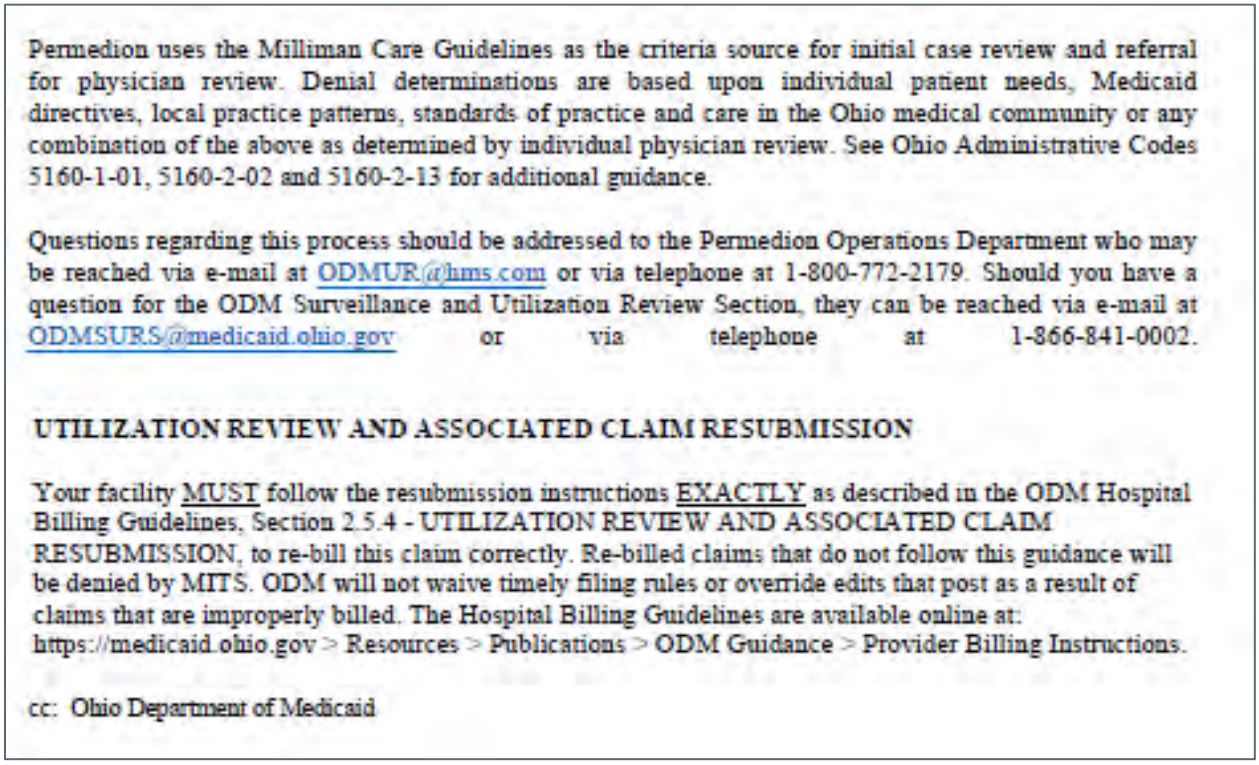
You may request an appeal of this decision in accordance with the Ohio Administrative Code 5160-2-12 by providing additional medical information in writing to Permedion Service Line Manager, postmarked within 60 days of this notification. Please identify the attending physician for this admission. **Electronic submission is preferred.** Submitting for reconsideration options:

- **Submit through DOTS provider portal. To obtain electronic submission access please contact DOTSQuestions@hms.com**
- **HMS**
  Attn: Ohio Medicaid Appeals
  5615 High Point Drive
  Irving, TX 75038
- **HMS-Permedion Secure Appeals Fax Line**
  1-866-206-6861

Upon receipt of this information and request for appeal, a second physician review will be conducted to evaluate the medical record and any submitted information. At the conclusion of the second level review, results will be mailed to your facility.

- 2 - (CONTINUED)

Figure 26. Example Denial Letter (page 3)



Permedion uses the Milliman Care Guidelines as the criteria source for initial case review and referral for physician review. Denial determinations are based upon individual patient needs, Medicaid directives, local practice patterns, standards of practice and care in the Ohio medical community or any combination of the above as determined by individual physician review. See Ohio Administrative Codes 5160-1-01, 5160-2-02 and 5160-2-13 for additional guidance.

Questions regarding this process should be addressed to the Permedion Operations Department who may be reached via e-mail at ODMUR@hms.com or via telephone at 1-800-772-2179. Should you have a question for the ODM Surveillance and Utilization Review Section, they can be reached via e-mail at ODMSURS@medicaid.ohio.gov or via telephone at 1-866-841-0002.

UTILIZATION REVIEW AND ASSOCIATED CLAIM RESUBMISSION

Your facility MUST follow the resubmission instructions EXACTLY as described in the ODM Hospital Billing Guidelines, Section 2.5.4 - UTILIZATION REVIEW AND ASSOCIATED CLAIM RESUBMISSION, to re-bill this claim correctly. Re-billed claims that do not follow this guidance will be denied by MITS. ODM will not waive timely filing rules or override edits that post as a result of claims that are improperly billed. The Hospital Billing Guidelines are available online at: https://medicaid.ohio.gov > Resources > Publications > ODM Guidance > Provider Billing Instructions.

cc: Ohio Department of Medicaid

Our secure-access website enables us to post approval/denial reports and denial letters, thereby allowing immediate and 24/7 access to reports and letters for hospital providers and ODM personnel. In addition to accessing approval/denial letters and reports electronically through our Provider Portal, providers will also be able to track active review status, receive and submit documentation, communicate directly with our staff, and initiate post-decision processes such as appeals or peer-to-peer reviews.

The security features of our website allow documents to be viewed only by those who have a “need to know” status. Thus, designated ODM personnel can access reports and letters related to the retrospective review program, while designated hospital personnel will be able to view only the letters and reports associated with their hospital.

9. Refer quality of care findings to ODM

Permedion nurse reviewers perform quality of care reviews according to generally accepted standards of care for records that have been selected for review according to our selection and targeting methodology. The quality concerns and findings are documented in Permedion‘s utilization management review system. Quality of care (QOC) concern identified by a nurse reviewer is sent to an Ohio-licensed physician reviewer for confirmation.

In addition to specific areas of concern identified by ODM, Permedion nurse reviewers will perform retrospective quality of care reviews in accordance with the quality screens, which include the following:

- Adequacy of discharge planning, follow-up, and/or rehabilitation plans
- Medical stability of the patient at discharge
- Death
- Nosocomial infection (hospital-acquired infection)

- Unscheduled return to surgery
- Trauma suffered in the hospital
- Medication or treatment changes within 24 hours of discharge without adequate observation

Additional areas that we review for quality include appropriate assessment and/or action on laboratory test results or imaging study results; implementation of an established plan in a competent, timely fashion; and establishment of adequate justification for a procedure performed that carries patient risk. Readmissions and admissions after ambulatory or office-based surgical procedures are also part of the quality review process. The severity level will be determined by an Ohio-licensed peer-matched physician reviewer.

Once a QOC finding is documented and sent to the provider, ODM also receives a copy of the quality letter in its client folder on the Provider Portal. Both SURS and Hospital Policy staff have access to this folder to review QOC findings notifications sent to the providers monthly. Additionally, Permedion will provide QOC findings to ODM in a quarterly report. This report describes the results of the statistical analysis of the QOC findings.

10. Monitor and provide suggested updates to the program

Permedion is committed to providing feedback to ODM via email, conference call with stakeholders, or other mutually agreed upon methods to improve the process. In our 35+ years of service to Ohio, we have walked hand in hand with the Department through many new engagements ranging from the deployment of the MITS system, transition to ICD-10, movement to a new provider system, and the COVID pandemic. Additionally, Permedion monitors ODM’s website, subscribes to updates to the OAC, and receives regular updates from our government services group on announcements from the Ohio Governor.

We, more than other vendors, know the importance of communication throughout transition periods. Our interactions with the providers provide unique insight that might otherwise be overlooked. This valuable, hands-on vision will allow us to offer further assistance to the Department to aid ODM in its endeavor to contain costs and improve the quality of service offered to its membership.

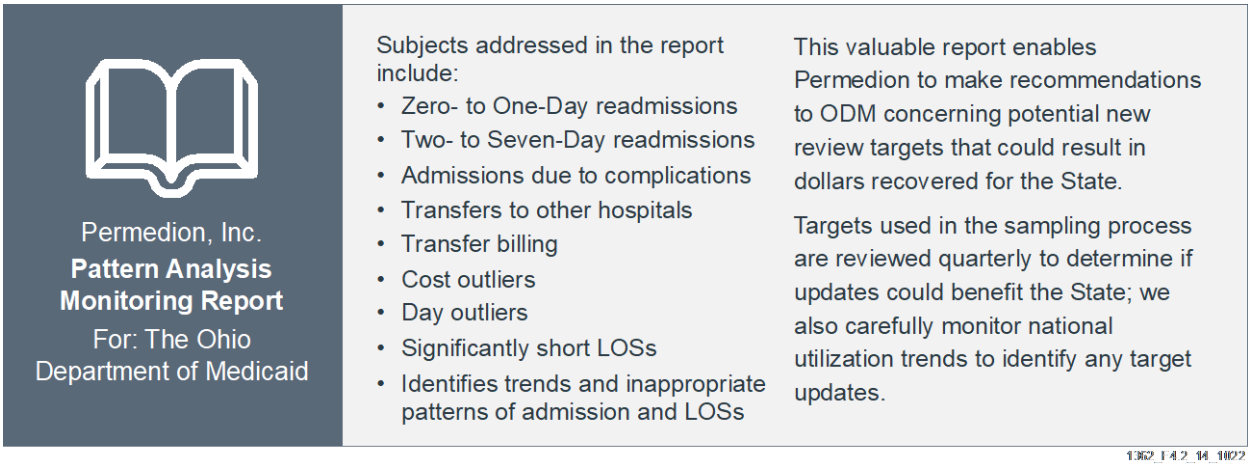
Providing value to ODM is an ongoing goal at Permedion. As we look forward, many of the opportunities that we see for upgrades are shaped by the dynamic environment of current healthcare reform legislation. Throughout our proposal, we have discussed innovations and improvements to current processes. Additional suggested and potential updates include the following:

- Increased functionality and ease of use of our provider portal for ODM and the provider community
- More detailed reporting of explanations for overpayments
- Additional focus on potentially preventable readmissions
- Enhanced review of outpatient and alternative settings and providers
- A collaborative approach to enhanced prior authorization
- Emphasis on post-adjudication, pre-payment options
- Review for excluded/ineligible providers
- Enhanced review of pharmaceuticals

- Focus on the initiatives in the Governor's Office for Health Transformation
- Enhanced use of technology

Permedion continually monitors the effectiveness of the retrospective review program by providing useful analytics and trends through dynamic reports. Our annual Pattern Analysis Monitoring Report examines eight indicators that are outlined in the following figure.

Figure 27. Pattern Analysis Monitoring Report



11. Support quality of care studies and the pre-certification program plan

Permedion has experience in supporting quality of care studies and the pre-certification program plan. Permedion understands the alignment between high-quality care and utilization management. Vital components of an effective UM/PA program include quality of care research studies and a precertification program. The retrospective review program supports and informs the quality-of-care studies program. Potential problem areas may be identified in retrospective review that can form the basis for a quality-of-care study.

Conversely, quality of care studies can identify a potential problem area that can be further investigated with retrospective chart review. These types of studies validate the existence of a potential opportunity. Once an opportunity has been confirmed and defined, steps can be taken to rectify it. Abstraction of data for both the quality-of-care studies and the retrospective chart reviews are performed by the same panel of experienced nurse reviewers. This is a valuable link between these two initiatives. The developers for our study- who design data collection tools- are the same individuals who developed our customized software application for retrospective review. This, again, is an advantage for our employees who abstract and interpret data. The use of similar software applications makes it easier for abstractors to perform their job, and it helps to decrease errors.

Our retrospective review program also supports the precertification plan. A comprehensive UM/PA program will incorporate both programs because they work especially well when implemented together. A current target for our retrospective review program is a precertification target; we select claims that contain a procedure on the required precertification list that does not have a precertification number on the claim and review them for compliance. This reinforces the benefit of precertification and the sentinel effect that occurs because a procedure is on a "precertification list."

Another example is psychiatric admissions that are approved based on retrospective eligibility. When a patient is not eligible for Medicaid at the time of admission the provider can submit the request on a retrospective basis and provide supporting information of eligibility. Since this review does not include a medical necessity review, these psychiatric admissions are targeted in our retrospective precertification target so that medical necessity can be determined.

Our comprehensive utilization review program, including precertification, retrospective record review, and quality of care studies, supports ODM's goals and initiatives. Identification of quality issues through incidental retrospective or precertification reviews can, in turn, lead to quality studies and/or new retrospective or precertification targets based on those incidental findings.

As an additional service, Permedion can supplement our standard retrospective claim reviews with more comprehensive "Focused and Quality Studies." These types of studies typically address a specific policy, quality, or expenditure concern identified by ODM. Often, the objective of these studies is to identify areas of improvement in the delivery of medical services to Medicaid members.

Permedion has conducted hundreds of Focused and Quality Studies for state Medicaid programs across a broad range of healthcare settings, using a variety of methodologies and processes. The studies discover patterns of inappropriate utilization of health services and standards of care, quality and access to care issues, non-compliance with Medicaid policies and rules, and claims billing and payment issues. Past studies have addressed:

- High utilization of targeted services (imaging, diagnostic, and surgeries),
- Potentially preventable hospital readmissions
- Emergency Room utilization
- Possibly Preventable Death—investigation of questionable occurrences that end in death or fatality
- In-depth Bill Audits for DRG-exempt hospitals and claims with high-cost outlier payments
- Inappropriate billing of dental surgery procedures for possible excessive operating room charges
- Compliance with Primary Care Clinician notification policy following hospital discharge
- Addiction and Recovery Treatment Services (ARTS) Dashboards
- Providers with Multiple Recipients in Same Households
- Community Mental Health Services Surrounding and Inpatient Psychiatric Admission

Upon completion of the study, Permedion produces a detailed final report that describes the background and objectives of the study, our approach (including definition of study population, study indicators/measures, methodologies applied, references and resources used), findings/outcomes, and recommendations to the state. Specific recommendations supported by study findings include:

- Changes/improvements to healthcare policies, rules, and regulations
- Changes/improvements to member care delivery methods and systems
- Development/enhancement of quality improvement programs and strategies
- Provider education opportunities

Focused and Quality Studies are more comprehensive in design structure and approach than our standard retrospective claim reviews, and thus are more resource intensive often requiring

in-depth research and data analysis, additional data and documentation collection, significant physician and clinical staff involvement, and extensive reporting. Upon contract award, we will present these types of studies and determine if and how they may fit into the scope of the contract.

Additional information on our proposed Focused Reviews and Health Care Studies is contained in Sections F4. 4.2.D and F14 4.2.N of our proposal.

F.3 4.2.C Special Reviews

RFP Reference: Section 4.2.C

> The selected Offeror shall be responsible for performing special reviews. The selected Offeror shall assist with reimbursement for noncovered items and services which may be available contingent upon an approved prior authorization. Prior authorization must be obtained from ODM, or its designee, by the provider before services are rendered or the items are delivered.

As requested by ODM, Permedion will perform special reviews for noncovered items and services contingent on an approved prior authorization. We understand the provider must obtain prior authorization before the services are rendered or the items are delivered.

Approach to Special Reviews

Permedion will conduct special reviews in accordance with the OAC rules 5160-2-03 outlining the conditions and limitations applicable to inpatient and outpatient hospital services and 5160-1-31 which outlines the rules of prior authorization. Permedion understands that reimbursement for some items and/or services listed as noncovered under the Ohio Medicaid program requires prior authorization. We will conduct the special review to confirm both medical necessity and appropriate setting for the requested service.

Requests must be submitted through the Provider Network Module (PNM) and it must include correct HCPCS, CPT code, and/or ICD-10 codes for the specific date of service. The request is completed by the review nurse within 10 days of receipt. If the request is identified as an urgent request, it will be processed within 48 hours of a request with sufficient information to make a determination.

If the initial request does not contain sufficient information to authorize the service, the request will be pended back to the provider for additional information. When sufficient information is received, the request is reviewed by the nurse reviewer. MCG will be utilized if a criteria set is identified specific for the request. If there is no specific criteria in MCG, our reviewers will apply OAC 5160-01-1, ODM’s medical necessity criteria. This will make certain that the request meets generally accepted standards of medical practice, is clinically appropriate in its type, frequency, extent, duration and delivery setting, it is appropriate to the health condition, it is the lowest cost alternative, it provides unique, essential and appropriate information if used for diagnostic purposes, and it is not provided primarily for the economic benefit of the provider, or for the sole convenience of the provider or others that care for the recipient.

Because Special Requests are typically not covered by Medicaid, these requests will be reviewed by an Ohio-licensed physician who will apply clinical judgment, their expertise in the area of their specialty, standards of care within Ohio, and findings from the evidence-based, peer reviewed medical literature.

When appropriate, Permedion's medical director may reach out to ODM for further collaboration on the medical necessity of the request.

Notable Special Request

This past year a request was received that is not typically covered by Medicaid. Permedion and ODM staff worked together to resolve both medical necessity aspects of the request and the technical issues of prior authorizing the request after a determination was made. The request was from a specialty clinic requesting out-of-state residential treatment for two young people diagnosed with Prader-Willi Syndrome. This is a rare genetic disorder affecting a child's metabolism causing changes in appearance and behavior.

Permedion's experience with clinical reviews including but not limited to, institutional, non-Institutional, and behavioral health along with our comprehensive panel of Ohio-licensed physicians and ability to quickly recruit a rare specialist if needs, ensures that we can meet the requirements to support requests for Special Reviews.

F.4 4.2.D Focused Reviews

RFP Reference: Section 4.2.D

> The selected Offeror will conduct focused reviews on an as-needed basis for specific provider's claims as determined by ODM. Focused reviews allow ODM the opportunity to take a closer look at issues that may arise out of the retrospective review program, quality of health care studies, or issues that come to the attention of ODM through any number of sources (e.g. consumer complaint, legislative inquiry, ODM Surveillance and Utilization Review Section (SURS), or other program integrity initiatives). Focused reviews may identify service and procedure targets for pre-certification review.
>
> As an example of a focused review, the selected Offeror would analyze the claims data of selected providers that rebill a large number of claims with codes that have been upgraded, to determine if a problem exists with that provider. A "bill audit" may be performed to compare a provider's medical records to the services and charges submitted on their claims.
>
> The methodology used for focused reviews must fulfill the agency's Medicaid utilization management objectives and permit focused reviews of either a physician or an institution. The selected Offeror will be required to participate in designing focused review projects through data analysis, targeting, sampling and reporting. The size and scope of the focused reviews will vary depending on the nature of the issue necessitating the review.

Permedion will complete focused reviews on an as-needed basis for specific provider's claims as determined by ODM. These focused reviews provide ODM the opportunity to take a closer look at issues that may arise out of the reviews performed or issues that come to the attention of ODM through any number of sources, such as other Departments, as consumer complaint, legislative inquiry, other program integrity initiatives.

Permedion has conducted focused reviews in Medicaid and Medicare environments since 1974. The Permedion team brings:

- Excellent working relationships with Ohio providers that facilitate acceptance and cooperation with special review activities
- Clinical analysts who are very responsive to requests for investigation of potential topics and can provide quick responses to initial inquiries
- Trained nurse reviewers, physician reviewers, and data analysts to look for and report any aberrant patterns in service delivery or billing processes

- Experience performing bill audits for Ohio providers including influencing providers to implement corrective actions for inappropriate unbundling of charges and billing for charges not substantiated in the medical record

The following are examples of focused reviews conducted by Permedion for ODM during the current contract period:

- We received a referral to perform a focused review to assess the quality of care for a patient with multiple hospital readmissions. The results of the focused review determined that there was a Severity Level 3 (actual harm to patient) quality of care issue with the patient's care due to serious safety concerns, and failure to recognize and investigate probable neglect.
- In response to a referral submitted to us from another State Agency, Permedion conducted a focused review of an Ohio Medicaid recipient in an institutional setting that had an acute incident and subsequently died. The assessment found that while the outcome of this patient's course was unfortunate, the care received was within the expected standards of care, and no deviations nor quality concerns were identified.

When a focused review includes a clinical review of medical record(s), a member of our client services team prepares a medical record request. Our Project Manager, Merrily Sable, RN oversees the process and works with our Medical Director, Anthony Beisler, MD to make sure that an appropriate peer-matched board-certified Ohio physician familiar with Ohio practice standards is assigned to perform the review of case(s) according to federal and state guidelines.

When a closer look at billing practices is needed, Permedion has extensive experience analyzing claims data and performing bill audits. We routinely perform bill audits of Medicaid claims, comparing the medical records to the services and charges billed. To further support ODM, Permedion has analytical capabilities and expertise in statistical process control (SPC) and can use a proactive approach using claims pattern analysis to identify areas where a focused review would provide ODM with information regarding a possible problem with a provider or physician. The use of reliable and valid measurable indicators/processes forms a solid basis for ODM's quality improvement processes. As part of the focused review process, we will execute queries that have a concentrated focus on both the general Medicaid population as well as specific sub-sets. For example, we can provide reporting that details utilization of a specific service by member, region, provider, or other additional measures selected.

The experience of our biostatistician, Caroline Black, and data analyst resources are described in proposal Section B.3.3. Staff Experience and Capabilities.

Permedion will continue to work closely with ODM staff to identify the need for and the performance of focused reviews as we have done throughout the current and previous contracts with ODM.

F.5 4.2.E Community Behavioral Health Service Reviews

RFP Reference: Section 4.2.E

The selected Offeror shall be responsible for performing Community Behavioral Health Service Reviews. Reimbursement for some behavioral health services covered under the Medicaid program is available only upon obtaining prior authorization; prior authorization must be obtained from ODM, or its designee, by the provider before services are rendered.

All reviews must be conducted in accordance with OAC Chapter 5160-27 and OAC rule 5160-8-05 as applicable. All reviews must include the use of Ohio-based physicians and medical staff to ensure practice patterns within Ohio are taken within consideration, where appropriate. The selected Offeror must perform the following tasks:

1. Develop the methodology and criteria used to determine the appropriateness of the behavioral health service. Criteria must align with the aforementioned OAC rules.
2. Conduct retrospective reviews of an agreed upon number of claims, if requested by ODM.
3. Conduct provider education as needed.
4. Provide activity and other types of reports as requested by ODM.
5. Participate, with ODM, in an agreed upon appeal process and participate in appeal hearings, as required.

The selected Offeror may be required, on a case-by-case basis, to review a prior authorization request for a behavioral health service not currently covered by Ohio Medicaid. The number of these types of reviews is expected to be low.

The selected Offeror will be required to support and respond to provider PA requests:

1. For Assertive Community Treatment (ACT), substance use disorder residential, and substance use disorder partial hospitalization services, the selected Offeror will respond by either approving or denying a PA within 48 hours of receiving a provider's request.
2. For all other PA requests, the selected Offeror will respond by either approving or denying a PA within 72 hours of the provider's request.

Permedion clinical reviewers are experienced in prior authorization of Community Behavioral Health Service Reviews including Assertive Community Treatment (ACT), Behavioral Health Outpatient, Intensive Home-Based Treatment (IHBT), Partial Hospitalization for Substance Abuse and Residential Services for Substance Abuse. Reviewers are knowledgeable at applying prior authorization requirements and service limitations as some Community Behavioral Health Reviews are only reimbursed after obtaining Prior Authorization. In addition to Ohio, Permedion conducts prior authorization of community behavioral health services in five other states.

Review Support

1. Methodology and Criteria

Prior authorizations reviews are conducted in accordance with OAC Chapter 5160-27 which regulates eligible providers, coverage and limitation of services, reimbursement, specific requirements for ACT, therapeutic behavior group services, substance abuse services, and MRSS as well as OAC rule 5160-8-05 which identifies what mental health professionals can deliver treatment.

Clinical reviewers have access to Ohio licensed physicians and medical staff to ensure practice patterns within Ohio are taken within consideration, where appropriate. The review process includes the steps described in the upcoming figure.

If the prior authorization request is incomplete and additional information is needed, the review is pended for additional documentation and returned to the provider via the PNM portal. If the provider does not respond within 30 days, the request will be denied by the prior authorization system.

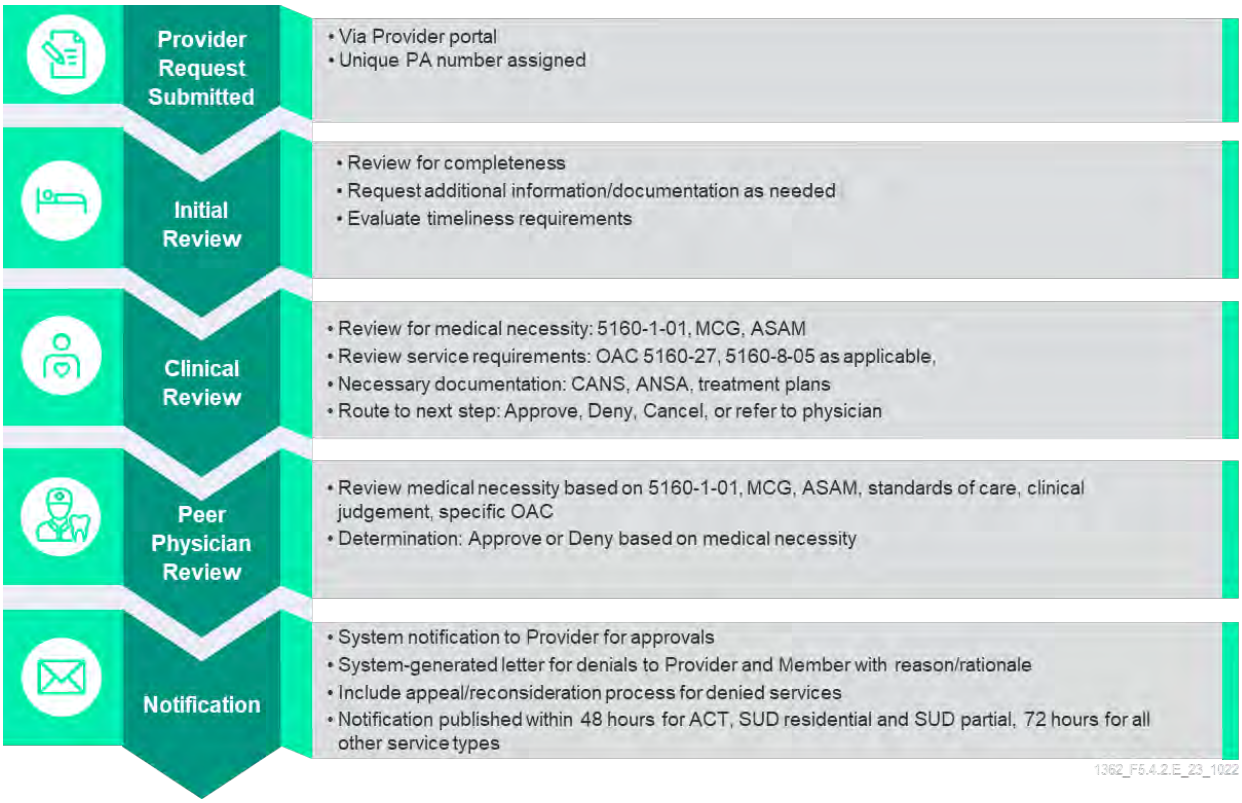
The nurse reviewer will review every line item and come to one of the following conclusions:

- **Cancel.** In certain instances, a request may be cancelled if, for example, more than one hospital inpatient prior authorization request is submitted for the same dates of services, or a request for prior authorization is not required based on the mandated procedure codes and fee schedules. The review nurse communicates with the provider to make sure they understand the next steps for submitting a revised request.
- **Approve**. After review, if all requirements are met, the reviewer will approve the request. Each service requested (CPT/HCPCS or procedure code) within the PA is addressed at the line level.
- **Refer**. However, if the reviewer cannot affirm that the service or procedure requested meets medical necessity, the request is referred to an Ohio-licensed physician along with supporting documentation.

The psychiatrist makes a determination based on medical necessity rules as well as considers practice patterns within Ohio, and then the psychiatrist will approve or deny as follows:

- **Approve**. After review, if all requirements are met, the physician will approve, at the line level, the service(s) or procedure(s) requested.
- **Deny**. If the requested service(s) does not meet medical necessity, the physician denies the request and documents the reasons/rationale that medical necessity was not met. This denial may be for a specific HCPCS/Procedure line within a request or the entire request, depending on the documentation submitted.

Figure 28. Prior Authorization for Community Based Behavioral Health Service Reviews



Permedion currently has clinical reviewers experienced in behavioral health who apply well developed policies, procedures, processes and tools in place to ensure Community Based Behavioral Health services are reviewed in accordance with OAC 5160-8-05 and 5160-27 1-13.

When a request for Community Based Service is submitted, the reviewer makes sure the request is complete by evaluating the HCPCs codes and information submitted utilized to ensure rules applied for medical necessity 5160-1-01, and specific rules related to the HCPCs have been submitted. If additional information is needed, the reviewer pends the request back for additional information. Reviewers use cases with insufficient information as opportunities to educate providers. When a complete request is submitted, the reviewer continues the review process, applying the specific rules.

Example: Processing a Request for Residential Substance Abuse

The following steps provide an example of how we process a request a Residential Substance Abuse case.

- The reviewer receives a complete request and identifies that the HCPS code is for H2036 or H2034 and has been submitted to the correct assignment category (53).
- The reviewer makes sure that the diagnosis submitted in the clinical information is an approved diagnosis for substance use disorder (SUD) residential treatment.
- The reviewer then applies the rules according to 5160-1-09 to be sure that the prior authorization was submitted after the service limit of treatment for 30 calendar days, or for the third or subsequent stay in a calendar year and was received within 24 hours of the requested start date.

- After affirming rules are met, the reviewer proceeds to evaluate medical necessity based on ASAM criteria for the level of care requested. Medical necessity for Level 3 Residential Treatment is appropriate when:
  - Withdrawal management is moderate to high risk but manageable
  - Biomedical conditions do not exist, or are not sufficient to distract from treatment
  - Emotional, behavioral, or cognitive conditions are mild to moderate severity
  - Resistance high and impulse control low despite negative consequences
  - Despite active participation in a Level 1 or 2 program, unable to control use
  - Dangerous recovery environment
  - Willing to commit to treatment
- If the clinical reviewer cannot approve the request, the case is forwarded to a psychiatrist to evaluate based on medical necessity criteria, clinical experience and local practices.
- If the determination is to deny the request, the notification is sent with the reason/rationale for the denial, and appeal rights for providers and members as applicable.

Although each Community Behavioral Health service type has specific medical necessity, rules, and regulations that are applied, the process is as follows:

1. Receive the request
2. Perform an initial review to identify the completeness of the case
3. Perform the clinical review
4. Refer requests that cannot be approved to the psychiatrist for determination
5. Send a notification of determination with appeal rights if a denial was issued remains the same, verifying inter-rater reliability and timeliness of completion

2. Retrospective Reviews If Requested

In the event ODM requests retrospective review of Community Based Behavioral Health Services, Permedion has a retrospective review process currently in place that can be aligned with the specific review requirements to support the request. Permedion has experience with applying utilization criteria, along with billing, documentation, coding requirements, and identifying care that had quality concerns for the safety of the individual.

Permedion Expertise in Ohio

Permedion has successfully worked with ODM when prior authorization service requests or special behavioral health review requests need our expertise.

3. Provider Education

If a provider has questions about any of the Community Based Behavioral Health services and needs additional guidance, Permedion’s experienced team are just an email or phone call away. Currently, providers contact the clinical team via phone, fax or email if a question arises. Because errors in prior authorizations by the provider are opportunities for education, Permedion has a “library” of educational materials that can be sent to the provider. For example, and as depicted in the following figure, ODM PowerPoint training on how to enter a new Prior Authorization for ACT, IHBT and SUD is sent out to providers struggling with their request entry.

Figure 29. Provider Education: Entering Prior Authorization Request

4. Activity Reports

Each month, Permedion provides ODM providers an activity report that details services prior authorized, including Community Based Behavioral Health Services, identifying how many requests were reviewed, and the outcomes (approved, denied or cancelled). Permedion has worked with ODM over the years, developing reports that meet ODMs needs to monitor the services provided and address any changes needed. Additional details regarding activity reports are described in proposal Section F.13, Reporting and Analysis.

5. Participate in Appeals

Under OAC 5101:6 Hearings, a recipient of a denied service has the right to a state hearing. The instructions regarding the process to request a state hearing are incorporated into the original Denial Letter.

Permedion currently has a process in place for preparing for and participating in appeal hearings on behalf of ODM. This includes making sure that case summaries are completed and distributed to the hearing officers and members prior to the hearing, and identified trained personnel attend the hearings to provide testimony regarding the rationale of the decision.

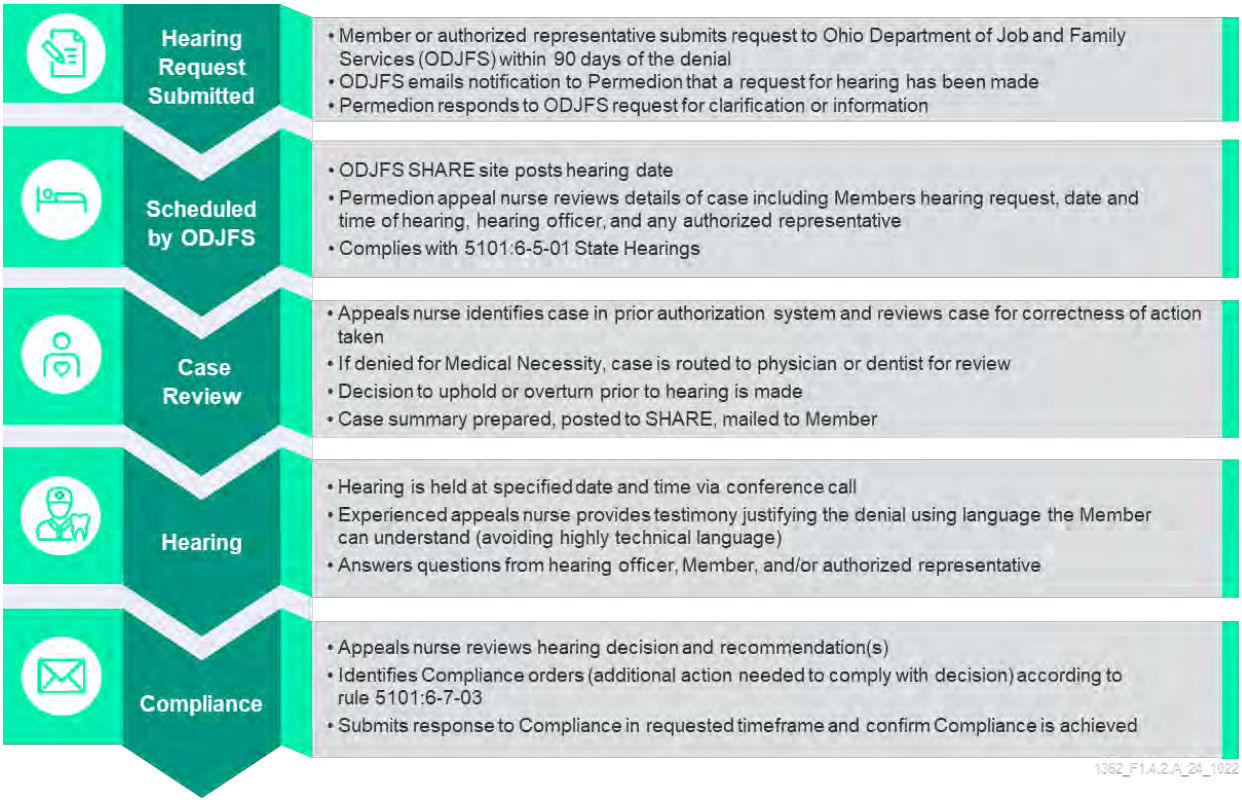
Permedion has been representing ODM in hearings related to fee-for service denials, and is experienced composing an appeal summary as well as providing testimony to uphold determinations that do not meet medical necessity or other rules required to be met in order to receive services.

When an adverse decision is made, under OAC 5101:6 “Hearings” a member of a denied service has the right to a state hearing. The Members are notified of their hearing rights, and the process on how to request a hearing in the adverse determination letter.

On average, Permedion prepares 15-20 appeal summaries and attends appeal hearings each month on behalf of ODM. This includes ensuring case summaries are completed and distributed to the hearing officers and members prior to the hearing, and identified trained personnel attend the hearings to provide testimony regarding the rationale of the decision.

The Ohio Department of Job and Family Services (ODJFS) is responsible for managing recipient hearing requests. Permedion is notified of a hearing request via email. We access ODJFS's State hearing Access to Records Electronically (SHARE) site which assists members guiding them through their appeal process as well as where appeal summaries and compliance actions are submitted. Permedion logs into SHARE for information on member demographics, the service being appealed, any authorized representatives and the hearing date and time.

Figure 30. Recipient Hearings Process



Prior to the hearing, an appeal nurse reviews the denied request. For medical necessity denials, peer matched physicians or dentists review the case to ensure the correct determination was made. If a Pre-Hearing determination approval is made, ODJFS and the member are notified in writing. If the adverse determination is upheld, Permedion prepares an appeal summary for the Hearing officer and member. The appeal summary includes:

- Prior Authorization number
- Appeal Number
- Hearing Officer
- Issue
- Medicaid Coverage
- Eligibility
- Reason for Denial
- Summary
- Exhibits: Information pertinent to the case

The appeal summary is posted to the SHARE site 3 business days prior to the hearing for the hearing officer's review. The summary is written in a way that is understandable for those not in the health care industry so that the reason for the denial is understood. A copy is sent to the member or authorized representative to the address located in SHARE. At the date and time of the hearing Permedion joins the conference call and presents the merits of the case and answers questions from both the Hearing officer, the member and any representative of the member attending and sworn in. After the hearing, the Hearing officer will issue a determination. Permedion reviews each determination for the outcome. At times, the hearing officer may order additional compliance, such as approving the request, or additional actions to reach out to the provider who submitted the request for additional information so that the request can be approved. Compliance is submitted on the SHARE site, as well as mailed to the member.

Special Behavioral Reviews

With Permedion's experience in partnering with ODM when new review types have been added over the past contract, we are well-qualified in interpreting regulations, and developing criteria guidance and processes. Since the beginning of the contract, Permedion has added SUD, ACT, IHBT, and MRSS, and we have had planning sessions regarding Applied Behavioral Analysis. Permedion has experience adding other behavioral health reviews and in assisting with unique ODM requests. Permedion has worked with ODM when prior authorization service requests or special behavioral health review requests need our expertise. ODM and Permedion recently reviewed a case with two young members who have Prader-Willi Syndrome, a rare genetic disorder with medical and behavioral health components, to determine if it met the requirements for an out-of-state residential specialty program. Discussions with multiple specialists helped ODM evaluate if the individuals had access to all services offered by Ohio, before authorizing a residential setting in Texas.

PA Requests

1. ACT Response Timeframe

Permedion currently processes prior authorization requests for Assertive Community Treatment (ACT), substance use disorder residential, and substance use disorder partial hospitalization services. The procedures currently in place ensure that prior authorization requests are completed within 48 hours of receiving a provider's complete request.

2. Timeline for Other Requests

For all other PA requests, Permedion will respond by either approving or denying a PA within 48 hours, but no later than 72 hours of the provider's request.

F.6 4.2.F Psychiatric Hospital Admission Reviews

RFP Reference: Section 4.2.F

The selected Offeror will be required to develop a plan for utilization management that emphasizes prospective reviews for prior authorization of services across all mental health and substance abuse settings.

The plan should include a mechanism to review services that can be performed for non-medically necessary purposes to determine that the procedure is medically necessary. The plan should also include a mechanism to determine the most appropriate location of care. The goal of the pre-certification program is to use prospective solutions to avoid inappropriate patterns of utilization and levels of care.

All reviews must be conducted in accordance with the OAC 5160:2-40, which describes the pre- certification review process for hospital services. The reviews must also meet applicable federal guidelines, and should reflect ODM's program integrity initiatives by ensuring appropriate utilization of hospital services. All reviews must include the use of Ohio-based physicians to ensure practice patterns within Ohio are taken into consideration, where determined appropriate ODM expects the selected Offeror to conduct continuous data analysis to monitor and update the pre-certification program.

To implement and manage the Pre-certification Review Program, the selected Offeror will be required to:

1. Develop the methodology and criteria that will be used to select psychiatric admissions.
2. Select the medical criteria used to determine appropriateness of the admission.
3. Train Medicaid providers, ODM staff, and the selected Offeror/subcontractor staff on the pre-certification review program.
4. Maintain a reporting mechanism that meets notification requirements described in OAC 5160-2-40.
5. Monitor and provide suggested updates to the program to ensure that appropriate admissions are reviewed.
6. Develop and implement procedures for all pre-certification review denials in accordance with OAC 5160-2-40, including documentation of all reasons for denials or subsequent reversals of determinations.
7. Develop a plan for and participate in hearings when pre-certification denials are appealed.

Permedion has partnered with ODM since 2013 completing psychiatric pre-certification reviews for authorization of services and have trained and experienced registered nurse reviewers and Ohio-licensed psychiatrics in place. Beyond our Ohio team, we can collaborate with colleagues providing similar reviews for three other Medicaid programs.

Permedion is well versed with Ohio Administrative Code (OAC) 5160-2-40 Psychiatric pre-certification review, which describes the pre-certification review requirements for inpatient psychiatric hospital services and OAC 5160-1-01 defining medical necessity.

Permedion URAC accredited policies and procedures for prior authorization makes sure that Permedion goes beyond regulatory compliance and represents a commitment to excellence in the review process, which includes the identification process for determining whether inpatient psychiatric admissions are medically necessary and are provided in the most appropriate and cost-effective setting.

The following paragraphs describe Permedion's Psychiatric Pre-certification Review Program.

1. Methodology

Permedion's methodology processes all inpatient psychiatric hospitalization pre-certification requests in accordance with OAC 5160-2-40. Providers who have Medicaid consumers that have been admitted with a primary diagnosis of mental illness, and not a medical or surgical

admission, are subject to pre-certification. The provider submits the request through the PNM portal within two business days of the admission.

In some instances, the provider may submit requests on a retrospective basis if one of the following conditions is met: a) the patient is not identified as a Medicaid Recipient, b) eligibility is pending at the time of admission, or c) application for Medicaid is made subsequent to admission. For retrospective review, the providers must submit information that supports one of the three conditions above for the retrospective review to be approved.

Pre-certification requests are responded to within three business days from receipt of a complete request. If the pre-certification request is incomplete and additional information is needed, the review is pended for additional documentation and returned to the provider via the PNM portal. If the provider does not respond within thirty days, the request would be denied by the prior authorization system.

Once a complete submission is received, the nurse reviews the symptoms of the illness such as safety risk, mental status, functioning, psychosocial factors as well as the plan of care and applies that information against national criteria set forth by Milliman Guidelines (MCG) to identify if medical necessity has met.

The nurse reviewer will review admission request and come to one of the following conclusions:

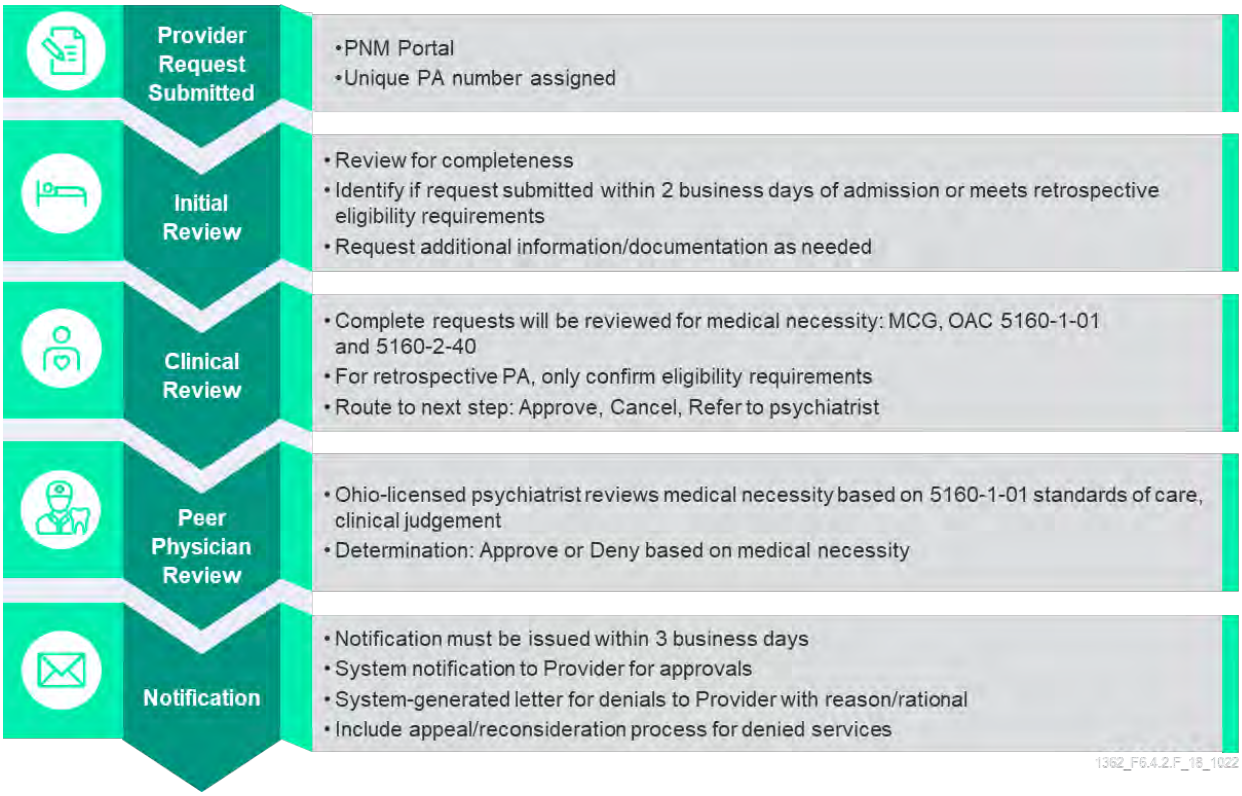
- **Cancel.** In certain instances, a request may be cancelled, for example in the event of a duplicate request. The review nurse corresponds with the provider to make sure they understand only one PA may be submitted for inpatient psychiatric admissions.
- **Approve.** After review, if medical necessity is met, the reviewer will approve the request
- **Refer.** However, if the reviewer cannot affirm that the psychiatric admission meets medical necessity, the request is referred to an Ohio-licensed psychiatrist along with supporting documentation.

Within three business days, our Ohio-licensed psychiatrist assigned makes a determination based on medical necessity rules as well as considers practice patterns within Ohio and either:

- **Approve.** After review, if all requirements are met, the physician will approve the admission
- **Deny.** If the request does not meet medical necessity, the physician denies the request and documents the reasons/rationale medical necessity was not met.

The following figure identifies the methodology of the review process and assures all components of prior authorization process are met:

Figure 31. Precertification for Psychiatric Hospital Admission Methodology



After a determination is made on the request, the provider is notified via the PNM portal. If an adverse determination is made, the letter provides rationale, and appeal rights to both the provider and the member.

2. Medical Criteria

When an individual is experiencing a mental health crisis and they may be a danger to themselves or others, it is imperative they get assistance quickly. ODM's rules for precertification makes sure that this happens. When an individual presents to the hospital with a diagnosis of mental illness, and is admitted to the psychiatric unit, pre-certifications must be requested by the provider. The provider can submit a request before the admission, but in the event of emergency admissions, they have up to two business days from the admission to submit the request. Requests must be assessed for medical necessity as defined by the Ohio Administrative Code 5160-1-01.

Medical necessity for a procedure, item, or service are met if all the following apply:

- It meets generally accepted standards of medical practice.
- It is clinically appropriate in its type, frequency, extent, duration, and delivery setting.
- It is appropriate to the adverse health condition for which it is provided and is expected to produce the desired outcome.
- It is the lowest cost alternative that effectively addresses and treats the medical problem.
- It provides unique, essential, and appropriate information if it is used for diagnostic purposes; and

- It is not provided primarily for the economic benefit of the provider nor for the sole convenience of the provider or anyone else other than the recipient.

To support consistent, accurate medical necessity assessments, Permedion uses MCG evidence-based care guidelines. Clinical reviewers have experience in behavioral health and are trained in applying nationally recognized MCG criteria to determine the appropriateness of admission.

MCG addresses both the severity of illness, and the intensity of the services, along with comorbid factors that would necessitate the individual to be treated at an inpatient level of care instead of an alternate level, such as observation or other outpatient services.

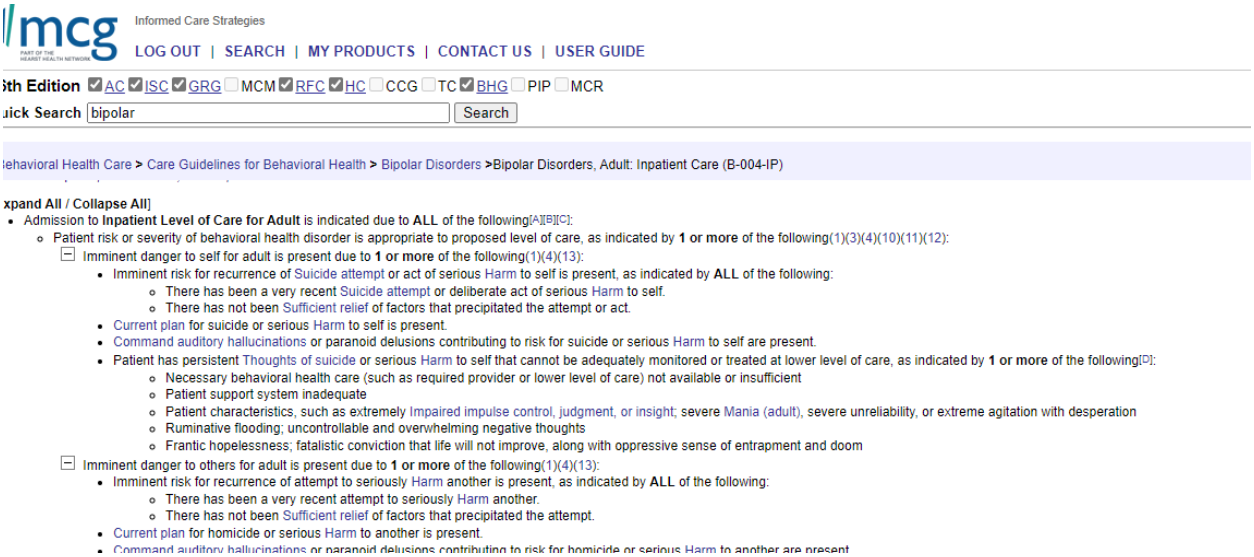
To meet medical necessity for inpatient care, individuals meet one of the following:

- An imminent danger to themselves or others, or their behavioral health disorder is too severe in symptoms, comorbidities or functioning to be treated at a lesser level of care
- Treatment can only be provided at the inpatient level to meet the patient needs
- Situation and expectations are appropriate for inpatient care

The following figure shows an example of MCG criteria for bipolar disorders in adults. Each highlighted field opens to additional categories of consideration, along with resource references and definitions. Reviewers with behavioral health experience, apply the guidance in MCG during the review process.

Figure 32. MCG Criteria for Bipolar Disorders in Adults

Figure 33. Detailed View of Bipolar Criteria



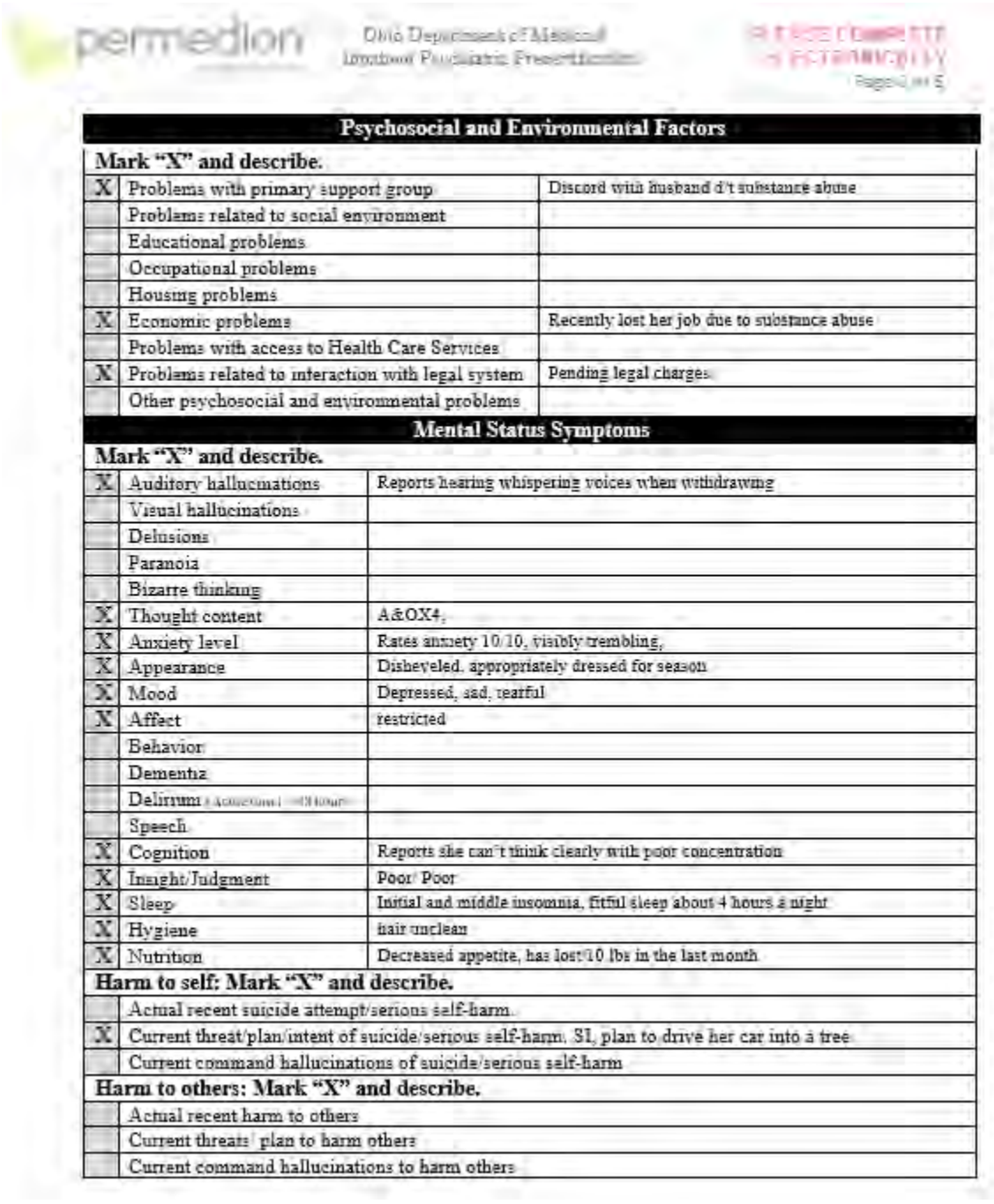
If a request cannot be approved by the reviewer, it is referred to a psychiatrist for a determination to approve or deny the case based on current, evidence-based clinical guidelines and local practices. The psychiatrist makes a determination to approve or deny the request. If the determination is to deny the request, the psychiatrist includes their rationale and reasons for the denial. The notification of the denial is issued with the reason for the denial, opportunity for a peer-to-peer if requested by the admitting physician, and appeal rights to both provider and member.

