State of Indiana
RFP – 21-2355
Attachment F – FADS Technical Response Template

Instructions:

Respondents shall use this template Attachment F to prepare their Technical Proposals. In their Technical Proposals, Respondents shall describe their relevant experience and explain how they propose to perform the work, specifically answering the question prompts in the template below.

Please review the requirements in Attachment I (Scope of Work) carefully – the requirements in the SOW should inform how Respondents complete their Technical Proposals in this template as the "Sections" referenced below correspond to the sections in the SOW.

Respondents should insert their text in the provided boxes which appear below the question/prompts. Respondents are allowed to reference attachments or exhibits not included in the boxes provided for the responses, so long as those materials are clearly referenced in the boxes in the template. The boxes may be expanded to fit a response.

Respondents are strongly encouraged to submit inventive proposals for addressing the Program's goals that go beyond the minimum requirements set forth in Attachment I of this RFP.

For all areas in which subcontractors will be performing a portion of the work, clearly describe their roles and responsibilities, related qualifications and experience, and how Respondent will maintain oversight of the subcontractors' activities.

OVERVIEW

Please provide an overview of your proposal in the box below.

Please provide a list of States to which you currently or in the past have provided similar services. In connection with this list, please provide information on:

a. *Programs you have initiated in other states that can be replicated in Indiana to help the State meet its goals*
b. *Programs you intend to initiate that would be specific to Indiana*
c. *Examples of how you have worked with all states in a collaborative manner to address changing program needs and priorities*
d. *Any sanctions or formal complaints that you have been subject to*
e. *Any corrective actions that you have been subject to*
f. *Experience with State and federal compliance*
g. *How you have set your goals and performed against those goals*

Overview

The State of Indiana's Family and Social Services Administration (FSSA) Office of Medicaid Policy and Planning (OMPP) is looking to execute on a bold vision of expanding its Fraud, Waste, and Abuse (FWA) efforts through a new and improved Fraud Abuse and Detection System (FADS) to prevent improper payments. FWA is becoming more prevalent in the healthcare industry, making it more challenging for Medicaid agencies to focus on their mission of compassionately serving Hoosiers of all ages and to connect them with social services, health care, and their communities.

PROJECT SPOTLIGHT

Deloitte's Presence in the U.S.

- [redacted]

Through development of programs like the Healthy Indiana Plan (HIP), FSSA has long been at the forefront of Medicaid innovation, and FADS is another example of this. It is a program that combines traditional approaches focused on overpayment recovery of improperly paid claims with a pre-payment review approach that includes proactive provider education. FSSA has made a commitment to protect the care and benefits upon which so many Hoosiers depend, which would be more difficult without maintaining a broad provider network. In a time of tightening budgets, agencies must find new and alternative ways of doing more with less – FSSA is doing just that.

In order to fully realize the vision of this program, FSSA needs a firm that not only delivers on the systems and technology solution, but also the business acumen and understanding to execute the entire post-pay and pre-pay review process. In addition, it requires a collaborator which has performed this type of work successfully before – through its people, with its teaming partners, and while leveraging technology for cost-effective delivery. Throughout the proposal, it will become clear that the Deloitte team brings this and more. Our experience in this area enables us to fully execute on all areas of the scope of services, to deliver in a timely and efficient manner, and to provide insight and innovative solutions throughout the performance of this program. [redacted]

Our Qualifications

We bring a number of strengths that will enable OMPP to realize its vision for this program to improve integrity of the payment systems by avoiding future overpayments and swiftly and accurately facilitating recovery of improperly paid claims.

[redacted]

[redacted]

[redacted]

[redacted]

A history of success in serving Indiana

[redacted] hrough all of these technology implementations, we have worked with FSSA and the respective departments to bring a business perspective, with a focus on the policies and programs that serve fellow Hoosiers.

Efficient clinical team that understands provider burden

Our certified professional coders and clinicians work together to evaluate medical records and clinical documentation for incomplete, imprecise, illegible, conflicting, or absent documentation of diagnoses, procedures, and treatments, as well as supporting clinical indicators to determine whether claims comply with OMPP policy. Our teams are experienced in communicating with the provider community in a way that minimizes the burden on the administrative staff. [redacted]

A full-service professional services Firm

In order to successfully implement the FADS, FSSA needs a vendor that can lead in all aspects of this project. **Deloitte has been recognized by Gartner as the world leader in Data and Analytics, Cloud, and Cybersecurity** for our completeness of vision and ability to execute. In addition, we employ hundreds of Project Management Professionals (PMPs) and Certified Fraud Examiners (CFEs), making us one of the most sought-after professional services firms for both program management and fraud risk management. [redacted]