3. Train Medicaid Providers, ODM Staff, and Others

Because Permedion has been performing pre-certifications for inpatient psychiatric care since 2013, providers have been trained and are well informed in the process. Permedion continues to individually educate providers as questions arise, as well as through newsletters and provider meetings. ODM staff and Permedion, currently work together to improve the precertification program, as well as working through changes, such as supporting the implementation of the OhioRISE program in July 2022 by coordinating with the MCE to properly route provider requests.

During the review process, the reviewers take any errors or omissions in the submission as an opportunity for education and training. For example, our website has a tool providers can fill out and attach/include clinical information to make sure that an accurate request is submitted. The providers are referred to the website as well as emailed educational information. Below is an excerpt from the precertification form.

Figure 34. Training for Providers, ODM Staff: Precertification Form



Psychosocial and Environmental Factors		
Mark "X" and describe.		
X	Problems with primary support group	Discord with husband d/t substance abuse
	Problems related to social environment	
	Educational problems	
	Occupational problems	
	Housing problems	
X	Economic problems	Recently lost her job due to substance abuse
	Problems with access to Health Care Services	
X	Problems related to interaction with legal system	Pending legal charges
	Other psychosocial and environmental problems	

Mental Status Symptoms		
Mark "X" and describe.		
X	Auditory hallucinations	Reports hearing whispering voices when withdrawing
	Visual hallucinations	
	Delusions	
	Paranoia	
	Bizarre thinking	
X	Thought content	A&OX4,
X	Anxiety level	Rates anxiety 10/10, visibly trembling,
X	Appearance	Disheveled, appropriately dressed for season
X	Mood	Depressed, sad, tearful
X	Affect	restricted
	Behavior	
	Dementia	
	Delirium	
	Speech	
X	Cognition	Reports she can't think clearly with poor concentration
X	Insight/Judgment	Poor/ Poor
X	Sleep	Initial and middle insomnia, fitful sleep about 4 hours a night
X	Hygiene	hair unclean
X	Nutrition	Decreased appetite, has lost 10 lbs in the last month
Harm to self: Mark "X" and describe.		
	Actual recent suicide attempt/serious self-harm	
X	Current threat/plan/intent of suicide/serious self-harm. SI, plan to drive her car into a tree	
	Current command hallucinations of suicide/serious self-harm	
Harm to others: Mark "X" and describe.		
	Actual recent harm to others	
	Current threats / plan to harm others	
	Current command hallucinations to harm others	

4. Maintain a Reporting Mechanism

Permedion will continue to submit Prior Authorization reports to ODM detailing all of the review activity for the previous month, based on the accessible data. We understand that reporting requirements and mechanisms have changed for precertification activities performed within the MITS and will continue to work with ODM to make sure that all reporting needs continue to be met in the required timeframe(s). In addition, we will provide a detailed listing of each PA completed including:

- Prior Authorization Number
- Header Status (Approved, Denied, Cancelled)
- Assignment Category
- Invoice Grouping
- Clerk ID (Reviewer ID)
- Date Request was Received
- Date Review was Completed
- Patient Age Category (Adult, Ped)
- PA Line-Item Number
- Codes for Service Type
- Description of Service Type
- Line-Item Decision Status

Refer to section 4.2.M Reporting and Analysis in our proposal for a listing of Permedion-provided reporting.

5. Monitor and Provide Updates

Permedion monitors and provides updates to the program to make sure that appropriate admissions are reviewed. Each month Permedion reports total pre-certification requests received and a breakdown of approvals, denials, and cancelled requests. An example of our partnership with ODM is the new OhioRISE program. Individuals under 21 who have prior authorization requests for psychiatric admissions are now managed by OhioRISE with Aetna. Permedion, ODM and Aetna worked together to formulate a plan to notify providers of admissions requested for fee-for-service and communicating these with Aetna for a smooth hand off and the process is working smoothly.

6. Procedures for PA Review Denials

Permedion has a current process in place for provider reconsiderations and member appeals of denials of inpatient precertification requests. The process is in accordance 5160-2-40, and 5160-2-12 both providers and members are notified in writing of the reason for the denial, and appeal rights for both members and providers.

> (E) Decisions made by the medical review entity as described in this rule are appealable to the medical review entity and are subject to the reconsideration process described in rule 5160-2-12 of the Administrative Code.
>
> (F) Recipients have a right to a hearing in accordance with division 5101:6 of the Administrative Code. This hearing is separate and distinct from the provider's appeal, as described in paragraph (E) of this rule.

In the adverse determination letter, Providers are informed of their right to reconsideration within 60 days of the determination, as well as requesting additional rationale, and the opportunity to speak with a peer physician. The provider is informed in writing that requests must include a letter requesting reconsideration, a statement of why the provider believes the decision was in error, and any additional documentation supporting the provider’s position. The provider would submit their appeal request via a facsimile or the provider portal. Permedion reviews requests within 30 thirty business days of the requests and responds in writing to the provider.

7. Recipient Hearings

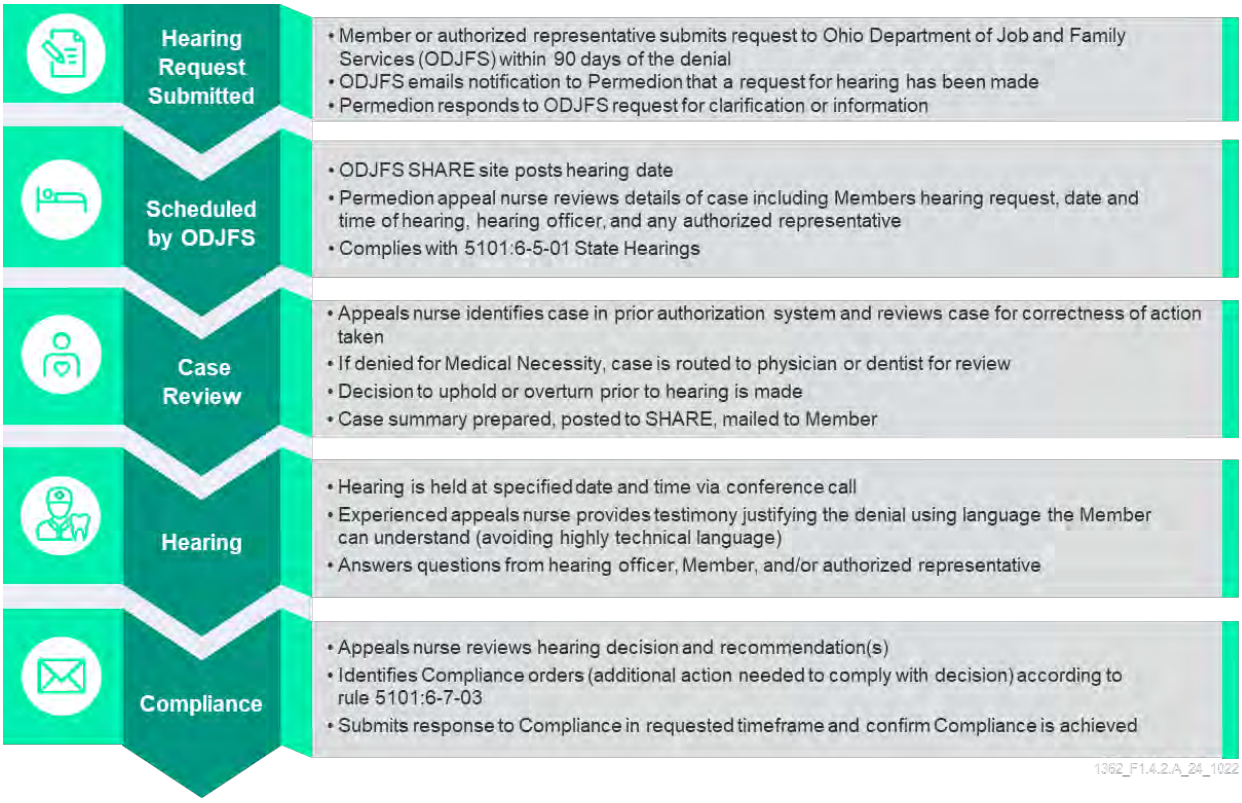
Permedion has been representing ODM in hearings related to fee-for service denials and is experienced composing an appeal summary as well as providing testimony to uphold determinations that do not meet medical necessity or other rules required to be met in order to receive services.

When an adverse decision is made, under OAC 5101:6 “Hearings” a member of a denied service has the right to a state hearing. The Members are notified of their hearing rights, and the process on how to request a hearing in the adverse determination letter.

On average, Permedion prepares 15-20 appeal summaries and attends appeal hearings each month on behalf of ODM. This includes ensuring case summaries are completed and distributed to the hearing officers and members prior to the hearing, and identified trained personnel attend the hearings to provide testimony regarding the rationale of the decision.

The Ohio Department of Job and Family Services (ODJFS) is responsible for managing recipient hearing requests. Permedion is notified of a hearing request via email. We access ODJFS’s State hearing Access to Records Electronically (SHARE) site which assists members guiding them through their appeal process as well as where appeal summaries and compliance actions are submitted. Permedion logs into SHARE for information on member demographics, the service being appealed, any authorized representatives and the hearing date and time.

Figure 35. Recipient Hearings



Prior to the hearing, an appeal nurse reviews the denied request. For medical necessity denials, peer matched physicians or dentists review the case to verify the correct determination was made. If a Pre-Hearing determination approval is made, ODJFS and the member are notified in

writing. If the adverse determination is upheld, Permedion prepares an appeal summary for the Hearing officer and member. The appeal summary includes:

- Prior Authorization number
- Appeal Number
- Hearing Officer
- Issue
- Medicaid Coverage
- Eligibility
- Reason for Denial
- Summary
- Exhibits: Information pertinent to the case

The appeal summary is posted to the SHARE site three business days prior to the hearing for the hearing officer's review. The summary is written in a way that is understandable for those not in the health care industry so that the reason for the denial is understood. A copy is sent to the member or authorized representative to the address located in SHARE. At the date and time of the hearing Permedion joins the conference call and presents the merits of the case and answers questions from both the Hearing officer, the member and any representative of the member attending and sworn in. After the hearing, the Hearing officer will issue a determination. Permedion reviews each determination for the outcome. At times, the hearing officer may order additional compliance, such as approving the request, or additional actions to reach out to the provider who submitted the request for additional information so that the request can be approved. Compliance is submitted on the SHARE site, as well as mailed to the member.

F.7 4.2.G Mobile Response and Stabilization Service (MRSS) Prior Authorizations

RFP Reference: Section 4.2.G

The selected Offeror must monitor practices to ensure consistent application of the ODM Service authorization criteria. The selected Offeror should ensure that an inter-rater reliability process is in place and should report the inter-rater reliability data to ODM upon request.

When issuing a denial of service, the selected Offeror must clearly state all the clinical rationale for the denial per approved clinical guidelines and standards of care and note whether a denial was reviewed by a nurse, physician, or other agreed upon practitioner type.

The selected Offeror must prior authorize some HCPCS code S9482 for the provision of stabilization services as a component of the mobile response and stabilization service in the fee-for-service system. The selected Offeror must do the following:

1. Develop the methodology and criteria used to determine the appropriateness of stabilization services rendered more than six weeks after the completion of mobile response. Criteria must align with OAC rules 5122-29-14, 5160-27-13, and 5160-1-01.
2. Conduct retrospective reviews of an agreed upon number of claims, if requested by ODM.
3. Conduct provider education as needed.
4. Provide activity reports, and other types of reports as requested by ODM.

Once the requirement of prior authorization is met, the appropriateness of stabilization services will be determined based on medical necessity.

Upon receipt of a prior authorization request, the prior authorization request must be reviewed and a decision rendered within 48 hours, including weekends. However, the decision may be pended if more information is needed and will restart when the additional information is received. This process applies to all prior authorization requests.

Selected Offeror shall comply with the following terms, or requirements, for this service;

1. Type of clinicians expected to perform the reviews will be determined by ODM during discussions with the selected Offeror.
2. All the selected Offeror's medical review policies should be available to ODM for review.
3. The selected Offeror must participate, with ODM, in an agreed upon appeal process and participate in appeal hearings as required.
4. The selected Offeror must meet with ODM staff regularly and upon request to discuss coverage policies and clinical needs.
5. The ODM clinical and policy teams will create a training that provides an overview of the current MRSS rule and any needed intricacies about interpretation. In addition, the clinical and policy teams will remain accessible to the selected Offeror for ongoing conversation and questions.

Permedion has policies in place that are designed to make certain consistent review practices and inter-rater reliability procedures are in place. Our reviewers follow an established set of review policies, and procedures as well, and apply specific rules related to the service type requested for review to make sure it meets the requirements for medical necessity, adheres to, and is compliant with the requirements set forth in the administrative code. In the event that an educational need is identified, the reviewer is provided with additional training and coaching. Permedion's quality review and inter-rater reliability is in place and available for ODM review upon request. In the following text, we detail our prior authorization process for some HCPCS code S9482 for the provision of stabilization services as a component of the mobile response and stabilization service in the fee-for-service system.

Requirements for Prior Authorization

1. Methodology and Criteria

Mobile Response and Stabilization Services (MRSS), HCPCS S9482, is a structured intervention and support program designed to address crisis situations with young people who are experiencing emotional symptoms, behaviors, or traumatic circumstances that have compromised or impacted their ability to function within their family, living situation, school, or community.

When reviewing MRSS, reviewers make sure that the following regulations are applied:

- 5160-27-13 Mobile response and stabilization service MRSS. Identifies coverage, limitations and reimbursement for MRSS services. It also identifies providers eligible to provide MRSS services, as well as the specific services required within MRSS that require prior authorization
- 5122-29-14 details the requirements and procedures for MRSS services. Includes the definition of when MRSS is used, for which population, and what team members make up the MRSS team
- OAC 5160-1-01 Medicaid medical necessity: definitions and principles. In addition to applying the above coverage limitations, the definition of medical necessity is applied.

- MCG, as applicable

2. Conduct Retrospective Reviews if requested

In the event ODM requests retrospective review of MRSS services, Permedion has retrospective review processes currently in place that can be aligned with MRSS requirements to support the request. Permedion has experience with applying utilization criteria, along with billing, documentation, coding requirements, and identifying care that had quality concerns for the safety of the individual.

3. Provider Education

In addition to the Provider Education outlined in the Provider Education section of the proposal, the clinical team is on hand to address specific provider questions related to prior authorization. Since Permedion processes over 3,000 prior authorization requests each month for ODM, this is the perfect opportunity for one-on-one provider education. When requests are submitted that are incorrect or incomplete, the requests are pended back to the provider with very specific information pertinent to the service type.

Educational information can range from:

- What additional clinical information is needed
- What services within MRSS may need prior authorization
- Procedure codes that do not need prior authorization until service limit is met
- Specific information needed to get a complete request submitted for consideration
- Direction or information to address any challenges in the PA submission process

If a provider has questions about any of the Community Based Behavioral Health services and needs additional guidance, Permedion’s experienced team are just an email or phone call away.

Because errors in prior authorizations by the provider are opportunities for education, Permedion has a “library” of educational materials that can be sent to the provider. For example, and as depicted in the following figure, ODM PowerPoint training on how to enter a new Prior Authorization for ACT, IHBT and SUD is sent out to providers struggling with their request entry.

Figure 36. Provider Education: Entering Prior Authorization Request

4. Activity Reports

Each month Permedion provides ODM with an activity report that outlines claim level details of services previously authorized, including MRSS, identifying how many requests were reviewed, and the outcomes (approved, denied or cancelled). Permedion has worked with ODM over the years in developing reports that facilitate ODM's monitoring of the services provided and address any changes needed.

Prior Authorization Review and Decision

MRSS is a structured intervention and support service provided by a mobile response and stabilization service team that is designed to promptly address a crisis situation for those under the age of 21. The services consist of three activities: screening/triage, mobile response, and stabilization.

Although prior authorization is not needed for screening/triage and mobile response, it is required if Stabilization Services are rendered more than six weeks from the initial mobile response. The prior authorization request is submitted through the Provider Portal and is evaluated by the clinical reviewer to make certain there is an individualized MRSS plan to achieve goals and assist the young person and their family to strengthen their capacity to prevent future crisis, facilitate an ongoing safe environment and to build resilience. The plan should include psychoeducation, referral for psychiatric consultation and medication management if indicated, advocacy and networking and coordination and linkage to services to support continued stabilization.

During the initial review, the submission is reviewed for completeness. At times, the request is pended back to the provider for additional information to be submitted before a determination can be made. Once sufficient information is submitted, Permedion will render the decision within

48 hours. Our clinical review staffing includes weekend and holiday coverage to ensure timeliness is met. If the reviewer cannot approve the medical necessity of the request, the request is forwarded to an Ohio-licensed psychiatrist for determination based on OAC rules, experience, and local practices.

After the clinical reviewer completes the review, if the request cannot be approved, it is forwarded to a peer physician for review. Only physicians make medical necessity denial determinations including, the rationale of which clinical guidelines or standards of care were not met. When a denial is issued, the notification includes the reason codes, rationale for the denial as well as appeal/reconsideration rights for the member and the provider.

1. Type of Clinicians

Currently, Permedion utilizes registered nurses or licensed social workers, trained, and experienced in the requirements for MRSS, to complete MRSS reviews. In the event the review team needs guidance or in the event of a request that doesn't meet medical necessity, Ohio-licensed psychiatrists are available for consultation and case review.

2. Medical Review Policies

Permedion's current policies and processes ensure that the clinical reviewers are applying the MRSS regulations cited above to the review and certify timeliness of completion. These policies and procedures are available to ODM on request. The upcoming figure shows the workflow process for MRSS Reviews.

If the prior authorization request is incomplete and additional information is needed, the review is pended for additional documentation and returned to the provider via the PNM portal. If the provider does not respond within thirty days, the request will be denied by the prior authorization system.

The nurse reviewer will review every line item and come to one of the following conclusions:

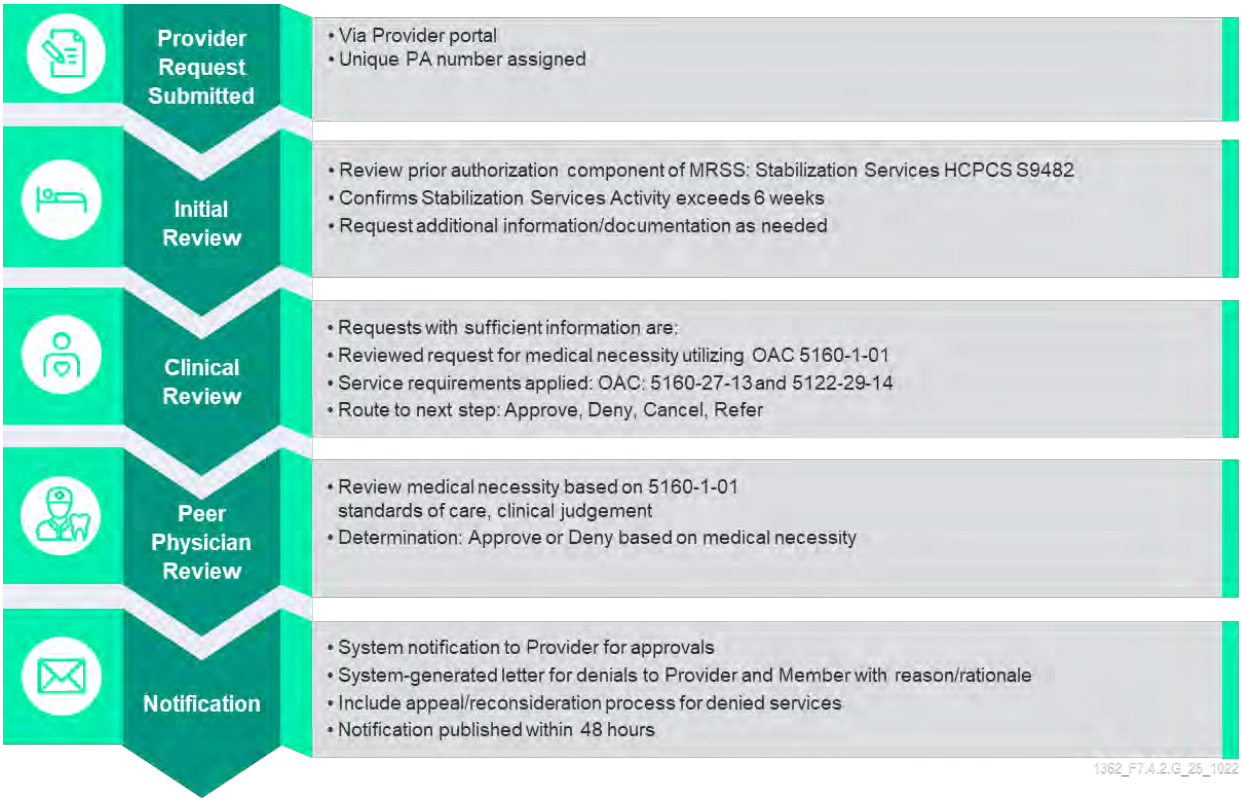
- **Cancel.** In certain instances, a request may be cancelled if, for example, more than one hospital inpatient prior authorization request is submitted for the same dates of services, or a request for prior authorization is not required based on the mandated procedure codes and fee schedules. The review nurse communicates with the provider to make sure they understand the next steps for submitting a revised request.
- **Approve**. After review, if all requirements are met, the reviewer will approve the request. Each service requested (CPT/HCPCS or procedure code) within the PA is addressed at the line level.
- **Refer.** However, if the reviewer cannot affirm that the service or procedure requested meets medical necessity, the request is referred to an Ohio-licensed physician along with supporting documentation.

The psychiatrist makes a determination based on medical necessity rules as well as considers practice patterns within Ohio, and the psychiatrist will approve or deny as follows:

- **Approve.** After review, if all requirements are met, the physician will approve, at the line level, the service(s) or procedure(s) requested.
- **Deny.** If the requested service(s) do not meet medical necessity, the physician denies the request and documents the reasons/rationale that medical necessity was not met. This

denial may be for a specific HCPCS/Procedure line within a request or the entire request, depending on the documentation submitted.

Figure 37. Prior Authorization for Mobile Response and Stabilization Service



3. Appeal Process

Member Appeals

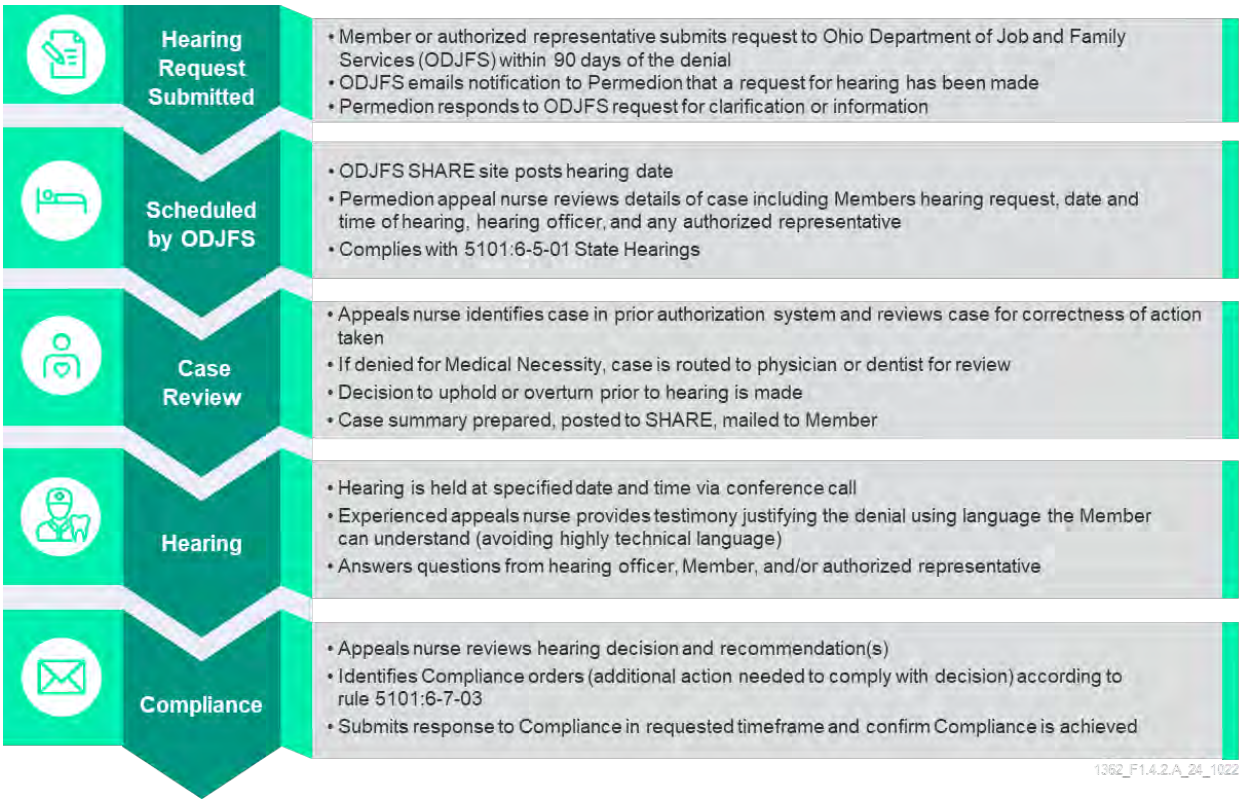
Permedion has been representing ODM in hearings related to fee-for-service denials for years and is experienced in composing an appeal summary as well as providing testimony to uphold determinations that do not meet medical necessity or other rules required to be met in order to receive services.

When an adverse decision is made, under OAC 5101:6 “Hearings”, a member of a denied service has the right to a state hearing. The Members are notified of their hearing rights, and the process on how to request a hearing in the adverse determination letter published via the FI.

The Ohio Department of Job and Family Services (ODJFS) is responsible for managing recipient hearing requests. Permedion is notified of a hearing request via email. We access ODJFS’ State Hearing Access to Records Electronically (SHARE) site which assists members, guiding them through their appeal process as well as where appeal summaries and compliance actions are submitted. Permedion logs into SHARE for information on member demographics, the service being appealed, any authorized representatives, and the hearing date and time.

The following figure illustrates Permedion’s recipient hearings process.

Figure 38. Recipient Hearings Process



Prior to the hearing, an appeal nurse reviews the denied request. For medical necessity denials, peer matched physicians or dentists review the case to ensure the correct determination was made. If a Pre-Hearing determination approval is made, ODJFS and the member are notified in writing. If the adverse determination is upheld, Permedion prepares an appeal summary for the Hearing officer and member. The appeal summary includes:

- Prior Authorization number
- Appeal Number
- Hearing Officer
- Issue
- Medicaid Coverage
- Eligibility
- Reason for Denial
- Summary
- Exhibits: Information pertinent to the case

Permedion posts the appeal summary to the SHARE site 3 business days prior to the hearing for the hearing officer's review. The summary is written in a way that is understandable for those not in the health care industry so that the reason for the denial is understood. A copy is sent to the member or authorized representative to the address located in SHARE. At the date and time of the hearing Permedion joins the conference call and presents the merits of the case and answers questions from both the Hearing officer, the member and any representative of the member attending and sworn in. After the hearing, the Hearing officer will issue a determination. Permedion reviews each determination for the outcome. At times, the hearing officer may order additional compliance, such as approving the request, or additional actions to reach out to the

provider who submitted the request for additional information so that the request can be approved. Compliance is submitted on the SHARE site, as well as mailed to the member.

Provider Reconsiderations

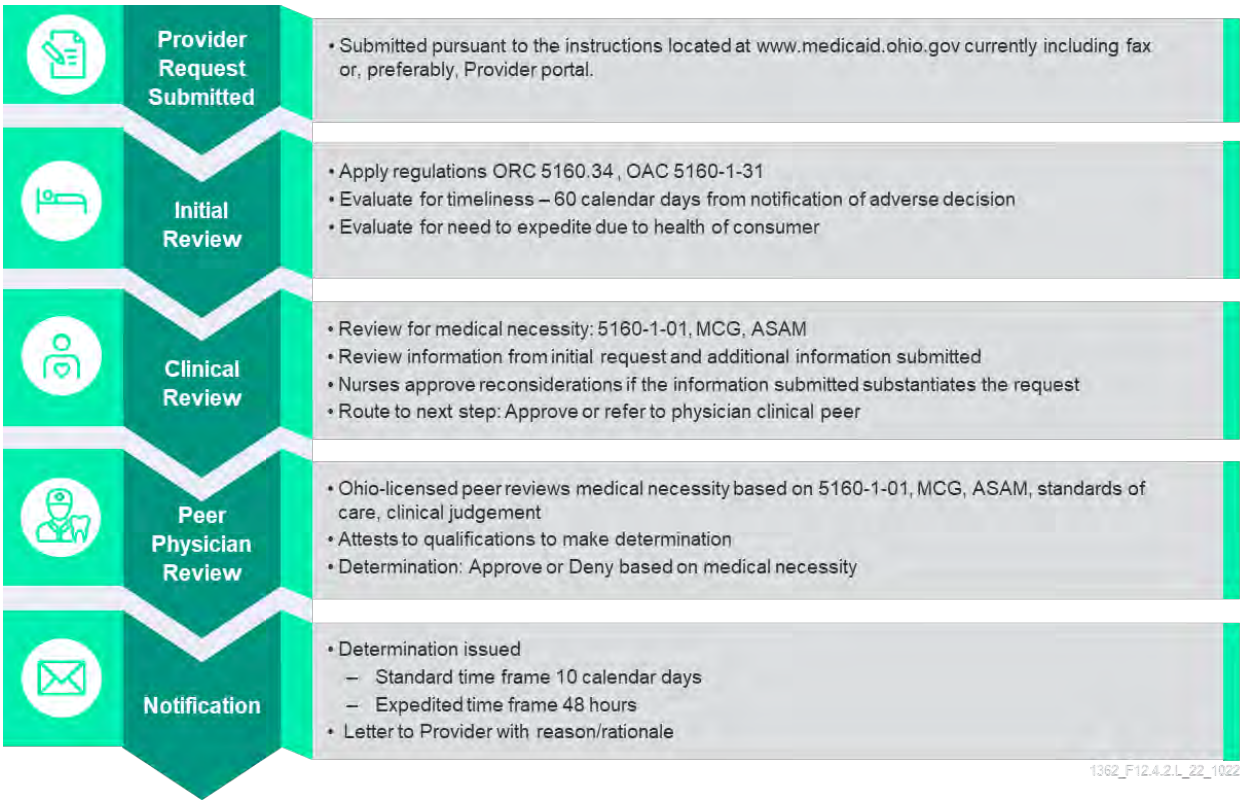
For adverse determinations regarding prior authorizations, the provider may appeal in accordance with 5160-1-31(E) which regulates the provider's right to a reconsideration. Providers may request a reconsideration within 60 days from the date on the adverse prior authorization determination. For a valid request, the provider should submit the following information:

- Medicaid recipient's name and Medicaid number
- Name of requested service or item and billing code
- Date of service or item request
- Clinical documentation supporting medical necessity for the service or item
- A reference to any relevant federal or state law or regulation, if applicable
- An explanation outlining the reason for reconsideration, including supportive information not previously submitted as necessary; and
- If applicable, an indication of whether the service or item qualifies as "urgent care services" as defined in section 5160.34 of the Revised Code.

In accordance with 5160.34(B12), Permedion will consider standard requests for reconsideration within10 days of receipt. For urgent care services, the appeals shall be considered withing 48 hours after the appeal is received.

The clinical reviewer will review all information during the appeals process, without regard as to whether information was submitted in the initial consideration of the case. If after review, the reviewer cannot approve the reconsideration request, the request is forwarded to a physician who is knowledgeable of the issue under review and has the clinical expertise that permits them to manage the medical or behavioral health condition or disease under review.

Figure 39. Reconsiderations/Provider Appeals Process



The Provider and member are notified of the determination, along with any other reconsideration rights. The provider reconsideration process afforded under 5106-1-31 does not interfere with the Medicaid recipient's right to appeal in accordance with OAC 5101:6 Hearings

4. Meetings with ODM

Permedion meets with ODM staff regularly and upon request to discuss coverage policies and clinical needs. On a regular basis, ODM and Permedion meet to discuss any issues regarding prior authorization, as well as any individual requests or clinical needs that may need attention and resolution. Our team is available to meet virtually or in person at the request of ODM.

5. Create Training

Permedion will support the ODM clinical and policy teams who create a training that provides an overview of the current MRSS rule and any needed intricacies about its interpretation. Permedion already appreciates ODMs clinical and policy teams being accessible to us for ongoing conversation and questions.

F.8 4.2.H Prior Authorization for Non-Institutional Services

RFP Reference: Section 4.2.H

The selected Offeror must have internal monitoring practices to ensure consistent application of the ODM Service authorization criteria. The selected Offeror should ensure that an inter-rater reliability process is in place and should report the inter-rater reliability data to ODM upon request.

When issuing a denial of service, the selected Offeror must clearly state all the clinical rationale for the denial per approved clinical guidelines and standards of care and note whether a denial was reviewed by a nurse and/or a physician. The selected Offeror will be responsible for development and presentation of appeal summaries in state hearings as part of member's due process rights.

The selected Offeror is expected to prior authorize some CPT/HCPCS Level II codes for types of services including but not limited to transportation, outpatient dental procedures, durable medical equipment, skilled therapies, hearing/vision, acupuncture, laboratory and chiropractor services and temporary procedure codes will require medical necessity reviews by the selected Offeror. Some CPT/HCPCS codes always require prior authorization while other procedures codes have limit-based edits in place. When there are limit-based edits in place, a PA review for medical necessity may be needed to either approve or deny the additional supplies or service. For limit-based edits that pay and post, a PA review would not be required

Regardless of a request's technical merits, all prior authorizations must be reviewed for medical necessity.

The selected Offeror must provide notice to the provider and individual as expeditiously as the individual's health condition requires, but no later than ten (10) calendar days following receipt of the request for service. If a provider indicates or the selected Offeror (or ODM) determines that following the standard authorization timeframe could seriously jeopardize the individual's life or health or ability to attain, maintain, or regain maximum function, the selected Offeror must make an expedited authorization decision and provide notice of the authorization decision as expeditiously as the individual's health condition requires but no later than forty-eight (48) hours after receipt of the request for service. All pediatric PA requests are to be reviewed for medical necessity according to federal EPSDT requirements and are time sensitive.

Types of clinicians expected to perform the review:

1. Prior authorization approvals may be processed by Registered Nurses (RN)
2. Prior authorization denials for medical necessity must be reviewed/approved by a physician under the direction of the Medical Director.

All selected Offeror medical review policies should be available to ODM for review.

The selected Offeror will meet with Clinical staff regularly and upon request to discuss coverage policies and clinical needs.

Additional reports as requested based on VUE360/FI system functionality and data access.

Because Permedion is currently reviewing prior authorization requests for non-institutional services we have internal monitoring practices, policies, and procedures for prior authorization that meets URAC accreditation to ensure consistent applications of ODM Service authorization criteria. We are committed to providing excellent service to all parties served including patients, providers, and other stakeholders. Our URAC accreditation also confirms that everything we do seeks to improve the quality of health care delivered to patients. Each step of the review process is supported by policies and procedures that confirms patients are receiving medically necessary services and that the criteria and review process is applied consistently throughout the team.

To verify inter-rater reliability and best practices, the team engages in annual policy training, as well as continuous education through weekly team meetings, more formal trainings with supervisors, as well as with ODM subject matter experts. We have a dedicated quality assurance nurse who performs quality audits and reviews each nurse on a regular basis. These

training policies and procedures are based on standards of excellence which fortify a high level of inter-rater reliability within our review team. When either a formal IRR process or ODM feedback indicates a reviewer needs additional training, the reviewer is engaged in immediate coaching to improve performance.

Permedion's clinical reviewers are experienced in managing prior authorizations for CPT/HCPCS Level II codes for the types of services referenced. We understand and adhere to fee schedule and limit-based prior authorization requirements as guided by the OAC codes referenced here:

Our reviewers have reviewed over 43,000 non-institutional service requests since July 1, 2021. Whether it's applying OAC rules and fee schedules to requests, applying specialized pricing methodologies, or interpreting the clinical information submitted, we have become very experienced with the ODM rules, policies, and regulations used in the multiple noon-institutional service categories. We collaborate during weekly meetings with the ODM Prior Authorization team to share valuable feedback, policies, concerns, and education materials. The following table shows applicable ODM PA requirements for non-institutional services.

Table 11. Prior Authorization Requirements for Non-Institutional Services

Service	Relevant portion of OAC
Dental services (including dentures, crowns, and orthodontia)	Chapter 5160-5
Vison services (eyeglasses, contact lenses, and optic training)	Chapter 5160-6
Spinal manipulation and related diagnostic imaging services	Rule 5160-8-11
Skilled therapy (physical therapy, occupational therapy, speech- language pathology, and audiology)	Rule 5160-8-35
Acupuncture	Rule 5160-8-51
Durable medical equipment, prostheses, orthoses, and supplies (DMEPOS)	Chapter 5160-10
Clinical laboratory services	Rule 5160-11-11

Our reviewers evaluate and apply all applicable guidelines to make a determination on the appropriateness of the request. Some service requests, such as wheelchairs, have multiple lines of HCPCS codes to review. Each of these lines can have different pricing methodologies and different rules that are applied to evaluate so reviewers knowledgeable of ODM policies and rules is imperative. To ensure we are utilizing the best reviewer for the request our reviewers specialize in some review types that are more complex such as enterals, wheelchairs, miscellaneous equipment, and repairs. However, since we are aware of that request volume can change from day today and we must adhere to turn around times to ensure members get their necessary items, the entire team is cross trained on all reviews that they can complete under their scope of license. For each request for non-institutional service the reviewer identifies the specific service that's being requested such as wheelchair, vision, repairs, or any of the items on the above chart.

After identifying the specific service requested and the associated HCPCS codes, the reviewer then navigates to the ODM fee schedules as well as the OAC regulations. These resources provide the reviewer with both the rule requirements of the selected item or service, as well as any pricing and service limits. After evaluating the schedule and applicable regulatory guidance

the reviewer notifies the provider if there is any needed that is necessary to complete the review. At this point in the review, we want to make sure that providers have submitted all of the information needed to review the requests. If additional information is needed the request is pended for up to 30 days to allow the provider time to submit it. If the provider does not submit additional information, the system generates a denial. This does not prevent the provider from submitting the request again. Once the reviewer receives a complete request, they continue the review addressing both the merits of the request and medical necessity.

All Prior Authorizations Reviewed for Medical Necessity

Reviewers utilize the review policies and procedures and apply specific rules regarding the service type that is being requested including:

- Medical Necessity
- Relevant Ohio Administrative codes
- Fee Schedule
- Pricing
- Service Limitations

Upon receipt of a non-institutional request, the reviewer will evaluate the submission for completeness, request additional information when the request is not complete, and consider all documentation submitted to support the request according to OAC Chapter 5160-01-1 Permedion processes ensures requests that are identified as priority, such as individuals under 21, urgent care identified by providers, or requests that impact the health of the individual, such as enterals, are completed with 48 hours. Standard requests are completed in 10 calendar days of a complete request, and that incomplete requests are pended back to providers to afford an opportunity to submit additional information to support their request.

If the standard timeframe could jeopardize the individual's life, or health or ability attain, maintain, or regain maximum function, the timeline is adjusted to provide a decision expeditiously, but no later than 48 hours after the receipt of the request. All pediatric PA requests are to be reviewed for medical necessity according to federal EPSDT requirements and are time sensitive.

In certain instances, a provider's request needs to be cancelled so that the provider can enter a correct prior authorization for the service they are requesting. For non-institutional service types, if the request for services is limit based or billed direct, a prior authorization is not required.

Since request for DME can be quite complicated, reviewers take the opportunity of error, to provide educational feedback on how to correctly submit a request and providing references to the fee schedule and frequency limits.

With technology developing at a high rate, some requests may not have clear criteria or are very expensive and need consideration that they are the most cost-effective device that can meet the individual's needs. ODM and Permedion work together to bring these to the ODM clinical team's attention for consultation and advisement.

Once a complete request is received, and the review complete, the nurse reviewer will review every line item and come to one of the following conclusions:

- **Cancel.** In certain instances, a request may be cancelled if, for example, prior authorization is not required as the limit has not been exceeded. The review nurse communicates with the provider to make sure they understand the next steps for submitting a revised request.

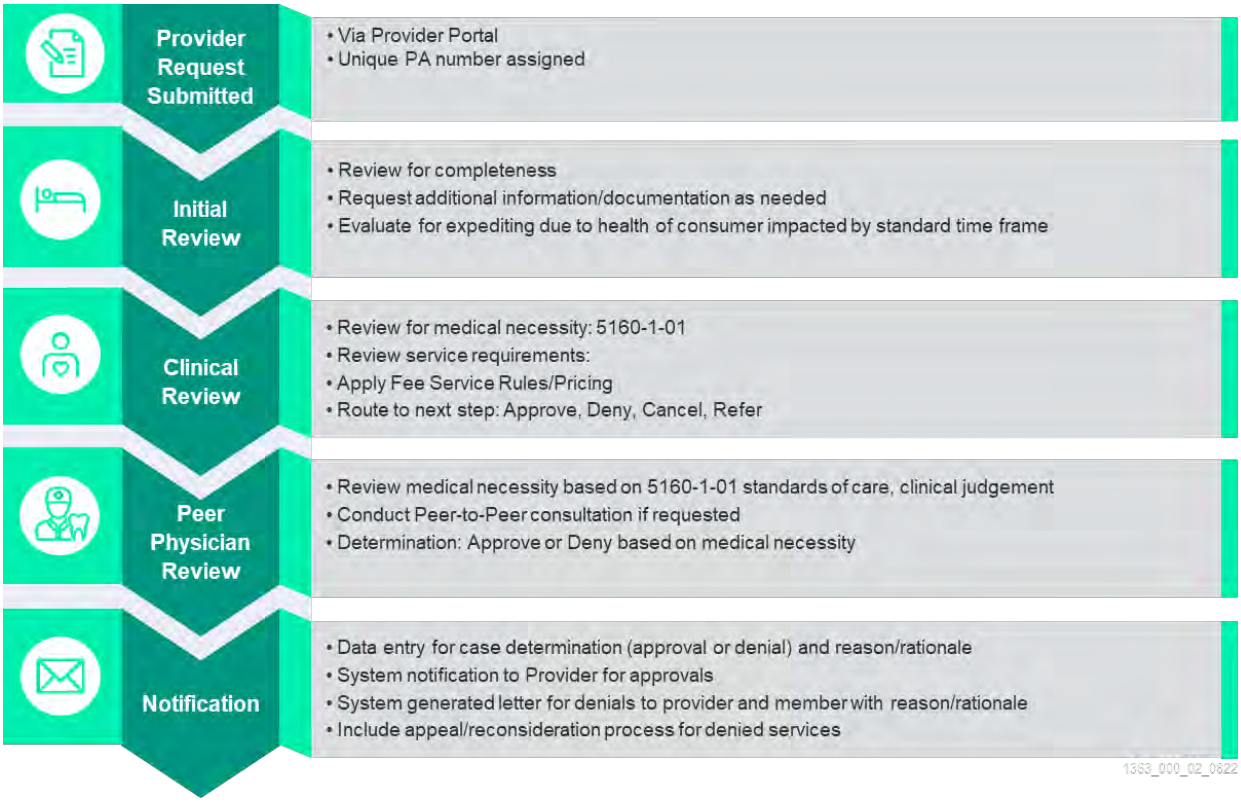
- **Approve**. After review, if all requirements are met, the reviewer will approve the request. Each HCPCS is authorized within the PA is addressed at the line level .
- **Refer.** If the reviewer cannot affirm that the service or procedure requested meets medical necessity, the request is referred to an Ohio-licensed physician along with supporting documentation. Depending on the service, ODM may be contacted for consultation.

The physician makes a determination based on medical necessity rules as well as considers practice patterns within Ohio, and then the physician will approve or deny as follows:

- **Approve.** After review, if all requirements are met, the physician will approve, at the line level, the service(s) or procedure(s) requested.
- **Deny.** If the requested service(s) does not meet medical necessity, the physician denies the request and documents the reasons/rationale that medical necessity was not met. This denial may be for a specific HCPCS/Procedure line within a request or the entire request, depending on the documentation submitted.

The following figure shows Permedion's PA process for Non-Institutional Services.

Figure 40. Prior Authorization for Non-Institutional Services



Approvals by Nurses

Prior authorization approvals are completed by trained and experienced registered nurses or licensed practical nurses for non-institutional services, and all dental and orthodontia reviews are performed by Ohio-licensed doctors of dental surgery. If a request does not appear to meet medical necessity, our nurse will refer the case to an Ohio-licensed doctor for determination.

Denials Based on Medical Necessity

Denials based on medical necessities are reviewed by Ohio-licensed doctor (physician or dentist for dental and orthodontia cases) under the direction of the AJ Beisler, our Medical Director. All denial notices will be process via the FI module and issued to the requesting provider along with member appeal rights.

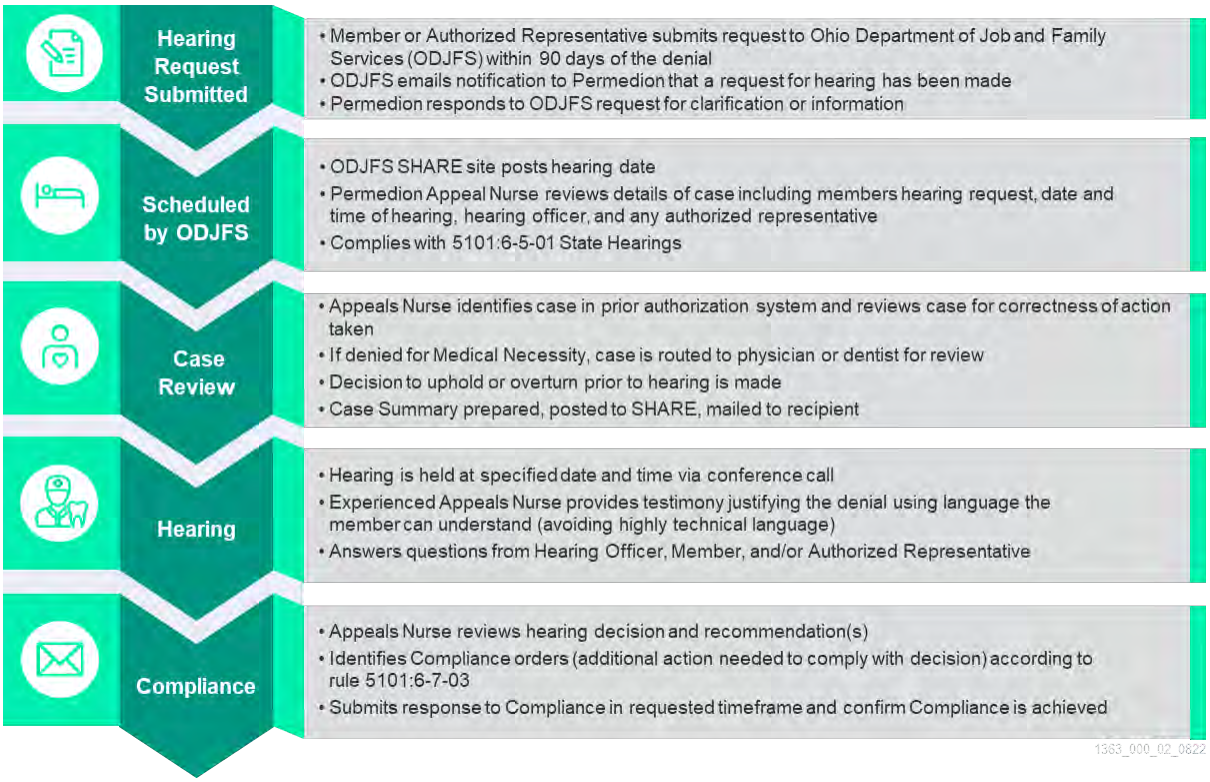
Appeals and Hearings Support

When an adverse decision is made, under OAC 5101:6 “Hearings” a member of a denied service has the right to a state hearing. The member is notified of their hearing rights, and the process on how to request a hearing in the adverse determination letter.

On average, Permedion prepares 15-20 appeal summaries and attends appeal hearings each month on behalf of ODM. This includes making sure that case summaries are completed and distributed to the hearing officer and member prior to the hearing, and identified trained personnel attend the hearing to provide testimony regarding the rationale of the decision.

The Ohio Department of Job and Family Services (ODJFS) is responsible for managing recipient hearing requests. Permedion is notified of a hearing request via email. Permedion accesses ODJFS’s State Hearing Access to Records Electronically (SHARE) site which assists members, guiding them through their appeal process as well as where appeal summaries and compliance actions are submitted. Permedion logs into SHARE for information on member demographics, the service being appealed, any authorized representatives and the hearing date and time.

Figure 41. Recipient Hearings



Prior to the hearing, an appeal nurse reviews the denied request. For medical necessity denials, peer matched physicians or dentist review the case to make sure the correct determination was made. If a Pre-Hearing determination is made, ODJFS and the member are notified in writing. If the adverse determination is upheld, Permedion prepares an appeal summary for the Hearing officer and member. The appeal summary that includes:

- Prior Authorization number
- Appeal Number
- Hearing Officer
- Issue
- Medicaid Coverage
- Eligibility
- Reason for Denial
- Summary
- Exhibits: System print out of denial, information submitted for the request, plan benefits and denial letter

The appeal summary is posted to the SHARE site three business days prior to the hearing for the hearing officers review. The summary is written in a way that is understandable so that the reason for the denial is clear to the member and others. A copy is sent to the member or authorized representative to the address located in SHARE.

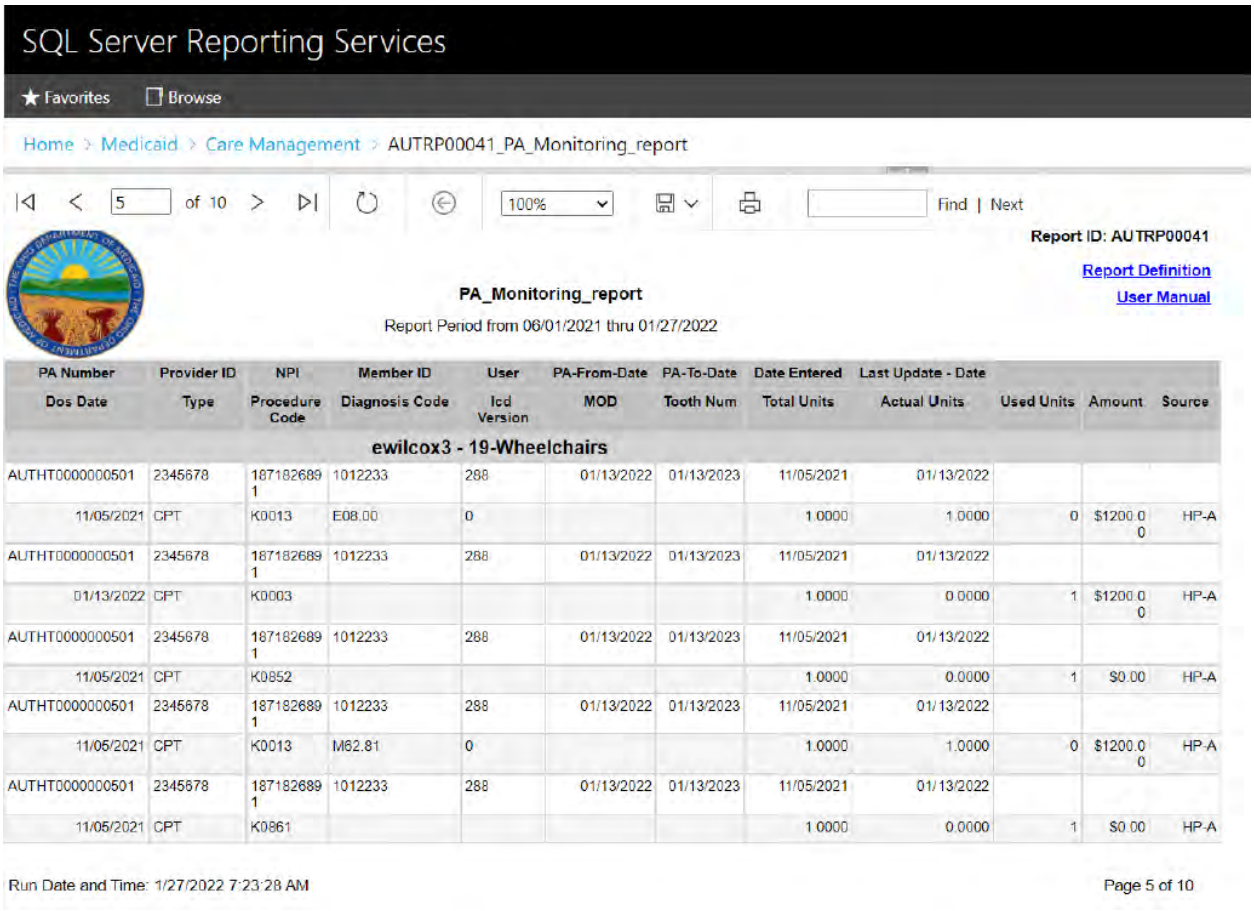
At the date and time of the hearing, Permedion joins the conference call and presents the merits of the case and answers questions from the Hearing Officer, the member, and any representative of the member attending. After the hearing, the Hearing Officer will issue a determination. Permedion will review each determination for the outcome. At times, the hearing officer may order additional compliance, such as approving the request, or additional actions to reach out to the provider who submitted the request for additional information so that the request can be approved. Compliance is submitted on the SHARE site, as well as mailed to the member.

Permedion meets regularly with ODM clinical staff. When we first implemented Non-Insitutional services, we met each week. With ODM guidance and educaiton, along with increased experience completing reviews, we now meet every other week. Our meetings include policiy updates, discussing challenging cases, and integrating ODM feedback into our reviews and address any clinical needs. We developed polices, procedures and review guides, available to ODM upon requet, to ensure consistent and compliant review practices.

Our review team utilizes the feedback from or trainings sessions and feedback from ODM, as evidenced by a quote from one of our nurse reviewers, “I appreciate the training provided by ODM when new rules are implemented for DME so the team can ensure they are all applied correctly and consistently.”

Permedion will leverage data monitoring and reporting functionalty in Gainwell’s Vue360 user interface tool. The tool includes PA monitoring capabilities, which will enable ODM to capture necessary data for monitoring SLA compliance and authorization outcomes.

Figure 42. Example Vue360 Report Screen



PA Number	Provider ID	NPI	Member ID	User	PA-From-Date	PA-To-Date	Date Entered	Last Update - Date			
Dos Date	Type	Procedure Code	Diagnosis Code	Icd Version	MOD	Tooth Num	Total Units	Actual Units	Used Units	Amount	Source
ewilcox3 - 19-Wheelchairs											
AUTHT0000000501	2345678	1871826891	1012233	288	01/13/2022	01/13/2023	11/05/2021	01/13/2022			
11/05/2021	CPT	K0013	E08.00	0			1.0000	1.0000	0	$1200.00	HP-A
AUTHT0000000501	2345678	1871826891	1012233	288	01/13/2022	01/13/2023	11/05/2021	01/13/2022			
01/13/2022	CPT	K0003					1.0000	0.0000	1	$1200.00	HP-A
AUTHT0000000501	2345678	1871826891	1012233	288	01/13/2022	01/13/2023	11/05/2021	01/13/2022			
11/05/2021	CPT	K0852					1.0000	0.0000	1	$0.00	HP-A
AUTHT0000000501	2345678	1871826891	1012233	288	01/13/2022	01/13/2023	11/05/2021	01/13/2022			
11/05/2021	CPT	K0013	M62.81	0			1.0000	1.0000	0	$1200.00	HP-A
AUTHT0000000501	2345678	1871826891	1012233	288	01/13/2022	01/13/2023	11/05/2021	01/13/2022			
11/05/2021	CPT	K0861					1.0000	0.0000	1	$0.00	HP-A

F.9 4.2.I Provider Prior Authorization Appeal Requests of MCE Denials

RFP Reference: Section 4.2.I

The selected Offeror will perform provider appeals of Managed Care Entity denials in accordance with OAC 5160-1-31. The selected Offeror will make a standard reconsideration determination within ten calendar days of receipt of a valid request. If an expedited review is requested because the service or item qualifies as urgent care services, the reconsideration determination will be made no later than forty-eight hours after receipt of a valid reconsideration.

1. Selected Offeror shall perform external medical reviews at the request of a provider for disputes resultingfrom an MCE's denial, limitation, reduction, suspension, or termination of a service due to a lackof medical necessity.
   a. Selected Offeror must assign a reference number to each request for external medical review, which is available for the provider, MCE, and ODM for tracking and reporting purposes.
   b. The request for external medical review from provider may be submitted in writing to the Selected Offeror.
   c. If the MCE and provider disagree that the reduction, limitation, denial, suspension, or termination of a service is subject to external medical review, ODM or its designee willdetermine if the EMR will be conducted.
   d. Selected Offeror shall review requests for EMRs to determine if they are valid requests byverifying:
      i. The denial, limitation, reduction, suspension, or termination was based on medical necessity.

ii. Provider has exhausted the MCE internal appeals process or provider claim dispute resolution process; or provider has attempted to complete MCE internal appeals process or provider claim dispute resolution process but has not received a timely response from the MCE.

e. Selected Offeror will track requests for external medical reviews that are determined to be invalid requests. If selected Offeror determines a request for an external medical review is not valid due to a denial reason other than medical necessity, selected Offeror will notify ODM usingan ODM approved established process.

f. The determination regarding whether or not a request is valid will be made by appropriately qualified staff.

2. Selected Offeror shall conduct the review and render a determination as to whether or not the MCE's denial, limitation, reduction, suspension, or termination of a service due to a lack of medicalnecessity was appropriate and in accordance with Ohio's rules and laws.

   a. Selected Offeror will request all appropriate documentation from the MCE to make itsdetermination.

   b. For external medical record requests that are associated with expedited service authorization decisions, the determination must be issued as expeditiously as the member's health condition requires, but no later than 3 business days from the selected Offeror'sreceipt of the valid external medical review.

   c. For external medical review requests that are associated with standard service authorization decisions or claim denials, the determination must be issued within 30 calendar days from the selected Offeror's receipt of the valid request for an external medical review.

   d. Selected Offeror will share the outcome of its determination with MCE and provider.

3. Selected Offeror shall allow for external medical review requests to be submitted by providers electronically. This portal must include at least the following:

   a. Ability for MCE providers to request EMR.

   b. Ability to send and receive narrative and any attachments as accompanyingdocumentation to support request for EMR.

   c. Any other information identified by ODM.

4. Selected Offeror shall provide ODM role-based access to routine and ad hoc reports with information both for individual and aggregate EMR data as specified by ODM. ODM may perform audits ormake other requests for information and documentation. Selected Offeror shall provide all informationrequested by ODM in a timely manner.

5. Selected Offeror shall permit ODM-contracted MCEs with role-based access to information about EMRsrequested from the MCE.

   a. This access will ensure the MCE can:

      i. Receive notification of a requested EMR.

      ii. Receive notification of the outcome of an external medical review and any associated documentation.

      iii. Permit the MCE to upload any attachments or other documentation to support their decision to reduce, deny, or suspend a service due to lack of medical necessity.

6. Selected Offeror shall assign as a clinical peer a health care professional who meets the following minimum qualifications:

   a. Is an expert in the treatment of the covered person's medical condition that is the subject of the review;

   b. Has knowledge of all relevant Ohio laws and rules specific to the service(s) subject to the external medical review;

   c. Is knowledgeable about the recommended health care service or treatment through recent or current actual clinical experience treating patients with the same or similar medical condition of the covered person; and

   d. Has no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit or regulatory body that raise a substantial question as to the clinical peer's physical, mental or professional competence or moral character.

7. Selected Offeror shall assure the clinical peer health care professional performing the review:

a. Is not under contract to provide the disputed service with the MCE at any time while considering the dispute

b. Is not rendering care and services to the member.

c. Does not have or acquire any personal or professional interest in connection with the review, direct or indirect, that could present a conflict or perceived conflict of interest, or that otherwise could compromise the impartiality of the review.

Reviews shall be performed by a physician Medical Director who holds a current and non-restricted Ohio license and is certified by the American Board of Medical Specialties. All review determinations will be authorized by an Ohio licensed physician.

Potential Offeror, or their proposed subcontractor, shall be nationally accredited in independent review.

PLEASE NOTE: It is at ODM's discretion to determine if services described in this Section I will be needed during the term of the contract. Additionally, during the term of the contract, ODM may determine that the Services in this Section I may be removed from this Contract and be procured separately.

Permedion provides external medical review (EMR) services on issues of quality of care, medical necessity, appropriateness of setting, and experimental/investigational treatment to clients across the country. We work with various state agencies, including Medicaid and departments of insurance, health plans and managed care organization.

urac® ACCREDITED Independent Review Organization: External Review Expires 05/01/2024

urac® ACCREDITED Health Utilization Management Expires 05/01/2024

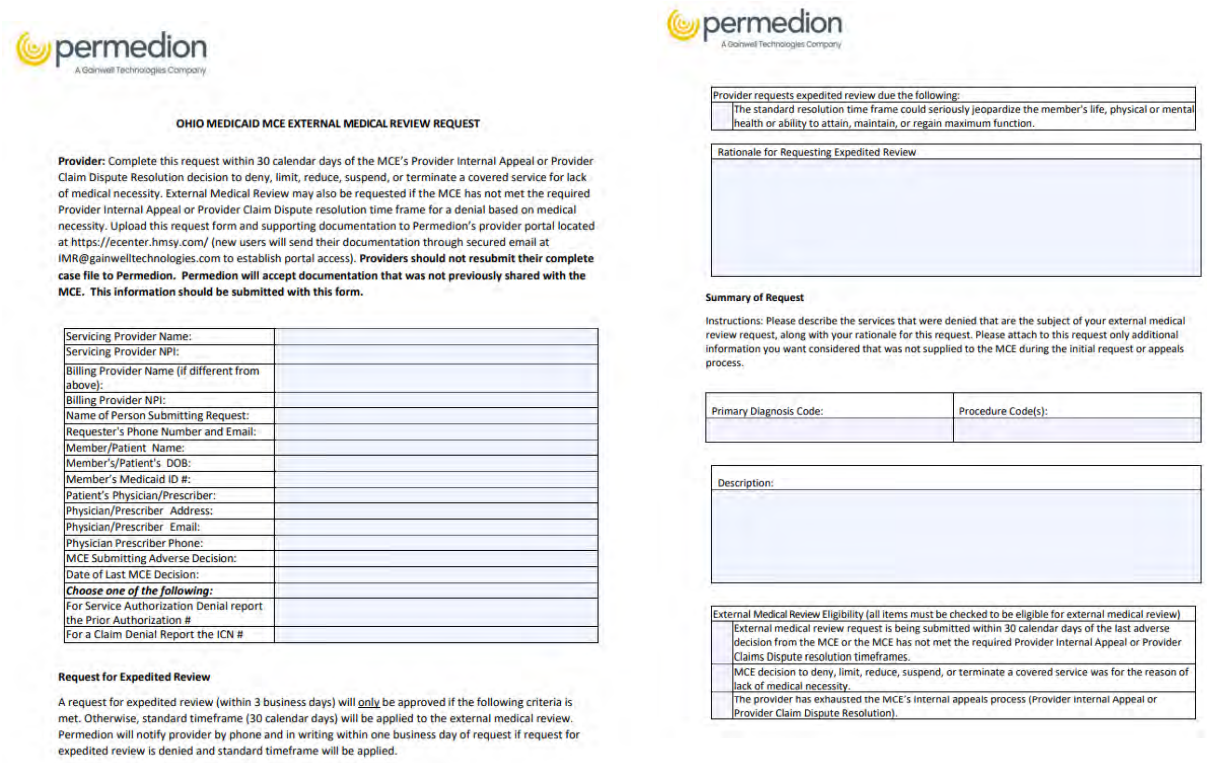
Being URAC accredited in both Utilization Management and as an External Independent Review Organization, Permedion has strict policies and procedures in place covering both prior authorization requests and appeals retrospective of services provided.

Permedion will make a standard reconsideration determination within 10 calendar days of receipt of a valid request. If an expedited review is requested because the service or item qualifies as urgent care services, the reconsideration determination will be made no later than 48 hours after receipt of a valid reconsideration.

Permedion has partnered with ODM to implement the new MCE External Review Program over the past several months. On July 1, 2022, the program went live with the OhioRise Managed Care Entity. On December 1, 2022, we will be going live with the seven other MCEs. Under OAC 5160-1-31 providers may request an external medical review for prior authorization denials made by a Managed Care Entity.

All MCEs have instructions from Permedion to notify their providers of the process to submit an External Medical Request. All activity will occur within our portal. Providers, MCEs, and ODM have role-based access to the Portal and allows the provider or MCE to submit documentation to support request for EMR and communication of the status and notifications related to an EMR. To initiate the request for an EMR, the current process requires that the provider submit via the portal, all documentation and complete the External Medical Review form, which outlines information required for the review, as shown in the following figure.

Figure 43. ODM Approved External Medical Review Request Form



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OHIO MEDICAID MCE EXTERNAL MEDICAL REVIEW REQUEST

Provider: Complete this request within 30 calendar days of the MCE's Provider Internal Appeal or Provider Claim Dispute Resolution decision to deny, limit, reduce, suspend, or terminate a covered service for lack of medical necessity. External Medical Review may also be requested if the MCE has not met the required Provider Internal Appeal or Provider Claim Dispute resolution time frame for a denial based on medical necessity. Upload this request form and supporting documentation to Permedion's provider portal located at https://ecenter.hmsy.com/ (new users will send their documentation through secured email at IMR@gainwelltechnologies.com to establish portal access). **Providers should not resubmit their complete case file to Permedion. Permedion will accept documentation that was not previously shared with the MCE. This information should be submitted with this form.**

Servicing Provider Name:	
Servicing Provider NPI:	
Billing Provider Name (if different from above):	
Billing Provider NPI:	
Name of Person Submitting Request:	
Requester's Phone Number and Email:	
Member/Patient Name:	
Member's/Patient's DOB:	
Member's Medicaid ID #:	
Patient's Physician/Prescriber:	
Physician/Prescriber Address:	
Physician/Prescriber Email:	
Physician Prescriber Phone:	
MCE Submitting Adverse Decision:	
Date of Last MCE Decision:	
Choose one of the following:	
For Service Authorization Denial report the Prior Authorization #	
For a Claim Denial Report the ICN #	

Request for Expedited Review

A request for expedited review (within 3 business days) will only be approved if the following criteria is met. Otherwise, standard timeframe (30 calendar days) will be applied to the external medical review. Permedion will notify provider by phone and in writing within one business day of request if request for expedited review is denied and standard timeframe will be applied.

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Provider requests expedited review due the following:	
	The standard resolution time frame could seriously jeopardize the member's life, physical or mental health or ability to attain, maintain, or regain maximum function.

Rationale for Requesting Expedited Review

Summary of Request

Instructions: Please describe the services that were denied that are the subject of your external medical review request, along with your rationale for this request. Please attach to this request only additional information you want considered that was not supplied to the MCE during the initial request or appeals process.

Primary Diagnosis Code:	Procedure Code(s):

Description:

External Medical Review Eligibility (all items must be checked to be eligible for external medical review)	
	External medical review request is being submitted within 30 calendar days of the last adverse decision from the MCE or the MCE has not met the required Provider Internal Appeal or Provider Claims Dispute resolution timeframes.
	MCE decision to deny, limit, reduce, suspend, or terminate a covered service was for the reason of lack of medical necessity.
	The provider has exhausted the MCE's internal appeals process (Provider Internal Appeal or Provider Claim Dispute Resolution).

When a request for an EMR is received, Permedion will assign a reference number and make that number available for the provider, MCE, and ODM for tracking and reporting purposes.

Once a request is received, a Permedion will confirm that the request is valid using the following criteria:

- The request is being submitted within 30 calendar days of the last adverse decision from the MCE, or the MCE has not met the required Provider Internal Appeal or Provider Claims Dispute resolution timeframes
- MCE's decision to deny, limit, reduce, suspend, or terminate a covered service was for the reason of lack of medical necessity
- The provider has exhausted the MCE's internal appeals process (Provider Internal Appeal or Provider Claim Dispute Resolution)

If a request is determined to be invalid, we will use our ODM approved letter template to notify the provider that the request is being rejected for:

- **Untimely Submission.** Providers have 30 calendar days to submit their external review request after receipt of the MCE's denial decision or provider claim dispute resolution. The external review request fell outside the allotted timeframe.
- **MCE Denial Reason.** Services denied, limited, reduced, or terminated for reasons other than lack of medical necessity are not subject to the external medical review process.
- **MCE appeal process was not exhausted.** A provider is required to exhaust the MCE's internal provider appeal process or provider claim dispute resolution process prior to requesting an external medical review.

If the request is determined to be valid, the request will continue through the EMR process. Permedion will notify the MCE of the EMR, and request documentation used to make their determination. The MCE must submit their documentation for:

- Expedited service authorizations within 1 business day of the notification
- Standard service authorizations within 5 business days of the notification

Permedion will continue to follow-up with the MCE to obtain necessary documentation if the above timeframes are not met. The EMR process will continue with provider's submitted documentation if the MCE is not compliant.

After receiving all documents from the MCE, Permedion will assign a clinical peer to review the request from our panel of 39 Ohio-licensed, credentialed reviewers to perform the review. The clinical peer will meet the following minimum qualifications:

- Expert in the treatment of the covered person's medical condition that is the subject of the review
- Knowledgeable of relevant Ohio laws and rules specific to the service(s) subject to the external medical review
- Knowledgeable about the recommended health care service or treatment through recent or current actual clinical experience treating patients with the same or similar medical condition of the covered person
- Has no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit or regulatory body that raise a substantial question as to the clinical peer's physical, mental, or professional competence or moral character

For every EMR a physician reviews, we require an attestation that they:

- Are not under contract to provide the disputed service with the MCE at any time while considering the dispute
- Are not rendering care and services to the member
- Do not have or acquire any personal or professional interest in connection with the review, direct or indirect, that could present a conflict or perceived conflict of interest, or that otherwise could compromise the impartiality of the review

The following figures show the receipt and review flowcharts for the Appeal Requests Review Process.

Figure 44. Receipt Flowchart for Appeal Requests Review Process

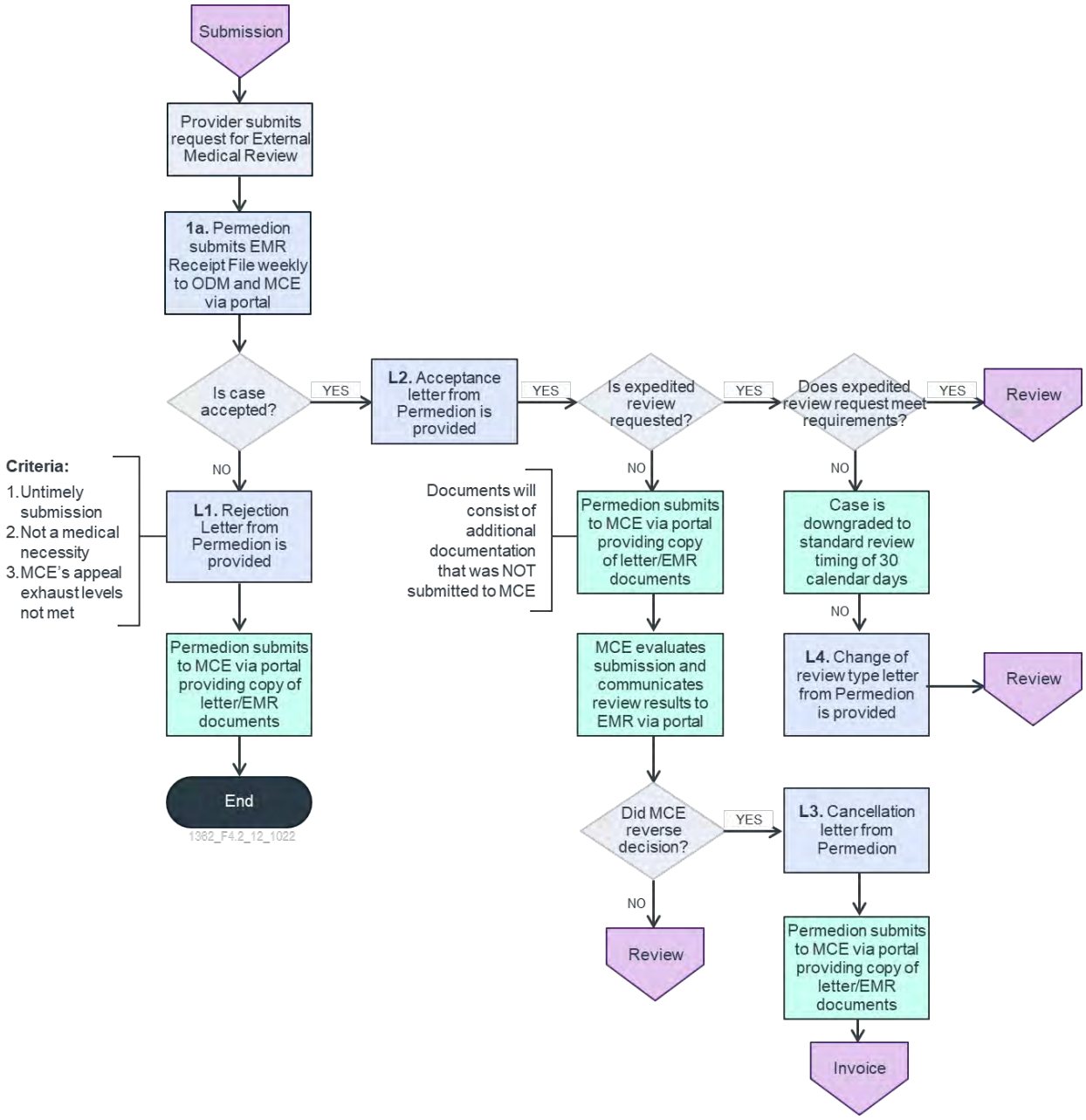
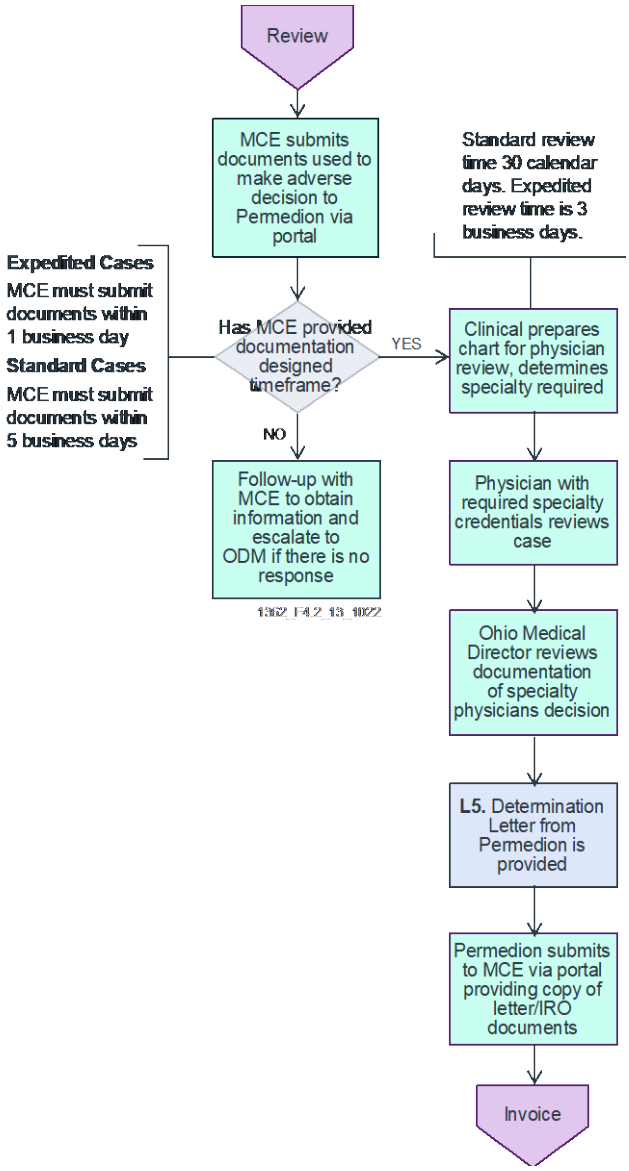


Figure 45. Review Flowchart for Appeal Requests Review Process



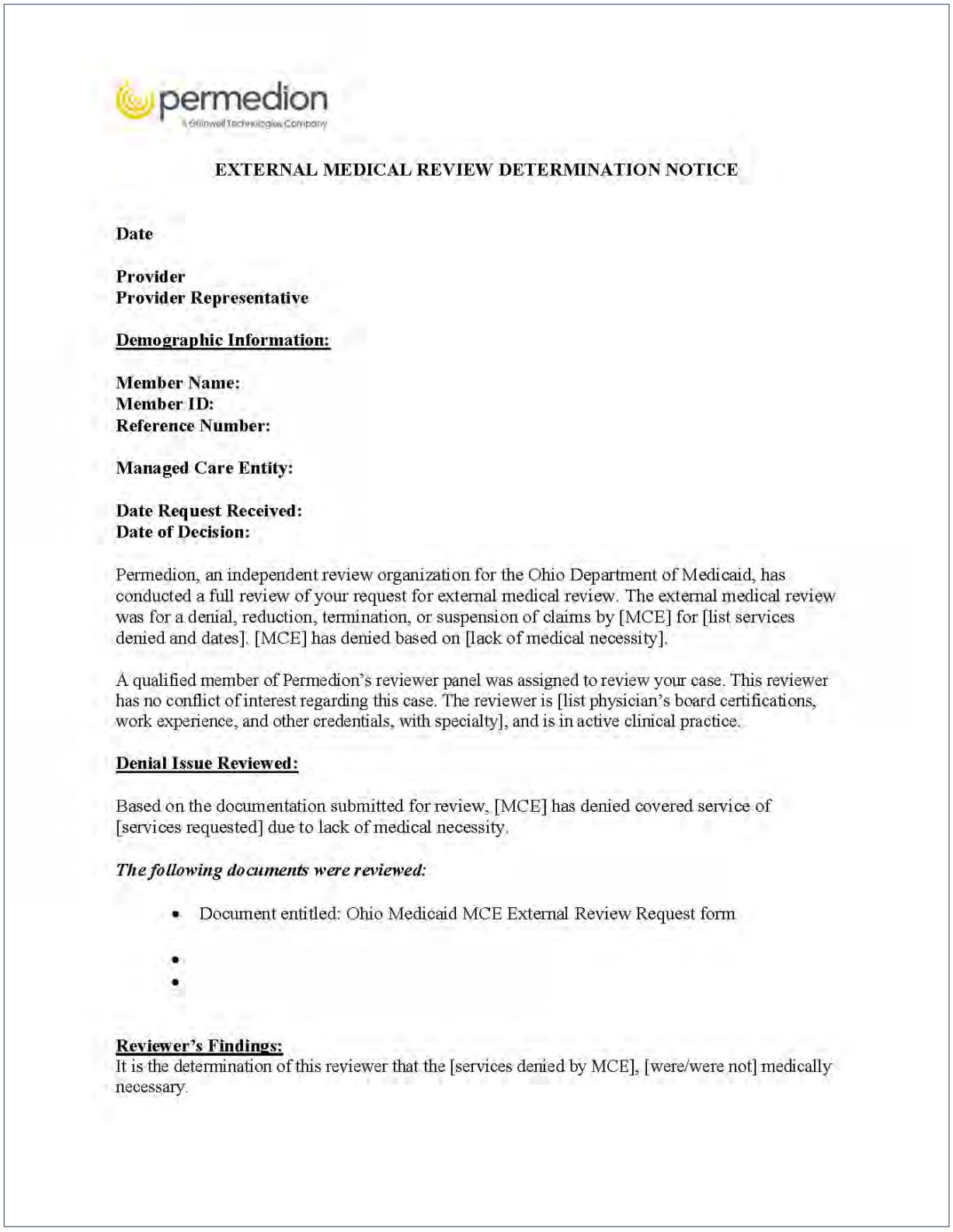
All reviews will be performed with the oversight of our Medical Director, Dr. AJ Beisler. We require that our Medical Director holds a current and non-restricted Ohio license and is certified by the American Board of Medical Specialties. Please refer to Section 3.3 Staff Experience and Capabilities for the resume of our Medical Director AJ Beisler, MD, and physician reviewers.

The determination will be made and posted to the portal for the provider and MCE. We use the following determination timeframes:

- Expedited service authorizations will be completed as expeditiously as the member's health condition requires but no later than three business days from receipt of the valid request for an external medical review.
- Standard service authorizations will be completed no later than 30 calendar days of receipt of the valid request for an external medical review.

The following figures show Page 1 and Page 2 of the two-page ODM-approved template for our determinations.

Figure 46. Determination Letter Template Page 1



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EXTERNAL MEDICAL REVIEW DETERMINATION NOTICE

Date

Provider
Provider Representative

Demographic Information:

Member Name:
Member ID:
Reference Number:

Managed Care Entity:

Date Request Received:
Date of Decision:

Permedion, an independent review organization for the Ohio Department of Medicaid, has conducted a full review of your request for external medical review. The external medical review was for a denial, reduction, termination, or suspension of claims by [MCE] for [list services denied and dates]. [MCE] has denied based on [lack of medical necessity].

A qualified member of Permedion's reviewer panel was assigned to review your case. This reviewer has no conflict of interest regarding this case. The reviewer is [list physician's board certifications, work experience, and other credentials, with specialty], and is in active clinical practice.

Denial Issue Reviewed:

Based on the documentation submitted for review, [MCE] has denied covered service of [services requested] due to lack of medical necessity.

The following documents were reviewed:

- Document entitled: Ohio Medicaid MCE External Review Request form
-
-

Reviewer's Findings:
It is the determination of this reviewer that the [services denied by MCE], [were/were not] medically necessary.

Figure 47. Determination Letter Template Page 2

This case involves a [summary of case].

[Criteria with rationale]

It is the recommendation of this reviewer that the denial due to lack of medical necessity issued by [MCE] for the [services denied by MCE], be [upheld/overturned].

References:

1. [Journals, Regulations]

As the Ohio Medical Director of Permedion, I have reviewed the decision and I concur with the determination of the physician reviewer. Therefore, we are recommending that the determination of [MCE] be [upheld/overturned].

Please be advised that this determination is binding to the extent that other remedies are available to either party under State or Federal law.

Sincerely,

cc: Ohio Department of Medicaid
[Contact Name, MCE]

F.10 4.2.J Prior Authorization for Home Health Services

RFP Reference: Section 4.2.J

The selected Offeror will act as a designee on behalf of ODM, to receive and prior authorize (or deny) requests for additional home health nursing and home health aide services, when the request is for additional units of service beyond fourteen hours per week, and if ordered by an individual's treating clinician.

Upon receipt from a Medicare Home Health Agencies (MCHHA) provider, the selected Offeror will review and consider all documentation submitted to support the request and ensure compliance with OAC Chapter 5160-12-01 prior to approving or denying the request.

Prior authorization approvals must be processed by Registered Nurses (RN). The selected Offeror must have an internal form and monitoring practices to ensure consistent application of the ODM Service authorization criteria. The selected Offeror should ensure that an inter-rater reliability process is in place and should report the inter-rater reliability data to ODM upon request. The selected Offeror will meet with Clinical staff regularly and upon request to discuss coverage policies and clinical needs. All selected Offeror medical review policies must be available to ODM for review.

The selected Offeror must provide notice to the MCHHA provider and individual as expeditiously as the individual's health condition requires, but no later than five (5) calendar days following receipt of the request for service, unless the MCHHA provider, or ODM determines that following the standard authorization timeframe could seriously jeopardize the individual's life or health or ability to attain, maintain, or regain maximum function. In such cases, the selected Offeror must adjust to provide an authorization decision and provide notice of the authorization decision as expeditiously as the individual's health condition requires but no later than forty-eight (48) hours after receipt of the request for additional service.

Permedion is currently receiving and processing requests from Ohio providers for increased state plan home health nursing and home health aide services for services exceeding fourteen hours a week. Prior authorization, for approval or denial, is required when additional units of service beyond fourteen hours per week are necessary. In addition to Ohio, we currently conduct home health prior authorization reviews for five other state Medicaid programs. Since there are several types of home health requests that can be made by providers, Permedion works with the provider, as well as ODM, to make sure requests are processed correctly based on service requested and provider type. Currently we receive provider requests through fax or mail; enter the request information in MITS, and then our registered nurses review the request. Permedion stands ready to educate the home health providers on the upcoming requirement to submit their requests via the PNM portal.

Upon receipt of a Medicare Home Health Agencies' (MCHHA) request for home health prior authorization, Permedion registered nurse reviewers evaluate the submission for completeness thus making certain the provider has identified the units and timeframe needed, that the request is for over the service limit, the Certification and Plan of Care (form 485) is included, signed and dated by the physician and if needed, a Certificate of Medical Necessity is included, along with the progress notes that support the medical necessity documentation. If the required information is not included, a request for additional information is made. Our reviewers consider all documentation submitted to support the request and process the request according to OAC 5160-12-01. Medical necessity criteria are applied utilizing OAC 5160-1-01 Medical Necessity criteria and MCG Guidelines.

Prior authorization requests are completed by Registered Nurses (RN). As a part of the quality review process, a sample of each reviewer's authorizations are analyzed for inter rater reliability of applying ODM Service authorization criteria. In the event that educational needs are identified, the nurse is provided with additional training and coaching. On an annual basis, all

applicable policies and procedures regarding prior authorization are reviewed, including URAC standards. On a weekly basis the clinical teams meet to discuss any changes to policies, interpretation of rules, or new rules, and to address any clinical questions and needs. Policies and procedures are available for ODM review.

Permedion's process makes certain that reviews are completed within five (5) calendar days from the receipt of a complete request, and that incomplete requests are pended back to the providers, which provides them with an opportunity to submit additional information to support their request. If the standard timeframe could jeopardize the individual's life, health, or ability to attain, maintain or regain maximum function, the timeline is adjusted to provide a decision expeditiously, but no later than 48 hours after the receipt of the request. The upcoming figure describes the steps in our PA process for home health services.

If the prior authorization request is incomplete and additional information is needed, the review is pended for additional documentation and returned to the provider via the PNM portal. If the provider does not respond within thirty days, the request will be denied by the prior authorization system.

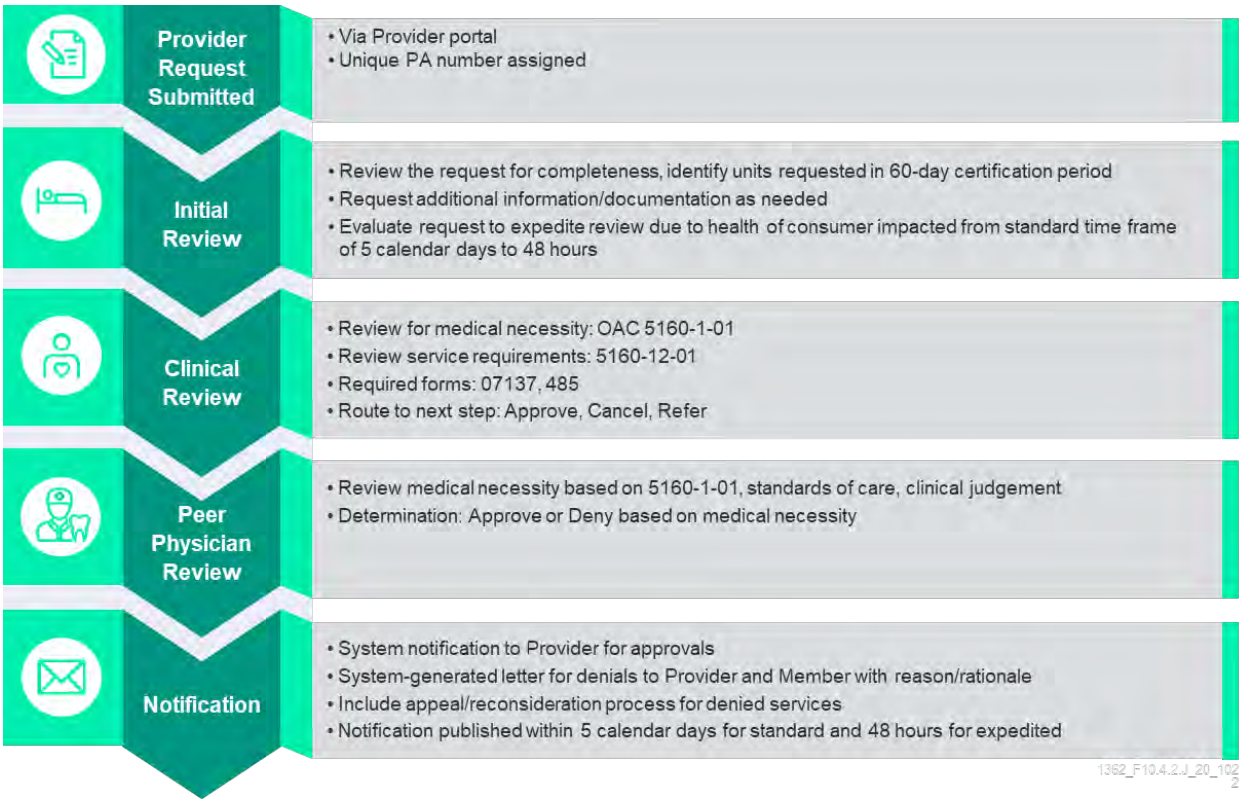
The nurse reviewer will review every line item and come to one of the following conclusions:

- **Cancel.** In certain instances, a request may be cancelled if, for example, more than one hospital inpatient prior authorization request is submitted for the same dates of services, or a request for prior authorization is not required based on the mandated procedure codes and fee schedules. The review nurse communicates with the provider to make sure they understand the next steps for submitting a revised request.
- **Approve**. After review, if all requirements are met, the reviewer will approve the request. Each service requested (CPT/HCPCS or procedure code) within the PA is addressed at the line level.
- **Refer.** However, if the reviewer cannot affirm that the service or procedure requested meets medical necessity, the request is referred to an Ohio-licensed physician along with supporting documentation.

The physician makes a determination based on medical necessity rules as well as considers practice patterns within Ohio, and then the physician will approve or deny as follows:

- **Approve.** After review, if all requirements are met, the physician will approve, at the line level, the service(s) or procedure(s) requested.
- **Deny.** If the requested service(s) does not meet medical necessity, the physician denies the request and documents the reasons/rationale that medical necessity was not met. This denial may be for a specific HCPCS/Procedure line within a request or the entire request, depending on the documentation submitted.

Figure 48. Prior Authorization for Home Health Services



Provider Reconsideration for Prior Authorizations

Permedion has been processing provider appeals (reconsiderations) for other service types and are prepared when this starts for providers of home health, which is anticipated for December 2022. For adverse determinations regarding prior authorizations, the provider may appeal in accordance with 5160-1-31(E) which regulates the provider's right to a reconsideration. Providers may request reconsiderations of an adverse prior authorization in accordance with section 5160.34 of the revised code. Providers may submit reconsiderations by mail or the provider portal. Providers may request a reconsideration within 60 days from the date on the adverse prior authorization determination. For a valid request, the provider should submit the following information:

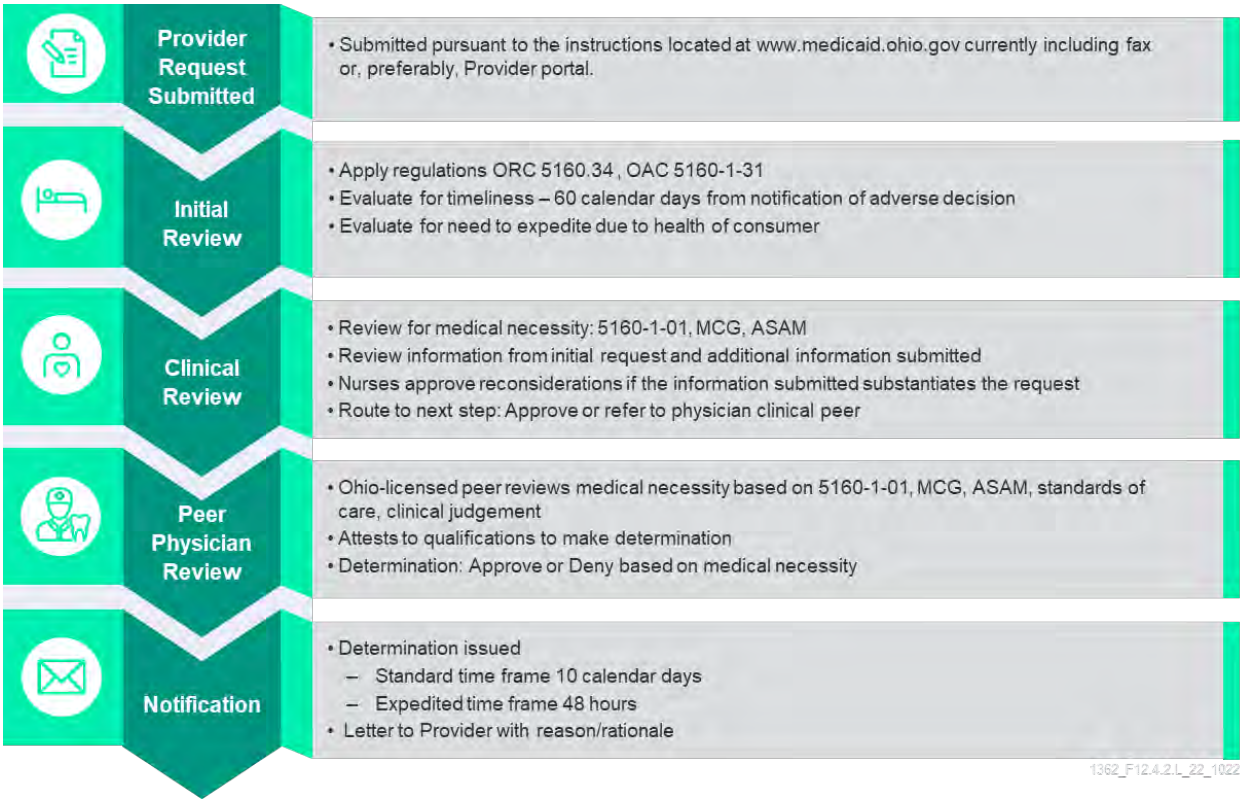
- Medicaid recipient's name and Medicaid number
- Name of requested service or item and billing code
- Date of service or item request
- Clinical documentation supporting medical necessity for the service or item
- Reference to any relevant federal, state law or regulation, if applicable
- An explanation outlining the reason for reconsideration, including supportive information not previously submitted, as necessary; and

- If applicable, an indication of whether the service or item qualifies as “urgent “care services” as defined in section 5160.34 of the Revised Code

In accordance with 5160.34(B12), Permedion will consider standard requests for reconsideration within 10 days of receipt. For urgent care services, the appeals shall be considered within 48 hours after the appeal is received.

The clinical reviewer will review and consider all information during the appeals process, without regard to whether or not the information submitted was submitted in the initial consideration of the case. If after review, the reviewer cannot approve the reconsideration request, the request is forwarded to a physician who is knowledgeable of the issue under review and has the clinical expertise that permits them to manage the medical or behavioral health condition or disease under review. The following figure shows the steps in Permedion’s Reconsiderations/Provider Appeals Process.

Figure 49. Reconsiderations/Provider Appeals Process



The Provider and member are notified of the determination, along with any other reconsideration rights. The provider reconsideration process afforded under 5106-1-31 does not interfere with the Medicaid recipient’s right to appeal in accordance with OAC 5101:6 Hearings.

Member/Recipient Appeals

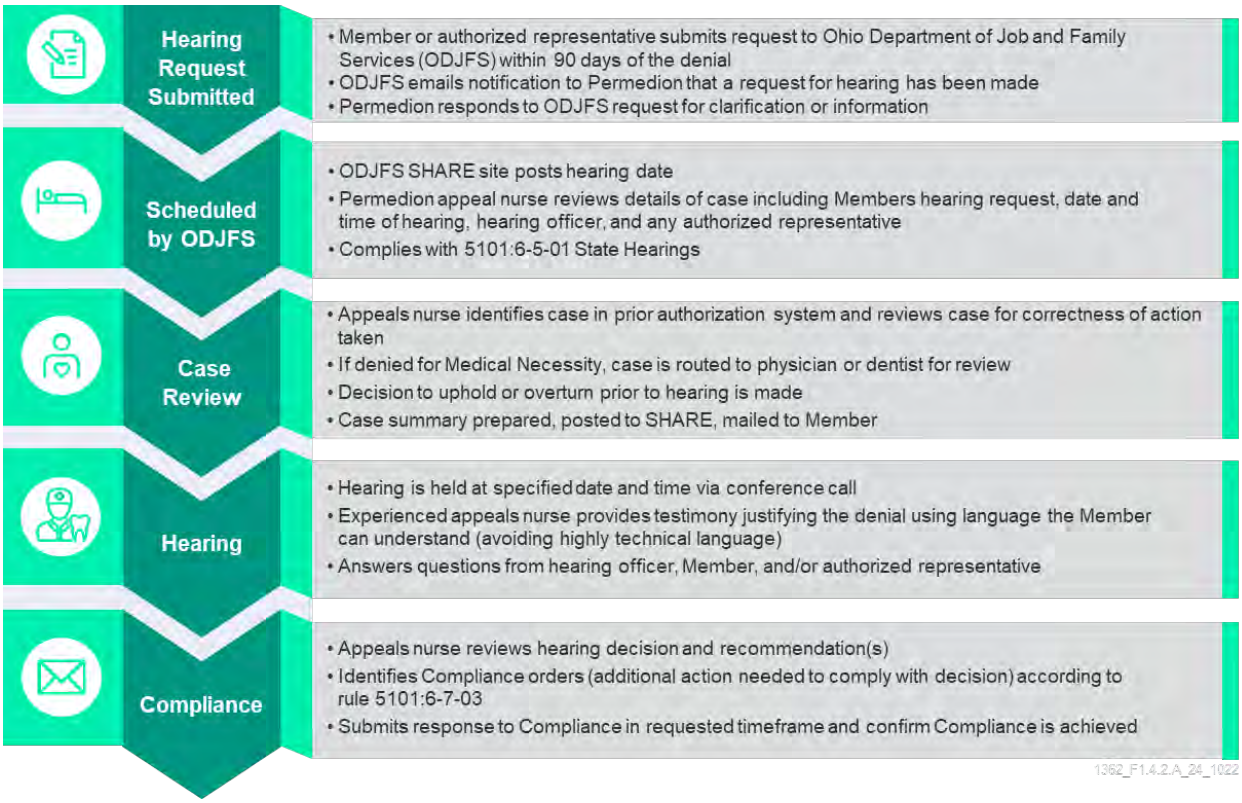
When an adverse decision is made, under OAC 5101:6 “Hearings” a member of a denied service has the right to a state hearing. The Members are notified of their hearing rights, and the process on how to request a hearing in the adverse determination letter.

On average, Permedion prepares appeal summaries and attends appeal hearings on behalf of ODM. This includes ensuring case summaries are completed and distributed to the hearing

officers and members prior to the hearing, and identified trained personnel attend the hearings to provide testimony regarding the rationale of the decision.

The Ohio Department of Job and Family Services (ODJFS) is responsible for managing recipient hearing requests. Permedion is notified of a hearing request via email. We access ODJFS's State hearing Access to Records Electronically (SHARE) site, which assists members by guiding them through their appeal process as well as where appeal summaries and compliance actions are submitted. Permedion logs into SHARE for information on member demographics, the service being appealed, any authorized representative information, and the hearing date and time.

Figure 50. Recipient Hearings Process



Prior to the hearing, an appeal nurse reviews the denied request. For medical necessity denials, peer matched physicians or dentists review the case to make sure that the correct determination was made. If a Pre-Hearing determination approval is made, ODJFS and the member are notified in writing. If the adverse determination is upheld, Permedion prepares an appeal summary for the Hearing officer and member, which includes:

- Prior Authorization number
- Appeal Number
- Hearing Officer
- Issue
- Medicaid Coverage
- Eligibility
- Reason for Denial
- Summary

- Exhibits: Information pertinent to the case

The appeal summary is posted to the SHARE site three business days prior to the hearing for the hearing officer's review. The summary is written in a way that is understandable for those not in the health care industry so that the reason for the denial is understood. A copy is sent to the member or authorized representative to the address located in SHARE. At the date and time of the hearing, Permedion joins the conference call and presents the merits of the case and answers questions from both the Hearing officer, the member, and any representative of the member attending and sworn in. After the hearing, the Hearing officer will issue a determination. Permedion reviews each determination for the outcome. At times, the hearing officer may order additional compliance, such as approving the request, or additional actions to reach out to the provider who submitted the request for additional information so that the request can be approved. Compliance is submitted on the SHARE site, as well as mailed to the member.

F.11 4.2.K Prior Authorization for Private Duty Nursing

RFP Reference: Section 4.2.K

The selected Offeror will act as a designee on behalf of ODM, to receive, review and adjudicate prior authorization requests for private duty nursing upon request from a Medicare certified home health agency (MCHHA) that meets the requirements in accordance with rule 5160-12-03 of the Administrative Code, an otherwise accredited agency that meets the requirements in accordance with rule 5160-12-03.1 of the Administrative Code, and a non-agency nurse that meets the requirements in accordance with rule 5160-12-03.1 of the Administrative Code, or a case manager from one of the following care coordination entities: Ohio Home Care Waiver Agency, PASSPORT Administrative Agencies, County Boards of Developmental Disabilities. The requestor must submit the following form https://medicaid.ohio.gov/static/Resources/Publications/Forms/ODM02374fillx.pdf and supporting documentation including a plan of care (e.g., https://www.cdc.gov/wtc/pdfs/policies/CMS-485-P.pdf).

Prior authorization denials for medical necessity must be reviewed/approved by a physician under the direction of the Medical Director. When issuing a denial of service, the selected Offeror must clearly state all rationale for the denial per approved clinical and procedural guidelines, and standards of care, and note whether a denial was reviewed by a nurse and/or a physician. The selected Offeror will be responsible for development and presentation of appeal summaries in state hearings as part of member's due process rights.

Upon receipt, the selected Offeror, specifically a Registered Nurse, will review and consider all documentation submitted to support the request and ensure compliance with OAC Chapter 5160-12-02 prior to approving or denying the request. A Registered Nurse must also complete an ODM-standardized assessment and acuity tool https://medicaid.ohio.gov/static/Resources/Publications/Forms/ODM02376.pdf. The assessment must be completed and documented no later than 10 business days following the initial request. Expedited requests must be completed the same day or within 24 hours. The selected Offeror must have the capacity to complete the assessments in-person as directed by ODM.

After the assessment is completed, the selected Offeror will determine the outcome of the referral request including notification of outcome and issuance of due process rights https://medicaid.ohio.gov/static/Resources/Publications/Forms/ODM02373fillx.pdf. The selected Offeror will notify the referral source (if authority exists to do so), individual, provider, and case manager, if applicable, of the determination (denial, modification, or approval) including authorized amount, scope and duration of services). The selected Offeror shall represent ODM at any hearing filed resulting from the prior authorization requested.

Permedion will act as a designee on behalf of ODM, to receive, review, and adjudicate valid prior authorization requests for private duty nursing. We have expertise conducting prior authorization reviews of private duty nursing services and are currently performing these services for 5 state Medicaid programs.

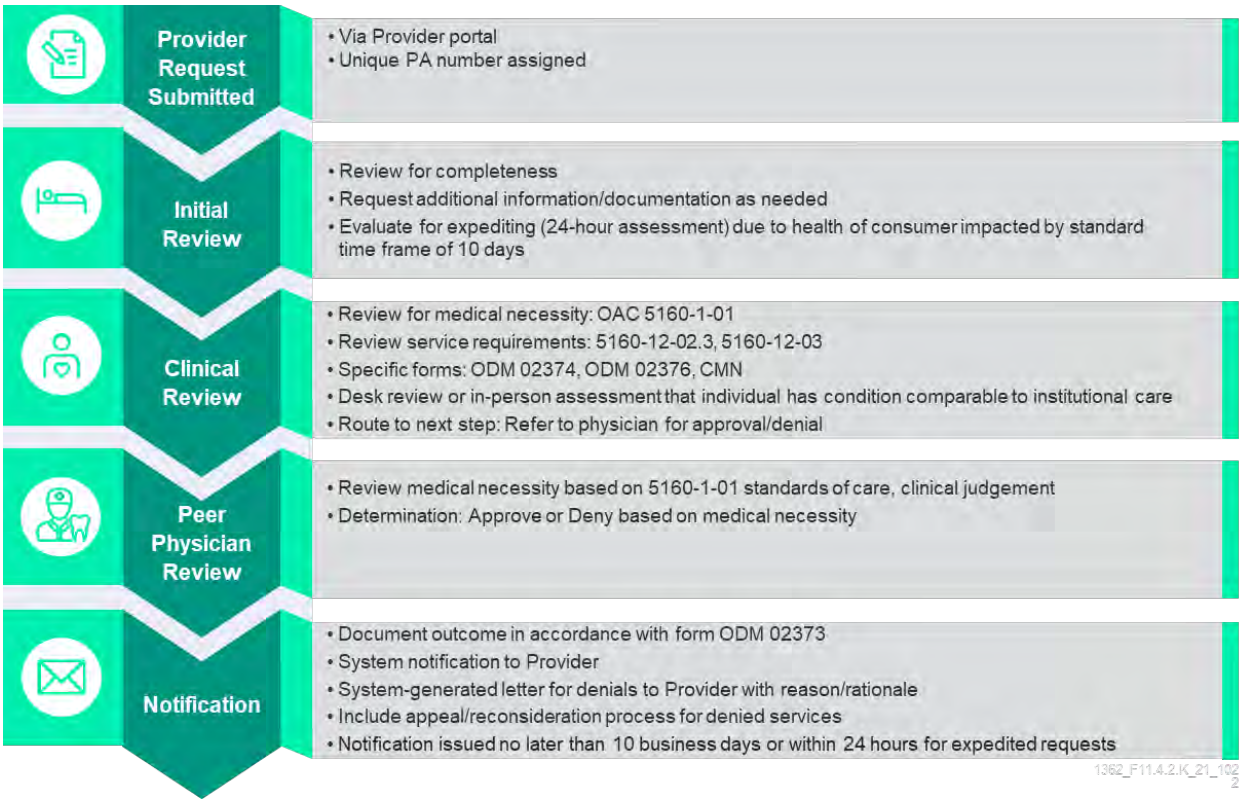
Prior Authorizations Process

Because Permedion is currently reviewing Increased State Home Health prior authorization requests, adding Private Duty Nursing will be quickly integrated into our review policies, procedures and processes already in place. We will review requests from Medicare certified home health agency (MCHHA) to ensure the requirements in accordance with rule 5160-12-02, 5160-12-03 and 5160-1-01 of the Administrative Code are met. For Non-agency nurses, and otherwise-accredited agencies, we will ensure they meet the requirements set forth in 5160-12-03.1 of the Administrative Code.

Private duty nursing (PDN) is a continuous nursing service, beyond the Medicaid State plan Home Health benefit to provide skilled nursing care for members with complex medical needs if the skilled care can be provided in the consumers residence. PDN requires the skills of, and is performed by a RN, or an LPN under the direction of an RN. Services are between 4 hours to 12 hours in length per nurse over a 24-hour period, and must be within the nurse's scope of practice, provided in accordance with the plan of care and medically necessary in accordance with 5160-1-01 of the Administrative Codes. A thorough review of a provider's request for PDN services is required to ensure requirements for delivery and medical necessity are met.

Permedion will review the information submitted by the provider on form ODM 02374 "Private Duty Nursing (PDN) Services" Request", and the Certificate of Medical Necessity, along with all supporting documentation in order ensure the requirements for the delivery of PDN services is met. A desk review or in-person assessment is conducted to ensure the individual has a medical condition that meets the criteria for a nursing facility-based level of care and that PDN services are medically necessary as set for in rule 5160-1-01.

Figure 51. Prior Authorization for Private Duty Nursing



Prior authorization denials for medical necessity must be reviewed/approved by a physician under the direction of the Medical Director. When issuing a denial of service, our reviewer will incorporate the PDN Assessment Outcome (form 02373) into the processes in place that clearly state all rationale for the denial per approved clinical and procedural guidelines, and standards of care. The denials related to medical necessity are always performed by our physicians. Permedion currently has processes in place regarding composing appeal summaries which review merits of the case and reason for the denial. We will represent ODM in state hearings and we're already experienced utilizing the SHARE site where information regarding requests for hearings, hearing scheduling, documentation submitted on appeal, as well as uploading the case summary for the hearing officer review prior to the hearing.

Permedion reviewers will use all documentation submitted to support the request and assure compliance with OAC Chapter 5160-12-02 prior to approving or denying the request. Our registered nurses will complete an ODM-standardized assessment ODM02376 and acuity tool. After assessing the acuity of the information presented, the assessment must be completed and documented no later than 10 business days following the initial request. If the health needs of the individual are at risk utilizing the standard review period, expedited requests will be completed the same day or within 24 hours. Permedion will conduct an in-person assessment or perform a desk review, in accordance with rule 5160-12-02 of the Administrative Code or as directed by ODM, to determine if the individual has a medical condition that meets the criteria for a comparable institutional level of care.

After the assessment is completed, our reviewer determines the outcome of the request (approved, reduced, increased, unchanged or denied). State Rights to a hearing, as well as how to submit the request, is included in the notification in the event the member disagrees with the decision. Notifications will be sent to the referral source (if authority exists to do so), individual, provider, and case manager regarding the determination (denial, modification, or approval) including authorized amount, scope, and duration of services).

Permedion currently has a process in place for preparing for and participating in appeal hearings on behalf of ODM. This process makes certain that case summaries are completed and distributed to the hearing officers and members prior to the hearing, and identified trained personnel attend the hearings to present the appeal summaries and provide testimony regarding the rationale of the decision.

Permedion has been representing ODM in hearings related to fee-for-service denials and is experienced composing an appeal summary, as well as providing testimony to uphold determinations that do not meet medical necessity or other rules required to be met in order to receive services.

When an adverse decision is made, under OAC 5101:6 "Hearings" a member of a denied service has the right to a state hearing. The Members are notified of their hearing rights, and the process on how to request a hearing in the adverse determination letter.

On average, Permedion prepares 15-20 appeal summaries and attends appeal hearings each month on behalf of ODM. This includes making sure that case summaries are completed and distributed to the hearing officers and members prior to the hearing, and identified trained personnel attend the hearings to provide testimony regarding the rationale of the decision.