Sections 4 and 5 – Contractor Systems and Technology and Contractor Services

[redacted]. Already deployed and operational in multiple Medicaid and commercial healthcare payers, it contains a cutting-edge, dynamic analytics engine that allows for provider peer comparisons tied into a seamless case management system. [redacted]. This continuously enhanced platform finds probable FWA in the Medicaid program through a timely and efficient completion of the Audit and Investigation, Overpayment Recovery, and Pre-Payment Review Process. It also has the necessary structure to support the MCE Oversight, Call Center, and Return on Investment (ROI) Calculation processes. It is a configurable platform that has been refined by our investigators, clinicians, and medical coders create an easy to use system with minimal training required. This allows for FSSA to "hit the ground running" with minimal risk for transition in. Finally, we recognize the value of Provider Education, both to maintain a solid provider network to better serve Hoosiers as well as to prevent the State from paying for improperly billed claims. [redacted]

Section 6 – Contractor Staff

We bring a cadre of industry leaders – **FWA specialists, data scientists, experienced medical reviewers, vulnerability experts, Medicaid advisors, clinical staff, and program management staff** – to fulfill the scope of this program. [redacted] Our team has the experience to implement, operate, and maintain the FADS while keeping an eye on changing fraud schemes and future directions that the State should take to better protect the vital benefits for over 1.6 million Hoosiers.

Sections 7 and 8 – Contractor Administrative Duties and Transition from Current Solution

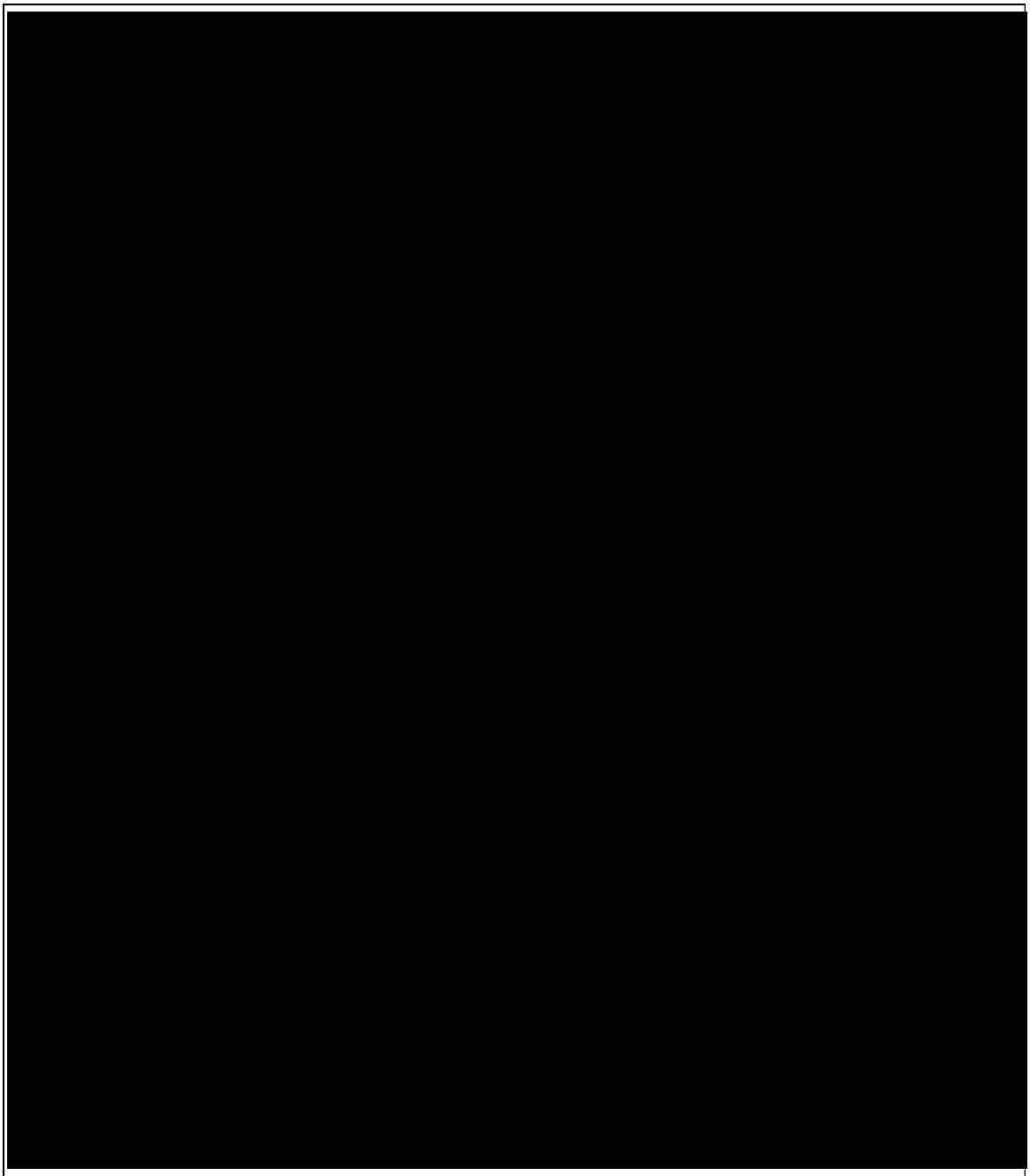
The Deloitte team brings the experience of designing thorough work plans built on Project Management Institute principles that are designed to deliver an efficient and effective project from Design, Deployment, and Implementation (DDI) to Maintenance & Operations (M&O). To help FSSA maximize its return on investment for this program, our DDI phase is estimated at 18 weeks thus **starting the Fraud and Abuse Detection process sooner in the first contract year**.

The Deloitte team is the right answer for FSSA. We understand your needs and have the proven ability to predict emerging needs as, and even before, they arise in a cost-effective manner.

Our Approach

We recognize that there are two major components of this project: (1) implementation and maintenance of a configurable platform for a Provider Peer Comparison Tool (PPCT) and Case Management System with the associated reporting and training as well as (2) provision of services for fraud and abuse detection including the complete lifecycle of investigation and review of post-pay and pre-pay claims. [redacted] There is a nuance to the development and execution of these components, and that is where our approach brings forth the right, innovative solution for FSSA.

This is a **complex program requiring communication and coordination with numerous external and internal systems and stakeholders**. We have meticulously analyzed the OMPP Medicaid Management Information System (CoreMMIS) in order to propose a technological solution that reduces OMPP risk and complexity by minimizing implementation time while leveraging our knowledge of FSSA as the IEDSS contractor. [redacted]



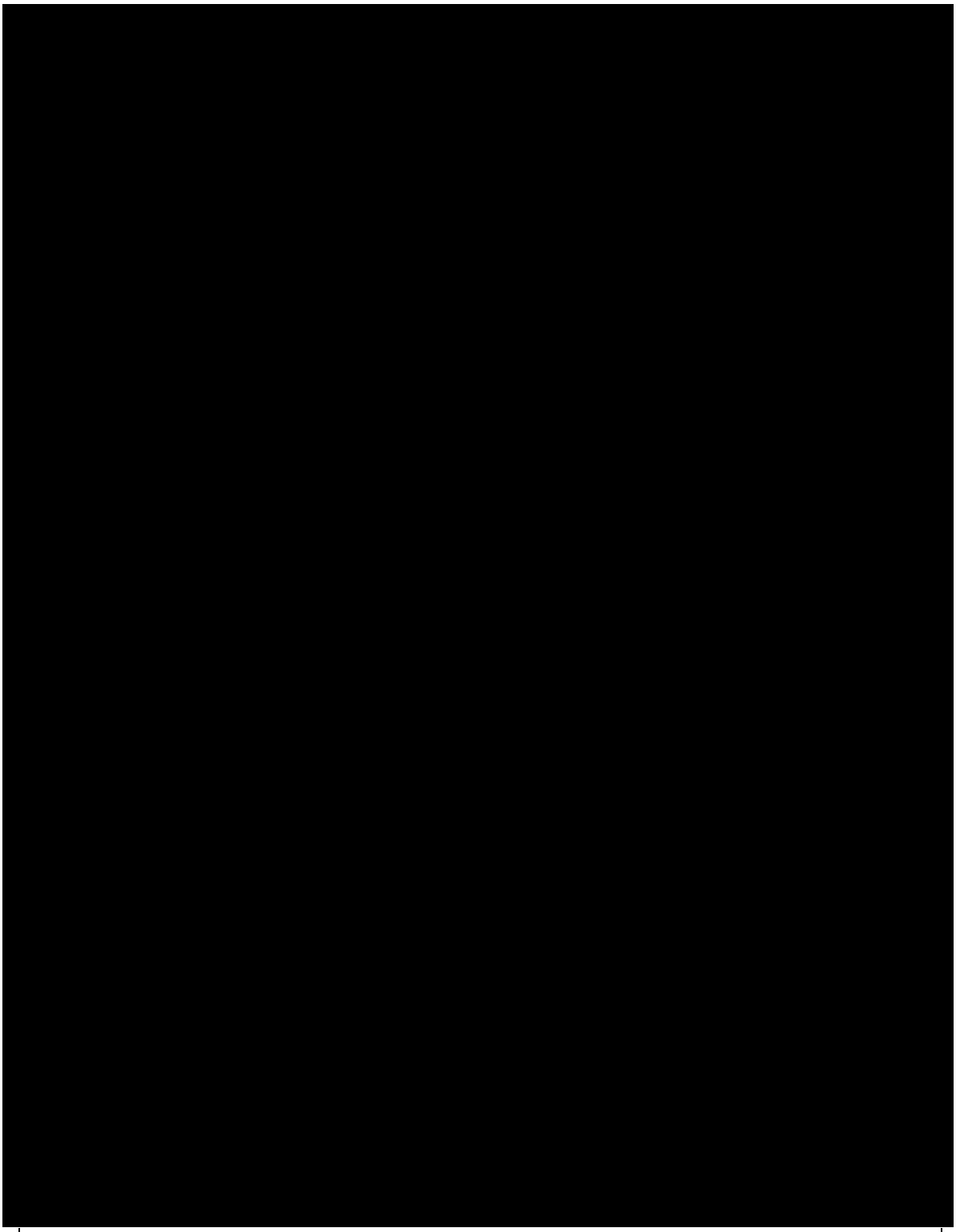
Our People

For the Department to effectively and efficiently implement this program, it needs a team with integrity, high standards of performance, customer service, and fiscal awareness. The Deloitte team brings all of this and more. When building a team of people, the sum of the parts is greater than the whole; this is the case for the Deloitte team. From the project leadership, to each workstream manager, to the staff performing the day-to-day operations, we pride ourselves on being not just a contractor, but a meaningful part of the OMPP team. We strive to provide **exceptional customer**

service through technical expertise and an organizational culture that is an excellent match for OMPP.

Our Vital Staff, Additional Staff, Project Leadership, and Subject Matter Advisors bring **combined experience working with FSSA, FSSA systems, State Medicaid programs, and PI in Medicaid, Medicare, and commercial insurance**. As an example, the proposed Project Manager, [redacted]