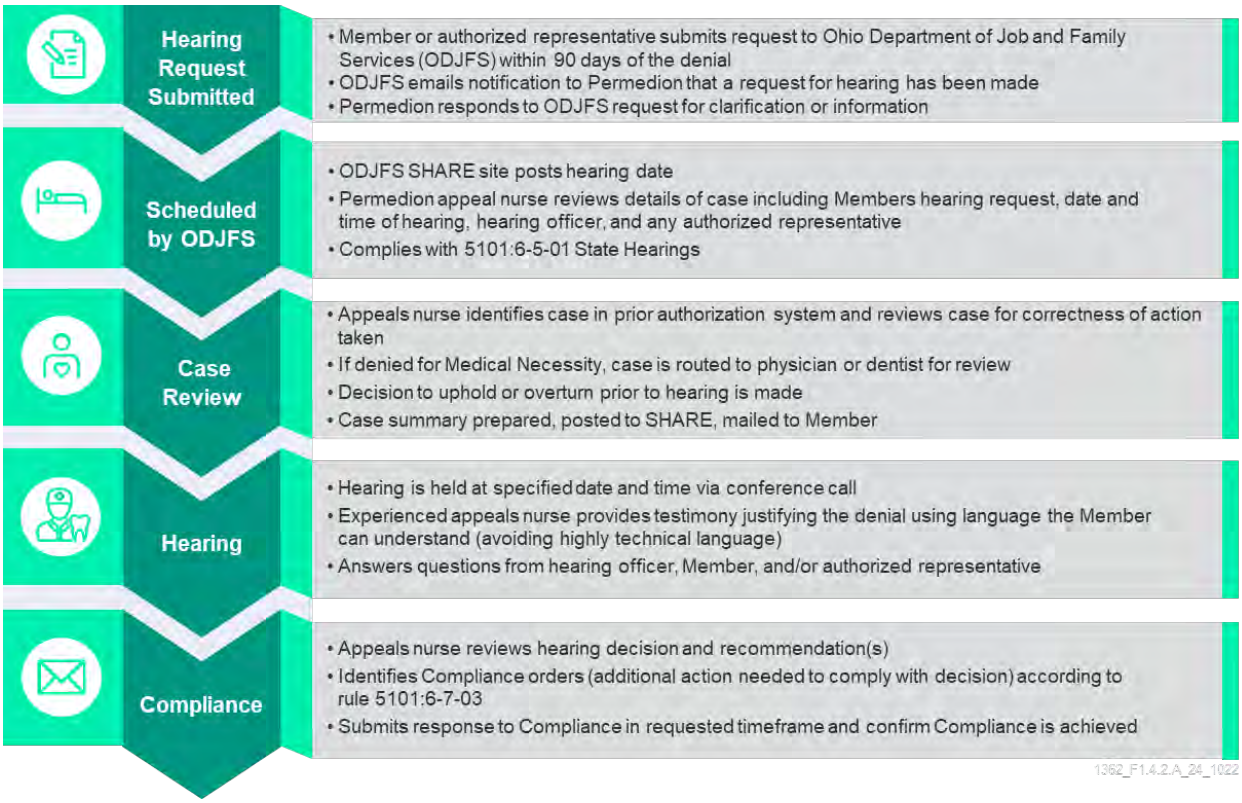
Recipient Hearings

The Ohio Department of Job and Family Services (ODJFS) is responsible for managing recipient hearing requests. Permedion is notified of a hearing request via email. We access ODJFS's State hearing Access to Records Electronically (SHARE) site which assists members

guiding them through their appeal process as well as where appeal summaries and compliance actions are submitted. Permedion logs into SHARE for information on member demographics, the service being appealed, any authorized representatives and the hearing date and time.

The following figure shows the steps included in our Recipient Hearings Process.

Figure 52. Recipient Hearings Process



Prior to the hearing, an appeal nurse reviews the denied request. For medical necessity denials, peer matched physicians or dentists review the case to ensure the correct determination was made. If a Pre-Hearing determination approval is made, ODJFS and the member are notified in writing. If the adverse determination is upheld, Permedion prepares an appeal summary for the Hearing officer and member. The appeal summary includes:

- Prior Authorization number
- Appeal Number
- Hearing Officer
- Issue
- Medicaid Coverage
- Eligibility
- Reason for Denial
- Summary
- Exhibits: Information pertinent to the case

The appeal summary is posted to the SHARE site three business days prior to the hearing for the hearing officer's review. The summary is written in a way that is understandable for those not in the health care industry so that the reason for the denial is understood. A copy is sent to the member or authorized representative to the address located in SHARE. At the date and time

of the hearing Permedion joins the conference call and presents the merits of the case and answers questions from both the Hearing officer, the member and any representative of the member attending and sworn in. After the hearing, the Hearing officer will issue a determination. Permedion reviews each determination for the outcome. At times, the hearing officer may order additional compliance, such as approving the request, or additional actions to reach out to the provider who submitted the request for additional information so that the request can be approved. Compliance is submitted on the SHARE site, as well as mailed to the member.

Provider Appeals

Permedion is also ready for any provider reconsiderations that may be received. Permedion has been processing provider appeals (reconsiderations) for other service types and are prepared when this starts for providers of PDN. For adverse determinations regarding prior authorizations, the provider may appeal in accordance with 5160-1-31(E) which regulates the provider's right to a reconsideration. Providers may request reconsiderations of an adverse prior authorization in accordance with section 5160.34 of the revised code. Providers may submit reconsiderations by mail or provider portal. Providers may request a reconsideration within 60 days from the date on the adverse prior authorization determination. For a valid request, the provider should submit the following information:

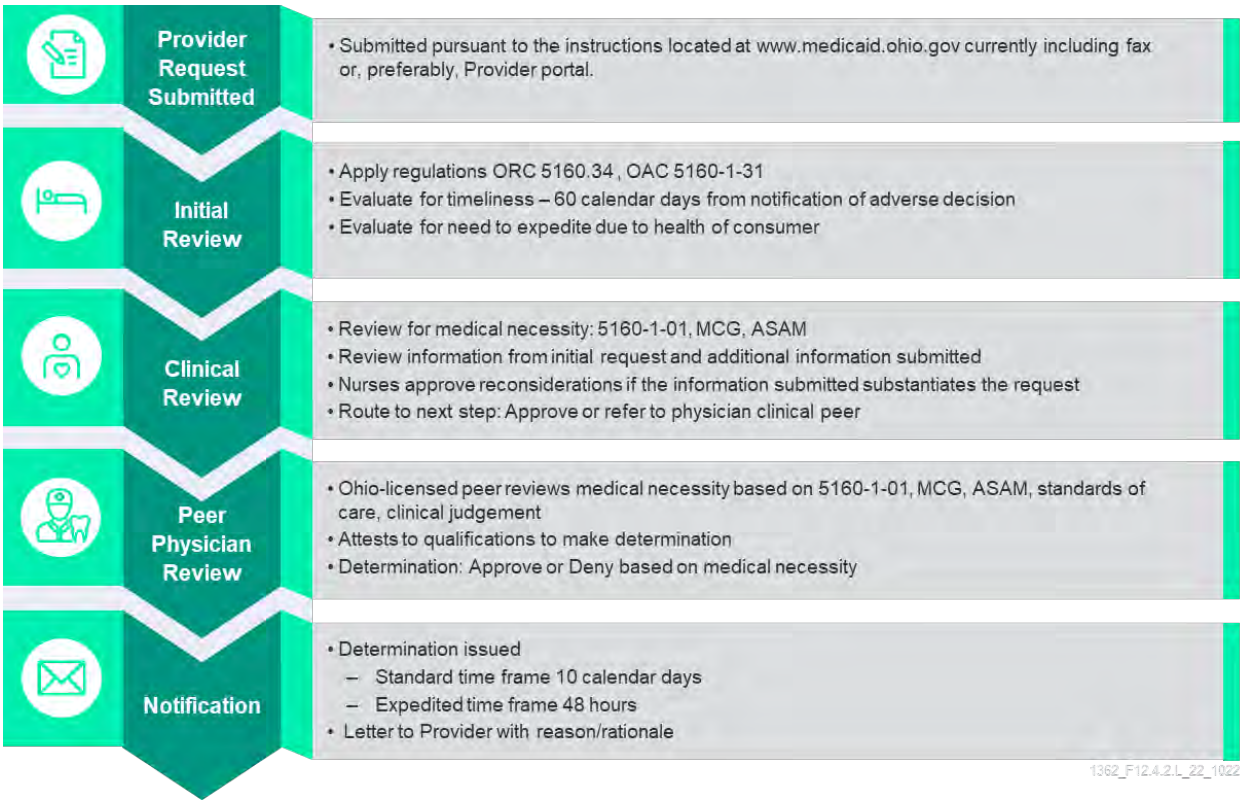
- Medicaid recipient's name and Medicaid number;
- Name of requested service or item and billing code;
- Date of service or item request;
- Clinical documentation supporting medical necessity for the service or item;
- A reference to any relevant federal or state law or regulation, if applicable;
- An explanation outlining the reason for reconsideration, including supportive information not previously submitted as necessary; and
- If applicable, an indication of whether the service or item qualifies as "urgent care services" as defined in section 5160.34 of the Revised Code.

In accordance with 5160.34(B12) Permedion will consider standard requests for reconsideration within 10 days of receipt. For urgent care services, the appeals shall be considered withing 48 hours after the appeal is received.

The clinical reviewer will review all information during the appeals process, without regard as to whether information was submitted in the initial consideration of the case. If after review, the reviewer cannot approve the reconsideration request, the request is forwarded to a physician who is knowledgeable of the issue under review and has the clinical expertise that permits them to manage the medical or behavioral health condition or disease under review.

The following figure illustrates the Reconsiderations/Provider Appeals Process.

Figure 53. Reconsiderations/Provider Appeals Process



The Provider and member are notified of the determination, along with any other reconsideration rights. The provider reconsideration process afforded under 5106-1-31 does not interfere with the Medicaid recipient's right to appeal in accordance with OAC 5101:6 Hearings.

F.12 4.2.L Prior Authorization Appeal Requests

RFP Reference: Section 4.2.L

> The selected Offeror will perform provider appeals when designated by ODM. The selected Offeror will make a standard reconsideration determination within ten calendar days of receipt of a valid request. If an expedited review is requested because the service or item qualifies as urgent care services, the reconsideration determination will be made no later than forty-eight hours after receipt of a valid reconsideration.
>
> The request for reconsideration may be reviewed by a nurse, and if the newly submitted documentation does not substantiate the request, a review would be conducted by a clinical peer.

While the scope of provider appeals for prior authorization will be expanding in December 2022, Permedion has been processing provider PA reconsiderations for ODM and several other Medicaid programs for decades. We have policies and procedures in keeping with ODM regulations and URAC accreditation standards of excellence. For adverse determinations regarding prior authorizations, the provider may appeal in accordance with OAC 5160-1-31(E).

If a Prior Authorization is denied, providers may request a reconsideration within 60 calendar days of the adverse determination. Permedion will receive requests submitted pursuant to the

instructions located at www.medicaid.ohio.gov currently including fax or, preferably, provider portal. A reconsideration request must include the following:

- Medicaid recipient's name and Medicaid number;
- Name of requested service or item and billing code;
- Date of service or item request;
- Clinical documentation supporting medical necessity for the service or item;
- A reference to any relevant federal or state law or regulation, if applicable;
- An explanation outlining the reason for reconsideration, including supportive information not previously submitted as necessary; and
- If applicable, an indication of whether the service or item qualifies as “urgent care services” as defined in section 5160.34 of the Revised Code.

Once a reconsideration is received, an appeal nurse will review the information associated with the initial request and determination, as well as appeal documentation submitted.

If the additional information submitted with the appeal supports the criteria for approval, the appeal nurse will issue an overturn decision to the provider utilizing an ODM approved letter template.

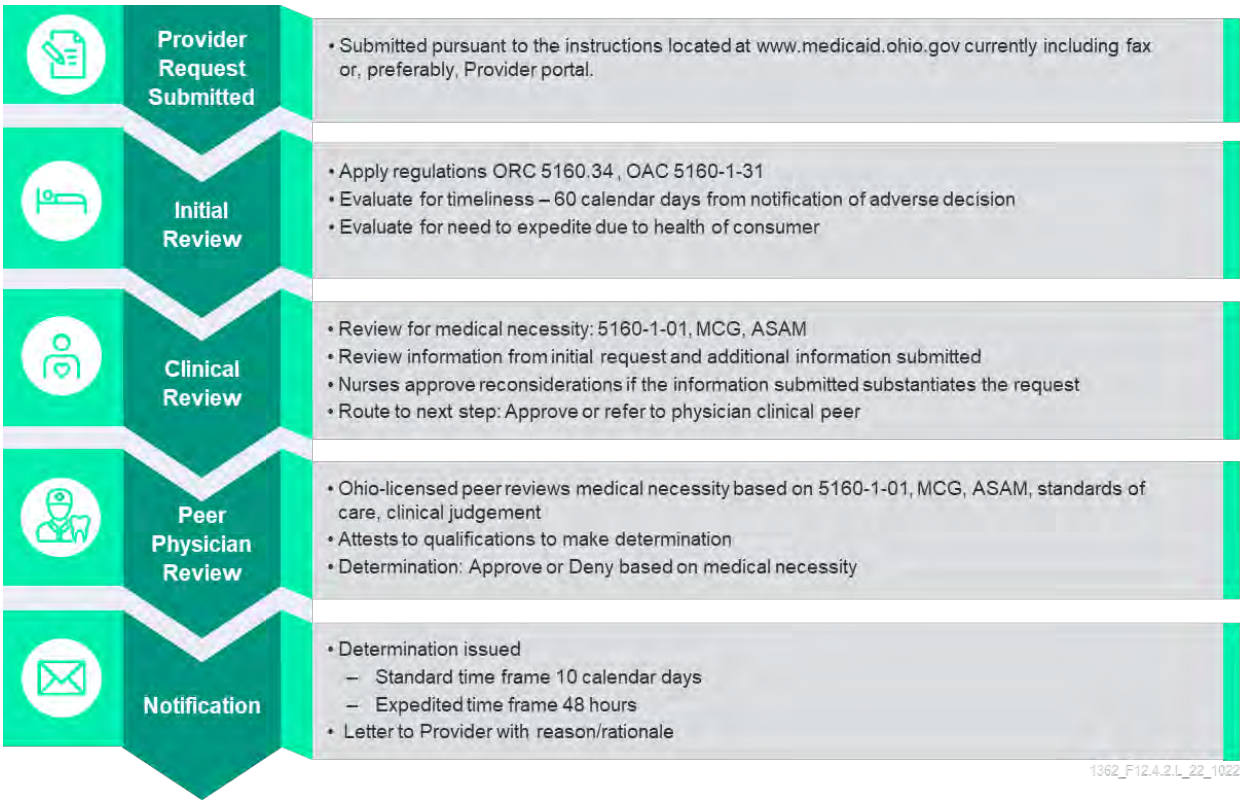
If the request cannot be approved by the nurse, the request is referred to a clinical peer that is a credentialed member of our physician panel. The reviewing physician will be Ohio-licensed and in the same, or in a similar, specialty that typically manages the medical condition, procedure, or treatment under review.

The determination will be issued pursuant to ODM requirements within the following timeframes:

- **Standard**. Determinations will be issued within 10 calendar days of receipt.
- **Expedited**. If the service or item qualifies as urgent care services, the determination will be issued within 48 hours after receipt.

The following figure illustrates our Appeal Process.

Figure 54. Reconsiderations/Provider Appeals



The provider reconsideration process does not interfere with the Medicaid recipient's right to appeal in accordance with division 5101-6 of the Administrative Code.

F.13 4.2.M Reporting and Analysis

RFP Reference: Section 4.2.M

In order to monitor and evaluate utilization of medical services in the Medicaid population, various reports will be required from the selected Offeror. These include, but are not limited to, activity reports related to the pre-certification, prior authorization, and special review program and the retrospective and quality review program. The accuracy of all reports must be verified by the selected Offeror prior to submission to ODM. The selected Offeror is responsible for developing and implementing all reports in accordance with ODM's specifications.

All reports must be submitted within thirty days of the end of the reporting period unless an alternate time frame has been established by ODM in writing. Reports must be submitted electronically, but also be available in hard copy form. Reports should be accurate and complete.

The following mandatory reports are required for the Pre-certification and Special Review Program:

1. A monthly report summarizing work completed. The source of the report will be mutually agreed upon by both parties. At a minimum, the report must include the total number of cases completed, the number of cases recommended, the number of cases referred to physician advisors, and the outcome of pre-certification/special review.
2. A monthly report detailing work completed including specific information related to individual cases.
3. A monthly report documenting reconsiderations of initial adverse decisions and the reconsideration outcomes.

The selected Offeror is encouraged to identify and develop additional reports needed to monitor utilization of medical services by the Ohio Medicaid population.

The following mandatory reports are required for the Retrospective Review Program:

1. A monthly retrospective review schedule and a frequency report.
2. A quarterly report summarizing work completed including the total number of cases denied by review category and the net dollar savings associated with these categories.
3. A monthly report detailing work completed, including specific information related to individual cases.
4. A monthly report finalizing all review activity for a specific review month after the appeal deadline has been reached.
5. A monthly report that details sample selection methodology.

Reports of quality concerns, using processes established by Medicare for quality screens and levels include:

1. Initial and final quality concerns issued on a monthly basis.
2. Quarterly report demonstrating trends.

The selected Offeror is encouraged to identify and develop additional reports needed to monitor utilization of medical services by the Ohio Medicaid population. Other reports may be requested by ODM as needed.

The following reports are required for Non-Institutional Services Prior Authorization: Monthly reports of number of finalized reviews by category sorted by approvals and denials and also sorted by adult and pediatric (under age 21).

Permedion will provide robust analytics and reporting to effectively monitor and evaluate the utilization of Ohio Medicaid services. Reports will include activity and outcomes related to the pre-certification, prior authorization, special review program, and the retrospective review program. All reports required in the RFP are reports currently in production under the current contract, however, Permedion will review all reports with ODM with the new contract.

Permedion will submit reports within 30 days of the end of the reporting period unless an alternate time frame has been established by ODM in writing. Reports will be accurate and complete, and we will submit reports electronically and in hard copy form, if requested. Reports are available to ODM personnel 24 hours per day, 7 days per week, via our secure web portal. Reports will be posted to our enhanced portal that will be implemented for this contract. The portal will not only house standard reports but also support search/report capabilities, such as finding the status of a specific ICN or viewing the status of all claims pending receipt of a medical record in a particular batch.

To meet ODM reporting requirements, we offer customized and ad hoc reporting capabilities leveraging the comprehensive data elements library housed in our review systems. We currently provide all of the reports outlined in the RFP and will continue to modify the reports according to the Department’s preferences on content, format, and frequency.

We will further refine reporting through collaborative work sessions with ODM to document and deploy the Department’s requirements. We can provide all reports to ODM through our secure web portal.

Reports for Precertification and Special Review

Permedion’s proposed solution includes a monthly report (Precertification/Special-Review Activity and Appeals Report) that both summarizes and provides detailed work completed-including information specific to individual cases, and documents reconsiderations of initial adverse decisions and reconsideration outcomes. The following table describes the contents of the mandatory Precertification/Special Review report and also highlights other reports that Permedion will provide to ODM as part of our solution.

Table 12. Precertification/Special Review (PA) Reports

Name	Description	Frequency
PA Summary Report (mandatory)	This is a summary report with the outcomes of PA prior authorization processed within the month. This report contains the following minimum elements: • Total number of cases completed • Number of cases recommended for review • Number of cases referred to physician reviewers/advisors • Outcome of the precertification review See Figure 55 for sample report.	Monthly
PA Detail Report (mandatory)	This report provides detailed information on the outcome of every line item for prior authorization processed within the month. This report contains the following minimum elements: • Details for every line item of every PA including specific information related to individual case See Figure 56 for a sample report.	Monthly
Precertification/ Special-Review Appeals Report (mandatory)	This report provide will detail the results of a reconsideration review decision resulting from an appeal request from the provider or physician. This report will include the following minimum elements: • Each reconsideration completed during the month including the initial adverse decisions and the reconsideration outcome	Monthly
Non-Institutional Services Prior Authorization (mandatory)	This report will include number of finalized reviews by category sorted by approvals and denials and also sorted by adult and pediatric (under age 21). See Figure 57 for a sample report	Monthly

Figure 55. Prior Authorization Review Summary Report

		Completed					Cancelled			
		Approved		Denied						
Assignment Category	Invoice Grouping	Adult	Ped	Adult	Ped	Total	Adult	Ped	Total	Grand Tota
ACT Enrollment	BH, Substance Abuse and ABA PA	7	0	3	0	10	0	0	0	10
Compression Garments	PA Medical	118	1	9	1	129	0	0	0	129
Decubitus Care Equipment	PA Medical	12	1	1	0	14	0	0	0	14
Dental	PA Dental	768	4	343	1	1,116	0	0	0	1,116
Dressings, Surgical	PA Medical	43	10	11	2	66	0	0	0	66
Enteral Nutrition and Supplies	PA Medical	308	194	38	28	568	7	4	11	579
Hearing Aids	PA Medical	175	4	17	0	196	2	0	2	198
Hospital Beds	PA Medical	57	5	39	1	102	0	0	0	102
Hospital Inpatient	PA Hospital and Home Health	47	1	4	0	52	7	1	8	60
Hospital OP-Behavioral Health	BH, Substance Abuse and ABA PA	2	0	0	0	2	0	0	0	2
Hospital Outpatient	PA Hospital and Home Health	77	1	10	0	88	54	10	64	152
Incontinence Supplies	PA Medical	62	13	20	1	96	0	1	1	97
INCREASED STATE PLAN HOME HLTH	PA Hospital and Home Health	154	0	0	0	154	8	0	8	162
Miscellaneous Equipment	PA Medical	57	41	30	21	149	5	1	6	155
Orthodontics	PA Dental	0	7	0	0	7	0	0	0	7
Orthotics (MTA)	PA Medical	93	29	12	5	139	1	4	5	144
Orthotics/Prosthetics (Nurses)	PA Medical	19	5	3	0	27	0	0	0	27
Psychiatric Inpatient	Pre-cert Psych Hosptial	366	2	17	8	393	16	0	16	409
Repairs	PA Medical	350	48	16	5	419	2	2	4	423
Respiratory (MTA)	PA Medical	60	28	20	1	109	4	0	4	113
Respiratory (Nurses)	PA Medical	33	54	11	11	109	0	2	2	111
Speech Generating Devices	PA Medical	19	18	0	0	37	0	0	0	37
SUD Partial Hosp Services	BH, Substance Abuse and ABA PA	236	0	55	0	291	11	0	11	302
SUD Residential Services	BH, Substance Abuse and ABA PA	107	0	8	0	115	18	0	18	133
Supplies (Miscellaneous)	PA Medical	21	12	4	2	39	5	0	5	44
Therapies	PA Medical	8	6	0	0	14	1	0	1	15
Vision	PA Medical	59	1	0	0	60	0	0	0	60
Wheelchairs	PA Medical	340	30	137	13	520	15	1	16	536
Grand Total	**Total**	**3598**	**515**	**808**	**100**	**5021**	**156**	**26**	**182**	**5203**

Figure 56. Prior Authorization Denied/Approved Monthly Detail Report

PA_NUMBER	Header Status	Assignment Category	Invoice Grouping	Day of DATE_RECV	Day of DATE_REVIEW	Patient Age Category	PA_LINE_ITEM	CDE_SVC_TYPE	DSC_STATUS
#	Denied	Enteral Nutrition and Supplies	PA Medical	05/26/2022	08/09/2022	Adult	01	2	DENIED
#	Denied	Miscellaneous Equipment	PA Medical	06/06/2022	08/02/2022	Adult	01	2	DENIED
#	Approved	Enteral Nutrition and Supplies	PA Medical	06/06/2022	08/03/2022	Adult	01	2	APPROVED
#	Approved	Enteral Nutrition and Supplies	PA Medical	06/06/2022	08/03/2022	Adult	02	2	APPROVED
#	Denied	Enteral Nutrition and Supplies	PA Medical	06/07/2022	08/09/2022	Adult	01	2	DENIED
#	Approved	Orthotics (MTA)	PA Medical	06/15/2022	08/12/2022	Adult	01	2	APPROVED
#	Approved	Orthotics (MTA)	PA Medical	06/15/2022	08/12/2022	Adult	02	2	APPROVED
#	Denied	Enteral Nutrition and Supplies	PA Medical	06/16/2022	08/01/2022	Adult	01	2	DENIED
#	Denied	Incontinence Supplies	PA Medical	06/16/2022	08/01/2022	Adult	01	2	DENIED
#	Denied	Incontinence Supplies	PA Medical	06/16/2022	08/01/2022	Adult	02	2	DENIED
#	Denied	Incontinence Supplies	PA Medical	06/16/2022	08/01/2022	Adult	03	2	DENIED
#	Denied	Miscellaneous Equipment	PA Medical	06/16/2022	08/01/2022	Ped	01	2	DENIED
#	Denied	Respiratory (Nurses)	PA Medical	06/16/2022	08/01/2022	Ped	01	2	DENIED

Figure 57. Non-Institutional Services Prior Authorization Report

Non-Institutional Services	Completed					Cancelled			
	Approved		Denied			Cancelled			
Assignment Category	Adult	Ped	Adult	Ped	Total	Adult	Ped	Total	Grand Total
Compression Garments	118	1	9	1/1/1900	5/8/1900	0	0	0	**129**
Decubitus Care Equipment	12	1	1	1/0/1900	1/14/1900	0	0	0	**14**
Dental	768	4	343	1/1/1900	1/20/1903	0	0	0	**1116**
Dressings, Surgical	43	10	11	1/2/1900	3/6/1900	0	0	0	**66**
Enteral Nutrition and Supplies	308	194	38	1/28/1900	7/21/1901	7	4	11	**579**
Hearing Aids	175	4	17	1/0/1900	7/14/1900	2	0	2	**198**
Hospital Beds	57	5	39	1/1/1900	4/11/1900	0	0	0	**102**
Incontinence Supplies	62	13	20	1/1/1900	4/5/1900	0	1	1	**97**
Miscellaneous Equipment	57	41	30	1/21/1900	5/28/1900	5	1	6	**155**
Orthodontics	0	7	0	1/0/1900	1/7/1900	0	0	0	**7**
Orthotics (MTA)	93	29	12	1/5/1900	5/18/1900	1	4	5	**144**
Orthotics/Prosthetics (Nurses)	19	5	3	1/0/1900	1/27/1900	0	0	0	**27**
Repairs	350	48	16	5	419	2	2	4	**423**
Respiratory (MTA)	60	28	20	1/1/1900	4/18/1900	4	0	4	**113**
Respiratory (Nurses)	33	54	11	1/11/1900	4/18/1900	0	2	2	**111**
Speech Generating Devices	19	18	0	1/0/1900	2/6/1900	0	0	0	**37**
Supplies (Miscellaneous)	21	12	4	1/2/1900	2/8/1900	5	0	5	**44**
Therapies	8	6	0	1/0/1900	1/14/1900	1	0	1	**15**
Vision	59	1	0	1/0/1900	2/29/1900	0	0	0	**60**
Wheelchairs	340	30	137	1/13/1900	6/3/1901	15	1	16	**536**
Grand Total	**3598**	**515**	**808**	**4/9/1900**	**9/29/1913**	**156**	**26**	**182**	**5203**

Reports for Retrospective Review

As part of our proposed solution, Permedion will provide ODM with the following required reports associated with retrospective review:

- Monthly retrospective review schedule and a frequency report (Review Schedule Report)
- Quarterly report summarizing work completed, including the total number of cases denied by review category along with the net dollar savings associated with these categories (Quarterly Denial Report)
- Monthly report detailing work completed, including specific information related to individual cases (Findings Report)
- Monthly report finalizing all review activity for a specific review month after the appeal deadline has been reached (Final Denial Report)
- Monthly report that details our sample selection methodology (Selection Methodology Report)

The following table provides information about these mandatory reports and also lists supplemental retrospective review reports that Permedion currently provides to ODM. For report examples, see the figures that appear immediately after this table.

Table 13. Retrospective Review Reports

Name	Description	Frequency
Review Schedule Report (mandatory) Figure 58	This report provides the schedule indicating what facilities will be reviewed for a specific review cycle and the volume of records by facility. Note: Providers have access to their individual reports and claim status.	Monthly
Quarterly Denial Report (mandatory) Figure 59	We produce reports on the cases denied as part of the retrospective review process during the quarter. This report includes results by review categories, percentages, and the total dollars denied for the three-month period. Note: Providers have access to their individual reports and claim status.	Quarterly
Monthly Approval Report (supplemental) Figure 60	Permedion currently produces a monthly report on cases approved during the retrospective review process. The report includes summary-level information for the provider (i.e., the total number of reviews during this period, the total number of approvals, and details of individual cases approved). Note: Providers have access to their individual provider approval report.	Monthly
Findings Report (mandatory) Figure 61	This report provides detailed information on all review decision for each case reviewed. It also includes a summary of results by facility and total facilities. Note: Providers will access to their individual reports and claim information and status.	Monthly
Final Denial Report (mandatory) Figure 62	This report provides detailed information on the review decision for each case reviewed in the review cycle, including the results after considering additional information provided during the appeal/reconsideration period. The Final Denial Report identifies the review outcomes after all appeals have been completed. Note: Providers have access to their individual reports and claim status.	Monthly
Selection Methodology Report (mandatory) Figure 63	This report provides detailed information on the distribution of cases selected for retrospective review for each review cycle. It includes a description of the inclusion and exclusion criteria used to screen the claims before selection. This report details the specific targets selected for review for hospital inpatient including psychiatric admissions and hospital outpatient claims.	Monthly

Figure 58. Review Schedule Report

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Inpatient Retrospective Review Schedule

Ohio Medicaid — Review Month/Year: 09 / 22

Off Site

Hospital	Provider #	Claims Count	Review Dates	Reviewer 1	Reviewer 2
ADENA HEALTH SYSTEM, Chillicothe	1475685	8	Off Site		
ADENA HEALTH SYSTEM, Chillicothe	6942509	3	Off Site		
AKRON GENERAL HOSP, Akron	0069483	20	Off Site		
ALLIANCE COMMUNITY HOSPITAL, Alliance	0127508	3	Off Site		
ASHTABULA COUNTY MEDICAL CTR, Ashtabula	0289343	3	Off Site		
ATRIUM MEDICAL CENTER, Dayton	5948505	7	Off Site		
AULTMAN HOSPITAL ASSN, Canton	0318758	6	Off Site		
AULTMAN ORRVILLE HOSPITAL, Orrville	2370250	1	Off Site		
Adams County Hospital, Seaman	0393627	1	Off Site		
Alecto Healthcare Services Martins Ferry LLC, Martins Ferr	0230820	1	Off Site		
Avita Ontario Hospital LLC, Galion	0217883	1	Off Site		
BAY PARK COMMUNITY HOSPITAL, Toledo	2276602	2	Off Site		
BEAVERCREEK MEDICAL CENTER, Miamisburg	0066896	6	Off Site		
BELLEVUE HOSPITAL ASSN, Bellevue	0592336	1	Off Site		
BETHESDA HOSPITAL - CINN, CINCINNATI	0684504	22	Off Site		
BLANCHARD VALLEY HOSPITAL, Findlay	0759666	1	Off Site		
BUCYRUS COMMUNITY HOSPITAL, Galion	3150076	4	Off Site		
CAMDEN CLARK MEM HOSP, Parkersburg	1252602	1	Off Site		
CHILDREN'S HOSPITAL AKRON, Akron	1473203	30	Off Site		
CHILDREN'S MEDICAL CENTER, Dayton	0465509	20	Off Site		
CHILDRENS HOSPITAL MED CTR-CINN, Cincinnati	1473285	42	Off Site		
CHWC MONTPELIER HOSPITAL, Montpelier	2533753	1	Off Site		
CLEVELAND CLINIC - AVON, Independence	0195495	3	Off Site		
CLEVELAND CLINIC HOSPITAL, Independence	1563562	48	Off Site		
COMMUNITY HOSP & WELLNESS CT, Bryan	1254404	3	Off Site		
COMMUNITY MERCY REGIONAL, Cincinnati	5281350	9	Off Site		
CSAHS/UHHS - CANTON INC., Canton	0298771	10	Off Site		

Figure 59. Quarterly Denial Report

Claim Type	Inpatient	
BatchNum	474	
	Cases	Dollars
Selected	1,400	$ 20,294,387.11
Approved	1,130	$ 16,527,805.58
Final Denials	270	$ 3,766,581.53
Total Denials	353	

Category	Total Denials	Final Denial Count	Final Denial Dollars
Medical Necessity	212	162	$ 1,647,806.79
DRG Reassignment	104	74	$ 1,113,444.93
Billing Error	25	23	$ 915,234.87
Technical Denial	7	6	$ 70,005.84
Readmission	5	5	$ 20,089.10
Total	353	270	$ 3,766,581.53

Claim Type	Outpatient	
BatchNum	475	
	Cases	Dollars
Selected	199	$ 1,234,399.52
Approved	102	$ 1,026,799.76
Final Denials	97	$ 207,599.76
Total Denials	111	

Category	Total Denials	Final Denial Count	Final Denial Dollars
Incorrect CPT Code	102	90	$ 182,986.46
Technical Denial	5	5	$ 18,953.04
Medical Necessity	4	2	$ 5,660.26
Total	111	97	$ 207,599.76

Claim Type	Inpatient Psych	
BatchNum	476	
	Cases	Dollars
Selected	200	$ 755,984.53
Approved	182	$ 701,879.74
Final Denials	18	$ 54,104.79
Total Denials	25	

Category	Total Denials	Final Denial Count	Final Denial Dollars
Medical Necessity	17	12	$ 36,106.17
DRG Reassignment	4	3	$ 9,489.57
Technical Denial	2	2	$ 6,215.12
Billing Error	2	1	$ 2,293.93
Total	25	18	$ 54,104.79

Figure 60. Monthly Approval Report

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Ohio Medicaid Hospital Retrospective Review

Hospital Summary of Utilization Approvals

Hospital Name: ABC PROVIDER
Hospital Address: 1234 ADDRESS ST
CITY, OH
Hospital Provider No.:
No. of Cases Reviewed: 6
No. of Cases Approved: 5

Admission Dates Reviewed: 05/05/17 through 02/14/20
Review Dates: 05/13/22 through 06/13/22
Batch: 489 4 / 22

Patient Name	Recipient ID	PRS ID	Admission Date	Discharge Date	Attending Physician	Total Amount Paid
SMITH, NAME	12345	12345 - 1	05/05/17	05/10/17		$6,020.36
JOHNSON, NAME	23456	23456 - 1	12/24/17	12/27/17		$5,064.98
SUMMER, NAME	34567	34567 - 1	02/14/20	02/16/20		$6,031.00
SNOWFLAKE, NAME	45678	45678 - 1	07/10/18	07/12/18		$4,069.82
RECIPIENT, NAME	56789	56789 - 1	04/11/19	04/14/19		$5,062.19
	No. of Approved Cases: 5					
	Totals for Hospital: ABC PROVIDER					$26,248.35

No. of Approved Cases for all hospitals: 5

Total: $26,248.35

Figure 61. Initial Findings Report

10/2/2022 **Permedion** Page 1 of 1

Ohio Medicaid Hospital Retrospective Review

Ohio Medicaid Hospital Retrospective Review Hospital Summary of Denials

Hospital Name: ANY PROVIDER
Hospital Address: 1234 Provider Lane
Anywhere, OH 12345
Hospital Provider No.: 1234567
No. of Cases Reviewed: 2 No. of Cases Not Reviewed: 0
No. of Denied Cases: 1
Review Month: 07 / 2022

Admission Dates Reviewed: 10/13/19 through 10/31/19
Review Dates: 08/30/22 through 09/14/22
Total Amount Paid for Cases Reviewed: $4,285.52
Total Amount Paid for Denied Cases: $2,115.19
Total Disagreement Amount: $2,115.19

Patient Name	Recipient ID	PRS ID	Type of Review	Admission Date	Discharge Date	Attending Physician	Total Amount Paid	Claim Disagreement Amount
SMITH, JOHN	1234567890	1234567 - 1	V	10/31/19	10/31/19		$2,115.19	$2,115.19
		Totals for Review Type of: V				Subtotal:	$2,115.19	$2,115.19
		No. of Denied Cases: 1						
		Totals for Hospital: ANY PROVIDER					$2,115.19	$2,115.19

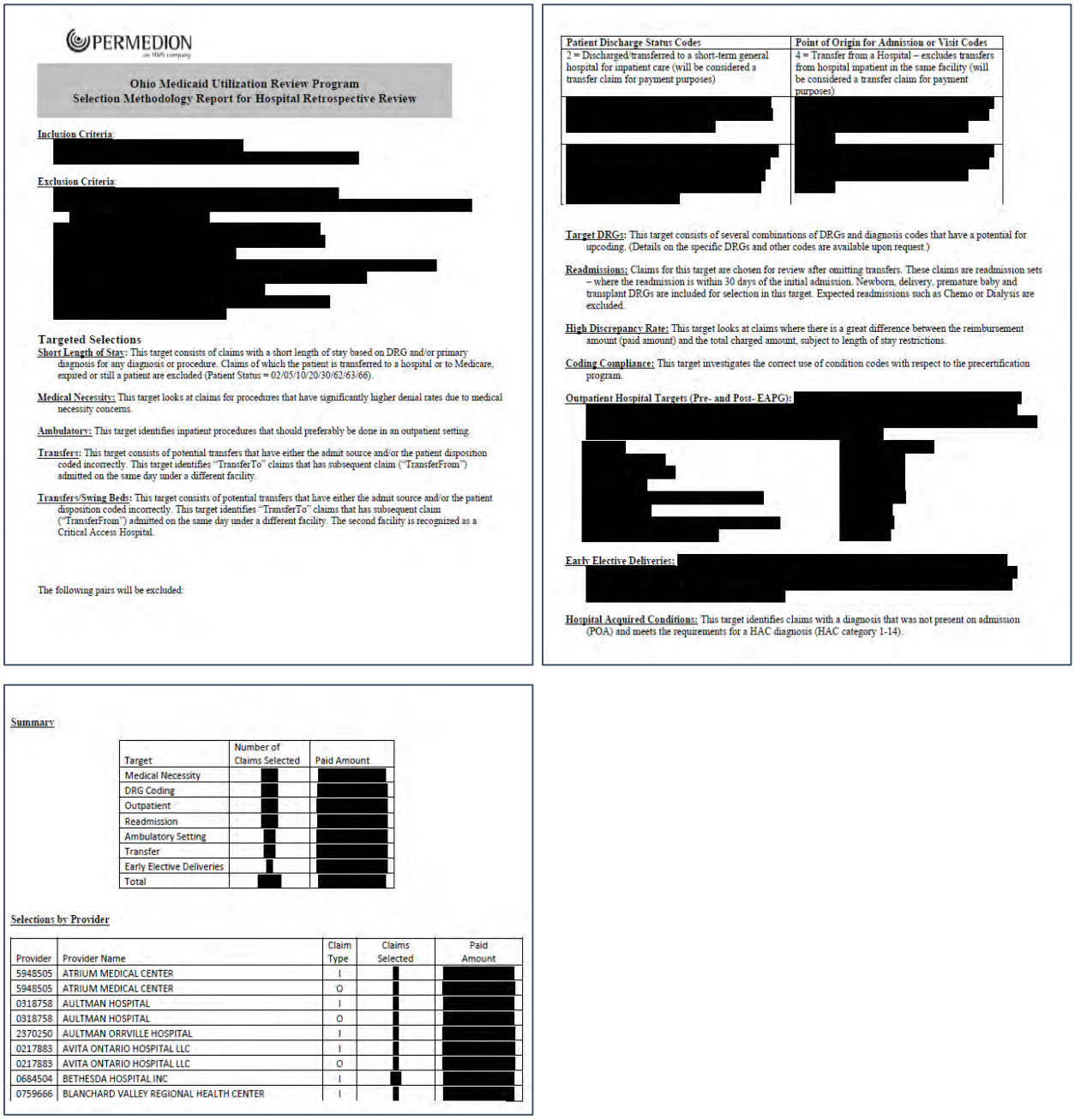
Definition of codes for Type of Reviews
A=Billing Error B=Bill Audit C=Compliance L=Technical Denial M=Medical Necessity
R=Readmission T=Transfer V=DRG Reassignment P=Present On Admission Z=DRG Underpayments

* **See Denial Letter**

Figure 62. Final Denial Report (Adjustment Report)

Review Period:	March 2022 Inpatient	OHIO MEDICAID RETROSPECTIVE REVIEW CLAIM DENIAL DETAILS													
Provider ID	Provider Name	TCN	Recipient ID	Review ID	Patient Name	Admission Date	Discharge Date	LOS	#	Type of Review	Denial Reason	Contractor Decision	Paid Date	Amount Paid / Disagreement Amount	Denied Amount
–	–	–	–	–	–	07/13/17	07/17/17	4	1	M	A02		08/03/17	$8,127.85	$8,127.85
–	–	–	–	–	–	07/15/17	07/17/17	2	1	M	A02		08/03/17	$4,998.93	$4,998.93
–	–	–	–	–	–	07/25/17	07/29/17	4	1	L	L01		08/10/17	$7,845.73	$7,845.73
–	–	–	–	–	–	07/22/17	07/26/17	5	1	M	A02		08/10/17	$8,253.97	$8,253.97
–	–	–	–	–	–	07/31/17	08/01/17	2	1	M	A02		08/17/17	$4,040.25	$4,040.25
–	–	–	–	–	–	07/23/17	07/26/17	3	1	M	A02		08/24/17	$5,626.46	$5,626.46
–	–	–	–	–	–	07/30/17	08/03/17	4	1	L	L01	O	08/31/17	$12,478.58	$12,478.58
–	–	–	–	–	–	08/10/17	08/15/17	5	1	M	A02	O	08/31/17	$8,253.97	$8,253.97
–	–	–	–	–	–	08/16/17	08/19/17	3	1	V	D04	U	08/31/17	$6,383.21	$6,383.21
–	–	–	–	–	–	08/18/17	08/21/17	3	1	A	B05		09/08/17	$8,948.77	$8,948.77
–	–	–	–	–	–	08/10/17	08/12/17	2	1	M	A02		09/14/17	$7,707.13	$7,707.13
–	–	–	–	–	–	08/06/17	08/07/17	1	1	M	A02		09/14/17	$6,017.42	$6,017.42
–	–	–	–	–	–	08/21/17	08/23/17	3	1	M	A02	U	09/14/17	$7,224.20	$7,224.20
–	–	–	–	–	–	08/28/17	09/01/17	4	1	V	D04		09/14/17	$7,426.54	$7,426.54
–	–	–	–	–	–	08/27/17	08/29/17	2	1	M	A02		09/28/17	$7,481.46	$7,481.46
–	–	–	–	–	–	06/04/17	06/06/17	2	1	M	A02		09/28/17	$5,498.85	$5,498.85
–	–	–	–	–	–	06/30/17	07/12/17	12	1	L	L01	O	09/28/17	$11,682.19	$11,682.19
–	–	–	–	–	–	08/23/17	08/30/17	7	1	P	OA2		10/05/17	$27,270.72	$27,270.72
–	–	–	–	–	–	08/23/17	08/30/17	7	2	V	D01		10/05/17	$27,270.72	$27,270.72
–	–	–	–	–	–	09/15/17	09/17/17	2	1	M	A02		10/05/17	$7,307.85	$7,307.85
–	–	–	–	–	–	09/19/17	09/22/17	3	1	M	A02		10/05/17	$5,884.64	$5,884.64
–	–	–	–	–	–	09/10/17	09/11/17	1	1	M	A02		10/13/17	$11,494.55	$11,494.55
–	–	–	–	–	–	09/28/17	09/29/17	1	1	M	A02		10/13/17	$5,260.28	$5,260.28
–	–	–	–	–	–	09/25/17	09/28/17	3	1	M	A02		10/13/17	$4,179.58	$4,179.58
–	–	–	–	–	–	10/09/17	10/12/17	3	1	M	A02		10/26/17	$5,062.44	$5,062.44
–	–	–	–	–	–	10/09/17	10/12/17	3	2	V	D01		10/26/17	$5,062.44	$5,062.44
–	–	–	–	–	–	10/06/17	10/08/17	4	1	M	A02		10/26/17	$4,656.28	$4,656.28
–	–	–	–	–	–	07/29/17	08/03/17	5	1	L	L01	O	10/26/17	$17,684.28	$17,684.28
–	–	–	–	–	–	10/03/17	10/08/17	5	1	A	B05		10/26/17	$4,460.90	$4,460.90
–	–	–	–	–	–	08/04/17	08/06/17	3	1	M	A02		11/02/17	$5,299.97	$5,299.97
–	–	–	–	–	–	09/14/17	09/17/17	3	1	L	L03		11/02/17	$2,793.17	$2,793.17
–	–	–	–	–	–	09/09/17	09/13/17	4	1	L	L03		11/02/17	$3,480.20	$3,480.20
–	–	–	–	–	–	10/15/17	10/17/17	2	1	V	D04		11/02/17	$6,912.26	$6,912.26
–	–	–	–	–	–	11/12/16	11/14/16	2	1	M	A02		11/09/17	$5,824.88	$5,824.88
–	–	–	–	–	–	06/07/17	06/08/17	1	1	M	A02		11/09/17	$6,612.05	$6,612.05
–	–	–	–	–	–	09/05/17	09/11/17	6	1	M	A02		11/09/17	$6,086.33	$6,086.33
–	–	–	–	–	–	02/19/17	02/22/17	3	1	V	D01	U	11/09/17	$13,742.17	$13,742.17
–	–	–	–	–	–	05/14/17	05/18/17	4	1	V	D01		11/09/17	$5,718.15	$5,718.15
–	–	–	–	–	–	05/04/17	05/06/17	3	1	M	A02		11/09/17	$5,384.29	$5,384.29
–	–	–	–	–	–	05/04/17	05/06/17	3	2	V	D01		11/09/17	$5,384.29	$5,384.29

Figure 63. Selection Methodology Report (sample)



PERMEDION
an HMS company

Ohio Medicaid Utilization Review Program
Selection Methodology Report for Hospital Retrospective Review

Inclusion Criteria:
[redacted]

Exclusion Criteria:
[redacted]

Targeted Selections

Short Length of Stay: This target consists of claims with a short length of stay based on DRG and/or primary diagnosis for any diagnosis or procedure. Claims of which the patient is transferred to a hospital or to Medicare, expired or still a patient are excluded (Patient Status = 02/05/10/20/30/62/63/66).

Medical Necessity: This target looks at claims for procedures that have significantly higher denial rates due to medical necessity concerns.

Ambulatory: This target identifies inpatient procedures that should preferably be done in an outpatient setting.

Transfers: This target consists of potential transfers that have either the admit source and/or the patient disposition coded incorrectly. This target identifies "TransferTo" claims that has subsequent claim ("TransferFrom") admitted on the same day under a different facility.

Transfers/Swing Beds: This target consists of potential transfers that have either the admit source and/or the patient disposition coded incorrectly. This target identifies "TransferTo" claims that has subsequent claim ("TransferFrom") admitted on the same day under a different facility. The second facility is recognized as a Critical Access Hospital.

The following pairs will be excluded:

Patient Discharge Status Codes	Point of Origin for Admission or Visit Codes
2 = Discharged/transferred to a short-term general hospital for inpatient care (will be considered a transfer claim for payment purposes)	4 = Transfer from a Hospital – excludes transfers from hospital inpatient in the same facility (will be considered a transfer claim for payment purposes)
[redacted]	[redacted]
[redacted]	[redacted]

Target DRGs: This target consists of several combinations of DRGs and diagnosis codes that have a potential for upcoding. (Details on the specific DRGs and other codes are available upon request.)

Readmissions: Claims for this target are chosen for review after omitting transfers. These claims are readmission sets – where the readmission is within 30 days of the initial admission. Newborn, delivery, premature baby and transplant DRGs are included for selection in this target. Expected readmissions such as Chemo or Dialysis are excluded.

High Discrepancy Rate: This target looks at claims where there is a great difference between the reimbursement amount (paid amount) and the total charged amount, subject to length of stay restrictions.

Coding Compliance: This target investigates the correct use of condition codes with respect to the precertification program.

Outpatient Hospital Targets (Pre- and Post- EAPG):
[redacted]

Early Elective Deliveries:
[redacted]

Hospital Acquired Conditions: This target identifies claims with a diagnosis that was not present on admission (POA) and meets the requirements for a HAC diagnosis (HAC category 1-14).

Summary

Target	Number of Claims Selected	Paid Amount
Medical Necessity	[redacted]	[redacted]
DRG Coding	[redacted]	[redacted]
Outpatient	[redacted]	[redacted]
Readmission	[redacted]	[redacted]
Ambulatory Setting	[redacted]	[redacted]
Transfer	[redacted]	[redacted]
Early Elective Deliveries	[redacted]	[redacted]
Total	[redacted]	[redacted]

Selections by Provider

Provider	Provider Name	Claim Type	Claims Selected	Paid Amount
5948505	ATRIUM MEDICAL CENTER	I	[redacted]	[redacted]
5948505	ATRIUM MEDICAL CENTER	O	[redacted]	[redacted]
0318758	AULTMAN HOSPITAL	I	[redacted]	[redacted]
0318758	AULTMAN HOSPITAL	O	[redacted]	[redacted]
2370250	AULTMAN ORRVILLE HOSPITAL	I	[redacted]	[redacted]
0217883	AVITA ONTARIO HOSPITAL LLC	I	[redacted]	[redacted]
0217883	AVITA ONTARIO HOSPITAL LLC	O	[redacted]	[redacted]
0684504	BETHESDA HOSPITAL INC	I	[redacted]	[redacted]
0759666	BLANCHARD VALLEY REGIONAL HEALTH CENTER	I	[redacted]	[redacted]

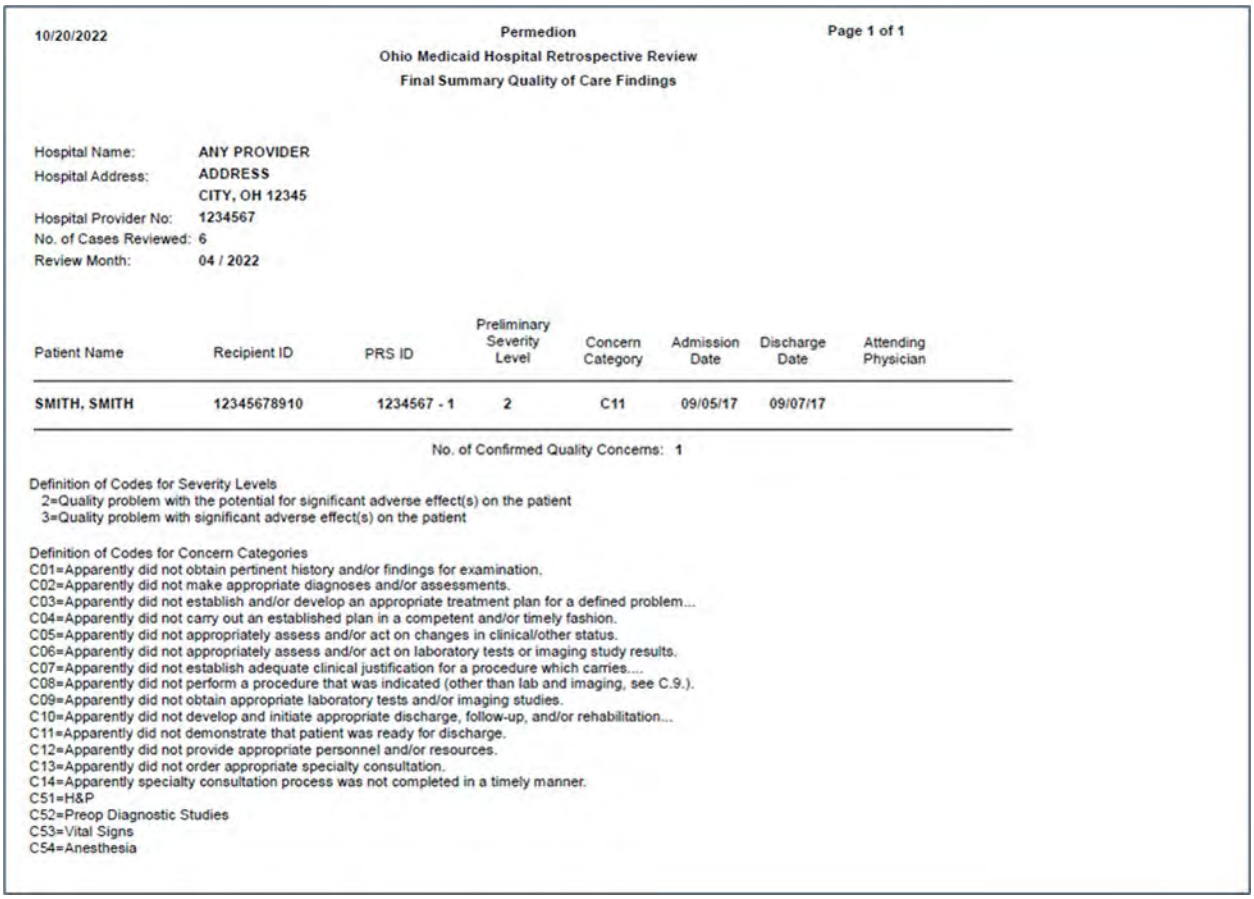
Quality Concerns

Permedion will provide reports related to quality concerns identified during a review. Our processes in place today are based on requirements established by Medicare for quality screens and levels. As part of our proposed solution, Permedion will provide the Quality of Care (QOC) reports shown in the following table. We also submit all quality concerns that are identified at a level of concern with the potential for significant adverse effect(s) on the patient or with significant adverse effect(s) on the patient to the Ohio Department of Health (ODM Complaints-Nursing Home and Healthcare at https://odh.ohio.gove/know-our-programs/complaints-nursing-home-and-healthcare-facilities/complaints).

Table 14. QOC Reports

Name	Description	Frequency
Preliminary QOC Findings Report Figure 64	We produce hospital-specific reports that list individual cases with initial quality concerns and severity levels identified during the retrospective review of records. Each hospital will receive a copy of its own Preliminary QOC Findings Report on the web portal, with ODM receiving a report for all the hospitals.	Monthly
Final QOC Findings Report Figure 65	This report lists all cases with a finalized (i.e., confirmed) QOC issue. It includes the concern category, the severity level, and any comments captured by the nurse and physician reviewers who made the determination.	Monthly
Summary of QOC Findings Report Figure 66	This report describes the results of the statistical analysis of QOC findings. It indicates when statistically valid trends exist for both individual facilities and facility peer groups. It also provides details on the QOC incidents on a facility basis. An example is a pattern of not justifying procedures that carry risk to the patient. We currently provide this report semiannually, but we will increase the frequency to quarterly upon contract award. The report is deliverable to ODM via mail, fax, secure email, and secure web portal.	Quarterly

Figure 64. Preliminary Quality of Care Findings Report



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Ohio Medicaid Hospital Retrospective Review

Final Summary Quality of Care Findings

Hospital Name: ANY PROVIDER
Hospital Address: ADDRESS
CITY, OH 12345
Hospital Provider No: 1234567
No. of Cases Reviewed: 6
Review Month: 04 / 2022

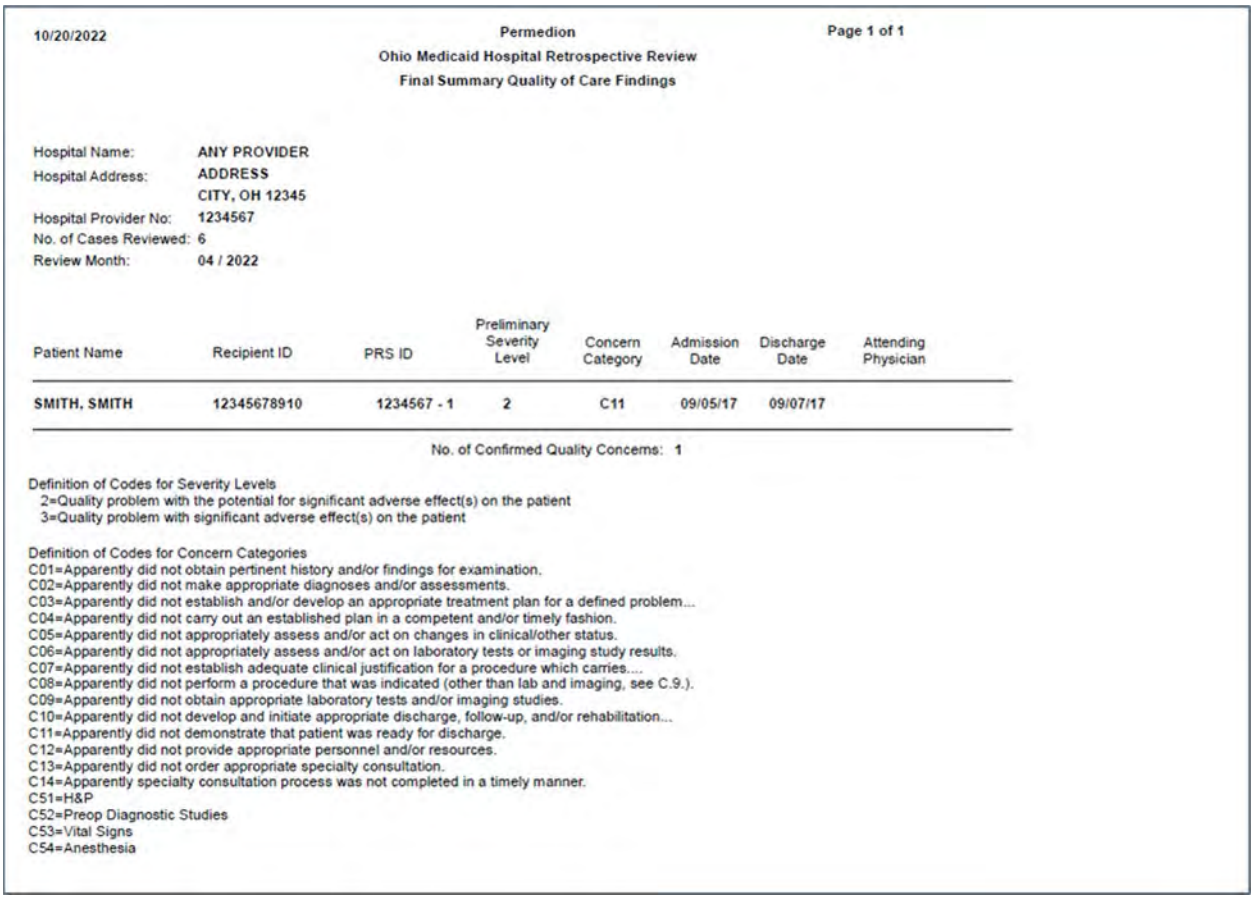
Patient Name	Recipient ID	PRS ID	Preliminary Severity Level	Concern Category	Admission Date	Discharge Date	Attending Physician
SMITH, SMITH	12345678910	1234567 - 1	2	C11	09/05/17	09/07/17	

No. of Confirmed Quality Concerns: 1

Definition of Codes for Severity Levels
2=Quality problem with the potential for significant adverse effect(s) on the patient
3=Quality problem with significant adverse effect(s) on the patient

Definition of Codes for Concern Categories
C01=Apparently did not obtain pertinent history and/or findings for examination.
C02=Apparently did not make appropriate diagnoses and/or assessments.
C03=Apparently did not establish and/or develop an appropriate treatment plan for a defined problem....
C04=Apparently did not carry out an established plan in a competent and/or timely fashion.
C05=Apparently did not appropriately assess and/or act on changes in clinical/other status.
C06=Apparently did not appropriately assess and/or act on laboratory tests or imaging study results.
C07=Apparently did not establish adequate clinical justification for a procedure which carries....
C08=Apparently did not perform a procedure that was indicated (other than lab and imaging, see C.9.).
C09=Apparently did not obtain appropriate laboratory tests and/or imaging studies.
C10=Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation...
C11=Apparently did not demonstrate that patient was ready for discharge.
C12=Apparently did not provide appropriate personnel and/or resources.
C13=Apparently did not order appropriate specialty consultation.
C14=Apparently specialty consultation process was not completed in a timely manner.
C51=H&P
C52=Preop Diagnostic Studies
C53=Vital Signs
C54=Anesthesia

Figure 65. Final Quality of Care Findings Report



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Ohio Medicaid Hospital Retrospective Review

Final Summary Quality of Care Findings

Hospital Name: ANY PROVIDER
Hospital Address: ADDRESS
CITY, OH 12345
Hospital Provider No: 1234567
No. of Cases Reviewed: 6
Review Month: 04 / 2022

Patient Name	Recipient ID	PRS ID	Preliminary Severity Level	Concern Category	Admission Date	Discharge Date	Attending Physician
SMITH, SMITH	12345678910	1234567 - 1	2	C11	09/05/17	09/07/17	

No. of Confirmed Quality Concerns: 1

Definition of Codes for Severity Levels
2=Quality problem with the potential for significant adverse effect(s) on the patient
3=Quality problem with significant adverse effect(s) on the patient

Definition of Codes for Concern Categories
C01=Apparently did not obtain pertinent history and/or findings for examination.
C02=Apparently did not make appropriate diagnoses and/or assessments.
C03=Apparently did not establish and/or develop an appropriate treatment plan for a defined problem...
C04=Apparently did not carry out an established plan in a competent and/or timely fashion.
C05=Apparently did not appropriately assess and/or act on changes in clinical/other status.
C06=Apparently did not appropriately assess and/or act on laboratory tests or imaging study results.
C07=Apparently did not establish adequate clinical justification for a procedure which carries....
C08=Apparently did not perform a procedure that was indicated (other than lab and imaging, see C.9.).
C09=Apparently did not obtain appropriate laboratory tests and/or imaging studies.
C10=Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation...
C11=Apparently did not demonstrate that patient was ready for discharge.
C12=Apparently did not provide appropriate personnel and/or resources.
C13=Apparently did not order appropriate specialty consultation.
C14=Apparently specialty consultation process was not completed in a timely manner.
C51=H&P
C52=Preop Diagnostic Studies
C53=Vital Signs
C54=Anesthesia

Figure 66. Samples from a Summary of QOC Findings Report

	Trended		Confirmed									
PEER GROUP	Claims w/Trended Concerns	Total Trended Concerns	Claims w/Confirmed Concerns	Claims w/Level 2 Concerns	Total Level 2 Concerns	Claims w/Level 3 Concerns	Total Level 3 Concerns	Total Reviewed Claims	% of Claims w/Trended Concerns	% of Claims w/Confirmed Concerns	% of Claims w/Level 2 Concerns	% of Claims w/Level 3 Concerns
MSA Parkersburg-Marietta & Steubenville-Weirton	5	6	14	14	14	1	1	220	2.27%	6.36%	6.36%	0.45%
MSA Columbus	28	30	48	48	55	1	1	1,704	1.64%	2.82%	2.82%	0.06%
MSA Lima	4	4	10	10	12	0	0	403	0.99%	2.48%	2.48%	0.00%
MSA Canton & Mansfield	4	4	13	13	15	0	0	355	1.13%	3.66%	3.66%	0.00%
Hamilton-Middletown & Lorain-Elyria	10	13	9	9	9	0	0	517	1.93%	1.74%	1.74%	0.00%
MSA Youngstown-Warren	7	9	11	11	14	0	0	432	1.62%	2.55%	2.55%	0.00%
Akron & Cincinnati & Dayton-Springfield	45	46	68	68	73	0	0	2,677	1.68%	2.54%	2.54%	0.00%
MSA Cleveland	27	27	40	40	57	0	0	1,252	2.16%	3.19%	3.19%	0.00%
Teaching Hospitals	48	49	72	71	79	1	1	2,671	1.80%	2.70%	2.66%	0.04%
MSA Toledo	13	13	30	28	30	2	2	829	1.57%	3.62%	3.38%	0.24%
Non-MSA < 100 Beds	5	5	6	6	6	0	0	147	3.40%	4.08%	4.08%	0.00%
Non-MSA >= 100 Beds	6	7	13	13	15	0	0	253	2.37%	5.14%	5.14%	0.00%
Children's Hospitals	11	12	11	10	11	1	1	1,774	0.62%	0.62%	0.56%	0.06%
Rural Referral Centers	4	4	11	11	15	0	0	317	1.26%	3.47%	3.47%	0.00%
Out of State	5	5	13	13	16	0	0	495	1.01%	2.63%	2.63%	0.00%
DRG Exempt	0	0	0	0	0	0	0	9	0.00%	0.00%	0.00%	0.00%
Grand Total	**222**	**234**	**369**	**365**	**421**	**6**	**6**	**14,055**	**1.58%**	**2.63%**	**2.60%**	**0.04%**

Additional Reporting

Permedion will identify and develop additional reports needed to monitor utilization of medical services by the Ohio Medicaid population, and recognizes that ODM may request other reports as needed. The following table lists additional report options for ODM. Upon contract award, we will meet with ODM to discuss the current reports we deliver to ODM as well as proposed new reports and analysis.

Table 15. Proposed Additional Reports

Name	Description	Frequency
Pattern Analysis Report	This report identifies areas of utilization that are “out of control” as determined by using Statistical Process Control. It profiles specific information relevant to healthcare trends and obtained through analysis of current claims. The report uses statistical process p-chart concepts to examine characteristics of claims submitted over a selected period of time to identify providers significantly above or below statewide or peer-group averages. The results of this analysis can be used to modify the identification and selection of procedures requiring precertification and the selection of claims to review retrospectively. Providers receive their own results compared to their peer groups and the State overall. Results for all providers are provided to ODM.	Annually, as requested
Utilization/ Trend Reports	These reports show key utilization, trending, and spend metrics by service category and/or provider and offers retrospective utilization insights such as a breakdown of admissions by inpatient vs. outpatient, length of stay distribution, top patient conditions, and targeted procedures/diagnoses. Deeper reporting insights will be developed upon ODM request into areas of interest such as utilization metrics specific to inpatient only, outpatient, professional, emergency room, hospital pharmacy, preventative care, high-cost imaging and cardiac procedures, high-cost members, etc. with data breakouts appropriate to the topic examined. For example, reporting on high-cost members would include the percentage of claims over $100K, the percentage of total spend coming from high-cost claims broken into $100K increments, percentage of claims volume generated by claimants in the top X% of claim total spend, and top providers based on spend to claim ratio. Further examination will be provided when appropriate that examines changes in areas such as patient demographic mix, service mix, condition mix, or catastrophic claim incidence.	Annually, as requested
Year-End Report	This report describes our team activities, accomplishments, future goals, objectives, and status regarding contract deliverables for each contract year. We recommend that the annual report be presented in person to ODM personnel to allow discussion of the activities of most interest to ODM.	Annually
Ad Hoc Reports	The need for ad hoc reports is a necessity during any contract activity. Our programming and health data analyst team members take pride in responding to client ad hoc–report requests. They produce accurate estimates of the effort required for such reports and provide them within expected time frames. For complex ad hoc requests, we will work within an agreed-on time frame for completion. The following figure provides an example of a customizable ad-hoc report.	As identified and/or requested

Figure 67. Example of Customizable Client Value Report for ODM

		Grand Total	August 2022	September 2022	July 2022	October 2022
Grand Total	Prior Auth Completed	9,583	3,355	2,972	2,889	367
	Denied PA Headers	2,175	708	682	654	131
	Gainwell Fee	$1,177,493	$395,783	$367,027	$341,255	$73,429
	Client Avoided Cost (Denied, Approx.)	$4,759,063	$1,468,451	$1,543,429	$1,435,249	$311,934
	Client Net Savings	$3,581,570	$1,072,668	$1,176,403	$1,093,995	$238,505
	Return on Client Investment	304%	271%	321%	321%	325%
	Adverse Decision Rate (#)	23.2%	21.4%	23.3%	23.4%	36.2%
	Adverse Decision Rate ($)	21.3%	19.2%	22.5%	22.1%	23.1%
PA Dental	Prior Auth Completed	3,215	1,109	1,026	1,024	56
	Denied PA Headers	1,028	341	321	339	27
	Gainwell Fee	$210,070	$73,160	$65,018	$67,880	$4,012
	Client Avoided Cost (Denied, Approx.)	$719,743	$234,193	$224,140	$242,780	$18,630
	Client Net Savings	$509,673	$161,033	$159,122	$174,901	$14,618
	Return on Client Investment	243%	220%	245%	258%	364%
	Adverse Decision Rate (#)	32.0%	30.7%	31.3%	33.2%	48.2%
	Adverse Decision Rate ($)	33.8%	31.3%	34.7%	34.8%	53.8%
PA Medical	Prior Auth Completed	6,368	2,246	1,946	1,865	311
	Denied PA Headers	1,147	367	361	315	104
	Gainwell Fee	$967,424	$322,623	$302,009	$273,375	$69,417
	Client Avoided Cost (Denied, Approx.)	$4,039,320	$1,234,258	$1,319,289	$1,192,469	$293,304
	Client Net Savings	$3,071,897	$911,635	$1,017,281	$919,094	$223,887
	Return on Client Investment	318%	283%	337%	336%	323%
	Adverse Decision Rate (#)	18.6%	16.7%	19.0%	17.7%	34.0%
	Adverse Decision Rate ($)	20.0%	17.8%	21.2%	20.6%	22.3%

Analysis

Effective reporting begins with effective data analysis. Permedion has developed data analysis processes that target improper payment scenarios across the full scope of Medicaid service types. We continually research and develop new algorithms to address each state's specific program issues. This combination offers ODM the best opportunity to maximize the identification and resolution of improper-payment issues in Ohio.

Our experienced data analytics team has in-depth understanding of and experience in coverage, billing, coding, clinical, and reimbursement policies and overpayment issues in Medicaid. The team members can analyze data and develop algorithms to recognize improper Medicaid payments. Our data analysts have the Medicaid and ODM-specific claim experience, analytic capabilities, and tools necessary to incorporate medical-review claims into our processes efficiently and accurately.

Analysis for Precertification Reviews

Our data analysis process employs data-modeling techniques that will identify/monitor utilization patterns of providers in Ohio Medicaid data. Our access to a vast amount of claim data in both public and private insurance markets will provide in-depth analyses and applications beyond Ohio data. This feature will provide ODM with benefits from reviewing and comparing nationwide trends/patterns, as well as provide provider-specific pattern reviews and billing analytics.

Analysis for Retrospective Reviews

We incorporate all claim types into our datamining and selection target review process. The success of our data-mining process depends on the inclusion of all claims. Such inclusion

allows us to establish benchmarks and to baseline trends that form the basis for certain selection rules correctly. Our team will continue performing extensive analyses of the Department's claims to compare them with our library of existing targets. We will fine-tune our methodologies to reflect ODM's unique population, regulations, and other directives accurately. Our rich review histories and research capacities for public and private insurance markets will allow our data analysts to detect unrecognized trends and patterns and suggest more targets.

Common Error-Pattern Logic

The core of our analysis process consists of a set of rules-based targeting algorithms developed over decades of experience in providing utilization review (UR) and clinical-review services to state agencies. We leverage machine learning algorithms using cutting edge analytics and historical clinical expertise to target claims for inaccurate billing of the correct place of service/level of care. We utilize results based on a large data set of claims have completed a full, clinical, medical record review. This automated approach identifies claims with the highest likelihood of a finding. Throughout the contract term, we will continually develop, adjust, and test our selection algorithms based on our experience with retrospective review projects for Medicaid programs.

Measuring Target Effectiveness

Our data analysts monitor the effectiveness of each of our targets to make sure they continue to be productive and are not producing the false positives that can be burdensome to providers. We routinely perform pattern analysis to monitor the results of our claim reviews and identify nonproductive targets or new areas on which to focus as well as general-error patterns in coding, inappropriate utilization of health services, and inappropriate standards of care.

In addition to monitoring target and attribute successes, we observe average dollars denied per claim to determine the cost-effectiveness of each target. We use both clinical expertise and statistical analysis to implement our methodologies and assure clients of the clinical validity of our process. Our highly trained team of health data analysts, biostatisticians, and nurse clinicians participate and assist in the process.

F.14 4.2.N Health Care Studies

RFP Reference: Section 4.2.N

In each fiscal year of the contract, the selected Offeror is responsible for production of up to four (4) studies which support efforts towards increasing quality of care, improving beneficiary access, and reducing costs. Specific study topics will be assigned to the selected Offeror by ODM. The number of studies in a given year is negotiable depending on the scope of each study and may be modified through a joint agreement between the selected Offeror and ODM depending on research needs and scope.

The selected Offeror may be required to conduct studies, share tools, or coordinate analysis with other ODM contractors. Clinical outcome-based studies are used to evaluate the quality of care delivered to Medicaid managed care organization (MCO) enrollees and to compare outcomes by MCO may be developed and performed.

The selected Offeror may work with current and historical FFS claims, as well as, managed care encounter data. The selected Offeror is expected, where necessary, to retrieve medical records for analysis, or survey individual patients about their outcomes. ODM will compare the results of quality reviews and coordinate improvement activities across delivery systems (managed care and fee-for-service). The studies will be supportive of ODM's overall health care quality improvement strategy.

For each of the health care studies, the selected Offeror is expected to make recommendations to ODM which include:

1. Prospective solutions to identified patterns of inappropriate utilization of Medicaid services.
2. Methods to identify/screen appropriate and inappropriate utilization of health care services through the use of provider profiling measures of claims data.
3. Suggestions for effectively incorporating study findings into ODM's quality improvement strategy, thereby furthering ODM's efforts as prudent purchasers of health care services.
4. Recommendations for defining and measuring improvement in utilization, clinical decision making, and clinical outcomes as a result of implementing these solutions. These solutions must proactively involve the education and cooperation of the provider community.

The selected Offeror is responsible for developing a plan for health care studies and necessary follow-up.

Data Collection and Sampling

The source of data for the health care studies will be medical records, administrative data, surveys, or a combination of the three. Eligibility data, FFS claims data, and managed care encounter data will be provided by ODM to the selected Offeror. Offeror will be responsible for transferring necessary data to its own systems for data analysis.

Offeror will sample the administrative data for the health care studies to determine which medical records to request, will request the records from institutional and physician providers, and then will extract the data needed to complete the study from the records. Depending on the number of records requested from a provider, the Offeror will either review the records at the provider's site or will review copies of the records sent by mail (secure mail, fax, or other secure electronic transfer).

The data collection and sampling performance standards are:

1. Obtaining from providers no less than 80% of the medical records that were selected as part of the sample .
2. Achieving an inter-rater reliability score, as measured by Cohen's Kappa or another measure appropriate to the data, of no less than 0.7 (95% confidence interval).
3. Submitting a final report for each study area to ODM on dates that are established by ODM in conjunction with the selected Offeror .
4. Submitting a complete report for each study area to ODM which addresses each of the topics identified by ODM for inclusion in the report and each other topic that is important to understanding the background, methods, results, and limitations of the study.

The selected Offeror is required to use qualified surveyors, provide training to the surveyors in data abstraction, and measure inter-rater reliability. The selected Offeror is responsible for selecting a sufficient sample of medical records and provider sites to assure valid studies. The expected statewide and sampling subgroup confidence interval for the studies is 95 percent.

The goal of developing and implementing a successful health care study is to provide measurable impact for ODM and health care consumers. The findings offer the insight needed to effect change in practice or policy. The study results and recommendations, when disseminated to stakeholders of Ohio Medicaid, can prompt the creation of a new policy or program, a change in what clinicians or patients do, improved access to care, and changes in health outcomes.

Permedion will produce of up to four studies which support efforts towards increasing quality of care, improving beneficiary access, and reducing costs. Our quality study team will be led by Matthew George, MD, our Director of Quality Studies, who has more than 17 years of leadership and national experience in researching, designing, conducting, analyzing, and reporting complex studies to support health care quality and improved outcomes. Our Ohio PA/UM biostatistician, Caroline Black, RN, PhD will support the data analysis.

Permedion will partner with ODM to identify topics of most value. We understand the study topic may warrant partnering with other agency stakeholders including other ODM contractors. The topics may be limited to Fee-for-Service (FFS) and/or may include encounter data from the Managed Care Entities (MCE), which we have done for other Medicaid agencies.

For each of the health care studies Permedion will make recommendations to ODM which include:

- Prospective solutions to identified patterns of inappropriate utilization of Medicaid services.
- Methods to identify/screen appropriate and inappropriate utilization of health care services using provider profiling measures of claims data.

Permedion has conducted health care studies and global analysis for multiple state agencies giving us additional insight to topics that could be of interest ODM

- Suggestions for effectively incorporating study findings into ODM's quality improvement strategy, thereby furthering ODM's efforts as prudent purchasers of health care services.
- Recommendations for defining and measuring improvement in utilization, clinical decision making, and clinical outcomes because of implementing these solutions.

Our solutions will proactively involve the education and cooperation of the provider community. Permedion will develop a plan for health care studies and necessary follow-up.

Permedion has supported the goal of improving health care for many state programs by performing hundreds of health care studies across a broad range of health care topics. We have a thorough knowledge of how study topics are selected, how they should be designed, effective sampling methodologies, data collection processes, data analysis techniques, and meaningful reporting. We have experience in designing complex electronic tools that facilitate data abstraction.

The purpose of conducting a health care study as part of the utilization management contract is to determine whether Medicaid members are receiving health care services in accordance with nationally accepted clinical guidelines, identify opportunities to promote quality health care, determine utilization patterns, and provide information needed to assist in policy changes. These studies may evaluate and monitor the following elements across ODM's FFS and MCE populations:

- Service delivery patterns
- Provider practice profiles
- Utilization related to medical care
- Utilization patterns related to behavioral health care
- Coding practices
- Hospital aquired conditions
- Unexpected death
- Member characteristics
- Readmission studies

Activities to evaluate the elements listed above may include the following:

- Retrospective record review and abstraction
- Claims-based review and analysis
- Predictive and risk modeling
- Provider surveys

Specific recommendations that are supported by study findings may include the following:

- Education of the provider community regarding the findings
- Development of quality improvement programs focused on the findings
- Use of risk modeling as alert and monitoring systems
- Use of findings to consider changes to health care policies

We have strong and comprehensive health care study experience through our history of studies performed for ODM and our successful quality review work performed for other states. Our state clients have used the results of these studies to shape program policies and procedures and to make budgetary decisions.

We understand that in order to achieve results based on the outcomes of our studies, the provider community must be educated. Because we already have strong relationships with Ohio providers, Permedion can leverage this to effectively communicate the goals of ODM's UM/PA program how to incorporate the results of our health care studies into their daily operations and practicies.

These studies identify and profile provider patterns of utilization of health care services, clinical decision making, and patient outcomes. Recommendations, as supported by the study results, are made and presented to ODM.

In the next section, we describe the following:

- Our experience performing health care studies and the benefits we provide ODM
- Description of our health care study personnel resources
- Coordination studies with other ODM contractors
- Our plan and approach to developing and performing health care studies and follow-up for ODM
- Our approach to working with claims data and performing analyses, which includes adherence to ODM data collection and sampling performance standards, to support the identification and development of recommendations for health care studies

Health Care Study Personnel

Our proposed Director of Quality Studies, Dr. Mathew George, has published and presented dozens of leading industry health care studies including several that have resulted in quality improvements for the Medicaid pediatric population.

Our proposed Director of Quality Studies, Mathew George, MD, will lead the development and execution of Health Care Studies for the Permedion Team with input from our Medical Director, Anthony Beisler IV, MD, FACS, CHCQM, who has overseen the production of several previous health care studies for ODM and other Medicaid programs. Dr. George has led (as principal investigator) or participated in the development of several health care studies across many different settings. He has more than 17 years of leadership and national experience in researching, designing, conducting, analyzing, and reporting complex studies to support health care quality and improved outcomes. He has overseen large teams in various roles to coordinate and deliver complex healthcare programs, including leading an inner-city pediatric emergency department and large addiction services program. Dr. George has published and presented dozens of leading industry health care studies including several that have resulted in quality improvements for the Medicaid pediatric population.

Caroline Black, RN, PhD, our biostatisican, will collaborate on the study analytics. With nine years of experience, Dr. Black utilizes her analytical problem-solving skills, and quantitative and qualitative information to provide informed data to assist in the research efforts for the medical, biology and public health industries. As an applied biostatistician, Dr. Black is responsible for planning and conducting statistical and epidemiological analysis of health care data, designing, and conducting analysis of health care databases and providing statistical input to study design, sampling methodology and reporting to assure statistical integrity of a project. Dr. Black is skilled at analyzing large, complex data sets to provide insight on performance improvement,

cost reduction, and utilizing clinical decision support tools in an agile development environment for clinical process improvement.

Dr. Black is experienced in leading conceptual-framework development and statistical modeling efforts across multiple markets. She has created multiple reports centered around review target effectiveness, recoupment statistics, and provider rebilling practices for the Ohio UM/PA contract. She has also conducted multiple project scoping reports for studies centered around sepsis patients leaving AMA, cost analysis of drug testing procedures and substance abuse.

As needed for review and abstraction of records, nurse reviewers and coding specialists have expertise in data abstraction and use nationally recognized criteria and coding guidelines and have the ability to apply other indicators to review the data and documention gathered during the study. They possess skills in the identification of quality of care and coding issues as well as excellent abstraction skills, ensuring that they can accurately record the information identified within a medical record in Permedion's proprietary data collection system. Our nurse reviewers are licensed registered nurses who have a minimum of five years of clinical experience and who have demonstrated experience in utilization review. The coding specialists have Health Care Information degrees and a minimum of three years of clinical coding experience. Our biostatistician will define the sampling criteria for the study and, with the health data analysts develop reports and pertinent analysis derived from the data collected during the study.

Permedion is committed to a collaborative approach to developing health care studies. We will partner with other ODM vendors as needed as well as our sister company Gainwell, which is the Fiscal Intermedidary and Single Pharmacy Benefit Mangager. As appropriate we would partner with ODM vendors including, but not limited, to IPRO EQRO vendor, Maximus the Provider Network Manager, Provider Oversite Ohio Home and Community Waiver Services. We believe partnering with other entities supports the goal of improving the quality of health care for Medicaid consumers.

Examples

We are aware that ODM will be assigning the specific study topics, but our partnership over the years, and our experience across other state agencies, allows us to also suggest ideas of health studies or analysis that have been well received and resulted in policy considerations in other states.

For another state Medicaid program, we complete two studies each year related to Community Mental Health and Rehabilitative Services. The program is very similar to ODMs Community Behavioral Health Services (CBHS). With ODMs development and implementation of OhioRISE, ODM may be interested in the patterns of Community Behavioral Health utilization across the state. Below are descriptions of two studies recently completed that resulted in policy updates:

- **Community Mental Health Services Before and After an Inpatient Psychiatric Hospitalization.** This analysis identified utilization of community mental health resources before and after an inpatient psychiatric hospitalization. Appropriate use of community mental health services, identifying underutilization and overutilization, could assist in reducing hospitalizations and keeping members in their community. What we found 38% of the consumers with an inpatient psychiatric admission did not have community mental health services either before or after the admission.
- **Multiple Service Types and/or Multiple Service Providers.** The purpose of this analysis was to identify patterns or trends of individuals receiving multiple CMHRS services during the same time and/or individuals being treated by multiple providers during the same time for CMHRS services.

- **Same Household Multiple Providers.** Permedion noted during clinical review of community behavioral records, that at times multiple individuals at the same address were receiving services, some of which appeared to be overutilization of services. The analysis identified providers with outlier patterns of delivering services to multiple individuals residing in the same household.

In the past, Permedion has provided to ODM health care studies with significant impact to the care of Ohioans. Repeating studies that had significant outcomes lets ODM monitor provider practices for continued concerns or identify improvements of concern.

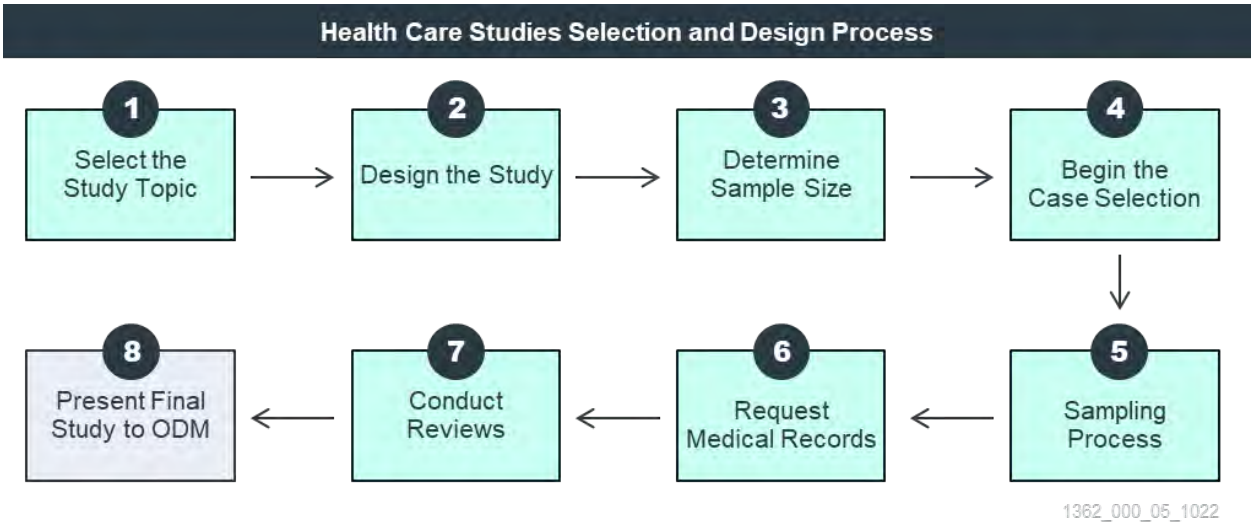
- **Pre-Mortality Quality of Care Issue (PMQCI).** The study revealed many preventable deaths had evidence of failure to recognize clinical changes or failure to communicate issues at transition of care at the time of discharge. Permedion was able to identify several areas of increased risk and make recommendations to improve the quality of care for recipients.
- **Dental Study** of providers billing for unlisted dental codes. This study identified two hospital systems had what appeared to be inappropriate hospital billing for individuals who had psychological issues getting dental care delivered in the hospital. The data led to a medical review of the record which identified the individual's care could have been safely could have been addressed in a dental office or clinic. This study resulted in ODM drafting house bill 59 (H.B. 59).

Approach for Health Care Studies

Our approach to study development is consistent with the approach outlined in the RFP. We will develop additional standardized tools, if necessary, that may be required to assess evidence-based quality measures, as directed by ODM. With the support of our Ohio-based Quality Studies Director, Mathew George, MD, MPH, and our Ohio-licensed peer reviewer physician panel, we are well positioned to provide medical consultation services in support of ODM's overall utilization review and prior authorization programs.

The following figure provides an overview of the steps included in our health care studies selection and design process, followed by a more detailed discussion of the activities associated with each step.

Figure 68. Permedion's Health Care Studies Selection and Design Process



Our method for designing and developing health care studies includes a multidisciplinary and collaborative approach to make certain we meet ODM's hospital utilization management program's goals.

Step 1: Select the Study Topic

We use available data, including our ongoing pattern analyses of claims, enrollment, provider, and encounter databases and the results of our review activities, to identify potential study topics. Based on this initial research, Permedion will work closely with ODM to provide information that facilitates the selection of topics based on their importance to the Medicaid program and their measurability.

Pattern analysis is the process of finding general relations in a set of data. It forms the core of statistical pattern recognition and data mining. Data analysis looks for general types of relations (e.g., rankings, classifications, regressions, and clusters). A Pattern Analysis Report can fulfill three major roles. First, it can identify trends in the field of interest; second, it provides information on the relevance of the factors or hypotheses being examined; and third, it can reveal the projected benefits of the research.

Once a study topic is selected, Permedion will work with ODM to identify a study group with expertise and interest in the topic area. Each study group will include physicians, nurses, allied health providers, other ODM vendors, and stakeholders as appropriate. If it is determined that Permedion will be the lead in a study, we will hold study group meetings to discuss the study background, potential study indicators, data requirements, and analytic plans. Study groups are facilitated using storyboards and other small-group techniques to gain maximum input in a limited amount of time. We have used this process very successfully, and it is widely accepted by study group members and state contractors.

Step 2: Design the Study

Following topic selection and initial research, the study group begins the study design. The key stakeholders in the study are identified and the team is formed to verify that stakeholders have adequate representation. The study team comprises data analytics professionals, physicians, nurses, and administrators and is led by the Director of Quality Studies. The study design starts with identifying the overall goal of the study, clarifying the questions to be answered, and determining the data required to achieve those end points with statistical significance. The study charge is then formed to represent the scope and goals of the study.

The study group will develop a draft study charge, including study purpose, objectives, study indicators and their definitions, sampling, and analysis methodologies. The study charge documents the scope and the direction of work, including data elements, numerators, and denominators (if applicable), and expected results. The completed study charge is reviewed with ODM for feedback and final approval.

Study indicators are measures providers, policy makers, and researchers can use to identify apparent variations in the quality, safety, and/or effectiveness of health care. These indicators must be objective and clearly and unambiguously defined. In addition, indicators must be capable of objectively measuring the outcome of interest, such as enrollee health, functional status, and satisfaction.

A detailed study design, approved by stakeholders, minimizes post study questions like:

- Should the populations have been defined differently?
- Why were certain study indicators included or excluded?

Step 3: Determine Sample Size

Permedion determines sample sizes using accepted sample size calculation methodologies so that we can make statistically significant statements about study indicators for each stratum with large enough eligible enrollment. The following is an example of the sample size calculation used when the primary indicator of interest involves nominal/attribute data.

Table 16. Methodology Notifications Used to determine Sample Sizes

Notification	Description
1-α	Coverage probability for confidence intervals
n	Required sample size
N	Number of observations in the population
p	Population (stratum) size; population proportion (of interest)
q	1–p
E	Margin of error or confidence interval half-width
D	E2/(z(1-(α/2)))2

Practically speaking, we do not know “p.” When no prior information on “p” exists, we can conservatively choose p = 0.5, thereby yielding a sample size estimate that is likely to be larger than is necessary. To estimate “p” with a margin of error, “E,” the required sample size is:

$$n = \frac{Npq}{(N-1)D + pq}$$

The estimated variance of the proportion estimate becomes:

$$\hat{V}(\hat{p}) = \frac{\hat{p}\hat{q}}{n-1}\left(\frac{N-n}{N}\right)$$

Our level of precision allows extrapolation of results to the population when appropriate

For calculating confidence intervals, we typically choose α = 0.05 and E = 0.05, thus yielding a 95% coverage probability with an associated confidence interval that is 10% wide. However, the requirement of statistically valid multiple comparisons between the strata for the focused studies may require different choices for these values, depending on the number of comparisons made.

For small strata, we still employ simple random sampling techniques to sample records. However, these samples are not sufficiently large to make statistically valid estimates. We produce anecdotal reports for groups falling into this category, which we clearly indicate on the affected reports.

We draw a 20% oversample in each of the focused studies to account for unavailable records (i.e., nonresponse) or records that do not meet the inclusion criteria upon medical record review. We can allocate sampled records proportional to the size of a given characteristic of interest within the population strata, such as race, gender, or county of residence. This helps to verify that the sample represents the population segments of interest. The resulting analyses would then be weighted according to the sampling proportion to accurately estimate the study indicators.

Step 4: Begin the Case Selection

For focused and baseline studies, we can use FFS claims and encounter data, to select cases that meet defined study criteria. For each population subgroup (or strata) of interest, records are randomly sampled so that statistically significant results can be reported.

Step 5: Sampling Process

The first step in drawing a sample is properly identifying the relevant population for the study. Once the population has been identified, the next decision is whether to study the entire population (i.e., do a census) or use a sample of that population. Using a sample is justifiable only if the sample is representative of the population and will allow results to be generalized at the statewide and, as necessary, provider levels.

The source of data for the health care studies will be medical records, administrative data, surveys, or a combination of the three.

Procedures used to collect data for a given study must confirm that the data collected on the study indicators are valid and reliable. Validity is an indication of the accuracy of the information obtained. Reliability is an indication of the repeatability or reproducibility of a measurement. The strategy for developing a data collection plan includes the following:

- Clear identification of the data to be collected
- Identification of where the data can be found
- Specification of who will collect the data
- Identification of instruments used to collect the data

For each study, we establish clear guidelines for obtaining and recording data. Selected members of the study group will develop a data dictionary that provides detailed instructions for the collection of data for each data element to be collected for the indicator calculation. The next step involves development of a laptop computer tool for this process that will contain the edits needed to eliminate errors in the actual data collection process. For example, the tool requires the reviewer to complete some fields before he/she can exit the system, it allows only specific entries for some fields, and some fields may contain ranges of acceptable values that the reviewer can enter.

Also available on the laptops are resource documents such as criteria, coding systems, drug formularies, and other data that may be appropriate for a particular study. Training sessions for the nurse reviewers provide in-depth information on the study topic and its background, but a complete review of the data collection tool and data dictionary dominates the training agenda. Reviewers practice collecting data from sample records and comparing their results with the “gold standard” (the correct answers). This part of the process allows the reviewers to gain feedback on their work before they begin collecting the actual study data.

Sampling Designs

Permedion identifies and uses appropriate sampling designs. We have worked with various sampling designs, such as the stratified, two-stage cluster sample, however, our sampling methodology typically requires more common sampling methods, including stratified, proportionate, cluster, and systematic approaches. During the development of each study charge, we will identify the sampling methodology necessary to meet the study’s defined goals.

We can customize samples based on ODM’s unique requirements for confidence level and precision. Permedion recognizes that the sample size must be sufficiently large to achieve

statewide and subgroup confidence intervals for clinical studies of 95% with a +5% level of precision. Our experience and familiarity with large health care data files (Ohio and other states) enable us to sample across individuals in various health care systems, including the managed care and FFS delivery systems.

Quality Assurance

In addition to implementing quality control measures before and during data collection, Permedion measures data reliability when data collection is complete. From the original sample of medical records, 5% are randomly selected and re-reviewed. We compare the results again with the “gold standard.” We also compare re-review results with the original review results.

We calculate agreement rates and Cohen’s Kappa statistics to determine the reliability of the original data collection process. Agreement rates must be at least 80% or higher. Otherwise, we re-review records to determine the disagreement issues. We share the results with each reviewer for continuous quality improvement and include them in the study report.

Step 6: Request Medical Records

It is imperative that we obtain a sample of sufficient size of medical records and or surveys for each study so that we can extrapolate the results to the entire study population with 95% confidence intervals with a desired margin of error. Although it can be a challenge to make certain that requested records are provided and survey information is received, Permedion has experienced repeated success in obtaining a large percentage of the documents requested from providers to make sure that our findings are statistically significant and broadly applicable.

Once we have selected the records, we will send medical record requests to each provider specifying the records selected. These request lists will include the information necessary for record identification, including patient name, Medicaid identification number, and dates of service. Permedion will provide the lists in a hardcopy format but can also provide them in an electronic format upon request. We will follow ODM guidelines regarding the period in which a provider must produce a medical record. In our experience, 30 days is customary.

Response Rate

We understand the need to achieve 95% confidence intervals with a desired margin of error for each measure within a study. We sample, and oversample, to obtain enough records to give us this precision. Our practice of at least a 20% oversampling confirms our ability to obtain a minimum of 80% of the medical records that we selected as part of the sample for each study

We will continually monitor study record return rates during the abstraction period so that we can address any shortfall prior to the completion of data collection.

Step 7: Conduct Reviews

We employ a hybrid review model. We consider the number and type of medical records selected in each study before determining whether a review needs to be onsite or offsite. Permedion is committed to fostering good provider relationships. We encourage providers to submit electronic records through our secure web portal applications. We also work with the state and providers to obtain secure access to their databases when possible.

> We have great success in obtaining a high percentage of medical records that we request from providers, assuring ODM that the study is representative of the size and scope of the Ohio Medicaid program.

Data Collection Tool

Our health care study data collection tool framework provides reviewers with a standard look and feel when collecting data while reviewing records. If the study requires complex medical record review Permedion has an extensive infrastructure in place to make sure Protected Health Information (PHI) is secure during data collection. When the study methodology is complete and data elements identified, the review team is trained on what indicators to identify and collect the data on from the records.

Permedion has the framework in place to quickly develop customized, study-specific applications. Such customization confirms that the collected data is available in a consistent manner for analysis and is just one measure that we employ to assure inter-rater reliability (IRR). Once the necessary data is collected, it is combined into one SQL database and provided to the lead data analyst for analysis to produce study conclusions.

Pattern Analysis Report

Pattern analysis is the process of finding general relations in a set of data. It forms the core of statistical pattern recognition and data mining. Data analysis looks for general types of relations (e.g., rankings, classifications, regressions, and clusters). A Pattern Analysis Report can fulfill three major roles. First, it can identify trends in the field of interest; second, it provides information on the relevance of the factors or hypotheses being examined; and third, it can reveal the projected benefits of the research

Interrater Reliability Report

Interrater reliability is a measure used to examine the agreement between two people (raters/observers) on the assignment of categories of a categorical variable. It is an important measure in determining how well an implementation of a coding or measurement system works. A statistical measure of IRR is Cohen’s Kappa, which ranges from -1.0 to 1.0, where large numbers mean better reliability, values near 0 suggest that agreement is attributable to chance, and values less than 0 signify that agreement is even less than that which could be attributed to chance. In essence, the Interrater Reliability Report measures the consistency of the data collection.

In the sample report below (pulled from a recent dental study), Permedion selected a sample of 30 records for re-abstraction by a coding specialist. Rates of overall agreement between the original abstraction and the re-abstraction ranged from 78% to 100%. This variability can be explained by the fact that answers to some of the questions were more subjective than others. We also calculated Kappa statistics for three data collection fields, with the evaluated fields falling into the range of “Excellent,” as shown in the following table.

Table 17. Sample Interrater Reliability Report

Variable	Agreement Level	Kappa	Classification of Kappa Value
Code included in study	97%	***	***
Specific CPT code more accurate	93%	84%	Excellent
Correct CPT code	78%	***	***
CPT code best describes procedure	95%	***	***

Variable	Agreement Level	Kappa	Classification of Kappa Value
Procedure described in detail	100%	100%	Excellent
Effort/equipment described	100%	100%	Excellent

*** The interrater matrix for these variables is nonsymmetric; therefore, a Kappa statistic cannot be computed.

Step 8: Present Final Study

Permedion develops and presents studies regarding many aspects of health care. The final study reports are the primary deliverable from the health care studies. Each study report fully documents the study and makes recommendations on how ODM can use the study results to improve Ohio Medicaid utilization and quality.

The study group makes recommendations based on its interpretation of the study findings and always includes a specialist in the study topic who provides expertise in making the recommendations. Many of our Medicaid studies have been primarily baseline or one-time measurements. The goal of the study discussion and recommendations is to interpret the study findings and verify that they are ready to use by health care decision makers, providers, and clinicians. The recommendations often address improvement of outcomes, quality of care services, reducing costs, and/or broadening access. Dissemination of the study findings and provider education are often included as recommendations.

Based on our findings, we will summarize the opportunities for improvement found in the study and make recommendations to ODM on the following:

- Prospective solutions to identified patterns of inappropriate utilization of Medicaid services
- Methods of effectively incorporating study findings into the quality improvement program, thereby furthering their efforts as value purchasers of health care services
- Methods of defining and measuring improvement in utilization, clinical decision making, and clinical outcomes because of implementing these solutions
- Suggested interventions that will proactively involve the education and cooperation of the provider community
- Dissemination of results to Medicaid providers and policy makers

Permedion looks forward to partnering with ODM and other stakeholders to complete studies in effort to improve efforts towards increasing quality of care, improving beneficiary access, and reducing costs.

F.15 4.2.O Provider Education

RFP Reference: Section 4.2.O

The selected Offeror will be required to develop educational materials and conduct provider education seminars at various times during the contract period. The selected Offeror will be:

1. Providing any necessary clinical criteria in support of changes made to the current program, in addition to communicating the changes to the provider community through educational seminars and mailing educational materials to providers.

2. Educating the provider community regarding prospective changes to the utilization review program resulting from the identification of inappropriate utilization of Medicaid services through the post payment and focused review processes. This educational opportunity may be through a seminar or through the development and dissemination of an Ohio Medicaid institutional utilization review program provider electronic newsletter.

3. Developing and regularly producing provider e-newsletters throughout the contract period with input and final content approval from the ODM team. The selected Offeror will be expected to provide ongoing updates regarding the operations of the Institutional Utilization Review program and communicate to the provider community through these periodic provider newsletters. Development will include: 1) a detailed concept for the newsletter (including frequency, length, focus, etc.); and 2) a plan to address provider education that incorporates utilization management activities and quality of care studies, and documented impact from provider education.

Permedion currently conducts clinical reviews of hospital and other services for multiple state Medicaid programs. We are aware of the importance of communicating effectively with the hospital and medical communities and their provider associations. We have built education programs and materials targeted for these and other provider types to address the specific needs they have and answer their questions related to the UM/PA review process, medical necessity decisions, documentation requirements, hearing process, etc. We meet both regularly and on an ad hoc basis with provider associations, hospital groups, and individual providers via webinars and one-on-one (telephone and in-person).

Ohio is home to more than 165,000 active Medicaid providers. The partnership between Ohio Medicaid and its provider network is critical in verifying that care for members across the State is reliable and timely. Permedion has educated and trained providers in Ohio on utilization review programs since 1997.

Permedion exceeds the requirements for supplying provider education through our performance of the following activities:

- Use of integrated provider education methods through established, effective provider communication/education processes
- Our development of educational materials for providers, which will continue into a new contract term
- Obtaining continuous feedback from providers and their associations and updating our materials and presentations accordingly
- Provision of evolving activities and technology to create new opportunities to educate providers
- Maintenance of effective relationships with Ohio Medicaid Providers since 1997

Provider Relations and Education Success

Communication with hospitals, physicians, and other healthcare facilities is most important in maintaining good provider relationships. At the heart of our approach is a focus on customer service, including delivering high-quality service to the providers with whom we interact in the course of ongoing projects. We understand and respect the complex relationship that ODM has with Providers. When interacting with Providers as an agent of ODM, we are always professional. Our personnel are respectful of Providers' time and the services they provide to the community—especially to Medicaid Members.

Performing provider review and recovery projects has allowed us to gain a deep appreciation for the importance of establishing and maintaining effective provider relations and provider communication processes. Our provider relations plan includes the following key components:

- Effective communications
- Relevant educational events
- Pertinent educational materials
- Informative publications

Our team will diligently maintain a positive working relationship with Ohio Medicaid Providers.

Education is Key—Our Proposed Approach

The following pages describe the provider's information and communication tools, as well as materials we will deploy, upon approval from ODM, and how we will meet/exceed the RFP requirements related to:

- Education and notification of the clinical criteria used in our review decisions
- Updates and education on UM/PA review results, program changes, inappropriate utilization of services, and other topics
- Development and dissemination of provider e-Newsletters

Provider Forums

We will use an integrated process to supply Provider education. Permedion will present education and training through live seminars, webinars, or by a combination of methods. We will give a program evaluation survey to each Provider and review the results of the survey with ODM. Knowledge of what works and opportunities for improvement and changes will be evaluated and implemented. Permedion has been an active participant in many teleconferences and meetings. Recent examples of our success in establishing high-quality working relationships with Ohio Providers include the following deliverables and activities:

- We routinely present at the quarterly Large Provider Group meeting and review upcoming changes, FAQs, and allow for real time Q&A with hospitals.
- In conjunction with ODM and the Ohio Hospital Association (OHA), we will hold Provider webinars with targeted topics. For example, in fall 2020, our Medical Director and Project Manager presented a COVID-19 Coding Webinar. It was attended by representatives from 75 different hospitals and counted towards Continuing Education Units (CEUs) for the attendees as applicable.

Webinars

Webinars help us communicate new procedures, system interfaces, and rules as well as trends and areas of providers' confusion or concern. Webinars can be stand-alone training devices. They can also serve as supplements to live meetings for providers unable to access training or communication sites.

Permedion has found that it is never too early to start establishing effective communication with providers. Although we currently hold the ODM UM/PA contract, we recommend after contract award, and with ODM's approval, we hold a kickoff provider webinar that will reintroduce Permedion and help educate providers on our processes. Going forward, we propose scheduling, creating, and conducting one-hour online seminars as frequently as quarterly. These sessions will address topics such as utilization trends and patterns, All Patient Refined Diagnosis Related Group (APR-DRG) and Enhanced ambulatory patient grouping system (EAPG) assignment, and billing issues. Our goal of conducting webinars on these topics will be to educate providers on appropriate coding and billing practices, utilization processes and procedures, and regulatory or policy updates. In our experience, using such webinars consistently promotes provider compliance with our state customers' programs and reduces provider abrasion. This approach also gives providers an opportunity to ask questions about the program in an open setting to promote feedback.

Permedion will develop content for the webinars in collaboration with ODM, using analysis from the previous quarter to identify and focus on key issues for that period. Our marketing and communications personnel will provide technical expertise regarding the conceptualization, design, and execution of the webinars.

Website

We will provide website access to ODM-specific policies and procedures, as well as links to other educational materials and resources. Permedion maintains a "Contact Us" section on the website for inquiries. We review emails daily, send them to the appropriate team member for an immediate response, and respond to emails with appropriate details. For example, we may receive a simple request for a complete copy of a published study in the newsletter. Another example may require a telephone call to the requestor for explanation or instructions, such as information on how a provider should handle a hospital-initiated denial.

Permedion will continue to give providers easy access to online Ohio Medicaid program information. Our user-friendly secure website is a tool that will facilitate communication with the provider community. Providers can access updates to programs, provider manuals, and contact information with the click of a button. If ODM desires, we can develop pages on the website for individual providers to which determination information, reports, and communication can be posted.

Newsletters

We will continue to produce our newsletter to share information and promote quality care in Ohio. Through the ODM Utilization Review newsletter, we publish material on trends and issues identified, retrospective and precertification review information, coding issues, billing instructions, program changes, results of reports, and quality healthcare studies. The newsletters will be available electronically through the ODM and Permedion websites and be provided electronically to Providers through our provider portal.

Our marketing and communications team members provide technical expertise regarding conceptualizing, designing, and producing the publication. Suggested future topics for the newsletter include:

- Results of recently completed utilization-improvement projects and healthcare studies
- Billing hot topics
- Upcoming educational opportunities
- Information regarding policy and/or review changes
- Retrospective-review updates
- Prior authorization – review updates
- Hospital - profiling findings
- Changes in clinical criteria affecting precertification, special reviews, and retrospective-review programs

Permedion has developed and published the Ohio Medicaid Newsletter since 1998. This newsletter highlights important updates relating to ODM and our role in enhancing the efficiency and effectiveness of care across the Ohio provider community. Some of the articles published during the latest two SFYs include:

- Update on Ohio's Other Epidemic: The Opioid Crisis
- Review Concepts: Observation Level of Care
- OhioRISE, An Integral Part of the Next Generation of Managed Care
- Prior Authorization / Precertification Guidance
- POA: Present on Admission Indicator (POA Reporting)
- The year 2021 and hopefully, the end of the COVID-19 pandemic
- Permedion Prior Authorization and Precertification Expansion
- Correct Billing of COVID-19 Treatments
- *The Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3): Five years of the new definition*

Our provider education efforts include creating and delivering a variety of program-related newsletters. The following figure shows a sample newsletter that we provide for clients in Ohio. The newsletter shares information that helps promote compliance with ODM's program. Such information includes details on policies and procedures as well as updates.

Figure 69. Publishing and Distributing Newsletters

SUMMER 2021

Medical Director Dialogue

REVIEW CONCEPTS: OBSERVATION LEVEL OF CARE

By Anthony J. Beisler, MD, MBA, FACS, FABQAURP, CHCQM

Medical Director, HMS-Permedion

A recent quality assurance examination of our chart reviews at Permedion indicates that some facilities may still not be fully familiar or facile with the application of the rules surrounding the observation level of care. So, for this issue's newsletter Medical Director Dialogue, let's review some concepts.

In a case involving an Ohio Medicaid beneficiary, where the issue being considered is whether or not the inpatient level of care was justified, it is **inappropriate** to base a decision on the amount of time the person actually spent in the hospital. Rather, did they meet the severity of illness criteria for inpatient admission?

As I am a general surgeon, I'll use a common scenario seen in surgical practice. On May 15, a 17 year-old male presents at 9 p.m. with progressive abdominal pain localizing to the right lower quadrant. CT scan confirms acute appendicitis. WBC=12.2, T=98.4, HR=98, BP=120/78, RR=16. At 6 a.m. on May 16, the patient undergoes an uneventful laparoscopic appendectomy with no perforation or abscess. He receives intravenous antibiotics and oral pain meds on May 16 and is discharged to home on May 17, at 9 a.m. The patient's total stay is less than 48 hours but encompasses three consecutive calendar days. However, in reviewing this chart, note that time in-house isn't the driving factor determining the appropriate level of care to assign. The issue is that severity of illness did not mandate the inpatient level of care as practiced in the community was not satisfied and thus the **observation** level of care is appropriate to assign. The medical necessity for the inpatient level of care was not established.

Furthering this example, let's say the patient came in at 9 p.m., May 15 and was found to have perforated appendicitis with a peritoneal abscess and spiked a fever. The patient underwent the appendectomy with abscess drainage and then defervesced. He was started on adequate oral antibiotics and was discharged on May 17. He would have met medical necessity for an **inpatient** admission level of care and the admission would be **approved**.

Determination Letters

We provide specific information regarding medical necessity denials, coding changes, billing errors, and quality of care in our Determination Letters. These letters provide details of the medical information obtained from the medical records and exact descriptions of the reasons for the disagreements, concerns, and/or changes. This information provides an effective tool to educate providers regarding proper practices.

We customize the format to meet the needs of our customers and include details regarding errors, which aide in informing providers of proper practices. We recognize that our Determination Letter is a powerful tool for educating providers.

Provider Portal

Our goal is to create a “virtual community” for our providers. With this new contract, we propose providers use the real-time provider portal. The portal will allow our team and healthcare providers to collaborate more quickly and more effectively. It confirms efficient communication of information regarding utilization and quality history. This tool is an on-demand resource for providers that can streamline utilization review related communication.

Providers will have access to a variety of data and reports, providing insight and education related to specific claims data. The available information provides detail for each reviewed case and identifies what has been approved or identified for denial or quality issues. In analyzing claims data and reports, providers will be able to quickly see where errors were made and apply this information to future cases, decreasing the number of incorrectly coded/billed claims and reducing provider appeals.

This actionable information not only allows providers to make timely and informed decisions but leads to improvements in overall population health. This system design will also give us the ability to identify and stratify high-risk participants, based on a risk score provided by integration with MCG criteria.

In addition to provider-specific folders, summary information will also be available on this web application for ODM to monitor and track our overall efforts to maintain excellent provider relations. Schedules for visits, numbers of telephone contacts, logs of issues/complaints with dates of resolution, and other information considered important to ODM will be included. This feedback and interaction with providers will be a major component of our internal Quality Assurance (QA) program.

Provider Education During the Prior Authorization (PA) Process

In addition to the above resources, the clinical team is on hand to address specific provider questions related to prior authorization. Since Permedion processes more than 3,000 PA requests each month for ODM, this is the perfect opportunity for one-on-one provider education. When requests are submitted that are incorrect or incomplete, the requests are pended back to the provider with very specific information pertinent to the service type, allowing home health providers to get information on home health, or DME providers to get information on a wheelchair they requested.

Educational information can range from:

- What additional clinical information is needed, for example a Certificate of Medical Necessity
- What type of invoice may be needed for the DME item requested
- Procedure codes that do not need prior authorization until service limit is met
- Specific information needed to get a complete request submitted for consideration
- Direction or information to address any challenges in the PA submission process

Providers also contact client services to get help addressing challenges they encounter in the PA submission process. The clinical staff is on hand to not only provide needed information but also to make sure the contact with our team is a positive experience for the provider; our goal is to turn a potentially frustrating moment into a learning experience to prevent future frustrations. Permedion's friendly and knowledgeable team shares helpful information, resource links, and can email the provider educational materials specific to their needs. The following list provides some examples from our clinical team's Library of Guidance developed from calls with Ohio Providers over the years:

- Basic Billing for HH Providers
- Basic Billing Hospital Providers
- MCO PA Phone Numbers
- Medicaid Recipient Liability 5160-1-13-1_20200101
- Medicare Primary Article for Providers
- MITS Adding Docs to Pending PAs
- MITS Additional Provider Information Panel Instructions
- MITS Agent Role Assign List
- MITS Benefit Screen Shot Example
- MITS Editing Contact Info for Providers
- MITS Eligibility Verify Quick Guide
- MITS Entry for BH PA ACT-IHBT-SUD PA 2018
- MITS New Provider Enrollment – FAQs
- MITS Online Tutorials for Providers Link 1-10-19
- MITS PA Error Messages Instructions for Provider
- MITS PA Error Messages
- MITS Portal Registration
- MITS Provider Assistance FAQ 5-2020

Delivering a Positive Provider Experience

One of our Permedion reviewers in Ohio described this positive interaction:

"A provider had a patient that required treatment for cancer that was deemed urgent by the physician. The treatment required a PA request. This provider also had not entered a PA into MITS for several months. I was able to provide assistance to the provider to ensure they were able to correctly submit their request for an urgent review."

These provider educational tools, free from protected health information (PHI), can easily be emailed to the provider who then can share with other team members.

Permedion makes sure providers have multiple resources for education: provider seminars, website, newsletters, webinars, determination letters, dissemination of clinical criteria, provider portal, and one-to-one phone discussions with our operations or clinical staff.

F.16 4.2.P Technical Assistance

RFP Reference: Section 4.2.P

ODM is structured to operate as a matrix organization to provide flexibility needed to respond to and act in an external environment that remains highly volatile, both at the level of federal policy and within the health care marketplace. ODM conducts much if its program development and reform activities through teams made up of staff from both policy and operational bureaus. The pace of change in health care, social services and in state/federal and state/local relationships makes organizational flexibility and "out of the box" thinking a critical success factor. This flexibility and creativity is enhanced through teamwork.

The selected Offeror may provide up to 600 hours of technical assistance to policy and operational units within ODM. This work will primarily involve clinical expertise and guidance, as needed, in support of policy development and operational

functions. Examples of technical assistance work may include, review of new or existing procedure codes for a recommendation on the appropriate setting (inpatient or outpatient), guidance on medical coding questions, or assistance in developing clinical screens to be used by ODM to make coverage determinations for services that require hospitalization (e.g. procedures related to the treatment of obesity).

We partner with various stakeholders within ODM to provide technical assistance by researching topics, offering subject matter expertise, and/or gathering data in support of the program.

Permedion's knowledgeable team has the experience to research ODM's technical assistance requests. Our team includes:

- Physicians across mutltiple specialties in active practice knowledgable of current practices, concerns and trends
- Clinicians with a variety of backgrounds and experiences, including behavioral health
- Team of professional coders
- Data and analytics specialists
- Operations staff working with providers

Permedion agrees with ODM that the pace of change in health care, social services and in state/federal and state/local relationships makes organizational flexibility and "out of the box" thinking a critical success factor. Permedion and ODM have developed a partnership when it comes to technical assistance requests, including discussing the purpose of request, responding within established timeframes, and discussing and providing documentation on the findings of the research or assistance request.

We look forward to continuing to provide ODM with a wide spectrum of technical assistance. Our services will include the following:

- Review of procedure codes requiring prior authorization
- Opinions on experimental and investigational services
- Coding review based on Coding Official Guidelines and ODM requirements
- Research regarding Behavioral Health and Substance abuse
- Assistance with MITS
- Other consulting

We commit to providing 600 hours of technical assistance to continue to meet ODM's needs during a new contract term. Our team stands ready to aid the State in its desire to incentivize quality, combat fraud, and sustain integrity. Throughout our current contract with ODM, Permedion has taken on a variety of technical requests ranging from how to code lactation consultation to comparing ASAM, InterQual and MCG criteria for substance disorder level of care consistency. These technical assistance projects were completed accurately, timely, and provided valuable information to ODM.

The following list highlights some of the technical assistance we have provided in the current UM/PA contract:

- Coding Assist for Lactation Consult
- Case Review of MCO Denial of Private Duty Nursing
- Inpatient Procedure Code Review
- Behavioral Health Diagnosis Review
- Spinraza Study Documentation and Quarterly Report

- Substance Use Disorder Prior Authorization Pilot
- Home Health Care Agency Education for Prior Authorization Submission
- Review of New Drug codes for Prior Authorization
- Assistance correcting MITS attachment errors
- HB 454 - Permedion PA Research, policy, criteria
- SUN Behavioral SUD PA Reviews
- Review of EAPG Code list for cosmetic procedures
- ACS isolation recovery research
- Readmission Retrospective Reviews
- Draft BH Readmission Policy
- External Review of MCE SUD PA Determinations
- ASAM vMCG v InterQual Comparison for level of care with Substance Abuse Disorders
- Report on reviews performed for DRG 770, 773, 774, 775, 776

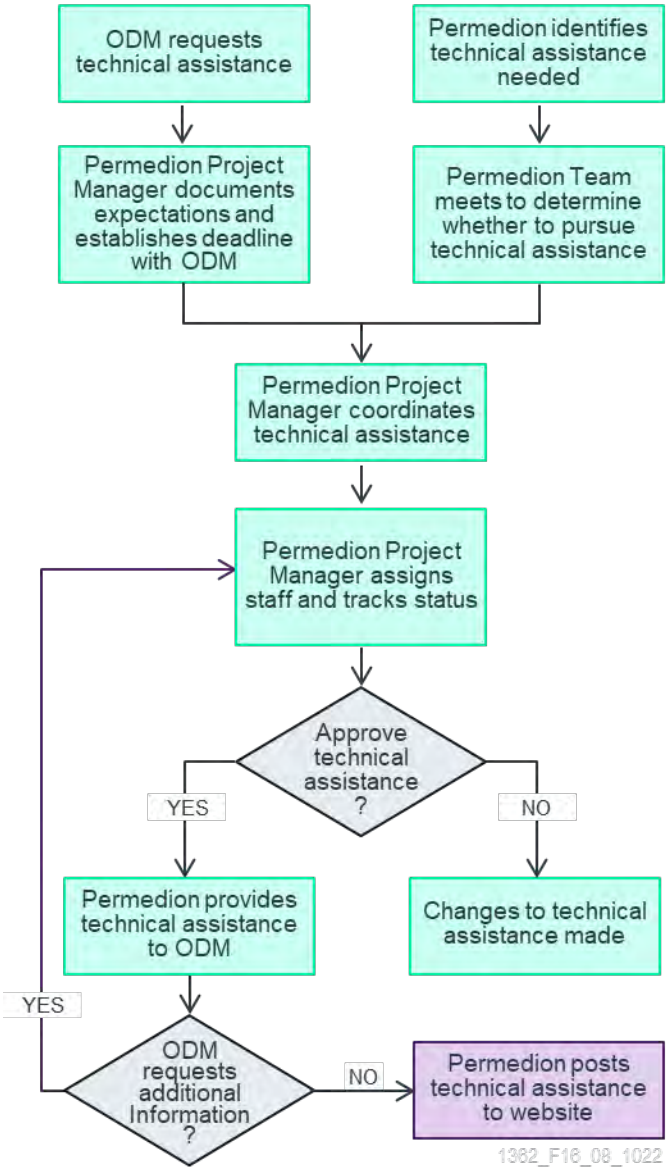
Technical Assistance Process

Permedion's process for handling technical assistance demonstrates our focus on responsiveness, flexibility, and accessibility. Our technical-assistance approach focuses on our desire to exceed client expectations.

Our project leader and project managers will quickly verify the technical-assistance request and deadline, assign personnel for request completion, communicate the estimated completion date, and track the request through submission. Through secured access, ODM will have the convenience of viewing all technical assistance activity electronically. This feature will also electronically provide the Department with a historical view of the technical assistance provided throughout the State Fiscal Year (SFY). The following figure illustrates our technical-assistance process. The steps involved in providing technical assistance will vary depending on whether the request originates from ODM or through identification by our team members.

Creativity and flexibility in providing valuable technical assistance to ODM will allow us to assist the Department in responding to the ever-changing healthcare-industry landscape. Our goal is to be responsive and proactive in providing ODM with technical assistance. ODM needs a vendor that can respond to technical-assistance requests both quickly and accurately. Permedion's expertise, experience in working with ODM, and proven record of providing timely, accurate technical assistance will allow us to meet these needs.

Figure 70. Permedion's Technical Assistance Process



F.17 4.2.Q Data Management

RFP Reference: Section 4.2.Q

1. Data Processing

ODM will provide data to the selected Offeror to carry out the functions of the contract. The cost of this Deliverable will be incorporated into the proposed fee of the project. Data to be provided may include:

a. FFS claims data;

b. MCO encounter data;

c. Medicaid eligibility data;

d. Long term care Minimum Data Set (MDS) data;

e. Medicaid provider files;

f. MCO primary care provider (PCP) database; and

g. Medicaid procedure, drug, and diagnosis reference files.

The selected Offeror will be responsible for maintaining reasonable access to data at all times and for receiving this data in a timely fashion. The following standards apply:

A. Reasonable access means the ability to retrieve all data in a batch processing mode so that analytical processing can be completed within 24 hours. Note that this is a minimum standard which should be applied to complicated analytical processes involving multiple large data sets over multiple years. Less complicated processes using smaller data sets should be able to be completed in less time.

B. Receiving data in a timely fashion means being able to provide reasonable access to monthly updates within 48 hours of receipt of the data.

To ensure successful data management, the selected Offeror must develop a plan and timetable for initial data base design and set-up of historical and initial reference files, and provide a description of how the data bases will be set up and accessed for use by the selected Offeror in carrying out the contract.

Permedion will carry out the functions of the UM/PA contract utilizing ODM-provided data. As the incumbent, we have responsibility today for maintaining reasonable access to data at all times and for receiving data in a timely fashion. We are responsible for transferring necessary data to our own systems for data analysis, and we already have an established mechanism.

Our data processing team is fully capable of handling the data requirements of the ODM's UM/PA contract. All data is stored in our secure data center in Richardson, Texas. Secured back-ups and redundancy are in multiple separate locations. We are deeply familiar with the intake of ODM's source data sets- including the FFS and MCO encounter claim data, Medicaid eligibility data, MDS data, provider files (including MCO PCP) and reference files. We have established high quality data mapping requirements so that necessary data elements are appropriately captured for UM/PA analytical processes to complete. Additionally, we have worked iteratively with the ODM and MMIS teams over time to address data element updates, file layout changes, historical version controls, and ongoing data linking, furthering the ability to effectively analyze ODM data sets.

We have extensive EDI and data transfer experience through our work via UM/PA, third-party liability, reporting, and other contracts with a variety of state MMISs, including serving as the current Ohio MMIS vendor. Additionally, Permedion has worked extensively to provide data transfer and processing utilizing the Ohio MITS portal. Such data activities include multiple file format changes, the addition of encounter data, and confirmation of high data quality in all received files. The following paragraphs address the RFP requirements related to data management, and how we are poised to meet each one through the data intake and processing framework we have already established for ODM.

Analytical Processing Completed within 24 Hours

When data is ingested, groomed, and ready for analytical processing, our automated processes will select staged data for queries. Selection queries will apply various logic, including service specific logic, time period, probability metrics, and other state selection criteria. Then exclusions run, then verification processes that considers internal scoring mechanisms to reach a final set of selected data. After all logic is applied, final level selection applies provider mailing limit logic.

The final data set is then made available to our internal teams for review and processing. This process is completed in a matter of hours.

Permedion will provide the ability to retrieve all data in a batch processing mode so that analytical processing can be completed within 24 hours. We understand that this is a minimum standard to be applied to complicated analytical processes involving multiple large data sets over multiple years. We will complete less complicated processes using smaller data sets in less time.

Access to Monthly Updates within 48 Hours of Data Receipt

Permedion will provide reasonable access to monthly updates within 48 hours of receipt of the data. Our EDI process is already set up with ODM. We process these files into our data warehouse in less than 48 hours from monthly receipt.

We have EDI protocols in place to transfer state data into the Permedion environment. Automated jobs continuously scan for available full data sets from ODM. Once data is available, it is translated into internal standard formats, run through quality checks and adjustment logic, and made available for analytical use. We will continue these processes under the new PA/UM contract.

Plan and Timetable for Database Design and Reference File Setup

Permedion currently manages healthcare information for over 250 million unique member lives. Permedion has established data exchange protocols in place and manages an in-place database for ODM transactions- eliminating the need for data management design and set-up. Our proposed solution accelerates the Permedion timeline to productivity by eliminating the need to develop a database or create new reference files. We have access to and a thorough understanding of ODM data and we have proven data management processes in place today. The Department will experience no service interruptions related to the transition to the new contract period.

The Permedion team maintains a secure processing environment. All of our data-handling protocols address data security in accordance with both state and federal requirements. ODM data managed by Permedion is accessible using internal systems and hardware. External access is restricted and limited to the parameters established during our initial implementations with ODM.

Through annual and as-necessary reviews of our policies and procedures as well as exercises designed to test our secure environment, we continually build our system for security. We handle all data according to strict protocols, document and maintain that information in a central database, and update it as necessary. We customize data-handling protocols to each client’s unique specifications, as we have done and will continue to do for ODM.

F.18 4.2.R Other Prior Authorizations

RFP Reference: Section 4.2.R

The selected Offeror may be required to perform prior authorizations in order to continue the provision of various services after an allowed amount of services has been rendered. This may include additional behavioral health prior authorizations, as well as others that may be required through changes to policies ODM is not currently aware of, but may come up through the life cycle of a contract resulting from this RFP.

Because we have a long partnership with ODM, Permedion is practiced in adding review types to our scope of work as the need arises. Our clinical team of nurses, social workers, dentists, psychiatrists, and multiple physician specialties, as well as our processes already in place, can easily accommodate new review types. An example of this was the implementation of Non-Institutional Services in July 2021. Our partnership with ODM was instrumental as we acquired an additional 4,000 prior authorization requests each month, which included learning new service types, applicable OAC rules, pricing methodologies, and medical necessity for the following:

- Compression Garments
- Decubitus Care Equipment
- Dental
- Dressings Surgical
- Enteral Nutrition and Supplies
- Hearing Aids
- Hospital Beds
- Incontinence Supplies
- Miscellaneous Equipment
- Orthotics (Mta)
- Orthotics/ Prosthetics (Nurses)
- Repairs
- Respiratory (Mta)
- Respiratory (Nurses)
- Speech Generating Devices
- Supplies Miscellaneous
- Therapies
- Vision
- Wheelchairs
- Orthodontics
- Chiropractic/Acupuncture

Permedion will perform prior authorizations to continue the provision of various services after an allowed amount of services has been rendered. Since we first began reviewing behavioral health requests for ODM in 2013, we have since added CPST, IHBT, Substance Abuse Residential, Substance Abuse Partial and outpatient services such as psychiatrist evaluations, psychological testing and therapy services after service limitations have been met. As ODM looks at any future changes to policies, we stand ready to add additional authorization review types as needed.

G. V. Business Continuity Plan

RFP Reference: Section V

A. Offeror recognizes that certain services covered in this RFP are vital to ODM and must be continued without interruption. Offeror shall be prepared to continue providing such services identified by ODM, during periods of disaster, crisis, or other unexpected break in services based upon a Business Continuity Plan (Plan). Offeror is required to implement and maintain a sustainable Plan throughout the term of the Contract resulting from this RFP and provide a summary of the Plan to ODM upon request. The Plan will, at a minimum address the following:
   1. How the Offeror will enable continued performance under this Contract in the event of a disaster or other unexpected break in services;
   2. How the Offeror will ensure the continuity for identified vital services and supporting facilities;
   3. Disaster recovery plans for critical technology and systems infrastructure; and
   4. Proper risk controls (collectively, the "Contingency Plans") to enable continued performance under the Contract in the event of a disaster or other unexpected break in services.

B. For purposes of this Section, the term “Disaster” means an unanticipated incident or event, including, without limitation, force majeure events, technological accidents or human-caused events that (i) may cause a material service or critical application to be unavailable without any reasonable prediction for resumption, or (ii) causes data loss, property damage, or other business interruption without any reasonable prediction for recovery within a commercially reasonable time period.

C. The awarded Offeror will update and test the operability of any applicable Plan at least annually and will implement such Plan upon the occurrence of a Disaster.

A.1. Continued Performance in Event of a Disaster

Proven Experience
Successful implementation of our BC/DR approach in Florida kept operations running during Hurricane Irma in 2017.

Continuity/Disaster Recovery (BC/DR) is an essential advantage that Permedion brings to ODM’s UM/PA program. In alignment with State and Federal requirements, Permedion will work with ODM to establish recovery priorities dedicated to preventing outages in the event of a disaster. We will maintain the existing BC Plan (BCP) and DR Plan (DRP) and support ODM in updating these plans based on the evolution of data, infrastructure/architecture, and tools. We understand MARS-E 2.0 and subsequent versions, SSA Security Requirements, and IRS Publication 1075 requirements cite DRP and BCP compliance expectations, and that the State maintains compliance with these requirements, including testing expectations, for the IEDSS M&O solution.

The COVID-19 pandemic and ensuing Public Health emergency reinforced the importance of protecting the well-being of employees and of having an effective business continuity plan in place. During the pandemic, beginning in 2020, the larger Gainwell team (including Permedion) activated our performance plans for times of disaster. Plan activation included imposing remote working arrangements for personnel when possible, suspending non-essential employee travel, canceling participation in in-person industry events and group meetings, promoting social distancing, and enhancing cleaning and sanitization efforts across office locations. Our plan included implementing protocols to quarantine employees who may have been exposed to COVID-19 or were showing relevant symptoms, and extending additional paid time off to employees to obtain a COVID-19 vaccine. We also invested in personal protective equipment, provided paid sick leave to affected employees, and implemented other policies and initiatives to reduce COVID-19 transmission. During this process, we also leveraged Permedion's internal In Case of Crisis application to communicate and coordinate with employees.

> In 2017, Permedion/HMS was certified as a 'Resilient Enterprise' by Disaster Recovery Institute International (DRII). The designation demonstrates extraordinary commitment to business continuity management (BCM), including emergency management, business continuity, disaster recovery, and crisis management. We maintain this designation today.

A.2. Continued Performance of Vital Services and Supporting Facilities

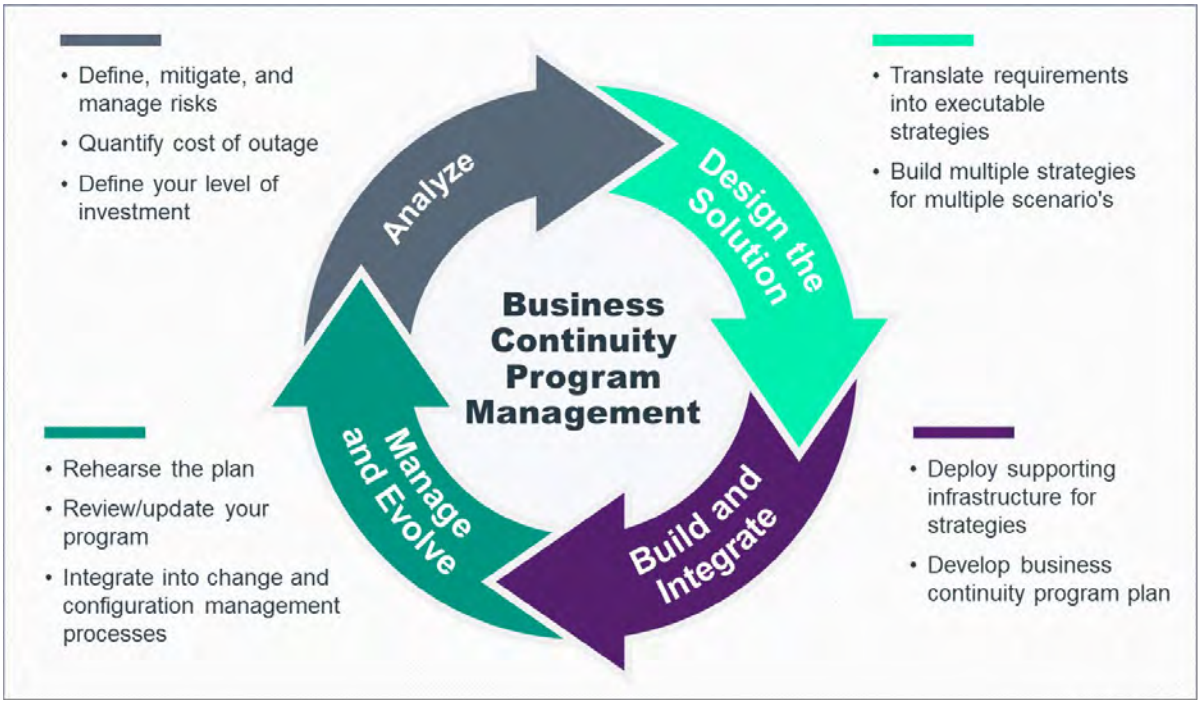
Permedion maintains a Disaster Recovery (DR), Business Continuity plan (BC) and Solution Back-up Plan as required in the RFP, in place today for ODM's contract. The DR Plan outlines the process used to provide immediate response and recovery from major events that result in the loss of critical processing capabilities at the Permedion Core operations facility in Richardson, TX, or with the AWS Cloud Services to verify continued alignment with program requirements.

The DR/BC, and Solution Back-Up plans include:

- Backup and Recovery Approach
- Business Continuity Plan and Analysis
- Disaster Recovery Demonstration and Test Plan
- Procedures to accommodate the loss of online communication between Permedion's processing site and the ODM facilities
- Procedures to be followed in the event of a disaster or occurrence, which causes a disruption to the business continuity and/or processing of Ohio transactions
- Procedures to be followed in the event of the loss of the Permedion's primary processing site, loss of cloud provider hosting site (including data communications infrastructure between sites), or loss of access for the ODM's online components of the solution.
- Options for recovery within four (4) hours of the event
- Definition of all critical operations
- Description of all services, hardware, software, software license, and infrastructure required for this functionality

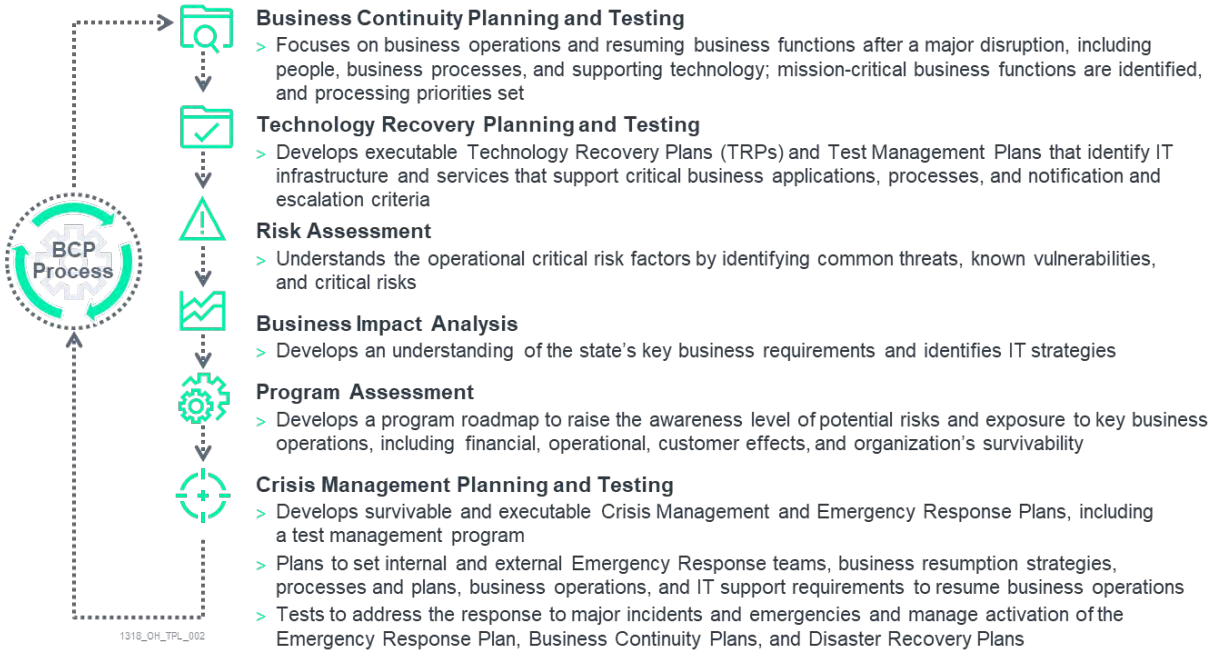
Permedion will maintain adequate backup to allow continued automated and manual processing. We will provide an alternate business area site in the event the primary business site becomes unsafe or inoperable. Permedion has the tools, technologies, and capabilities to conduct synchronized point-in-time recovery of the entire solution at any given time, as shown in the following figure. Data resides within the contiguous United States at all times.

Figure 71. Permedion BCP Process



The Permedion Business Continuity planning process provides for best practices as described in the following figure.

Figure 72. Business Continuity Planning Process



A.3 Disaster Recovery for Critical Technology and Systems Infrastructure

Our disaster recovery infrastructure is a central component of our Business Resilience Program and consists of two hosted colocation data centers. These enterprise-class centers are in Richardson, TX (primary), and Las Vegas, NV (secondary). The Information Technology Services (ITS) department uses a comprehensive back-up methodology to protect our systems from failure or disaster and provides fast recovery in the event of a loss or outage.

A.4 Risk Controls to Enable Continued Performance

The Business Continuity Plan we will continue to use for ODM's UM/PA project will encompass all sites where we perform contracted activities and/or store data and will accommodate different types of disasters (such as disasters that affect all services or those that affect one or more service).

The plan will address the specific functions that we can transfer to our National Operation Center (NOC) in Irving, TX, and describe how we will execute these tasks in the event of a natural or manmade emergency. It will also outline the process that we will deploy to transfer operations to our NOC, including, but not limited to, the following project components:

- Training
- Telecommunications
- Mailroom operations
- Customer service
- Systems administration

Our plan also addresses issues that could arise from, but are not part of, a disastrous event that would mandate that we transfer operations from their original location. For example, in the event of a significant telephone system outage at our local office or an excessively high call volume, we can leverage our sizable, fully trained customer service team. Likewise, in the event of an extended communications outage, we can switch from one line/vendor to another because of the redundancy built into our telecommunications infrastructure that results in multiple communications lines provided by multiple vendors. We document these types of contingency plans as part of our telephone system failure–planning process.

As stated previously, our BRP consists of two hosted colocation data centers. These enterprise-class centers are in Richardson, TX (primary), and Las Vegas, NV (secondary). The Information Technology Services (ITS) department uses a comprehensive back-up methodology to protect our systems from failure or disaster and provides fast recovery in the event of a loss or outage. This provides recovery and technical support of the ODM data servers and infrastructure in the AWS cloud during recovery. Additionally:

- Permedion uses an off-site storage provider network for tape rotation
- Back-ups are rotated to highly secure, fireproof climate-controlled locations
- Recovery of data tapes from these facilities occurs within four hours of declaration of a disaster
- Autoloader systems (robots) help automate Permedion’s back-up procedures
- All locations use either Digital Linear Tape (DLT) format or replicate their data to our corporate data center
- Data is replicated nightly through our private network to our SSAE16 compliant data center. It is then captured at the data center through a multi-tiered back-up process
- Live replication serves as an on-disk copy
- A nightly back-up routine captures that copy to disk, which is transferred to tape and rotated off site to another storage facility

B. Understanding of the Term “Disaster”

Permedion confirms that we have a clear understanding of the term “disaster” that matches the definition of the word included in the RFP. During such events, the Crisis Management Team Leader declares the event and invokes the recovery plans. Permedion-HMS is certified as a ‘Resilient Enterprise’ by Disaster Recovery Institute International (DRII). The designation demonstrates extraordinary commitment to business continuity management (BCM), including emergency management, business continuity, disaster recovery, and crisis management. We serve the needs of public healthcare and government entities across the nation, and we recognize the importance of protecting sensitive information our clients entrust to us. Our data-security measures result from proven, tested methodologies designed to safeguard the data of government and public health clients. We protect the integrity of their data and the health information of the citizens that each program serves. Information technology (IT) data security is a constantly evolving field. Permedion is committed to remaining a leader in ongoing, innovative data-security measures in the healthcare industry.

C. Updates and Tests of the Plan

Permedion conducts disaster recovery tests on an annual basis, meeting ODM's minimum requirements. After testing, we undergo Response and Recovery Debriefing meetings and use the results to assess, improve, and update our established plans. In each test conducted to-date, we have successfully restored and tested our systems and application infrastructures. During the testing exercises, we compile all process incidents and situations and conduct a Post–Disaster Recovery Technical and Business Review meeting on lessons learned. We report these findings in an Executive Disaster Recovery Exercise Report and incorporate them into our overall plan so the BRP will operate efficiently if a real disaster occurs.

The following figure provides a sample Table of Contents page and a sample Overview page of the Executive Disaster Recovery Exercise Report.

Figure 73. Sample Pages of Executive DR Exercise Report

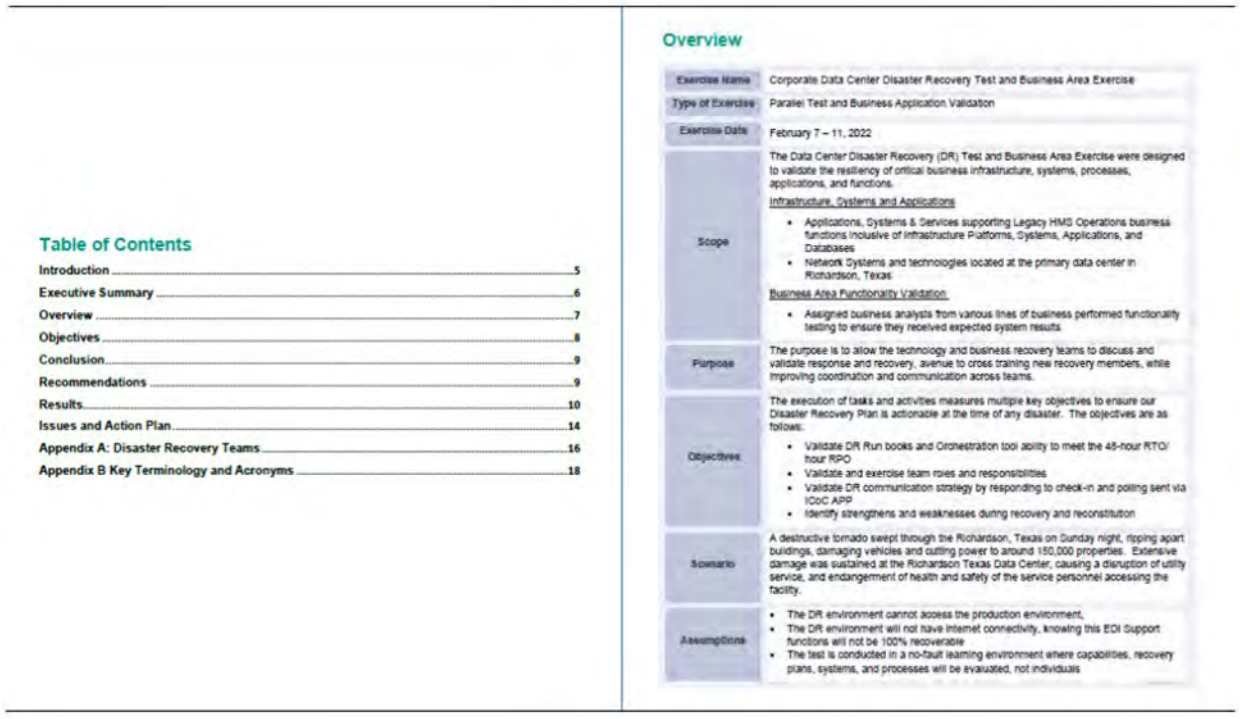


Table of Contents

Overview

Exercise Name	Corporate Data Center Disaster Recovery Test and Business Area Exercise
Type of Exercise	Parallel Test and Business Application Validation
Exercise Date	February 7 – 11, 2022
Scope	The Data Center Disaster Recovery (DR) Test and Business Area Exercise were designed to validate the resiliency of critical business infrastructure, systems, processes, applications, and functions. Infrastructure, Systems and Applications • Applications, Systems & Services supporting Legacy HMS Operations business functions inclusive of Infrastructure Platforms, Systems, Applications, and Databases • Network Systems and technologies located at the primary data center in Richardson, Texas Business Area Functionality Validation: • Assigned business analysts from various lines of business performed functionality testing to ensure they received expected system results
Purpose	The purpose is to allow the technology and business recovery teams to discuss and validate response and recovery, avenue to cross training new recovery members, while improving coordination and communication across teams.
Objective	The execution of tasks and activities measures multiple key objectives to ensure our Disaster Recovery Plan is actionable at the time of any disaster. The objectives are as follows: • Validate DR Run books and Orchestration tool ability to meet the 48-hour RTO/ hour RPO • Validate and exercise team roles and responsibilities • Validate DR communication strategy by responding to check-in and polling sent via ICoC APP • Identify strengthens and weaknesses during recovery and reconstitution
Scenario	A destructive tornado swept through the Richardson, Texas on Sunday night, ripping apart buildings, damaging vehicles and cutting power to around 150,000 properties. Extensive damage was sustained at the Richardson Texas Data Center, causing a disruption of utility service, and endangerment of health and safety of the service personnel accessing the facility.
Assumptions	• The DR environment cannot access the production environment, • The DR environment will not have internet connectivity, knowing this EDI Support functions will not be 100% recoverable • The test is conducted in a no-fault learning environment where capabilities, recovery plans, systems, and processes will be evaluated, not individuals

H. 9.11 MBE Documentation

RFP Reference: Section 9.11

This RFP contains a sheltered solicitation subcontracting requirement which requires the Offeror to seek and set aside at least 15 percent of the work to be exclusively performed by Ohio certified Minority Business Enterprise (MBE) businesses. Proposal must include the selected subcontractor's name, MBE certification number, and the stated percentage of the cost of work to be performed. Proposal must also include a letter from the selected MBE subcontractor, on company letterhead and signed by an individual authorized to commit the business to performing the work outlined in the Proposal.

Permedion proposes to use two qualified and experienced subcontractors to support our delivery of industry-best UR/UM services to the State of Ohio: Ardent Technologies, Inc. (Ardent) and Diversified Systems, Inc. (Diversified). Ardent and Diversified are both certified by the State of Ohio as Minority Business Enterprises (MBEs).

Ardent currently serves as a subcontractor for Permedion in multiple state contracts, including the ODM UM/PA contract, and will provide staffing augmentation for programming and quality assurance positions. Ardent is an MBE headquartered in Dayton, Ohio, and its certification number is MBE-19239. Work to be performed by Ardent is 7.5% of the total dollar amount of the contract per state fiscal year. Refer to proposal Section H for a letter of commitment from Ardent and the company's MBE certification.

Diversified will provide provider authorization request review support to Permedion to support our delivery of UM/PA services to ODM. We have subcontracted with Diversified under the current UM/PA contract to provide the services of four dentists. Diversified is an MBE headquartered in Westerville, Ohio, and its certification number is MBE-7944. Work to be performed by Diversified is 7.5% of the total dollar amount of the contract per state fiscal year. Refer to proposal Section H. for a letter of commitment from Diversified and the company's MBE certification.

October 11, 2022

Office of Contracts and Procurement, RFP/RLB Unit
Ohio Department of Medicaid
ODMR-2223-0006
50 West Town Street
Columbus, Ohio 43215

Re: Subcontractor Identification and Participation Information: Health Management Systems, Inc. (HMS) Response to Request for Proposals (RFP) ODMR-2223-0006 for Clinical Utilization Management and Prior Authorization Program

Dear Sir or Madam:

Ardent Technologies, Inc., a Minority Business Enterprise, is pleased to be selected by HMS to perform as subcontractor for the scope of work described in the above-referenced RFP. We are willing and eager to fulfill the responsibilities described in this letter. **Figure 1** provides responses to the requirements included in RFP Section 3.5.

Figure 1: Subcontractor Responses to RFP ODMR-2223-0006 Section 3.5

RFP Requirement	Response
Name of Subcontractor	Ardent Technologies, Inc.
Proposed Tasks to Be Performed by Subcontractor	Staffing augmentation for programming and quality assurance positions
Is the Letter of Subcontractor Participation Signed by a Person Authorized to Legally Bind the Subcontractor?	Yes
Subcontractor's Legal Status	Corporation
Subcontractor's Federal Tax ID Number	31-1692371
Subcontractor's Principal Business Address	Ardent Technologies, Inc., 6234 Far Hills Ave., Dayton, OH 45459
Name and Title of Company Contact Person Who is Authorized to Legally Bind the Subcontractor to Contractual Obligations	Tamiko C. Lawton, Contracts Manager

Figure 1: Subcontractor Responses to RFP ODMR-2223-0006 Section 3.5

RFP Requirement	Response
Telephone Number of Company Contact Person	937-312-1345
Email Address of Company Contact Person	Contracts@ardentinc.com
Commitment to Do the Work	I, the undersigned, hereby commit Ardent Technologies, Inc. to perform the work subcontracted to it by HMS to support the fulfillment of the Clinical Utilization Management and Prior Authorization Program described in RFP ODMR-2223-0006 on behalf of ODM.
Statement that the Subcontractor Has Read and Understands the RFP, the Nature of the Work, and the Requirements of the RFP.	I, the undersigned, have read and understand RFP ODMR-2223-0006, the nature of the work, and the requirements of the RFP.
Minority Business Enterprise (MBE) Certification Number, if applicable	MBE-19239

Thank you for your interest in HMS and Ardent Technologies, Inc. We look forward to working with HMS to provide industry-best services to the State of Ohio. Please contact us with any questions or comments regarding our company and/or our proposed services for ODM.

Sincerely,

Tamiko C. Lawton
Contracts Manager

Ohio | Department of Development

Mike DeWine, Governor
Jon Husted, Lt. Governor

Lydia L. Mihalik, Director

11/16/2021

Vas Appalaneni
Ardent Technologies, Inc.
6234 Far Hills Ave.
Dayton, OH 45459

Certification Number: **MBE-19239**
Effective Dates: **11/16/2021** through **11/16/2023**

Dear Vas Appalaneni:

The Ohio Department of Development, Minority Business Development Division(MBDD) has reviewed your business's application to obtain certification as a Minority Business Enterprise (MBE) in Ohio. The Ohio Department of Development, Minority Business Development Division is pleased to inform you that Ardent Technologies, Inc. has been certified by MBDD as a MBE Business Enterprise.

The Ohio Department of Development, Minority Business Development Division has determined that Ardent Technologies, Inc. satisfactorily meets the requirements set forth in Section 123:2-14 of Administrative Code as is required for participation in the MBE program. This certification letter shall serve as the state's official certification.

This letter also acknowledges that Ardent Technologies, Inc. has been categorized under the Information Technology Services category for MBE program participation and has demonstrated capability for a period of at least one-year in the following UNSPS code(s):

1.	43232200	Content management software
2.	43232400	Development software
3.	43232800	Network management software
4.	43233700	System management software
5.	80101500	Business and corporate management consultation services
6.	80101500	Business and corporate management consultation services
7.	81111500	Software or hardware engineering
8.	81111600	Computer programmers
9.	81111800	System and system component administration services
10.	81111800	System and system component administration services
11.	81112200	Software maintenance and support

NOTE: Ardent Technologies, Inc. is required to inform MBDD in writing (letter or email) within 30 days of the occurrence of any material change(s). A material change is defined as: any change in circumstances affecting the business or the at least 51 percent eligible owner(s); including but not limited to current contact information, changes in ownership, business structure, independence, managerial and/or operational control, or any material change in the information provided in its application including changes in management responsibility among owner(s) of the certified business. Similar notification must be provided to MBDD of any changes to the company's name, business address, Email address, telephone numbers, principal products/service or other basic contact and commercial activity information. For additional information, please refer to Ohio Administrative Code 123:2-14-01, 123:2-14-02, and 123:2-14-07.

Failure to notify MBDD of any material change is cause for revocation of Ardent Technologies, Inc.'s MBE certification.

eligibility for continued participation in the MBE program.

If you need any assistance or have questions about the MBE program, please contact MBDD at 614-466-8380.

Sincerely,

Eric M. Seabrook
Division Chief

77 South High Street
Columbus, Ohio 43215 U.S.A.

614 | 466 3379
800 | 848 1300
www.development.ohio.gov

October 13, 2022

Office of Contracts and Procurement, RFP/RLB Unit
Ohio Department of Medicaid
ODMR-2223-0006
50 West Town Street
Columbus, Ohio 43215

Re: Subcontractor Identification and Participation Information: Health Management Systems, Inc. (HMS) Response to Request for Proposals (RFP) ODMR-2223-0006 for Clinical Utilization Management and Prior Authorization Program

Dear Sir or Madam:

Diversified Systems, Inc., a Minority Business Enterprise, is pleased to be selected by HMS to perform as subcontractor for the scope of work described in the above-referenced RFP. We are willing and eager to fulfill the responsibilities described in this letter. **Figure 1** provides responses to the requirements included in RFP Section 3.5.

Figure 1: Subcontractor Responses to RFP ODMR-2223-0006 Section 3.5

RFP Requirement	Response
Name of Subcontractor	Diversified Systems, Inc.
Proposed Tasks to Be Performed by Subcontractor	Provider Authorization request review support
Is the Letter of Subcontractor Participation Signed by a Person Authorized to Legally Bind the Subcontractor?	Yes
Subcontractor's Legal Status	Ohio Corporation
Subcontractor's Federal Tax ID Number	31-1383824
Subcontractor's Principal Business Address	Diversified Systems, Inc., 100 Dorchester Sq., Suite 200, Westerville, OH 43081

Figure 1: Subcontractor Responses to RFP ODMR-2223-0006 Section 3.5

RFP Requirement	Response
Name and Title of Company Contact Person Who is Authorized to Legally Bind the Subcontractor to Contractual Obligations	Archie D. Williamson Jr., President/Sr. Managing Director
Telephone Number of Company Contact Person	614-476-9939, ext. 13
Email Address of Company Contact Person	awilliamson@diversifiedsystems.com
Commitment to Do the Work	I, the undersigned, hereby commit Diversified Systems, Inc. to perform the work subcontracted to it by HMS to support the fulfillment of the Clinical Utilization Management and Prior Authorization Program described in RFP ODMR-2223-0006 on behalf of ODM.
Statement that the Subcontractor Has Read and Understands the RFP, the Nature of the Work, and the Requirements of the RFP.	I, the undersigned, have read and understand RFP ODMR-2223-0006, the nature of the work, and the requirements of the RFP.
Minority Business Enterprise (MBE) Certification Number, if applicable	**MBE-7944** Effective Dates: **09/26/2022** through **09/26/2024**

Thank you for your interest in HMS and Diversified Systems, Inc. We look forward to working with HMS to provide industry-best services to the State of Ohio. Please contact us with any questions or comments regarding our company and/or our proposed services for ODM.

Sincerely,

Archie D. Williamson Jr.
President/Senior Managing Director

Ohio | Department of Development

Mike DeWine, Governor
Jon Husted, Lt. Governor

Lydia L. Mihalik, Director

09/26/2022

Archie Williamson
Diversified Systems Inc.
100 Dorchester Square, North, Suite 200
Westerville, OH 43081

Certification Number: **MBE-7944**
Effective Dates: **09/26/2022** through **09/26/2024**

Dear Archie Williamson:

The Ohio Department of Development, Minority Business Development Division(MBDD) has reviewed your business's application to obtain certification as a Minority Business Enterprise (MBE) in Ohio. The Ohio Department of Development, Minority Business Development Division is pleased to inform you that Diversified Systems Inc. has been certified by MBDD as a MBE Business Enterprise.

The Ohio Department of Development, Minority Business Development Division has determined that Diversified Systems Inc. satisfactorily meets the requirements set forth in Section 123:2-14 of Administrative Code as is required for participation in the MBE program. This certification letter shall serve as the state's official certification.

This letter also acknowledges that Diversified Systems Inc. has been categorized under the Information Technology Services category for MBE program participation and has demonstrated capability for a period of at least one-year in the following UNSPS code(s):

1.	43232800	Network management software
2.	64131600	Contracts
3.	72151600	Specialized communication system services
4.	80101500	Business and corporate management consultation services
5.	80101600	Project management
6.	80111600	Temporary personnel services
7.	80111700	Personnel recruitment
8.	80161500	Management support services
9.	80171900	Stakeholder management and relations services
10.	80172000	Professional communication services
11.	81111500	Software or hardware engineering
12.	81111600	Computer programmers
13.	81111700	Management information systems MIS
14.	81111800	System and system component administration services
15.	81111900	Information retrieval systems
16.	81112000	Data services
17.	81112100	Internet services
18.	81112200	Software maintenance and support
19.	81112300	Computer hardware maintenance and support
20.	81112400	Computer hardware rental or leasing services
21.	81112500	Computer software licensing rental or leasing service
22.	81141500	Quality control
23.	81141700	Production planning and control

24. 81161500 Access management services
25. 81161600 Electronic mail and messaging services
26. 81161700 Telecommunication Services
27. 82111500 Technical writing
28. 86101800 In service training and manpower development
29. 86132100 Training planning, facilitation and delivery services
30. 86132200 Educational support services
31. 93151600 Public finance

NOTE: Diversified Systems Inc. is required to inform MBDD in writing (letter or email) within 30 days of the occurrence of any material change(s). A material change is defined as: any change in circumstances affecting the business or the at least 51 percent eligible owner(s); including but not limited to current contact information, changes in ownership, business structure, independence, managerial and/or operational control, or any material change in the information provided in its application including changes in management responsibility among owner(s) of the certified business. Similar notification must be provided to MBDD of any changes to the company's name, business address, Email address, telephone numbers, principal products/service or other basic contact and commercial activity information. For additional information, please refer to Ohio Administrative Code 123:2-14-01, 123:2-14-02, and 123:2-14-07.

Failure to notify MBDD of any material change is cause for revocation of Diversified Systems Inc.'s MBE certification.

Re-certification Note: one month prior to the expiration date of this certification, your business is required to submit a completed Re-certification Application for MBDD's review relative to the Diversified Systems Inc.'s eligibility for continued participation in the MBE program.

If you need any assistance or have questions about the MBE program, please contact MBDD at 614-466-8380.

Sincerely,

Monica L. Womack
Interim Chief
Minority Business Development Division

77 South High Street
Columbus, Ohio 43215 U.S.A.

614 | 466 3379
800 | 848 1300
www.development.ohio.gov

Attachment A1
REQUIRED OFFEROR INFORMATION

Purpose: ODM requires the following information from Offerors who submit Proposals to this RFP, in order to facilitate the development of the Contract (or finalization of a purchase) with the selected Offeror. ODM reserves the right to reject an Offeror's Proposal if it fails to provide this information fully, accurately, and/or by the deadline set by ODM. **Failure to provide such required supplier information may result in immediate disqualification of Offeror's Proposal.**

Instructions: Provide the following information regarding the Offerors submitting the Proposal. Offerors may either print this attachment, complete and sign, or may provide the required information and certifications (each fully re-stated from this attachment) on their letterhead as the opening pages of their Proposal. It is mandatory that the information provided is certified with an original signature (in blue ink, please) from a person with authority to represent the Offeror. Offerors are to provide the completed and signed information and certifications as the cover pages of their original application submitted to ODM.

IMPORTANT: If the RFP specified a maximum page limit for Proposals, the attachment of any required certifications, other documents, or additional pages needed to fully provide the information requested here will NOT be counted against that page limit.

1. ODM RFP# and TITLE: **ODMR-2223-0006; Clinical Utilization Management and Prior Authorization Program**

2. Proposal Submission Due Date: **October 26, 2022 at 2:00 pm Columbus Local Time**

3. Offeror's Name: (legal name of Offeror to whom Contract payments will be made):
   Permedion, Inc.

4. Offeror's Corporate Address: **5615 High Point Drive, Irving, TX 75038**

5. Offeror's Remittance Address: (or "same" if same as number 4. above):
   same

6. Print or type the following information for the Offeror's representative/contact person authorized to answer questions on the Proposal/application:

   Offeror's Representative Name and Title: **Lauren Rizzo, Vice President, Government Services**

   Offeror's Representative Phone #: **973.285.5478**

   Offeror's Representative Email Address: **lauren.rizzo@gainwelltechnologies.com**

7. Is this Offeror an Ohio certified MBE? ___Yes **X** No
   If yes, attach a copy of current certification to Proposal/application.

8. Offeror agrees to comply with the requirements to maintain a complete affirmative action plan and affirm they will be in compliance with ORC § 125.111 prior to being awarded a Contract.
   Yes

9. Offeror's Employee Information:

Total Number of Employees Nationwide: **1,712***	% of Women Employees Nationwide: **62.7***
Total Number of Employees in Ohio: **97***	% of Women Employees in Ohio: **4.4***
% of Minority Employees Nationwide: **51.4***	% of Minority Employees in Ohio: **2.4***

***Includes Health Management Systems, Inc., (HMS, Inc.), parent company of Permedion, Inc.**

Attachment A2

ETHICS CERTIFICATION AND MANDATORYAFFIRMATIONS

1. If selected, as a vendor or granteedoingbusinesswith[1] or receiving grants from the State of Ohio, the Offeror certifies **Permedion, Inc.** that:
   (1) The Offeror has reviewed and understands Ohio ethics and conflict of interest laws, as found in Chapter 102 and Sections 2921.42 and 2921.43 of the Ohio Revised Code; and

   (2) The Offeror acknowledges that failure to comply with this certification, is, by itself, grounds for termination of this Contract or grant with the State of Ohio.

Paul Sam — October 26, 2022

2. The Offeror affirms that they have read the ODM Model Contract attached to the RFP, and if awarded a Contract, they will not ____(or) they will __X__ request changes to the standard language, and have identified the requested changes in Attachment F. (All requested changes to model Contract language are subject to ODM approval.)

3. The Offeror affirms that this Proposal accurately represents the capabilities and qualifications of **Permedion, Inc.** (Offeror's name), and hereby affirms that the cost(s) bid to ODM for the performance of services and/or provision of goods covered in this application in response to the ODM RFP is a firm fixed price, inclusive of all incidental, as well as primary, costs. (Failure to provide the proper affirming signature on this item may result in the disqualification of Offeror's Proposal.)

4. The Offeror hereby attests that they understand that any and all information included in this Proposal is not confidential and/or trade secret information (as defined in the RFP) and that the Proposal submission may be posted in its the Internet for public viewing. Following submission to ODM, all Proposals submitted may become part of the public record. ODM reserves the right to disqualify any Offeror whose Proposal is found to contain such prohibited personal information. The Offeror affirms that it shall be solely responsible for any and all information disclosed in the Proposal submission and any or all information released by ODM in a public records request(s).

5. The Offeror hereby attests that their organization will maintain the confidentiality of information and records in accordance with state and federal laws, rules, and regulations. As a condition of receiving a Contract from ODM, their company, and any subcontractor(s), will be required to comply with 42 U.S.C. §§ 1320 (d) through 1320 (d)(8), and the implementing regulations found at 45 CFR § 164.502 (e) and § 164.504 (e) regarding disclosure of protected health information under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Protected Health Information (PHI) is information received by their organization from or on behalf of ODM that meets the definition of PHI as defined by HIPAA and the regulations promulgated by the United States Department of Health & Human Services, specifically 45 CFR 164.501 and any amendments thereto.

6. The Offeror affirms that their organization will disclose whether their company or any proposed subcontractor has received a formal claim for breach of Contract. For purposes of this disclosure, "formal claims" means any claims for breach that have been filed as a lawsuit in any court, submitted for

[1] "Doing business with" includes all Contracts for goods and services, excluding purchases made using the State of Ohio's Payment Card Program that cost less than $1,000.

arbitration (whether voluntary or involuntary, binding or not), or assigned to mediation. If any such claims are disclosed, their company shall fully explain the details of those claims, including the allegations regarding all alleged breaches, any written or legal action resulting from those allegations, and the results of any litigation, arbitration, or mediation regarding those claims, including terms of any settlement.

7. The Offeror affirms that their organization will disclose whether their organization and any of the proposed subcontractor(s) has been the subject of any adverse regulatory or administrative governmental action (federal, state, or local) with respect to performance. It will be fully explained, in detail, the nature of the governmental action, the allegations that led to the governmental action, and the results of the governmental action including any legal action that was taken against Offeror by the governmental agency.

8. The Offeror affirms that their organization will comply with the requirement to maintain a complete affirmative action plan and affirm to be in compliance with ORC § 125.111 prior to being awarded a Contract.

Paul Sauer — **October 26, 2022**

Signature of authorized Offeror's representative — Date

Attachment A3
LOCATION OF BUSINESS AND OFFSHORE DECLARATIONFORM

Location of Business Declaration: Offerors responding to any ODM RFP (etc.) must certify that no public funds shall be spent on services provided/performed offshore by completing, signing, and returning the "Location of Business Form," which is the final section of this attachment. **FAILURE TO PROPERLY COMPLETE, SIGN AND RETURN THIS FORM MAY RESULT IN DISQUALIFICATION OF THE OFFEROR FROM CONSIDERATION FOR AWARD OF THIS ODM CONTRACT.**

Offeror affirms that Offeror has read and understands the applicable Executive Orders regarding the prohibitions of performance of offshore services, locating State data offshore in any way, or purchasing from Russian institutions or companies. The Executive Order is available at the following website: (https://governor.ohio.gov/media/executive-orders).

The Offeror shall provide all the name(s) and location(s) where services under this Contract will be performed and where data is located in the spaces provided below or by attachment. Failure to provide this information may result in no award. If the Offeror will not be using subcontractors, indicate "Not Applicable" in the appropriate spaces.

1. Principal location of business of Offeror:

5615 High Point Drive — (Address)

Irving, TX 75038 — (City, State, Zip)

Name/Principal location of business of subcontractor(s):

Ardent Technologies, Inc., 6234 Far Hills Avenue — (Name)

Dayton, OH 45459 — (Address, City, State, Zip)

Diversified Systems, Inc., 100 Dorchester Sq., #200 — (Name)

Westerville, OH 43081 — (Address, City, State, Zip)

2. Location where services will be performed by Offeror:

5475 Rings Rd., Suite 200
5615 High Point Drive — (Address)

Dublin, OH 43017
Irving, TX 75038 — (City, State, Zip)

Name/Location where services will be performed by subcontractor(s):

Ardent Technologies, Inc. — (Name)

6234 Far Hills Avenue, Dayton, OH 45459 — (Address, City, State, Zip)

Diversified Systems, Inc., — (Name)

5475 Rings Rd., Suite 200, Dublin, OH 43017 — (Address, City, State, Zip)

3. Location where state data will be stored, accessed, tested, maintained or backed-up, by Offeror:

3150 Waterview Parkway — (Address)

Richardson, TX 75080 — (Address, City, State, Zip)

Name/Location(s) where state data will be stored, accessed, tested, maintained or backed-up by **subcontractor(s)**:

Ardent Technologies, Inc.	**3150 Waterview Pkwy, Richardson, TX 75080***
(Name)	(Address, City, State, Zip)
Diversified Systems, Inc.	**3150 Waterview Pkwy, Richardson, TX 75080***
(Name)	(Address, City, State, Zip)

***State data will accessed by subcontractors only; data will be stored at Permedion.**

4. Location where services to be performed will be changed or shifted by Offeror:

Not applicable	
(Address)	(Address, City, State, Zip)

Name/Location(s) where services will be changed or shifted to be performed by **subcontractor(s)**:

Not applicable	
(Name)	(Address, City, State, Zip)

Offeror also affirms, understands and agrees that Offeror and its subcontractors are under a duty to disclose to the State any change or shift in location of services performed by Offeror or its subcontractors before, during and after execution of any contract with the State. Offeror agrees it shall so notify the State immediately of any such change or shift in location of its services. The State has the right to immediately terminate the contract, unless a duly signed waiver from the State has been attained by the Offeror to perform the services outside the United States.

On behalf of the Offeror, I acknowledge that I am duly authorized to execute this Affirmation and Disclosure Form and have read and understand that this form is a part of any Contract that Offeror may enter into with the State and is incorporated therein.

Paul Saleh	**October 26, 2022**
Signature	Date
Permedion, Inc.	**5615 High Point Drive**
Offeror's Name	Address (Principal place of business)
Paul Saleh, President and Chief Executive Officer	**Irving, TX 75038**
Printed name of individual authorized to sign on behalf of entity	City, State, Zip

Attachment A4
OFFEROR'S CORPORATE STRUCTURE AND FINANCIAL INFORMATION

Offeror must provide the information requested in the table. If the response is not applicable to the Offeror, please indicate "N/A" in the table.

Name of Parent Company(if applicable)	**Health Management Systems, Inc. (HMS, Inc.)**
Industry (NAICS) (North American Industry Classification System)	**518210**
Type of Legal Entity	**Corporation**
Company Ownership (e.g., private / public, joint venture)	**Private**
Number of Full Time Employees	**1,640**
Last Fiscal Year Company Revenue	**$673.3 million (FY2020) for HMS, Inc.**
Last Fiscal Year Company Net Income	**$70.1 million (FY2020) for HMS, Inc.**
% of Revenue from State and Local Government Clients in the United States	**This information is not available as we do not track revenue from state and local government clients separate from all other revenue**
Number of Years in Business	**48**
Number of Years Offeror has been Providing the Type of Services Specified in the RFP	**35**
Number of Employees Providing the Type of Services Specified in the RFP	**800+ (includes contracted employees)**
Headquarters in the USA	**HMS, 5615 High Point Drive, Irving, TX 75038**
Locations in the USA	**Alabama (Montgomery); Alaska (Anchorage); Arizona (Phoenix); Arkansas (Conway, Little Rock); California (Rancho Cordova, Rancho Cucamonga, Roseville, West Sacramento); Colorado (Denver, Longmont); Connecticut (East Hartford); Delaware (Newark); Washington, DC; Florida (Tallahassee); Georgia (Atlanta); Idaho (Boise); Indiana (Indianapolis); Kansas (Lenexa, Topeka); Kentucky (Frankfort); Louisiana (Baton Rouge) Maine (Augusta); Massachusetts (Malden); Michigan (Rochester Hills); Mississippi (Jackson, Ridgeland); Nevada (Reno); New Jersey (Hamilton); New York (Albany); North Carolina (Raleigh); Ohio (Dublin); Oklahoma (Oklahoma City); Oregon (Salem); Pennsylvania (Camp Hill); Rhode Island (Warwick); Texas (El Paso, Irving); Vermont (Williston); Virginia (Richmond, Tysons, Virginia Beach); West Virginia (Charleston); Wisconsin (Janesville, Madison)**

Attachment A5
Existing Business Relationships with Ohio

Describe any existing or recent (within the last five (5) years) business relationships the Offeror or any of its affiliates or proposed subcontractors has with ODM, the State of Ohio, or any of the State's counties. Description shall include the following information:

- Current and previous contracts;
- Scope of current and previous contracts;
- Any breach of contract with ODM, or other state agency; and
- Any litigation, and result, brought on by the State of Ohio

HMS and Permedion, Inc.

Permedion is contracted with ODM to perform Hospital Utilization Management. The most recent renewal of this contract began in 2018. The scope of work includes:

- **Inpatient and outpatient hospital retrospective reviews**
- **Inpatient psychiatric reviews**
- **Prior Authorization and Pre-certification of services such as Home health, DME, therapies, dental, behavioral health and medical/surgical prior authorizations**
- **Appeals and Reconsiderations**
- **External Review for Ohio Managed Care Entities (going live in SFY 2023)**

From 2013 – 2018, Permedion was contracted with the Ohio Department of Mental Health and Addiction Services under the Statewide Utilization Management/Utilization Review Program for Specified Behavioral Health Care Services for Medicaid Recipients from 2013 – 2018. Portions of this contract were incorporated into the Hospital Utilization Management contract and continue with ODM as listed above.

HMS has been providing TPL services to Ohio Department of Medicaid since 1999. In support of our Casualty recovery scope of work, we have also established effective working relationships with the legal community and attorneys throughout the State that enable case identifications and settlements.

Gainwell

Gainwell has been providing technology services to ODM since 2007 as the Medicaid Management Information System (MMIS) vendor. As ODM transitions to the next generation modular model, Gainwell will provide systems and business services as the department's Fiscal Intermediary. Gainwell is actively working toward an implementation in Q4 2022 to support claims processing, call center functions, financial management and support for coordination between ODM and its managed care partners. Gainwell is also the Single Pharmacy Benefit Manager (SPBM) with ODM. Gainwell administers Ohio Medicaid's prescription drug program pharmacy coverage for recipients enrolled in a managed care plan, except for those with Medicare Part D coverage. Through this innovative program, Gainwell will operate as a pre-paid ambulatory health plan (PAHP), a first-of-its-kind approach to pharmacy care in Medicaid. Gainwell will partner with managed care plans for care coordination, adjudicate and pay pharmacy claims and operate full service call centers to support both member and provider needs. Gainwell has an extensive history of working with the State and Ohio counties over the years. Our Ohio customer base includes: Ohio Department of Medicaid; Ohio Department of Developmental Disabilities; Department of Health Ohio; Ohio Public Employees Retirement System; Ohio Department of Job and Family Services; State Teachers Retirement System of Ohio; Ohio Bureau of Workers' Compensation; Ohio Department of Administrative Services; Ohio Department of Rehabilitation and Correction; Ohio Department of Taxation; Ohio Turnpike and Infrastructure Commission; Ohio Public Employee Deferred Compensation; Franklin County Board of Commissioners; and the State of Ohio.

Ardent (MBE Subcontractor)

- Ohio Dept. of Education: Help Desk Support, Teaching Leading Learning Project
- Various agencies through OST Inc. (the VMS to State of Ohio): DODD, DOT, ODM, OAKS, DJFS
- Dept. of Admin. Services: OMIG (ORACLE developer)
- Ohio Public Employees Retirement System: Java Support
- Dept. of Medicaid
- Ohio Attorney General

Ardent breaches; litigation: None reported

Diversified (MBE Subcontractor)

Currently working as subcontractor to Gainwell supporting existing MITS system from DDI to current Maintenance and Operation mode since 2006; SOW--providing staff augmentation services in areas of development, testing, business analysis and reporting.

Currently working as primary subcontractor to Gainwell supporting new OMES system from both a DDI and M&O standpoint since 12/2021; SOW--For DDI provided Testers, Data Conversion, ETL, EDI, Report Writers, Database, and Technical Writing support. For M&O providing Claims Resolution Analysts and Customer Service Representatives as well as the Lead Claims Manager position

Also working as primary subcontractor to Gainwell supporting SPBM system since 1/22; SOW-- provided Key Lead positions in Claims Manager, Compliance, Quality and initially Training. For M&O are providing Pharmacy Network Account Manager, MCE Liaison Leads, and Pharmacy Technicians.

Have been providing subcontract support for the Medicaid review of dental claims for HP/DXC/HMS/Gainwell since at least 2015 or longer; SOW-- providing active licensed Dentists to review all Medicaid claims and approve or deny

Currently working as primary subcontractor to Accenture on Ohio Benefits (Integrated Eligibility) since 2013; SOW--for initial stages (DDI) provided staff augmentation in the areas of development, business analysts, testing resources, policy automation developers. We then provided training (both classroom and on-site one-on-one throughout the counties, along with Tier Two help desk support

Ohio Attorney General – Program Management Services; SOW--Program Management Services for company modernization project to include Procurement Management Advise; Schedule Management; Integration Management; Scope Management; Cost Management; Human Resources Management; Risk Management; Quality Management; and Communications Management

Diversified breaches; litigation: None reported

Attachment A6
Business Disputes

1) Offeror must provide information for all service contracts/clients related to the work requested in this RFP during the last eight (8) years that are pending litigation or were Terminated for Cause or Convenience. If the Offeror uses subcontractors, associated companies, or consultants that will be involved in any phase of this Project, each of these entities must also submit this information as part of the Offeror's response.

Permedion, Inc. and Health Management Systems, Inc. (HMS) (Parent of Permedion, Inc.)
During the last eight years, neither Permedion, Inc. nor HMS have had a contract related to the work requested in this RFP terminated for cause or convenience and no service contracts related to the work that is the subject of this RFP were in pending litigation during the past eight years.

Subcontractors: **None of the other proposed subcontractors reported any client contracts that were terminated for cause or for which there is pending litigation. As is the usual course with most businesses, clients of our subcontractors do occasionally terminate contracts for convenience. The ebb and flow of clients are part of the normal business cycle and not unexpected, especially given the impact that the COVD-19 pandemic has generally had on businesses worldwide.**

2) Offeror must identify all state and federal disciplinary, securities, or law enforcement actions against the Offeror and/or other entities listed below that were commenced at any time during the last fifteen years.

Permedion, Inc.: **None.**

HMS: **In 2013, the New York State Office of Inspector General ("IG") commenced an investigation into whether Jeff Flora, a senior New York Office of Medicaid Inspector General official, violated the Public Officers Law by accepting impermissible gifts. As a result of the IG investigation, the New York Joint Commission on Public Ethics ("JCOPE") conducted an informal inquiry into whether certain then-HMS employees: (i) provided food and beverages that Mr. Flora participated in during 2010-2013 in the aggregate amount of approximately $1,500, and (ii) made a job offer to Mr. Flora. HMS rescinded that job offer upon learning that Mr. Flora did not have the approval of the State of New York to take the job. As a result of this inquiry, HMS reached a voluntary settlement with JCOPE wherein HMS did not admit a violation of law and denied that it had any intent to violate the law, but HMS agreed to pay $75,000. HMS fully cooperated with JCOPE's informal inquiry and the IG's prior investigation of Flora. Before JCOPE even began its informal inquiry, HMS had already taken a series of aggressive steps to ensure that its employees would fully comply with New York law. Currently, HMS has a robust code of conduct, compliance and training program in place to prevent any such incidents in the future. New York OMIG remains a valued client of HMS.**

Subcontractors: **None reported.**

3) Offeror must identify all litigation and administrative proceedings against the Offeror and/or other entities listed below that involve claims of $100,000 or more and that was commenced at any time during the last ten years.

Permedion, Inc.: **Permedion has not had any litigation or administrative proceedings that involve claims of $100,000 or more.**

HMS:

(a) **In July 2012, Demetre and Lewis filed an action in the Supreme Court of the State of New York against HMS Holdings Corp. ("Holdings") claiming an undetermined amount of damages alleging that various actions by Holdings unlawfully deprived the plaintiffs of the acquisition earn-out portion of the**

purchase price for Allied Management Group Special Investigation Unit, Inc. ("AMG") under the applicable Stock Purchase Agreement (the "SPA") and that HMS had breached certain contractual provisions under the SPA and the implied covenant of good faith and fair dealing. Holdings asserted a counterclaim for breach of contract based on contractual indemnification costs recoverable under the SPA. Following a jury trial in which a verdict was returned in favor of the Plaintiffs on a breach of contract claim, Holdings entered into a settlement agreement with the Plaintiffs to resolve all matters in controversy pertaining to the lawsuit.

(b) In 2016, HMS Holdings Corp., Health Management Systems, Inc., and HMS Business Services, Inc. settled various trade secret lawsuits against Public Consulting Group, Inc. (PCG) and certain individuals related to allegations that PCG and those individuals, amongst other things, unlawfully misappropriated HMS' confidential, proprietary and trade secret information. PCG counterclaimed against HMS. PCG subsequently agreed for seven years not to develop, plan, market, provide, offer, or sell any TPL services and to withdraw any pending TPL bids, bid protests and/or contract negotiations. All pending cases or appeals between the parties were dismissed.

(c) On March 3, 2017, a putative securities class action was filed in the Federal District Court for the District of New Jersey, entitled *Danahar v. HMS Holdings Corp., et al.* The complaint alleged that Holdings' Form 10-K for the period ending December 31, 2015, and its quarterly reports on Form 10-Q for the period January 1, 2016 to September 30, 2016 were false and misleading for failing to disclose certain matters. On May 19, 2017, the New Jersey District Court granted HMS' motion to transfer the action to the United States District Court for the Northern District of Texas. HMS vigorously defended the matter, and the case was dismissed without prejudice on July 28, 2017.

(d) In September 2018, Christopher Frey, a former HMS employee, filed an action in the New York County Supreme Court alleging whistleblower retaliation under New York law. The complaint sought recovery of an unspecified amount of monetary damages, including back pay and other compensatory and equitable relief. In July 2020, the Court granted HMS' motion to dismiss the complaint in its entirety. Subsequently, the New York Supreme Court Appellate Division affirmed the lower court's dismissal of Frey's complaint in its entirety.

(e) In April 2022, Christopher Frey, a former HMS employee, filed a False Claims Act lawsuit against HMS and three co-defendants in the Southern District of Texas alleging improper retention of contingency fees under its RAC program. HMS is aggressively defending against this lawsuit, which it believes to be meritless. HMS and the three co-defendants all filed motions to dismiss this lawsuit on June 10, 2022, and these motions are pending with the court.

(f) On December 22, 2020, HMS was served with two qui tam lawsuits filed by Christopher Frey, a former HMS employee, alleging claims under federal and state False Claims acts relating to HMS' performance of certain third-party liability services. The lawsuits contain allegations relating to HMS' third-party liability services prior to 2013. The cases are based in substantial part on allegations in a whistleblower complaint that was previously investigated by the U.S. Department of Health and Human Services Office of the Inspector General ("HHS") and rejected by HHS. HHS' findings were later upheld by the U.S. Fifth Circuit Court of Appeals (see below). The case also repeats certain allegations that were dismissed in the Frye's New York action (see above). The Department of Justice declined to intervene or participate in either lawsuit. HMS strongly denies the allegations in these lawsuits in their entirety and is vigorously defending against them. The two matters were consolidated before the Honorable Jayne Boyle of the Northern District of Texas. The Court dismissed 20 of Frey's claims on HMS' motion to dismiss and 6 claims remain pending. HMS believes that Frey's claims are frivolous, and HMS is aggressively defending itself against such claims. This case is now in the discovery phase.

(g) In 2019, Sweeney and Carbajal filed suit against Denver Health and Hospital Authority, Denver Health Medical Plan, Inc., HMS Holdings Corp., and FluidEdge Consulting, LLC. The lawsuit alleged that amounts were inaccurately sought and/or recovered by the defendants and others on behalf and at

the direction of Denver Health Medical Plan, Inc. and included alleged class action claims on behalf of a putative class of unnamed individuals similarly situated to the named plaintiffs. HMS strongly disputed the entirety of the allegations and aggressively contested the suit. The parties reached a confidential settlement in April 2021, and the case was dismissed against HMS.

(h) **In October 2019, in connection with HMS hiring seven former Cotiviti employees, Cotiviti filed lawsuits in Texas and NY against HMS and the former employees alleging claims against HMS for misappropriation of trade secrets, tortious interference with contract, and unfair competition, and claims against the former Cotiviti employees for breach of contract related to their restrictive covenant agreements with Cotiviti, breach of implied covenant of good faith and fair dealing, misappropriation of trade secrets, unfair competition, tortious interference with business relationships, breach of the duty of loyalty, and unjust enrichment. On November 19, 2020, the New York court in which Cotiviti had filed claims against six of the seven individual defendants dismissed all but the breach of contract claims. On November 20, 2020, the parties reached agreement on a settlement of all cases.**

(i) **In 2021, eight purported stockholders of Holdings filed lawsuits against HMS Holdings and the members of its board of directors in connection with the Gainwell merger/acquisition of HMS Holdings Corp. The complaints generally alleged that the preliminary proxy statement issued in connection with the merger omitted material information in violation of Sections 14(a) and 20(a) of the Securities Exchange Act of 1934, rendering the preliminary proxy statement false and misleading. The parties settled the lawsuits effective August 30, 2021.**

Subcontractors: None reported.

4) Offeror must identify all litigation and administrative proceedings against the Offeror and/or other entities listed below that included claims of employment discrimination or antitrust with respect to the Offeror's sourcing activities and that were commenced at any time during the last five years.

a) "Identify" as used above means to state the caption or case name, the case number, the jurisdiction, the year when the matter began, how the matter resolved (if it has resolved), and a short and concise description of the claims.
b) "other entities listed below" as used above means to also provide responses for the Offeror's current or former parent company (if any) and for any current or former subsidiary (if any) in which the Offeror holds or has held a controlling share or interest. Disclosures for any parent company and any subsidiary should be only for the time period when the parent or subsidiary has or had the aforesaid corporate relationship with the Offeror.
c) "and/or" should be read conjunctively or disjunctively to give each sentence the most expansive meaning and scope possible.

HMS: In 2013, the Office of Inspector General (OIG) for the U.S. Department of Health and Human Services (HHS) notified HMS that Christopher Frey, a former employee of HMS, made a complaint of employment-related retaliation against HMS. HMS denied the allegations. Mr. Frey was terminated by HMS in 2013 as part of a reduction in force and not for reasons of retaliation. Following a thorough investigation by OIG, HHS rejected Mr. Frey's claims in their entirety and found them meritless. HHS issued its final decision denying Mr. Frey's claim in January 2018. In March 2018, Mr. Frey appealed HHS' decision to the 5th Circuit Court of Appeals, which on April 4, 2019 issued its opinion upholding the HHS decision denying Mr. Frey's claims. Mr. Frey filed a petition for rehearing of the 5th Circuit *en banc*, which was denied.

Subcontractors: None reported.

At its sole discretion, ODM may request the opinion or case decision associated with some, all, or none of the disclosures.

If the Offeror uses subcontractors, associated companies, or consultants that will be involved in any phase of this Project, each of these entities will submit this information as part of the Offeror's response.

Attachment F: Acknowledgements, Exceptions, and Assumptions

ODMR-2223-0006

Instructions

The Offeror must review ***Attachment F – Acknowledgements, Exceptions, and Assumptions***, signing each of the four (4) provided signature blocks to note the Offeror's acknowledgment and intent of compliance. All original signatures must be in blue ink.
The Offeror must identify any exceptions to the Terms and Conditions. If exceptions are not noted in this ***Attachment F*** but raised during Contract negotiations, ODM reserves the right to cancel the negotiation if, at its sole discretion, it deems that to be in the best interests of ODM.

RFP and Contract Terms and Conditions

RFP and Contract Terms and Conditions consist of provisions throughout the ***RFP package.*** Moreover, these provisions encapsulate instructions, state procedures, and ODM's expectations of Offerors when submitting a Proposal. Offerors must understand and strictly adhere to the RFP and Contract Terms and Conditions. Failure to follow any instructions within this RFP may, at ODM's sole discretion, result in the disqualification of the Offeror's Proposal. **Please provide an authorized signature stipulating the Offeror's acknowledgment, understanding, and acceptance of these RFP and Contract Terms and Conditions.**

Paul Saleh — October 26, 2022

Printed Name / Signature of Authorized Personnel — **Date**

PAUL SALEH

State Customary Terms and Conditions

By entering a Contract with ODM as a result of this RFP, the Contractor agrees to be bound by terms in the following documents:

- *RFP 2223-0006 Clinical Utilization Management and Prior Authorizations*
- *Attachment A: Required Offeror Information*
- *Attachment B: Technical Proposal Score Sheet*
- *Attachment C: Cost Proposal Form*
- *Attachment D: ODM Model Contract*
- *Attachment E: Cost Point Calculation*
- *Attachment F: Acknowledgements, Exceptions, and Assumptions*

Please provide a signature stipulating the Offeror's acknowledgment and complete review of these documents.

PAUL SALETH Paul Saleth October 26, 2022

Printed Name / Signature of Authorized Personnel **Date**

RAUL SALETH

If the Offeror is not taking exceptions to any of ODM Customary Terms and Conditions, provide a binding signature stipulating the Offeror's acceptance of these documents.

Not Applicable

Printed Name / Signature of Authorized Personnel **Date**

Prohibitive Terms

The following items are Prohibitive Terms. The Offeror's Proposal must not contain any language that would require ODM to waive or bypass any rights that are duly owed to ODM. Please be advised, the Offeror **must** agree to comply with the prohibitive terms listed below and provide its acceptance of these items in order to move forward with consideration under this RFP.

- In no event will ODM agree to terms which:
    - Require indemnification by the State of the Contractor
    - Waive ODM's right to a jury trial
    - Establish applicable law anywhere other than the State of Ohio, or jurisdiction in any venue other than the Ohio Court of Claims
    - Designate a governing law other than the laws of the State of Ohio
    - Constitute an implied or deemed a waiver of the immunities, defenses, rights, or actions arising out of the State's sovereign status or under the Eleventh Amendment to the United States Constitution
    - Limit the time within which an action may be brought
    - Require arbitration
    - Require the ability to defend a lawsuit without the approval of the Ohio Attorney General's office
    - Pay attorney fees

Offerors who are not able to enter into a Contract under these conditions should not submit a bid.

Please provide an authorized signature stipulating the Offeror's acknowledgment, understanding, and acceptance of the Prohibitive Terms and Documents stipulated in this section.

PAUL SALETH Paul Saleth October 26, 2022

Printed Name / Signature of Authorized Personnel **Date**

Pre-Existing Materials

The Offeror must list any **Pre-Existing Materials** it owns that will be included in a Deliverable if the Offeror wants a proprietary notice on copies that ODM distributes. The Contractor will retain ownership of all tools, methods, techniques, standards, and other development procedures, as well as generic and preexisting shells, subroutines, and similar material incorporated into any custom Deliverable (**Pre-Existing Materials**), if the Contractor provides ODM a worldwide, non-exclusive, royalty-free, perpetual license.

Pre-Existing Materials include Permedion's reports, analyses, processes and process flows, programs, concepts, materials, confidential Information, software systems and documentation, works of authorship, analytical methodologies and algorithms, information management systems, code, logic, analyses, data, associated proprietary forms of data organization and reports, trade and service marks, copyrights, whether confidential or not confidential, all enhancements, modifications, improvements or derivatives thereof, and all of Permedion's intellectual property Rights therein.

Commercial and Proprietary Materials

The Offeror must list any **Commercial and Proprietary Materials** that the Offeror will deliver that are easily copied, such as Commercial Software, and in which ODM will have less than full ownership (**Commercial Materials**). Generally, these will be from third parties and readily available in the open market. The Offeror is not required to list patented parts of equipment since they are not readily copied.

eCenter software platform/suite, DOTS

Exceptions

Offerors must indicate exceptions to any provision in this RFP package, including but not limited to ODM's Terms and Conditions and the RFP Base document (exceptions.) Any exception must include an explanation for the Offeror's inability to comply with such term or condition or item and, if applicable, alternative language the Offeror would find acceptable. Rejection of ODM's terms and conditions or provisions, in part or in whole, or without any explanation, may be cause for ODM's rejection of a Offeror's Proposal. If an exception is not noted in this response attachment but is raised during Contract negotiations, ODM reserves the right to cancel the negotiation, at its sole discretion, if it deems that to be in the best interests of ODM.

Instructions: Identify and explain any exception using the tables provided below, adding tables, as needed. If no changes are listed, the Offeror is indicating that no changes are proposed, and that the Offeror intends to accept the entire RFP package as written if the Offeror's Proposal is selected. Mandatory contractual terms noted in ***Prohibitive Terms*** are non-negotiable. Please refer to **State Customary Terms and Conditions in** this **Attachment F** document for lists of contractual documents. For the following exceptions:

- The Offeror may add additional tables, as appropriate.
- Do not submit the Offeror's Standard Terms and Contracting Provisions in lieu of stipulating exceptions below.
- Making revisions to State statutes and regulations is prohibited. ODM
- has no obligation to accept any exception(s).

Exception #1 — Article 1; Purpose; Deliverables

Document Title	Offeror's Explanation	Offeror's Proposed Alternative Language (if applicable)
Attachment D, ODM Model Contract, Article 1, Section E	Permedion requests that the definition of "Deliverables" be included as the contract uses the term without definition.	E. Ownership of Deliverables. For purposes of this Contract, "Deliverables" means CONTRACTOR's delivery of reports, files, data, findings, and financial recoveries that are the tangible outputs of CONTRACTOR's performance of the under this Contract. For clarity, Deliverables shall not include any items that constitute CONTRACTOR Intellectual Property.
NOTES/COMMENTS: <FOR STATE USE ONLY>		

Exception #2 — Article 1; Purpose; Deliverables

Document Title	Offeror's Explanation	Offeror's Proposed Alternative Language (if applicable)
Attachment D, ODM Model Contract, Article 1, Section E; Add new subsection 4 to Section E	For purposes of defining and protecting Permedion intellectual property, we propose the addition of a new subsection 4 be included which is similar to the language from the existing contract between ODM and Permedion.	4. Contractor Intellectual Property. Notwithstanding any contrary language in this Contract, ODM acknowledges that all rights, title and interest in CONTRACTOR's reports, analyses, processes and process flows, programs, materials, confidential Information, software systems and documentation, works of authorship, analytical methodologies and algorithms, information management systems, associated proprietary forms of data organization and reports, whether confidential or not confidential, all enhancements, modifications, improvements or derivatives thereof, and all Intellectual Property Rights therein (collectively, "CONTRACTOR Intellectual Property"), shall remain at all times the property of CONTRACTOR (and its licensors, as applicable). ODM shall not acquire or claim or purport to transfer any proprietary rights or licenses in the CONTRACTOR Intellectual Property, whether such proprietary rights are used by CONTRACTOR in the course of

		performance under this Contract. ODM will not use or attempt to reverse engineer, replicate, de-encrypt, disassemble, or decompile CONTRACTOR Intellectual Property. ODM acknowledges that the CONTRACTOR Intellectual Property includes valuable trade secrets of CONTRACTOR (and/or its licensors, as applicable), and is protected or protectable by domestic and international trade secret, copyright and patent laws and other forms of proprietary rights. For purposes of this Contract, "Intellectual Property Rights" means all intellectual property rights of any kind or nature throughout the world, however, whether existing now or in the future, including without limitation rights with respect to (i) inventions (whether or not patentable and whether or not reduced to practice), designs, patents and patent applications; (ii) trademarks and service marks together with all goodwill associated therewith and registrations, applications and renewals related thereto; (iii) copyrights, copyrightable works (in whatever form or medium), and all registrations, applications, and renewals for any of the foregoing; (iv) trade secrets, data, database rights, and confidential information; and (v) all claims, causes of action and remedies of any kind related to the foregoing. Notwithstanding any contrary language in this Contract, CONTRACTOR Intellectual Property provided by CONTRACTOR to ODM in the course of performance under this Contract as incorporated into the Deliverables is for ODM's own internal use.
NOTES/COMMENTS: <FOR STATE USE ONLY>		

Exception #3 — Article II. Confidentiality of Information

Document Title	Offeror's Explanation	Offeror's Proposed Alternative Language (if applicable)
Attachment D, ODM Model Contract, Article II, Section H	Permedion requests that the prefatory clause be added to account for disclosures permitted in the BAA to contractors and subcontractors.	Unless otherwise permitted under this Contract, CONTRACTOR shall not share or otherwise disclose any of the above referenced information to any third party without the express written authorization of the Director of ODM. If there is an incident of unauthorized disclosure of information, ODM must be notified in an acceptable timeframe to support regulatory requirements for breach notifications
NOTES/COMMENTS: <FOR STATE USE ONLY>		

Exception #4 — Article II. Confidentiality of Information

Document Title	Offeror's Explanation	Offeror's Proposed Alternative Language (if applicable)
Attachment D, ODM Model Contract, Article II, Section I	Permedion requests that in the absence of a requirement of law or a regulator, that the proposed language be added to afford Permedion ample opportunity to be prepared for an inspection and to be responsive to any site/audit requests.	I. CONTRACTOR shall permit onsite inspection by the State of Ohio (including but not limited to ODM, the Auditor of the State of Ohio, the Inspector General of Ohio, the Ohio Attorney General or any duly authorized law enforcement officials) and by agencies of the United States government. Unless otherwise required by law or a regulator, ODM will provide at least 30 days prior written notice regarding any on-site inspection.
NOTES/COMMENTS: <FOR STATE USE ONLY>		

Exception #5 — Article II. Confidentiality of Information

Document Title	Offeror's Explanation	Offeror's Proposed Alternative Language (if applicable)
Attachment D, ODM Model Contract, Article II, Sections L, M, N, and O	Permedion requests that new sections M and N be added to address protection of Permedion Confidential Information. Added because the Permedion language added at Sections M and N pertains to protection of Permedion Confidential Information. Section L is modified to account for the new sections M and N. Additionally, we request the addition of the new proposed Section O to address exceptions to the requirement to return confidential information.	L. The express terms and conditions of this Article (except for language of Sections M and N immediately below) shall be included in all subcontracts executed by CONTRACTOR for any and all work under this Contract. M. Contractor Confidential Information. "HMS Confidential Information" means all non-public Contractor information provided, displayed, or made available by Contractor which would be reasonably understood to be confidential under the circumstances of disclosure, or that is marked, designated, or communicated by Contractor to ODM to be confidential. Contractor Confidential Information includes all materials, processes and process flows, programs, software systems and documentation, information management systems, code, logic, analytical methodologies and algorithms, reports, analyses, data, associated proprietary forms of data organization and reports, all Contractor IP or any other information, or other work product whether or not disclosed to Client by or on behalf of HMS pursuant to this Agreement. "Contractor IP" means HMS intellectual property, collectively, Contractor's analyses, tools, designs, database rights, processes and process flows, programs, software, materials, works of authorship, inventions (whether or not patentable), trade secrets, patents, trademarks, trade names, systems and documentation, analytical methodologies and algorithms, information management systems, associated proprietary forms of data organization, whether or not confidential, all enhancements, modifications, improvements or derivatives thereof, and all intellectual property and proprietary rights whether arising by operation of law, contract, license, or otherwise in and to the foregoing. **N. Use of Confidential Information.** ODM agrees (i) to exercise the same care to protect Contractor Confidential Information as it would to protect its own comparable

		confidential information, but in no event less than reasonable care; (ii) to use or disclose Contractor Confidential Information only for the purposes of this Agreement and will not disclose such Confidential Information to any third party without the Contractor's prior written consent, other than to ODM's authorized employees and officers, directors, contractors, advisors and agents on a need-to-know basis and who are bound by confidentiality obligations that are at least as protective as those contained in this Contract, and (iii) that in the event of a state or federal open records or freedom of information act request for disclosure of any Confidential Information related to or arising out of this Contract, ODM shall provide written notice to Contractor to allow Contractor the opportunity to respond to the open records or other freedom of information act requester and protect any Confidential Information. Notwithstanding the foregoing, either party may retain the other party's data (including confidential information) that are: (i) backed-up in accordance with each party's archival and disaster recovery processes; or (ii) required for compliance with each party's recordkeeping requirements, legal obligations, applicable laws, regulations, and other mandated record keeping requirements. Such retained information shall continue to be treated as confidential and will be subject to destruction in due course. Latent data such as deleted files and other non-loqical data types, such as memory dumps, swap files, temporary files, printer spool files and metadata that can customarily only be retrieved by computer forensics experts and are generally considered inaccessible without the use of specialized tools and techniques will not be within the requirement for the return or destruction of records as contemplated by this paragraph.
NOTES/COMMENTS: <FOR STATE USE ONLY>		

Exception #6 — Article IV. Compensation

Document Title	Offeror's Explanation	Offeror's Proposed Alternative Language (if applicable)
Attachment D, ODM Model Contract, Article IV, Section A	Permedion does not agree to waive the interest provisions as provided by Ohio law.	A. The total amount payable under this Contract is TOTAL AMT Dollars ($TOTAL). ODM will pay an amount up to _____ Dollars ($) for State Fiscal Year 20XX and up to _____ Dollars ($_____) for State Fiscal Year 20XX expressly for the completion of the Deliverables. CONTRACTOR understands that the terms of this Contract do not provide for compensation in excess of the total amount listed in this section. ORC 126.30 shall govern with regard to interest on overdue payments.
NOTES/COMMENTS: <FOR STATE USE ONLY>		

Exception #7 — ARTICLE V. SUSPENSION AND TERMINATION, BREACH AND DEFAULT

Document Title	Offeror's Explanation	Offeror's Proposed Alternative Language (if applicable)
Attachment D, ODM Model Contract, Article V, Section E, 4 and 5	Permedion requests that Article V, Section E, subsection 4 be edited to be in sync with the language proposed above in Article II.B. Permedion requests that the usual and customary term "reasonably" be inserted in subsection 5 of section E of Article V.	4. Return all records in their native format relating to cost, work performed, supporting documentation for invoices submitted to ODM, and copies of all materials produced under or pertaining to this Contract subject to Article II (O) above; and 5. Perform any other tasks ODM reasonably requires.
NOTES/COMMENTS: <FOR STATE USE ONLY>		

Exception #8 — ARTICLE V. SUSPENSION AND TERMINATION, BREACH AND DEFAULT

Document Title	Offeror's Explanation	Offeror's Proposed Alternative Language (if applicable)
Attachment D, ODM Model Contract, Article V, Sections F and H	Permedion requests that the language in section H be this mutual. Edits to sections F and H are self-explanatory.	F. In the event of suspension or termination under this Article, ODM will, upon receipt of a proper invoice from CONTRACTOR, determine the amount of any unpaid Contract funds due to CONTRACTOR for Deliverables performed before CONTRACTOR received notice of termination or suspension. In order to determine the amount due to CONTRACTOR, ODM will base its calculations on the payment method described in ARTICLE IV and any funds previously paid by or on behalf of ODM. ODM will not be liable for any further claims submitted by CONTRACTOR subject to Section I below.

		H. Upon CONTRACTOR's breach or default of provisions, obligations, or duties embodied in this Contract or any term of an award, a federal statute or regulation, an assurance, a State plan or application, a notice of award, or other applicable rule, ODM reserves the right to exercise any administrative, contractual, equitable, or legal remedies available without limitation. Any waiver by either party of an occurrence of breach or default is not a waiver of subsequent occurrences. If ODM or CONTRACTOR fails to perform any obligation under this Contract and the other party subsequently waives the failure, the waiver will be limited to that particular occurrence of a failure and will not be deemed to waive other failures that may occur. Waiver by ODM will not be effective unless it is in writing signed by the ODM Director, and a waiver by CONTRACTOR will not be effective unless is in writing signed by an individual that has the authority to bind Contractor.
NOTES/COMMENTS: <FOR STATE USE ONLY>		

Exception #9 — Article VII. RECORDS, DOCUMENTS AND INFORMATION

Document Title	Offeror's Explanation	Offeror's Proposed Alternative Language (if applicable)
Attachment D, ODM Model Contract, Article VII, Sections A, B and C	Permedion requests the edit to section A, as some of this language is not applicable to the subcontracted work being performed further to this Contract. Permedion requests that the last sentence of section B be deleted because we believe the first sentence addresses Permedion's confidentiality obligations under Ohio law. Permedion requests the clarifying edit in section C as it ties to the proposed language added at Article II above.	CONTRACTOR agrees that all records, documents, writings, and other information, created or used pursuant to this Contract will be treated according to the following terms, and that the terms, if applicable, will be included in any subcontracts executed for the performance of the Deliverables under this Contract: A. CONTRACTOR agrees that any media produced pursuant to this Contract or acquired with Contract funds will become the property of ODM. This includes all documents, reports, data, photographs (including negatives), and electronic reports and records. ODM will maintain the unrestricted right to reproduce, distribute, modify, maintain, and use the media in any way ODM deems appropriate. Subject to Section I (E) (4) (Contractor Intellectual Property), CONTRACTOR further agrees not to seek or obtain copyright, patent or other proprietary protection for any materials or items produced under this Contract. Subject to Section I (E) (4) (Contractor Intellectual Property), CONTRACTOR understands that all materials and items produced under this Contract will be made freely available to the public unless ODM determines that certain materials are confidential under federal or state law. B. All ODM information that is classified as public or private under Ohio law will be treated as such by CONTRACTOR. Should the nature of any information be in question, ODM will determine whether the information is public or

		private. CONTRACTOR will restrict the use of any information, systems, or records ODM provides to the specific Deliverables of this Contract. C. Without limiting ODM's obligations under Article II (Confidentiality) above, CONTRACTOR information that is proprietary and has been specifically identified by CONTRACTOR as proprietary will be held as confidential by ODM. Proprietary information is information that would put CONTRACTOR at a competitive disadvantage in CONTRACTOR's market place and trade if it were made public. ODM reserves the right to require reasonable evidence of CONTRACTOR's assertion of the proprietary nature of any information. The provisions of this Article are not self-executing. CONTRACTOR must demonstrate that any information claimed as proprietary meets the definition of "trade secrets" found at ORC 1333.61.
NOTES/COMMENTS: <FOR STATE USE ONLY>		

Exception #10 — Article VIII. AMENDMENT AND ASSIGNMENT

Document Title	Offeror's Explanation	Offeror's Proposed Alternative Language (if applicable)
Attachment D, ODM Model Contract, Article VIII, Section A	Permedion requests that the same language as is proposed above in Article 1, section C be included in this section A.	A. This writing constitutes the entire agreement between ODM and CONTRACTOR with respect to all matters herein. Only a writing signed by both parties may amend this Contract. However, this Contract is governed by and construed in accordance with all applicable state or federal laws and regulations; and the Contract is automatically amended to conform to any changes in laws or regulations without the necessity for written amendment, provided the changes do not materially alter the terms and conditions of this Contract and CONTRACTOR's performance under this Contract. Any written amendment to this Contract will be prospective in nature.

Exception #11 — Article IX. BUSINESS ASSOCIATE REQUIREMENTS UNDER HIPAA

Document Title	**Offeror's Explanation**	**Offeror's Proposed Alternative Language (if applicable)**
Attachment D, ODM Model Contract, Article IX, Section B.6	As written, this provision requires that subcontractors agree to the "same" restrictions, conditions, and requirements that apply to Contractor. Because our subcontractors may perform work related to several client contracts, our agreements with them are not necessarily client specific. All of our downstream BAAs with our subcontractors are HIPAA compliant and stringently written, and are unlikely to vary substantially in their terms	6. **Agents and Subcontractors.** CONTRACTOR, in compliance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2) as applicable, will ensure that all its agents and subcontractors that create, receive, maintain, or transmit PHI from or on behalf of CONTRACTOR and/or ODM agree to have, in a written agreement, substantially the same restrictions, conditions, and requirements that apply to CONTRACTOR with respect to the use or disclosure of PHI.
NOTES/COMMENTS: <FOR STATE USE ONLY>		

Exception #12 — Article IX. BUSINESS ASSOCIATE REQUIREMENTS UNDER HIPAA

Document Title	Offeror's Explanation	Offeror's Proposed Alternative Language (if applicable)
Attachment D, ODM Model Contract, Article IX, Section B.13 and 14	As written, this provision does not acknowledge or include reference to circumstances in which the return or destruction of PHI is infeasible. Permedion believes that this language should be amended to reflect such a circumstance, We propose the edit accordingly. Permedion requests the deletion of the indemnification provision in the BAA at section 14, such that indemnification can be addressed holistically Article XII.C under the Contract. The indemnification provision at Article XII.C is already written to address unauthorized disclosure or loss of ODM data (which would include PHI).	**13. Return or Destruction of Information.** Upon termination of this Contract and at the request of ODM, CONTRACTOR will return to ODM or destroy all PHI in CONTRACTOR's possession stemming from this Contract as soon as possible but no later than 90 days, and will not keep copies of the PHI except as may be requested by ODM or required by law, or in the event that return or destruction of PHI is reasonably infeasible or as otherwise allowed for under this Contract. If CONTRACTOR, its agent(s), or subcontractor(s) destroy any PHI, then CONTRACTOR will provide to ODM documentation evidencing such destruction. Any PHI retained by CONTRACTOR will continue to be extended the same protections set forth in this Section, HIPAA regulations and this Contract for as long as it is maintained.
NOTES/COMMENTS: <FOR STATE USE ONLY>		

Exception #13 — Article XII. MISCELLANEOUS PROVISIONS, Subcontracting

Document Title	Offeror's Explanation	Offeror's Proposed Alternative Language (if applicable)
Attachment D, ODM Model Contract, Article XII, Subcontracting, Section B, d, and g.	Given that there are express provisions throughout the Contract that are required to be flowed down to subcontractors, Permedion requests that these sections be modified as we propose as not all the provisions in this contract are applicable to Permedion's subcontractors. The financial terms of the agreements between Permedion and its subcontractors are confidential as between Permedion and the subcontractor, and therefore, we request that only redacted copies be furnished to ODM subject to the confidentiality provisions of the Contract.	d. If the Contractor uses any subcontractors, each subcontractor must have a written agreement with the Contractor that reference the provisions of this Contract that are applicable to the subcontractor's performance further to this Contract. Such provisions include without limitation: the limitations on the Contractor's remedies, record keeping obligations, Confidentiality, Business Associate terms, Special Conditions, and audit provisions. Should the Contractor fail to pass through such applicable provisions of this Contract to one of its subcontractors and the failure damages ODM in any way, the Contractor must indemnify ODM for the damage. g. CONTRACTOR must allow ODM to review the terms of any subcontractor arrangement (subject to any redacted financial terms and the Confidentiality provisions in this Contract) upon ODM's request.
NOTES/COMMENTS: <FOR STATE USE ONLY>		

Exception #14 — Article XII. MISCELLANEOUS PROVISIONS, Limitation of Liability, Indemnification, Jurisdiction

Document Title	Offeror's Explanation	Offeror's Proposed Alternative Language (if applicable)
Attachment D, ODM Model Contract, Article XII, Section C, Limitation of Liability, Indemnification, Jurisdiction	Permedion requests discussion and negotiation to determine the amount of the general damages cap (subject to usual and customary carve-outs) and a damages "super-cap" for security incidents. We propose that the amount of the general damages cap be the fees paid by ODM for the 12-month period preceding the claim. Permedion proposes to break this section out into the stated categories. Data security indemnification and BAA indemnification are now included all in one paragraph at subsection 2. Patent and copyright indemnification is addressed at Section D below. Permedion proposes to limit the indemnity to 3rd party claims and the tailor the scope of the indemnity as noted with usual and customary qualifier language. Other edits are for clarity and are self- explanatory.	1. **General Indemnification**. To the extent allowable by law, CONTRACTOR, to the extent caused by its acts(s) or omission(s) (or that of any subcontractor or contractor of CONTRACTOR) agrees to defend, indemnify and hold ODM, its officials, employees and agents (collectively, "ODM Parties") harmless from and against any and all liability, loss and expense (including reasonable attorneys' fees) or claims asserted by third parties against any ODM Party for personal injury and real/personal property damage. **2. Data Security Incidents/Breach of Business Associate Requirements**. CONTRACTOR, to the extent caused by its acts(s) or omission(s) (or that of any subcontractor of CONTRACTOR), must indemnify the ODM Parties for all liability and expense resulting from third party claims (including any governmental/regulatory actions) attributable to: (i) the unauthorized disclosure or loss of ODM data, including personally identifiable information (including PHI), and ODM sensitive information); and a (ii) breach of Contractor's obligations under Article IX (Business Associate Requirements under HIPAA). Notwithstanding any contrary language in this Contract, damages resulting from the unauthorized disclosure or loss of ODM data shall be considered direct damages under this Contract and are limited to, the following: (i) expenses for legally-required notification of impacted individuals; (ii) responding to inquiries from such notifications; (iii) government fines and penalties assessed against ODM; (iv) reasonable costs to ODM for investigations, audits or forensic services as applicable related to the disclosure or loss; (v) mitigation

		measures, including 12 months of credit monitoring for individuals impacted by a disclosure; (vi) reasonable costs to ODM to reconstruct data that was lost or to repair any damaged ODM information technology infrastructure; and (vii) third party claims against by ODM as a result of the unauthorized disclosure or loss of ODM data. 3. **Claims against ODM/Jurisdiction.** CONTRACTOR's sole and exclusive remedy for any ODM failure to perform under this Contract will be an action in the Ohio Court of Claims pursuant to ORC Chapter 2743 that will be subject to the limitations set forth in this Article. To the extent that ODM is a party to any litigation arising out of or relating in any way to this Contract or the performance thereunder, such an action shall be brought only in a court of competent jurisdiction in Franklin County, Ohio. Subject to ORC 109.02, and CONTRACTOR agrees to defend ODM against any such claims or legal actions pursuant to the terms and conditions of this Contract if called upon by ODM to do so. **Limitation of Certain Damages.** In no event will ODM or CONTRACTOR be liable for any indirect or consequential damages, including loss of profits, even if ODM or CONTRACTOR was advised, knew or should have known of the possibility of such damages however, this limitation shall not apply as to Contractor if such damages result from the gross negligence, willful misconduct or violation of law by Contractor. Any limitation provisions contained in the documents and materials incorporated by reference into this Contract are considered stricken and of no force and effect.

		5. **Contractor's Limitation of Liability.** A. **General Liability Cap.** SUBJECT TO SECTION 5(B) AND SECTION 5(C) BELOW, AND NOTWITHSTANDING ANY CONTRARY LANGUAGE IN THIS CONTRACT, CONTRACTOR'S SOLE AND AGGREGATE LIABILITY FOR ANY AND ALL DAMAGES, CLAIMS, LOSSES, OR LIABILITIES ARISING OUT OF THIS CONTRACT, INCLUDING PERFORMANCE BY CONTRACTOR PURSUANT TO THIS CONTRACT (COLLECTIVELY, "CLAIMS") WILL IN NO EVENT EXCEED THE FEES PAID OR PAYABLE TO CONTRACTOR IN THE PRECEDING TWELVE (12) MONTH PERIOD UNDER THIS CONTRACT GIVING RISE TO THE LIABILITY AND ASSOCIATED WITH THE SERVICES PROVIDED. B. **Data Security Cap**. EXCEPT AS PROVIDED IN SECTION 5.C BELOW, CONTRACTOR'S TOTAL LIABILITY TO ODM UNDER THIS CONTRACT, WHETHER IN CONTRACT OR IN TORT (INCLUDING BREACH OF WARRANTY, NEGLIGENCE AND STRICT LIABILITY IN TORT), FOR ALL CLAIMS RELATING TO OR ARISING FROM THE FOLLOWING, WILL BE LIMITED IN THE AGGREGATE, TO $[ ]: (i) CLAIMS THAT ARE SUBJECT TO INDEMNIFICATION UNDER ARTICLE XII (C)2 ABOVE; AND

		(ii) CONTRACTOR'S (OR THAT OF ANY SUBCONTRACTOR OF CONTRACTOR) BREACH OF ITS OBLIGATIONS UNDER ARTICLE IX (BUSINESS ASSOCIATE REQUIREMENTS UNDER HIPAA). C. **Exceptions to General Liability Cap and Data Security Cap.** THE LIMITATIONS AND EXCLUSIONS OF LIABILITY SET FORTH IN THIS SECTION C (5) SHALL NOT APPLY TO: (i) CLAIMS ATTRIBUTABLE TO THE INTENTIONAL MISCONDUCT OR GROSS NEGLIGENCE OF CONRACTOR (OR THAT OF ANY SUBCONTRACTOR OF CONTRACTOR); (ii) CLAIMS FOR WHICH LIABLITY CANNOT BE EXCLUDED UNDER LAW; (iii) CLAIMS FOR PERSONAL INJURY; AND (iv) CONTRACTOR'S INDEMNIFICATION OBLIGATION PURSUANT TO SECTION D (INFRINGEMENT OF PATENT OR COPYRIGHT) BELOW.
NOTES/COMMENTS: <FOR STATE USE ONLY>		

Exception #15 — Article XII. MISCELLANEOUS PROVISIONS, General Representations and Warranties

Document Title	Offeror's Explanation	Offeror's Proposed Alternative Language (if applicable)
Attachment D, ODM Model Contract, Article XII, Section E, General Representations and Warranties	Permedion requests that this section be edited to provide a warranty that is aligned with the services to be rendered and to add a disclaimer of warranty paragraph.	1. The performance of CONTRACTOR under this Contract will be in accordance with the industry's professional standards, the requirements of this Contract and without material defect. 2. The Deliverables shall conform in all material respects to the written requirements specified in this Contract. 3. If applicable, the Deliverables comply with all governmental, environmental and safety standards. (Add the following text after #5) If CONTRACTOR breaches the foregoing warranties, as ODM's sole and exclusive remedy, CONTRACTOR shall correct any such breaches or non-conformities. Contractor disclaims all other warranties.
NOTES/COMMENTS: <FOR STATE USE ONLY>		

Assumptions

Offerors must list all the assumptions made in preparing its Proposal. If any assumption is unacceptable to the State, the State may, at its sole discretion, request that the Offeror remove the assumption or choose to reject the Proposal. No assumptions may be included regarding the outcomes of negotiations, terms, and conditions, or requirements. Assumptions should include reference(s) to the section(s) of the RFP that the assumption applies to.

Document the assumptions related to this RFP in the table below. The Offeror may add additional rows, as needed.

Important: Offerors are NOT to change any of the pre-filled cell labels in the following tables below. The **<Response>** placeholder is used in the subsections below to indicate where the Offeror must provide its response for the specific subsections.

Item #	Reference (RFP Artifact, Section, Page, Paragraph)	Description	Rationale
1.	Specification of Deliverables	All required prior authorization determination notifications will be distributed via the MMIS/FI/PNM. Including SOW 4.2.A, 4.2.E, 4.2.F, 4.2.G, 4.2.H, 4.2.J, 4.2.K, 4.2.L, 4.2.R	No labor, materials or mailing costs are included
2.	RFP Attachment C	The costs for the deliverable Pre-certification Reviews are associated with the SOW items 4.2.A and 4.2.F	Reconciling the RFP-required deliverables with the Attachment C Deliverables
3.	RFP Attachment C	The costs for the deliverable Provider Prior Authorization Appeal Requests are associated with the SOW 4.2.L	Reconciling the RFP-required deliverables with the Attachment C Deliverables
4.	RFP Attachment C	The cost for the deliverables including Behavioral Health and Substance Abuse Reviews, Pre-certification Reviews, Mobile Response and Stabilization Service Prior Authorization, Prior Authorization for Non-Institutional Services, Prior Authorization for Home Health Services, Prior Authorization for Private Duty Nursing, and Other Prior	Fee includes all prior authorizations processed by the vendor including requests reviewed and canceled by the vendor

Item #	Reference (RFP Artifact, Section, Page, Paragraph)	Description	Rationale
		Authorization is inclusive of all reviews regardless of approved, denied or canceled status	
5.	RFP Attachment C	The proposed fee for prior authorization-private duty nursing assumes up to 125 of the 750 assessments will be performed onsite and the remaining reviews will be processed virtually	The costs associated with performing additional onsite reviews for this population would result in an increase to the fee required for this scope of work
6.	RFP Attachment C	Fees for 4.2.I MCE Provider Appeals are not included	Contract is with the individual MCEs and fees are not paid by ODM for 4.2.I MCE Provider Appeals

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-02-01
Baltimore, Maryland 21244-1850

Gary Call
Chief Medical Officer
Permedion
350 Worthington Road
Suite H
Westerville, Ohio 43082

Dear Mr. Call:

We have reviewed your application of July 19, 2019 requesting that the Centers for Medicare & Medicaid Services certify Permedion as a Quality Improvement Organization (QIO)-like entity for the State of Ohio. As a result of this review, we have determined that Permedion of Ohio meets the requirements to be a QIO-like entity, namely:

- It is able to perform limited medical and quality review functions required under Section 1154 of the Act;
- It has one individual who is representative of health care providers and consumers on its governing body under section 1152 of the Act; and
- It is not a health care facility, health care facility affiliate, or payor organization as defined in 42 CFR 475.105.

This certification designates Permedion of Ohio as a QIO-like entity eligible to fully operate in Ohio. Permedion of Ohio may also operate in other states with the exception of performing Medicare medical reviews. For the conduct of Medicare medical review work, a QIO-like entity must meet the requirement that the QIO-like entity have access to or agreements with peer reviewers in the state in question.

If the QIO-like entity determines to conduct Medicare medical review work in a state other than the state for which it has submitted a list of medical reviewers, this criterion must be met and submitted for approval by CMS before such work can be undertaken.

Your certification is granted for a period of 5 years and will expire on September 19, 2024.

This certification of eligibility permits your organization to seek a contract with the states for review activities within the requirements. In addition, states have specific qualifications and performance requirements depending upon the scope of work they desire to procure. This certification does not reflect a determination as to whether your organization has the ability to meet those requirements. The state is responsible for making that determination.

We have certified your organization to review cases and analyze patterns of care related to medical necessity and quality review. We have not certified the organization as meeting the State Medicaid Agency's requirements for external quality review or related functions such as utilization review specified in 1903 (a) (3) (c) and 1932 (c)(2) of the Act. In addition, we have not evaluated the organization to perform the same functions as a QIO under contract with CMS.

You must provide an annual assurance statement of your continued adherence to certification requirements within 30 days of the last month of the first certification year and within 30 days of the last month of the second certification year. In addition, if there are any changes in the name, address, or pool of physician reviewers you must notify this office for a reevaluation of your certification. Recertification requires submission of the complete package a minimum of 60 days prior to the expiration of the current certification.

At any time during the certification period that Permedion of Ohio no longer meets the above criteria, you must notify the agency and it will no longer be considered a QIO-like entity. The certification will be terminated. You may reapply at any time if this occurs.

If you have questions, please contact Malinda Greene of my staff on (410) 786-7829 or via Email-malinda.greene@cms.hhs.gov.

Sincerely,

Renee Dupee

Renee Dupee, Director
Division of Program Management,
Communications, and Evaluation

Appendix D – Resumes

On the following pages, Permedion provides resumes for the key personnel we propose to support the Ohio UM/PA project. At the beginning of each resume, we summarize the individual's qualifications and experience related to the areas described in the RFP's Scope of Work and Specifications of Deliverables.

Medical Director: Anthony Beisler, MD, FACS, CHCQM

Summary of Qualifications and Experience

Permedion proposes Dr. Anthony Beisler to serve on our project team in the key position of Medical Director. Dr. Beisler has more than 14 years of experience in this position with our company and currently serves in this role for multiple Medicaid UM/PA projects, including the one we provide to Ohio. He is an Ohio-licensed Doctor of Medicine and is based in Dublin. Dr. Beisler applies the following qualifications and experience to his role of Medical Director:

- Extensive experience conducting medical review determinations and participating in hearings, health care studies, and client meetings for multiple state-level Medicaid UM and clinical review projects: Ohio, Massachusetts, New Jersey, Colorado, and Texas
- 14 years with Permedion serving as a division medical director, applying knowledge of Medicaid programs, and providing clinical expertise to contract and project teams
- Board-certified Doctor of Medicine, specializing in General Surgery
- Current and unrestricted Ohio and New Jersey medical licenses
- 20 years of experience as a practicing physician in the medical field

Career History

Gainwell Technologies, LLC. (formerly Health Management Systems, Inc.)
Division Medical Director, *2008 – Present*

- Participates in corporate, contract, and project teams by providing a link to the scientific and clinical community that aligns contracts and projects for the greatest likelihood of clinical success
- Provides clinical expertise to contract and project teams
- Makes review decisions regarding medical necessity, experimental/investigational status, diagnosis-related group assignment/reassignment, and quality of care
- Leads the development health care/quality studies and focused reviews
- Performs literary searches to determine appropriateness of review decisions
- Interacts with reviewers to clarify clinical, administrative, and scientific issues
- Assists in developing processes to monitor quality of reviewers and reviews for timeliness, completeness, and processes while securing appropriate levels of productivity and efficiency
- Leverages experience in offering testimony in administrative or judicial proceedings
- Participates on teams in support of the quality management system
- Develops relationships with states at the medical director level to align missions and clarify objectives

Mary Rutan Hospital
Chairman, Department of Surgery, *2012 – Present*

- Serves as an officer of the Medical Executive Committee
- Presides over the Quality Committee, Medical/Surgical Committee, and The Joint Commission (TJC) readiness efforts

Staff Surgeon, *2009 – Present*

- Provides surgical care
- Works in all areas of general surgical practice

President, Medical Staff, *2015 – 2018*

- Served as the medical staff member of the Board of Trustees
- Presided over medical personnel, the Medical Executive Committee, and the Quality Council

The Ohio State University College of Medicine

Clinical Assistant Professor, Department of Surgery, *2010 – 2021*

- Served as a member of the surgical faculty for the rural medicine training program
- Supervised residents and medical students while providing surgical education during rotations in rural general surgery

Professor of Surgery, Auxiliary Faculty, Department of Family Medicine, *2009 – 2016*

- Served as a member of the surgical faculty for the rural medicine training program
- Supervised residents and medical students while providing surgical education during rotations in rural general surgery

Adjunct Professor of Surgery, Kettering College of Medical Arts, *2005 – 2010*

- Supervised physician assistant–program students
- Provided surgical education during rotations in rural general surgery

Madison County Hospital

Vice President, Medical Staff, *2008–2009*

- Functioned as an officer of the medical team
- Presided over the Quality Committee and The Joint Commission (TJC) readiness efforts

Medical Director, Breast Care Clinic, *2007 – 2009*

- Presided over the clinic's conceptual development and marketing efforts
- Directed clinical implementations of breast-care efforts

Staff Surgeon, *2005 – 2009*

- Provided surgical care
- Worked in all areas of general surgical practice

U.S. Naval Reserve

Lieutenant Commander, Medical Corps, *2002 – 2007 (Honorable Discharge)*
Lieutenant, Medical Corps, *1997 – 2002*
Commissioned Ensign, Medical Corps, *1993 – 1997*

- Served in the Operation Enduring Freedom and Operation Iraqi Freedom campaigns
- Received several decorations, including the Navy and Marine Corps Commendation Medal, National Defense Service Medal, and Global War on Terrorism Service Medal

Staff Surgeon, Halyburton U.S. Naval Hospital, Marine Corps Air Station Cherry Point, *2002 – 2005*

- Provided surgical care in all areas of general surgical practice to active-duty personnel and retirees
- Provided surgical care while deployed in combat environments

Staff Surgeon, U.S. Naval Hospital Camp Lejeune, Marine Corps Base Camp Lejeune, *2002 – 2005*

- Provided surgical care in all areas of general surgical practice to active-duty personnel and retirees
- Provided surgical care while deployed in combat environments

Adjunct Professor of Surgery, Uniformed Services University of Health Sciences, *2002 – 2005*

- Provided expert instruction and proctored surgeons in the technique of sentinel lymph node biopsy
- Oversaw residents and medical students
- Provided surgical education during rotations in general surgery

Education

- Internship and Residency in General Surgery, Dartmouth Medical School/Dartmouth-Hitchcock Medical Center
- Doctor of Medicine, The Ohio State University College of Medicine
- Master of Business Administration, Auburn University
- Bachelor of Arts, Ohio University

Licensure/Certifications/Accreditations

- DEA# BB9161643
- UPIN I43090
- NPI #1740366392
- State of Ohio, State Medical Board, License #35-085084, 2005–present
- State of New Jersey, State Board of Medical Examiners, Lic. #25MA09278400, 2013-present
- American Board of Surgery Diplomate, Certificate #48684
- American Board of Surgery Recertification Exam – Dec 2011 – exp. December 2024
- American Board of Quality Assurance and Utilization Review Physicians Board Certification in Care Quality Management and Patient Safety (CHCQM)

Associations/Affiliations

- Lifetime Member, The Association of Military Surgeons of the United States
- Lifetime Member, Reserve Officers Association

- Member, American College of Physician Executives
- Ohio State Medical Association
- The American Society of Breast Surgeons
- Society of American Gastrointestinal Endoscopic Surgeons
- American Medical Association

Published Works

- “Our #1 Public Health Concern” Medical Director Dialogue, Ohio Medicaid Quality Monitor,
- Volume 17, Number 1
- “The COVID-19 Pandemic” Medical Director Dialogue, Ohio Medicaid Quality Monitor,
- Volume 17, Number 2
- “The CMS Two Midnight Rule and the ODM Inpatient Admission Order Requirements” Medical
- Director Dialogue, *Ohio Medicaid Quality Monitor*, Volume 16, Number 1
- “The Obesity Epidemic” Medical Director Dialogue, *Ohio Medicaid Quality Monitor,* Volume 15, Number 3
- “Continuity of Care – Part 2” Medical Director Dialogue, *Ohio Medicaid Quality Monitor,* Volume 15, Number 2
- “Bariatric Surgery” Medical Director Dialogue, *Ohio Medicaid Quality Monitor,* Volume 15, Number 1
- “Update: The New Ohio Medicaid Admission Orders Policy” Medical Director Dialogue, *Ohio Medicaid Quality Monitor,* Volume 14, Number 4
- “Update: The IHI’s STAAR Initiative and the OHA Results” Medical Director Dialogue, *Ohio Medicaid Quality Monitor,* Volume 14, Number 3
- “Peer Groups, Quality and Care Delivery” Medical Director Dialogue, *Ohio Medicaid Quality Monitor,* Volume 14, Number 2
- “ICD-10 for Physicians” Medical Director Dialogue, *Ohio Medicaid Quality Monitor,* Volume 14, Number 1
- “Medicaid and PPACA” Medical Director Dialogue, *Ohio Medicaid Quality Monitor,* Volume 13, Number 3
- “Admission Orders” Lead Article, *Ohio Medicaid Quality Monitor,* Volume 13, Number 2
- “Breast Reconstruction: Standards of Care” Medical Director Dialogue, *Ohio Medicaid Quality Monitor,* Volume 13, Number 2
- “Public Report Cards for Physicians” Medical Director Dialogue, *Ohio Medicaid Quality Monitor,* Volume 13, Number 1
- “Where is the Quality in Health Care Reform?” Medical Director Dialogue, *Ohio Medicaid Quality Monitor,* Volume 12, Number 4
- “The STAAR Initiative from the IHI and its Early Lessons” Medical Director Dialogue, *Ohio Medicaid Quality Monitor,* Volume 12, Number 3

- “Observation Level of Care” Medical Director Dialogue, *Ohio Medicaid Quality Monitor,* Volume 12, Number 2
- “EHRs and Meaningful Use” Medical Director Dialogue, *Ohio Medicaid Quality Monitor,* Volume 12, Number 1
- “Quality of Care Determinations” Medical Director Dialogue, *Ohio Medicaid Quality Monitor,* Volume 11, Number 4
- “Guidelines and Medical Decision Making” Medical Director Dialogue, *Ohio Medicaid Quality Monitor,* Volume 11, Number 3
- “The New Normal” Medical Director Dialogue, *Ohio Medicaid Quality Monitor,* Volume 11, Number 2
- “Nonpayment for Never Events – a Tool for Quality Improvement?” Medical Director Dialogue, *Ohio Medicaid Quality Monitor,* Volume 11, Number 1
- “Continuity of Care” Medical Director Dialogue, *Ohio Medicaid Quality Monitor,* Volume 10, Number 4
- “Health Care Reform” Medical Director Dialogue, *Ohio Medicaid Quality Monitor,* Volume 10, Number 3
- *Breast Cancer Q&A*, The Madison Press; Madison County, Ohio; Saturday January 12, 2008; page 7A
- “October is Breast Cancer Awareness Month,” *The Windsock*, MCAS Cherry Point, Cherry Point, North Carolina, October 7, 2004

Director of Quality Studies: Mathew George, MD

Summary of Qualifications and Experience

Permedion proposes Dr. Mathew George to serve on our project team in the key position of Director of Quality Studies. Dr. George has more than 17 years of experience in the healthcare industry with a focus on pediatric and addiction care and quality. He currently serves as a Physician Reviewer for Permedion in which he applies his medical expertise to help our Medicaid clients improve their delivery of healthcare services, specifically in the area of utilization review. Mathew applies the following qualifications and experience to his role of Director of Quality Studies:

- Over 17 years of education, leadership, and national experience in researching, designing, conducting, analyzing, and reporting complex studies to support health care quality and improved outcomes
- 17+ years of direct patient care (in active practice with attending privileges in multiple hospitals)
- Oversees large teams in various roles to coordinate and deliver complex healthcare programs
- Board certified in five subspecialties: General Pediatrics, Pediatric Pulmonology, Medical Toxicology, and Addiction Medicine, Sleep Medicine
- Conducted dozens of health care studies over the past 15+ years across multiple topics as principal investigator or assisting the principal investigator
- Performed extensive clinical research focused on Pediatric Emergency Department (ED) workflow management and reducing the costly lab work up in various clinical settings and was successful in securing multiple grants in the ED to improve workflow
- 13 years conducting reviews of hospital inpatient and outpatient, and other services for validation of medical necessity, proper level of care, coding, and readmissions, for Ohio and other Medicaid programs

Career History

As listed below, Dr. George has provided direct patient care for multiple providers and facilities across multiple settings and disciplines:

- AtlantiCare Health System, Egg Harbor Township, NJ
  - Sleep Physician, *2021 – Present*
- Amwell, Inc., Boston, MA
  - Sleep Physician, *2021 – Present*
- AtlantiCare Health System, Egg Harbor Township, NJ
  - Medical Director for Addictions, *2021 – Present*
- Community Care Behavioral Health, AtlantiCare Health System, Hammonton, NJ
  - Medical Director, *2021 – Present*
- Community Care Behavioral Health, AtlantiCare Health System, Atlantic City, NJ
  - Medical Director, *2021 – Present*

- Bridge Clinic for Substance Abuse Clinic, AtlantiCare Health System, Atlantic City, NJ
  – Medical Director, *2021 – Present*
- John Brooks Hospital for Addictions, Atlantic City, NJ
  – Medical Director Designee
- Pediatric Emergency Department, Coney Island Hospital Center, Brooklyn, NY
  – Physician, 2017 – Present (per diem)
- Private Practice, Tappan, NY
  – Pediatric Pulmonology, *2021 – Present*
- Private Practice, Tappan, NY
  – Sleep Medicine, *2021 – Present*
- Telemedicine Practice, Rockland County, NY
  – Pediatric Pulmonology/Sleep Medicine, *2021 – Present*
- Pediatric Asthma Dsrip Program Coney Island Hospital, Brooklyn, NY
  – Lead Attending, *2018 – Present*
- Queens Hospital Center; Queens, NY
  – Pediatric Attending, *2014 – Present*
- St. Barnabas Hospital, Bronx, NY
  – Pediatric Attending, Emergency Department, *2012 – Present*
- Stonybrook University, Smithtown, NY
  – Sleep Medicine Fellow, *2020 – 2021*
- Pediatric Emergency Department, Coney Island Hospital Center, Brooklyn, NY
  – Medical Director, 2017 – 2021 (full-time)
- Addiction Medicine, Guidance Center of Westchester, Westchester, NY
  – Medical Director, *2017 –2018*
- Downstate Medical Center, Brooklyn, NY
  – Pediatric Pulmonology Fellow, *2014 – 2017*
- Floating Hospital, Bronx, NY
  – Pediatric Practice, *2013 – 2016*
- Metropolitan Hospital, NY, NY
  – Attending, Pediatric Emergency Department, *2013 –2017*
- Wyckoff Hospital Medical Center, Brooklyn, NY
  – Pediatric Hospitalist/NICU Hospitalist, *2012 – 2014*
- Morton Hospital; Taunton, MA
  – Pediatric Hospitalist Practice, *2010 –2013 (part-time)*
- Harvard Vanguard Medical Associates, Braintree, MA
  – Urgent Care Center Physician, *2011 – 2013 (part-time)*
- Southshore Hospital, Weymouth, MA
  – Pediatric Hospitalist, *2010 – 2012*
- Maine Medical Center, Portland, ME
  – Post Pediatric Portal Resident, *2010 – 2011*

- Pediatric Hospitalist and Primary Care, NY, NY
  - 2005 – 2010
- Permedion (HMS/Gainwell), Dublin, Ohio
  - Conducts clinical reviews for multiple state Medicaid utilization management contracts including reviews of prior authorization requests, continued stay reviews, and retrospective reviews. Validates medical necessity, proper level of care, coding, and readmissions for hospitals and other provider types. *2009-current*

Education

- Master of Business Administration, Bowling Green State University (student)
- Sleep Medicine Fellow, Stonybrook University
- Pediatric Pulmonology Fellowship, Downstate Medical Center
- Addiction Medicine Certification (through ASAM and ABPM)
- PGY2 Psychiatry, Maine Medical Center
- Harvard Medical Toxicology Fellowship
- Pediatrics Residency, John H. Stroger Hospital of Cook County
- MBBS from Medical College, Kottayam, Kerala, India

Licensure/Certifications/Accreditations

- State of Ohio, Full License; 35.095188
- State of Connecticut, Full License; 72574
- Commonwealth of Massachusetts, Full License; 227399
- State of New York, Full License; 238538
- State of New Jersey, Full License; 25MA10794400
- State of Nebraska, Full License; 27646
- Travancore Cochin Medical Society License
- DEA (Federal)
- DEA (MA)
- ECFMG Certified, August 2000
- PALS, Expiration Date: October 31, 2022
- NRP, Active until October 2022
- ACLS, October 2022
- Board Certification – American Board of Pediatrics (General Pediatrics, Pediatric Pulmonology, Medical Toxicology, Sleep Medicine, and Addiction Medicine)
- Board Certification – American Board of Preventative Medicine (Addiction Medicine)
- Certified Medical Review Officer
- Certified Workers Compensation Analyst

Associations/Affiliations

- Clinical Assistant Professor of Psychiatry, Neuroscience Institute at Geisinger Commonwealth School of Medicine, PA, 2021 – Present
- Lecturer in Pediatrics, Touro College of Medicine, NY, 2017 – Present
- Clinical Assistant Professor of Pediatrics, St. George University, Antigua, 2017 – Present
- AtlantiCare Hospital, Pomona, NJ, 2021 – Present
- AtlantiCare Hospital, Atlantic City, NJ, 2021 – Present
- Coney Island Hospital, Brooklyn, NY, 2017 – Present
- Queens Hospital Center, Queens, NY, 2013 – Present
- Member, Emergency Medicine Working Group Council Member, NYC Health, and Hospitals NY, 2017 – Present
- Member, Pediatric EM Group Council Member, NYC Health and Hospitals, NY, 2017 – Present
- Member, Pharmacy Committee member, Coney Island Hospital, NY, 2017 – Present
- Member, Code Committee Member Coney Island Hospital, NY, 2017 – Present
- Member, American Fraud Association
- Member, American Academy of Sleep Medicine
- Member, American Academy of Pediatrics
- Member, American College of Medical Toxicology
- Member, American Society of Addiction Medicine
- Founding Member of Central Travancore Medical Society, Kerala, India
- Founding Member of Mission India Foundation
- Volunteer for Samaritans of New York
- Code Committee Member, Coney Island Hospital, NY, 2017 – 2021
- Pharmacy and Therapeutics Committee Member, Coney Island Hospital, NY, 2017 – 2021
- Assistant Professor, Pediatrics, St George University, Grenada, 2017 – Present
- Assistant Program Director, Addiction Medicine Fellowship, Emergency Department, Coney Island Hospital, NY, 2017 – 2020
- Adjunct Faculty, Pediatrics Residency, Downstate Medical Center, NY, 2017 – 2021
- Resident Education Director for Pediatrics, Coney Island Hospital, NY, 2017 – 2021

Published Works

- M George, M Pereda Alejandra, T Noorudin, S Wadowski' "Will switching to Metered Dose Inhalers (MDI)/Spacers from Nebulization improve the Length of Stay (LOS) of patients with mild asthma exacerbation in the Pediatric Emergency Department (PED): A Quality Improvement (QI) Project in an inner-city hospital". (To be published in November 2022)

- Pollock K, M George, et al. Roto-Clipper Injury to the Neck in a 4-Year-Old Female. Pediatr Emerg Care Med Open Access. Vol. 4 No.1:1.
- M George. H Lee. “Cystic Lung Disease in Down Syndrome: A Case Report and Literature Review.” Case Rep Pediatr. 2016; 2016:4048501. Epub 2016 Oct.
- M George, MD, Saumya Vinod Joshi, MD, Emily Concepcion, DO, Haesoon Lee, MD. “Paradoxical Bronchospasm from BenzalkoniumChloride (BAC) Preservative in Albuterol Nebulizer Solution in a Patient with Acute Severe Asthma: A Case Report and Literature Review of Airway Effects of BAC.” Respiratory Medicine Case Reports (2017), doi: 10.1016/j.rmcr.2017.
- M George. “Innate Immunity and Asthma Risk." N Engl J Med. 2016 Nov 10;375(19):1897.
- M George, Ahmad SQ, Wadowski S. “Community-Acquired Pneumonia Among U.S. Children.” N Engl J Med. 2015 May 28;372(22):2166-7.
- M George, Lindsey Korbel, Maya Haasz, Alvaro Coronado, Joseph Kitzmiller. “Managing Acute Asthma Exacerbations in Pediatric Patients: Should PeakFlow Measurements (PFM) or Pediatric Respiratory Assessment Measure (PRAM) Scores be used to TitrateBronchodilator Treatment?” Ann Pediatr Child Health. 2(2):1013.
- M George, Haasz M, Coronado A, Salhanick S, Korbel L, Kitzmiller JP. “Acute Dyskinesia, Myoclonus, and Akathisa in an Adolescent Male Abusing Quetiapine via Nasal Insufflation: A Case Study.” BMC Pediatr. 2013 Nov 16;13(1):187.
- L Korbel, M George, J Kitzmiller. “Clinically Relevant Pharmacogenomics Testing in Pediatric Practice.” Clin Pediatrics. 2014; 53(9): 831-8.
- M George, JJ Campbell. "Venlafaxine Causing Akathisia: A Case Report.” J Neuropsychiatry Clin Neurosci. 2012 Summer;24(3): E3-4. doi: 10.1176/appi.neuropsych.11060144.
- M George, J Kitzmiller. “Acetaminophen Pediatric Dose Selection: Caregiver Satisfaction Regarding the Aantipyretic Efficacy of Acetaminophen in Children.” Clin Pediatr (Phila). 2012 Nov;51(11):1030-1. doi: 10.1177/0009922812456592. Epub 2012 Aug 13.
- M George, J Kitzmiller, et al. “Methadone Toxicity and Possible Induction and Enhanced Elimination in a Premature Neonate." J Med Toxicol. 2012 Dec;8(4):432-5. doi: 10.1007/s13181-012-0249-8.
- M George, A Delgaudio, “Poison Center Awareness Among Parents in a Pediatric Primary Care Practice.” Journal of Med Toxicol;7(2): 177-78 (2011).
- Y. Finkelstein, M George, et al. “Incidence, Recurrence and Long-Term Outcome of Steven Johnson Syndrome and Toxic Epidermal Necrolysis in Children: A Retrospective study.” Pediatrics. 2011 Oct;128(4):723-8.
- M George, A Delgauido, S Salhanick. “Exertional Rhabdomyolysis – When Should We Start Worrying?” Pediatric Emerg Care. 26(11);864-6 (2010).
- M George, M Heeney, AD Woolf. “Encephalopathy Masquerading as Flu-Like Syndrome in an Autistic Child.” Pediatric Emerg Care. 26(5):370-3(2010).
- M George. “Severe and Persistent Lactic Acidosis Secondary to Calcium Channel Blocker Toxicity.” Pediatric Emerg Care. 26:68 (2010 January).
- M George, MW Shannon. “Serum Osmolality Changes After Intravenous Contrast Administration: A Pilot Study.” Peds Emerg Care. 25(9): 555-557(2009).

- M George, N Alduaij, K Odonnell, MW Shanon. “Zofran Toxicity in a Toddler and Subsequent Altered Mental Status and Seizure Which Required Tracheal Intubation and Intensive Care Admission: A Case Report.” Clin Toxicol. 46(10):1064-6 (2008 Dec).
- M George, MA Sheriff, MB Ewald, MW Shannon. “Neonatal Methergine Poisoning – Index of Suspicion.” NeoReviews. Vol.10 No.6: e303(2009).
- C Vitale, M George, A Sheroff, C Hernon, E Boyer. “Tracheal and Bronchial Obstruction Following Cyanoacrylate Aspiration in a Toddler.” Clin Toxicol. :46(6):560-2(2008).
- M George, N AlDuaij, ML Becker, MB Ewald. “Ethylene Glycol Treated Only with Fomepizole.” Journal of Medical Toxicology. 4(1): 67(2008).
- M George, N AlDuaij, MB Ewald. “Mouthwash: Time for Policy Change?” Pediatric Emergency Care. 25(1):58-9(2009).
- V Char, M George, S Rao. “Role of Autopsies in Pediatric Education and Clinical Practice.” Illinois Pediatrician. Volume 22, No 3 (2005).
- M George. “Trends in Publication of Mental Health Related Articles in 2 Mainstream Pediatrics Journals: Comparison of Years 2000 and 2010.” Journal of Pediatrics. (submitted).

Project Leader: Seana Ferris

Summary of Qualifications and Experience

Permedion proposes Seana Ferris to serve on our project team in the key position of Project Leader. Seana has worked on and served as the project leader of comprehensive, large-scale healthcare cost containment and program integrity projects for more than 20 years. Her project management expertise includes UM/PA services as demonstrated by her current role of project leader for our scope of work delivered to ODM. She has been with Permedion since 2000 and is based in Central Ohio. Seana applies the following qualifications and experience to her role of Project Leader:

- Expertise in all of the scopes of work described by ODM in its RFP including prior authorization and retrospective review of medical necessity, proper billing, and quality of care, as well as the federal and state regulations and rules that guide them
- Four years of experience as Project Leader of Permedion's UM/PA contract with ODM
- Ability to confirm that Permedion meets/exceeds ODM's contract requirements throughout all phases of the engagement
- Directs and supports a range of project teams, obtains, and allocates needed resources, and recommends best practices used in other Medicaid UM programs to benefit ODM

Career History

Gainwell Technologies, LLC. (formerly Health Management Systems, Inc.)
Senior Director, State Solutions, *2018 – Present*

- Responsible for account management including client management, budget forecasting and reporting contract deliverables for contracts with Medicaid Agencies in Massachusetts, Ohio, Virginia, and New Jersey
- Contract and account responsibility with scope of work including Utilization Management, Prior Authorization, Prepayment and Post payment Clinical Reviews, Compliance Audits, Third Party Liability Coordination of Benefits, and Casualty Recoveries
- Coordinate with operations for delivery of contract requirements

Director, Strategic Initiatives and Clinical Product Analysis, *2007 – 2018*

- Develops and implements operational quality assurance and improvement programs, including producing and analyzing quality indicators
- Directed URAC accreditation processes through three successful accreditation cycles
- Analyzed and implemented new Payment Integrity products and services

Permedion, Inc. (acquired by Health Management Systems, Inc.)

Vice President, Permedion, Inc., *2000 – 2007*

- Managed all operational aspects of the commercial division including supervisory, budgetary, and customer relations.
- Managed client relationships with state agencies, hospitals, and health plans.
- Identified and developed new services.

- Developed and implemented marketing and sales of services.

Johnson & Johnson Health Care Systems, Inc.
Management Consultant, *1997 – 2000*

- Health Care Systems Consulting specializes in surgery management consulting and hospital-wide expense reduction, quality improvement and re-engineering.
- Audited and developed solutions to improve effectiveness, efficiency, and competitiveness of hospital and free-standing surgical services.
- Presented operational improvement potentials to hospital, executive, and medical staffs and board members
- Managed consulting engagements including project plans, budgets, and client relationships throughout the United States, Canada, and the Caribbean
- Benchmarked and evaluated financial, labor, and performance indicators for surgical programs.
- Facilitated multidisciplinary teams to implement operational changes.

Riverside Methodist Hospitals *1988 – 1997*

Management Engineer, Senior Management Engineer, Director, Management Engineering

- Facilitated hospital process improvement initiatives in the business and clinical departments.
- Led Reengineering Team responsible for reducing $80 million from the operating budget.
- Participated in the development of hospital operational and fiscal goals and objectives.
- Facilitated merger of departments between hospitals entering the Ohio Health system.
- Developed clinical and financial utilization reports for physicians

Education

- Bachelor of Science, Miami University
- Certified HEDIS Compliance Auditor, NCQA 2004 – 2006

Professional Associations

- National Association of Independent Review Organizations
  - President 2007 – 2009
  - Vice President 2005 – 2007
  - Secretary 2004 – 2005

Project Manager, Quality and Hospital Utilization Management: Merrily Sable, RN

Summary of Qualifications and Experience

Permedion proposes Merrily Sable, RN to serve on our project team in the key position of Project Manager, Quality and Hospital Utilization Management. Ms. Sable has decades of experience in healthcare as an Ohio-licensed Nurse, Clinical Reviewer, UM/PA Clinical Project Manager and UM/PA Clinical Supervisor. She currently serves as the project manager of our

clinical review processes as part of our UM/PA scope of work for ODM. Ms. Sable applies the following qualifications and experience to her role of Project Manager, Quality and Hospital Utilization Management:

- Successful management of multiple Medicaid UM/PA contracts with scopes of work including utilization management, medical necessity/level of care, coding, quality improvement, billing compliance, and hearings and appeal proceedings
- Expert knowledge of review processes for prepay and post-pay retrospective reviews across multiple service types including inpatient and outpatient hospital, long-term care, durable medical equipment, dental, rehabilitation therapy (speech, occupational, physical), behavioral health and home health services
- Experience managing coding and clinical validation reviews of inpatient hospital claims and strong knowledge of APR-DRG reimbursement methodology
- 12+ years of clinical review project experience at Permedion

Career History

Gainwell Technologies, LLC. (formerly Health Management Systems, Inc.)
Associate Manager Clinical Review, Program Integrity Clinical Solutions, *2010 – Present*

- Manages clinical review processes, including prepay and post pay retrospective reviews (hospital and other services), for UM/PA contracts with Massachusetts and Ohio Medicaid programs
- Supervises a team of nurse reviewers and makes certain reviews are completed accurately and timely
- Serves as subject-matter expert to project team members
- Participates in staff interviews, hiring recommendations and assists with training efforts
- Collaborates with state representatives, clinical leadership, provider services, account management, and analytics to ensure deliverables are completed accurately and timely

Clinical Project Manager, *2010 – 2013 and 2016 – 2018*

- Served as Project Manager responsible for hospital clinical review contracts with multiple Medicaid programs and assures compliance with contract requirements and deliverables
- Lead the monitoring and oversight of review activities to provide excellence in contract performance including review quality, appropriate quantity, and positive customer and provider relations
- Resolved or escalated provider, clinical staff, and other internal and external issues
- Made final appeal case determinations and wrote responses to send to state appeals agency
- Coordinated and consolidated clinical and technology resources and processes for clinical team
- Assisted with several clinical review projects and implementations across the company
- Evaluated the Special Investigations Unit (SIU) processes, platforms, and clinical training needs

- Created and implemented action plans for improving clinical review and operational support processes
- Performed ongoing review of federal and state regulations to make certain compliance of review procedures and notifications
- Provided leadership and mentoring to clinical supervisor and operations staff
- Provided guidance, interviewing and other expertise for clinical staff recruitment efforts

Professional Coach, Shift Change Coaching Group
Executive Partner, *2007 – 2010*

- Provided individual and group coaching and presentations to take nurses from Surviving to Thriving
- Created teleconference CEU session for RNs nationwide; Presentation examples: schools of nursing at UNC Chapel Hill, NC, Duke University and East Carolina University; breakout session for the annual statewide NC Nurses Association Conference

State of North Carolina, Division of Medical Assistance (DMA) Program Integrity
Nurse Reviewer/Analyst, Policy Consultant, *1993 – 2007*

- Performed clinical review for multiple specialties and services
- Planned, organized, and directed the work of the NC Medicaid Child/adolescent and adult psychiatric post-payment review process
- Tracked Medicaid mental health policy and regulatory changes and dissemination of information to all entities involved
- Monitored procedures and results of contract activity referenced above to make certain that services were provided to meet Division goals in a cost-effective manner, consistent with state and federal laws and regulations
- Planned and represented Medicaid's position in informal and OAH (Office of Administrative Hearings) formal level appeals and mediated settlement conferences; Supervised/trained contract staff in appeals process and presentation
- Served as subject matter expert for AGO's office, DMA Financial Operations and Controller's Office, Medicaid providers, DMA Medical Policy, etc. to clarify and interpret mental health reform rules and policies
- Evaluated and developed solutions to complex medical and/or regulatory issues
- Represented the Medicaid Program Integrity division in planning and problem-solving meetings with various agencies and outside entities
- Made recommendations for development or changes in policies and procedures affecting cost, quality of care, under or over utilization of services, and levels of service

Capitol Pediatric and Adolescent Center
Clinical Coordinator, *1992 – 1993*

- Supervised 13 nurses and two medical technicians for an eight Physician Pediatric Practice
- Created and implemented plan for OSHA compliance resulting in passing the OSHA inspection

Integrated Health Services at Crabtree Valley
Director of Nursing Services, *1991 – 1992*

- Director of Nursing and Supervisor for a staff of 71 nurses and nursing assistants for a 138 bed Long Term Care Facility
- Assisted with coordination and implementation of the first sub-acute care unit in a North Carolina LTC Facility
- Liaison with patients' families and any State inspections including Medicare and Medicaid compliance

Education

Bachelor of Science, Nursing, East Carolina University

Licensure/Certifications/Accreditations

- Registered Nurse
- Professional Certified Life and Business Coach, Associate Certified Coach (ACC) with the International Coach Federation (ICF)

Published Works

None

Project Manager, Behavioral Health: Lisa Thompson, RN

Summary of Qualifications and Experience

Permedion proposes Lisa Thompson to serve on our project team in the key position of Project Manager, Behavioral Health. Ms. Thompson is an Ohio-licensed RN and Nurse Reviewer with eight years of experience with Permedion. She currently serves in this position under our current UM/PA contract with ODM. Ms. Thompson applies the following qualifications and experience to his role of Project Manager, Behavioral Health:

- Experience providing day-to-day project management of Permedion's delivery of UM/PA services to ODM since 2019
- Clinical review expertise in all levels of mental health and chemical dependency including precertification, concurrent and retrospective reviews for medical necessity, aftercare planning and identification of appropriate discharge plan resulting in cost containment
- Extensive, in-depth knowledge of Ohio Administrative codes and medical necessity criteria and how they are interpreted and applied to fulfill prior authorization requirements
- 32 years of experience in the medical field

Career History

Gainwell Technologies, Inc. (formerly Health Management Systems, Inc.)
Project Manager, *2019 – Present*

- Coordinates communication and exchange of information between Permedion and ODM
- Creates, updates, and maintains internal policies and processes in compliance with applicable laws, rules, regulations, and accreditations, and in accordance with contract requirements
- Provides technical assistance to ODM
- Identifies and communicates educational or training needs to ODM and Permedion project team members
- Coordinates and provides education and training

Nurse Reviewer, *2014 – 2019*

- Performed prior authorization reviews of Behavioral Health and Psychiatric services for Ohio Department of Medicaid, and two Medicaid MCOs
- Performed retrospective overpayment reviews and compliance audits for Psychiatric services and Community Behavioral Health services for the Ohio Department of Medicaid and the Virginia Department of Medical Assistance Services
- Utilized MCG care guidelines

Dublin Springs Hospital
Staff Nurse, *2012 – 2014*

- Provided care for mentally ill patients on all three of their inpatient units and also in the PHP, and IOP programs.
- Served routinely as charge nurse on all the units.

Sedgwick CMS Inc.
Case Manager, *2011 –2012*

- Worked as a case manager working with Ohio Workman's compensation clients.
- Worked with medically unstable injured workers assisting them with their return to work.
- Collaborated with employers and providers to coordinate care and delivery of services and with the Ohio Bureau of Workman's Compensation

Molina Healthcare Inc.
Utilization Review/ Complex Case Manager, *2007 –2011*

- Worked as a Utilization Review nurse on the Behavioral Health team. Reviewed inpatient stays for the Medicaid population for hospitals throughout the state.
- Assisted case managers with discharge planning. Communicated with hospitals for concurrent review of stays. Helped design the behavioral health review system at Molina when they decided to perform in house reviews.
- Served as Complex Case Manager for the ABD population

Careworks
Utilization Management RN/ Case Manager, *2003 – 2007*

- Served as Nurse Case Manager working with Ohio Worker’s Compensation Clients.
- Worked in UR for two years determining medical necessity for requested services based on Milliman and ODG guidelines. Utilized Miller guidelines for chiropractic treatment.

The American Red Cross
Collection Specialist II/ Apheresis Collection, *2001 – 2003*

- Worked as nurse in charge of blood mobiles supervising staff members working on the on-site drives and the buses.
- Worked in Apheresis department collecting blood products.

The Ohio State University Hospitals
Staff RN, *1990 – 2001*

- Worked in the psychiatric department with children and adolescent inpatient population.
- Worked on the adult psychiatric unit with adults with chronic psychiatric illness. Crisis stabilization, medication management and teaching multiple nursing groups in effort to promote positive outcomes. Also functioned as charge nurse.
- Member of QA committee designed and implemented tools for on unit QA audits.
- Audited information and assisted with formulating solutions for quality improvement.
- Worked on Labor and Delivery and worked with wide range of pregnant patients including Level 3 high risk patients. At that time OSU was the only Level 3 L&D in Columbus. Used the

first EMR system in clinical setting at OSU, as L&D was one of the trial units that began using EMR.

Education

Diploma of Nursing, Mount Carmel School of Nursing, 1987

Licensure/Certifications/Accreditations

- RN, Ohio: License #209792
- The Ohio State University Medical Center, Columbus, Ohio
- Presented at Two Annual Psychiatric Nursing Conferences:
  - First in the spring of 1992 and second in the spring of 1993. Presented study findings of effectiveness of medication teaching on compliance for children aged 5-12.
  - OSU 1st Annual Psychiatric Nursing Conference. “Beyond Crisis Intervention.”
    OSU 2nd Annual Psychiatric Nursing Conference. “Moving Beyond Crisis Intervention.”

Published Works

None

Database Administrator: William Walo

Summary of Qualifications and Experience

Permedion proposes William Walo to serve on our project team in the key position of Database Administrator. Mr. Walo has more than 30 years of experience in application development, database design and administration, and planning and analysis of infrastructure and applications. On the UM/PA service delivery team, he will lead our efforts to support regular data loads for analysis, troubleshoot issues, and maximize efficiency and user experience. Mr. Walo applies the following qualifications and experience to his role of Database Administrator:

- Expertise in all phases of UM/PA IT system development and implementation including system analysis, design, development, testing and ongoing support
- In-depth knowledge of the availability, performance, and architecture of databases associated with Permedion's delivery of UM/PA services
- Application of a thorough understanding of database disaster recovery, capacity planning, security, process control, system deployments, system architecture, performance, and report generation
- Experience with the proactive monitoring and optimization of database systems (hardware and software) in a 24x7 environment
- 7+ years of application development experience at Permedion

Career History

Gainwell Technologies, Inc. (formerly Health Management Systems, Inc.)
Director of Application Development, *2015 – Present*

- Manages day-to-day application development activities
- Directs and manages an application development and delivery team consisting of developers, technical leads, business analysts, help desk support and business/vendor partners
- Provides leadership and coordination of multiple development teams
- Works closely with business partners to scope, define, justify, and prioritize initiatives and projects in direct partnership with business and technology leaders across the enterprise
- Serves as the key divisional IT leader for the adherence to all SOX and SOC 2 compliance regulation and the IT representative in all audits

Las Vegas Color Graphics
Director of Information Technology, *2014 – 2014*

- Provided daily management of all Information Technology related operations
- Served as leader and liaison between customers and the application development team
- Responsible for defining the disaster recovery and business continuity plans and recommending solutions to implement those plans
- IT representative on the SAS 70 / SSAE 16 SOC 1 audit committee that set internal controls on processes.

Nevada General Insurance Company / Auto Insurance America
Director of Application Development, *2012 – 2013*

- Managed all enterprise-wide application development
- Served as key advisor to departmental management and leadership team on the recommendation and justification of critical architecture decisions
- Responsible for the delivery of a company core policy and claims application upgrade
- Lead and directed the development of the Android and iPhone Mobile application to allow a customer to make policy payments and electronically generate, in real time, policy documentation using a smart phone
- Lead and directed the replacement of the company's internal forms development solution that delivered all policy related documents to the consumer. Project included the documentation of existing enterprise workflows in relation to printing and enhancement of existing document management workflows to increase efficiency across all departments, using a newly acquired enterprise-wide forms management solution

Senior Director, Information Systems, *2005 – 2012*

- Responsible for the day-to-day direction of IT operations including user support, business and technical operations, software development, networking, infrastructure, and security.
- Managed the design, development, deployment, and online marketing of the company e-commerce web sites. Simultaneously implemented and deployed a customer internet facing policy issuance system to allow customers to issue new business policies via the internet.
- Managed the design, development, and deployment of an enterprise wide ASP.Net based application to streamline the agent to company policy issuance process.
- Managed the enterprise-wide deployment of a document imaging and workflow solution including contract negotiation, defining implementation schedules, and managing the implementation go-live.
- Key sponsor and designer of the re-architecting of the company Wide Area Network from a Frame-Relay based network to a VPN based network. Reduced annual WAN cost by 42%.
- Managed the implementation of a Cisco CallManager Voice-Over-IP (VoIP) solution to reduce the overall telecommunications cost.

Education

Bachelor of Science, California Lutheran University

Published Works

None

Biostatistician: Caroline Black, PhD, RN

Summary of Qualifications and Experience

Permedion proposes Caroline Black to serve on our project team in the key position of Biostatistician. Ms. Black has nine years of applied experience in analysis and data visualization and currently supports our UM/PA work on behalf of ODM. She is a registered nurse with a PhD in Biomedical Engineering and specializes in mathematical modeling, and programming. Ms. Black applies the following qualifications and experience to her role of Biostatistician:

- Extensive experience planning and conducting statistical and epidemiological analysis of healthcare data to assess statistical integrity of a project
- Demonstrated ability to analyze large, complex data sets to provide insight on healthcare service performance improvements and cost reduction
- Applied understanding of ODM data used to create multiple Permedion service and results reports centered around clinical review target effectiveness and provider rebilling practices
- Expertise in the areas of healthcare data analysis, healthcare operations, product development, and national deployment of healthcare business intelligence tools

Career History

Gainwell Technologies, Inc. (formerly Health Management Systems, Inc.)
Clinical Performance Analyst, Payment Integrity, *2019 – Present*

- Plans and conducts statistical and epidemiological analysis of healthcare data on behalf of clients including ODM
- Designs and conducts analyses of healthcare databases to assess effectiveness and efficiencies
- Provides statistical and epidemiologic input to study design, sampling methodology, analysis, and reporting to assure statistical integrity of project
- Develops data formatting and cleaning criteria for healthcare data from various sources and evaluates relevant data
- Prepares service and results reports and presentations documenting analytic methods and results

Evolent Health
Associate Director, Client Analytics, *2018 – 2019*

- Served major insurance company to inform/shape clinical/network savings plans through claims-based cost and utilization reporting, quality measures, care management, and client-specific initiatives
- Defined scope, construct methodologies, and built implementation plans as well as personally executing to create needed deliverables
- Managed and scaled reporting/analytic needs across multiple markets
- Provided solution building around unavailable or unreliable data, on-demand analytics support, and standardizing analytics products for cross-market needs

Apogee Informatics Corporation
Healthcare Informatics Engineer, *2013 – 2018*

- Analyzed large, complex data sets (EMR/EHR, billing, HIPPA, HL7) to provide insight on performance improvement, cost reduction, staffing optimization, and resource utilization
- Identified new data potentials and metadata captures
- Developed and maintained operational reporting, ad hoc analysis, dashboards, and clinical decision support tools in an agile development environment for clinical process improvement, clinical quality, enterprise analytics and regulatory reporting requirements
- Translated business needs into product/reporting for a variety of customers (hospitals, physician groups, EMR vendors, and researchers)

Huntsville Hospital
Project Lead, *2013 – 2014*

- Researched, evaluated, and assessed data sets and forecasted costs necessary to create a strategic facility plan
- Served as project lead for a multi-hospital system integration to support clinical care for seven locations.

Education

- Doctor of Philosophy, Biomedical Engineering, University of Tennessee Knoxville
- Master of Science, Biomedical Engineering, University of Tennessee Knoxville
- Bachelor of Science in Nursing, Nursing and Mechanical Engineering, University of Alabama Huntsville
- Bachelor of Science in Engineering, Nursing and Mechanical Engineering, University of Alabama Huntsville

Licensure/Certifications/Accreditations

- State of Alabama Nursing License
- Executive Data Science Specialization, Johns Hopkins University Coursera
- Business Intelligence tools (SAS Enterprise Guide, Tableau, Power BI, R, and others), ETL, Relational Database Design
- SAS, SQL, Python, R, MATLAB, MongoDB, Database Programming, ZurmoCRM, text editors

Published Works

- Journal and Conference Publications
- O'Neal, P., Black, C.B., Armentrout, D. "Human Factors Associated with the Use of Manual Bulb Suction Devices." Nursing Research. Wolters Kluwer. May 2019.
- Black, C.B., Alexander, S. "Data and the Nurse Combining Expertise in Clinical Domains and Data Analytics." Clinical Nurse Specialist. Wolters Kluwer Health, Inc. Nov. 2018.

- Black, C.B., Klubert, D. “Correspondence.” Journal of the American Medical Informatics Association. Apr. 2018.
- Black, C.B., Till, J., Rucker, C. “Parallel Continuum Robots: Modeling, Analysis, and Actuation-Based Force Sensing”, in IEEE Transactions on Robotics, vol. 34, no. 1, pp. 29-47, Feb. 2018.
- Ponten, R., Black, C.B., Rucker, C. “Analysis of a Concentric-Tube Robot Design and Feasibility for Endoscopic Deployment”, in SPIE Conference February 2017.
- Orekhov, A.L., Bryson, C.E., Till, J., Chung, S., Rucker, C., "Analysis and Validation of a Teleoperated Surgical Parallel Continuum Manipulator," in IEEE Robotics and Automation Letters January 2016.
- Till, J., Bryson, C.E., Chung, S., Orekhov, A., Rucker, D.C., "Efficient computation of multiple coupled Cosserat rod models for real-time simulation and control of parallel continuum manipulators," in Robotics and Automation (ICRA), 2015 IEEE International Conference on, vol., no., pp.5067-5074, 26-30 May 2015.
- Orekhov, A.L., Bryson, C.E., Till, J., Chung, S., Rucker, D.C., "A surgical parallel continuum manipulator with a cable-driven grasper," in Engineering in Medicine and Biology Society (EMBC), 2015 37th Annual International Conference of the IEEE, vol., no., pp.5264-5267, 25-29 Aug. 2015.
- Bryson, C.E., Rucker, D.C. "Toward parallel continuum manipulators." (ICRA), 2014 IEEE International Conference on Robotics and Automation, pp.778-785, May 31, 2014-June 7, 2014.

Conference Presentations

- Bryson, C.E., Rucker, D.C. "Toward parallel continuum manipulators." (ICRA), 2014 IEEE International Conference on Robotics and Automation, May 31, 2014. Hong Kong, China.
- Chung, S., Bryson, C.E., Till, J., Carlton, J., Rucker, D.C. "Teleoperation of Parallel Continuum Manipulators using Approximate Kinematic Models." IEEE/RSJ International Conference on Intelligent Robots and Systems, September 14-18, 2014.
- Orekhov, A.L., Bryson, C.E., Till, J., Chung, S., Rucker, D.C., "A surgical parallel continuum manipulator with a cable-driven grasper," in Engineering in Medicine and Biology Society (EMBC), 2015 37th Annual International Conference of the IEEE 29 Aug. 2015. Milan, Italy.
- Bryson, C.E., Orekhov, A.L., Rucker, D.C. "Miniature Continuum Stewart-Gough Platforms for Endoscopic Surgery." Vanderbilt Initiative in Surgery and Engineering, 2014.

Appendix E: Job Descriptions for Other (Non-key) Positions

Job Title and Summary	Job Duties	Qualifications	Minimum Work-Related Experience
Medical Record Extractors: Responsible for auditing medical records of assigned cases. The primary focus of this position is to properly identify overpayments and possible underpayments through verification of billed charges in the medical records documentation.	• Under the supervision of Manager, Clinical Audits, the bill auditor, audits medical records and itemized bills to verify billing accuracy for services provided and documented in the medical record. • Support health care studies, and other projects/reviews requiring medical record extraction • Collect demographic, clinical, and statistical information from medical records • Evaluate bills assigned for audit. • Coordinate all audit/extraction activity with the appropriate provider personnel to schedule and finalize audits • Abide by National Audit Review Guidelines to review bill and medical record. • Prepare progress reports to communicate timeline of audit process. • Verify timely processing as per	• RN, LPN, RHIT, CCS, or CPC • Expert knowledge of data collection of medical records elements and understanding physician terminology and documentation • Accredited RN Education Program preferred • AAMAS Certification preferred • Working knowledge of HIPAA privacy and security rules. • Comprehensive understanding of hospital coding and billing techniques and revenue centers	• 3 years' clinical experience • 1 year experience in line-item review and/or audit of hospital bills • Experience supporting extracting medical records for health care studies and focused reviews preferred

Job Title and Summary	Job Duties	Qualifications	Minimum Work-Related Experience
	state and provider mandates.		
Review Nurse: Responsible for performing clinical reviews to determine if the medical record documentation supports the need for the service based on clinical criteria, coverage policies, and utilization and practice guidelines as defined by review methodologies specific to the contract for which services are being provided. This involves accessing proprietary systems to audit medical records, accurately documenting findings and providing policy/regulatory support for determination.	• Performs prior authorization, precertification, and retrospective reviews and prepares decision letter, as needed in support of the utilization review contract • Evaluates case for medical necessity, level of care, quality of care, proper coding, compliance, etc. • Document decisions and rationale to justify review findings or no findings • Responsible for attending training and scheduled meetings to enhance skills and working knowledge of clinical policies, procedures, rules, and regulations. • Actively cross-trains to perform reviews of multiple claim types to provide a flexible workforce to meet client needs. • Recommends, tests, and implements process improvements, new audit concepts, and technology improvements that will enhance production, quality, and client satisfaction	• Active and unrestricted RN license required • Maintains current knowledge of MCG and other clinical criteria guidelines and successfully completes required CEUs to maintain RN license	• 5+ years clinical experience required, preferably as direct patient care • 2+ years utilization review experience or claims auditing required • Experience using MCG or InterQual criteria required •

Job Title and Summary	Job Duties	Qualifications	Minimum Work-Related Experience
	• Assists management with training new Nurse Reviewers to include daily monitoring, mentoring, feedback, and education.		
Physician Reviewer: Uses medical practice experience and medical judgment, along with demographic and clinical information to review cases. Physician Reviewers are asked to provide a brief synopsis of the clinical case, provide their determination regarding whether to approve, deny, or uphold/overturn/modify the denial, and provide a clinical rationale in support of their determination.	• Performs review of retrospective and prior authorization requests and appeals/ reconsiderations regarding issues of medical necessity, resource utilization, standard of care, and overall quality, and provides a reasoned opinion as well as responses to any specific questions posed • Holds peer-to-peer discussions with attending/admitting physicians • Provides support and testimony for state fair hearings including meetings and pre-hearings • Provides specialized, consultative assistance to state health care programs on specific cases, providers, medical conditions (diagnoses, procedures), clinical criteria, policies, etc.	• Doctoral-level degree: Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO), or Doctor of Dental Medicine (DDM) • Unencumbered license in the State of Ohio • Current board certification in specialty practiced • Broad knowledge of clinical guidelines, criteria, and practices • Knowledge of systems/applications used to process case reviews • No conflicts of interest with services being performed and cases being reviewed • No loss of personnel privileges or restrictions on participation • No history of sanctions or disciplinary actions • Not presently suspended or debarred or proposed for suspension or debarment by any government agency or licensing authority.	• Experience in stated specialty for a minimum of five years • Must have practiced in specialty within the last 12 months • Experience conducting clinical reviews • Experience providing testimony in appeals and hearings a plus

Job Title and Summary	Job Duties	Qualifications	Minimum Work-Related Experience
Data Processor: Responsible for developing and maintaining setups, scripts, and processes that manage inbound and outbound data	• Plans, writes, develops, modifies, and adapts existing and new computer programs using standard procedures and techniques • Leads efforts in establishing protocols for and testing of data transmission to and from state claims adjudication, eligibility, and other systems, and data warehouses • Develop and maintain programs and processes that manage inbound and outbound data. • Act as liaison for internal & external technical staff as well as business areas to set up data transfer processes. • Troubleshoot and repair failed Momentum scripts. • Review older setups and suggest/implement automated improvements. • Manage and coordinate source data, electronic data, I/O data, and cycle processing data. • Transfer data between systems. • Provide technical support during and after implementation for EDI applications.	• Associates degree or equivalent work experience • Bachelor's degree in Computer Science, or post graduate a plus • Ability to understand mainframe, server, and PC environments, and how to effectively move data between various platforms. • Ability to write and debug scripts • Ability to analyze information and use logic and process to address work-related issues and problems. • Ability to troubleshoot existing applications. • Working knowledge of HIPAA privacy and Security rules. • Knowledge of FTP, general EDI, GENTRAN, and Networking skills	• Minimum of three years' experience or an equivalent combination of education and experience • 2+ years' experience in a technical customer service environment, experience with moving data between various platforms required, • Experience using various encryption tools, especially PGP, some experience troubleshooting of networking or data issues, helpdesk support preferred • Momentum experience preferred • Healthcare experience and knowledge of ANSII transaction sets preferred • Windows/Network Admin, Unix/Linux, NDM/Connect Direct, WebSphere/MQSeries preferred

Job Title and Summary	Job Duties	Qualifications	Minimum Work-Related Experience
	• Respond to inquiries regarding EDI technical transfers issues with enrollment, claims, payments, and/or clearinghouse activities.		
Data Analyst: Responsible for analyzing claims and other data, conducting analysis for focused reviews and health care studies, and preparing standard and ad hoc reports to make sure the claim review selection process is optimal, quality improvements areas are identified, and contract requirements are met.	• Plans and conducts statistical and epidemiological analysis of healthcare data • Coordinates with the Medical Director, clinical team, and others to define/refine, write/program, and produce analysis of UM claim selection and utilization patterns and trends of Medicaid services to evaluate efficiency of health care delivery, appropriate use of health services and opportunities to improve savings to the Medicaid program and quality of care to its members • Verifies the timely and successful submission of contract deliverables to meet customer needs and objectives • Leverages tools, reports, and metrics in place to proactively perform analysis • Presents findings and	• Master's degree in statistics, preventive medicine, or related field with two years' relevant experience (preferred) • Bachelor's degree in statistics, preventive medicine, or related field with at least five years' relevant experience; or equivalent combination of education and experience • Strong analytical, problem-solving, and presentation skills • Demonstrated experience in the use of statistical analysis and database software, spreadsheets, and graphics • Understanding of medical/healthcare principles and terminology	• 2+ years' experience conducting data analytics in healthcare environment • 2+ years' experience working with standard industry claims processing systems and tools • 2+ years' experience working with Medicaid data (claims, provider, eligibility, etc.)

Job Title and Summary	Job Duties	Qualifications	Minimum Work-Related Experience
	recommendations of analysis • Suggests changes to claim review targets and selection criteria • Reviews processes related to claim transactions and payments • Gains technical understanding and competency in the clients' programs, systems, and solutions		
Registered Health Information Administrator (RHIA): **R**esponsible for reviewing medical records as part of Permedion's utilization management, clinical review, and fraud, waste, and abuse services. These reviews determine correct coding as defined by review methodologies specific to the contract for which review services are being provided.	• Reviews medical records to collect data and confirm appropriate billing of and compliance with coding guidelines and rules. • Forwards case findings to physicians, dentists, nurses for further review • Responds to questions or concerns raised by clinical reviewers and healthcare providers • Access proprietary systems to audit medical records, accurately document findings and provide policy/regulatory support for determination	• Current RHIA, RHIT, CCS, CPC, or other coding-related licensed/accredited healthcare professional • High level of understanding in reimbursement guidelines specifically an understanding of the MS-DRG, AP-DRG and APR-DRG, EAPG, ASC and APC payment systems. • Ability to analyze and evaluate medical information and collect specific healthcare information • Background in either facility-based inpatient coding and/or outpatient coding edits	• 3+ years' clinical coding experience • Demonstrated experienced in International Statistical Classifications of Diseases and Related Health Problems, Ninth Revision, Clinical Modification, and Current Procedural Terminology coding for the clinical area under evaluation • Demonstrated experience with APR-DRG and EAPG groupers preferred • Demonstrated experience in medical review, chart audits, and quality improvement processes preferred
Information Systems Manager: Responsible for IT/IS operations including infrastructure, networks, software, applications, systems	• Verifies efficient functioning of all systems. • Manages information technology field-	• Bachelor's degree in Computer Science, Information Services or equivalent combination of	• 9+ years' application development administration experience

Job Title and Summary	Job Duties	Qualifications	Minimum Work-Related Experience
administration, and security.	support personnel in Ohio and other offices • Makes sure that the technical-support function is meeting all user needs in an effective, timely fashion • Maintains, administers, and troubleshoots technical systems, as required • Oversees set up of user accounts on company servers and runs necessary system backups to make sure that company systems are secure and updated • Interacts with end uses to determine software and hardware needs • Plans, designs, and upgrades networks to make sure that applications support • Coordinates with product development, telecommunications, database administration and web systems administration staff to enhance communication among various functions to improve overall efficiency	education and experience • Extensive knowledge of IT systems infrastructure including hardware configuration, operating systems, and networks • Extensive knowledge of IT mainframes, scheduling software and other related technologies	• 5+ years' leadership or supervisory experience • Experience working with technology involved in systems applications, PC networks and usage of company internet system • Experience working with software, systems, applications, and network markets
Client Services Analyst: Responsible for daily, weekly, and monthly delivery processes, ensuring timeliness and	• Conducts non-clinical contract operations, workflow management, and system user acceptance testing	• High School Diploma or GED required • Bachelor's degree desired	• 3+ years' operational support experience • 1–2 years' experience in health care environment within customer service,

Job Title and Summary	Job Duties	Qualifications	Minimum Work-Related Experience
accuracy of processes and deliverables across multiple service lines.	• Receives, triages, and enters prior authorization requests into MITS • Responds to provider, member, and other stakeholder calls • Routes calls to appropriate parties as needed • Conducts provider education and training • Conducts quality steps to confirm the accuracy of letters, reports, and other deliverables	• Strong attention to data quality with a focus on data reconciliation between sources or platforms • Ability to build effective relationships across internal teams in order to successfully implement cross-functional initiatives. • Demonstrates exceptional customer service and follow up skills. • Ability to work proficiently with Microsoft Excel, Vizio, PowerPoint	provider relations, admissions, or call center. • Experience with call center telephony and computer equipment