Additionally, our organizational structure is designed for efficient delivery through clear lines of responsibility from DDI through M&O. [redacted] This structure enables and challenges our professionals to think in new and pioneering ways. All of this will have a direct, positive impact on OMPP and this project. Additionally, we present a diverse team, possessing a variety of backgrounds, with a mix of professional experiences and specialties. It is the strength of that diversity that sets us apart from our competitors.



As the world's largest professional services firm, Deloitte is distinct from other major professional consulting firms in that we are a full service, multi-functional professional services organization. We have a dedicated Government and Public Services practice which is focused on developing solutions and services tailored to our Federal, State,

and Local Government clients. Specifically, State Government is an important priority for Deloitte as we provide this full range of services to bring an informed, 360-degree perspective to each State Government project we undertake.

This perspective includes a dedicated Program Integrity practice to help government agencies prevent and detect fraud, waste, abuse, and improper payments, while also meeting high standards of quality and access. The team's offering combines program-specific health and human services knowledge with our capabilities in fraud risk management, machine learning and analytics, domain expertise, medical review, investigations, litigation support, and forensic technology.

We recognize the vital importance of medical assistance and the imperative that these benefits are managed with integrity. Deloitte's Government & Public Services (GPS) Program Integrity practice drives program efficiency, effectiveness and trust through improved payment and program management. Our fusion of Federal, State, and commercial experiences provides us with unique end-to-end payment lifecycle insights from program initiation, to processing and management, and payment. Our offerings leverage FWA analytics, FWA vulnerability identification, information technology, forensics analysis, behavioral insights, and workforce enhancement. These capabilities, coupled with our extensive experience with the State of Indiana, make our team uniquely qualified to deliver this solution.

We are proud to have received top rankings from industry analysts based on client testimonials about our services. This includes Deloitte being recognized by independent analysts for our global leadership position as –

Figure F-3. Deloitte's Global Leadership Recognition.

We are excited about the prospect of delivering the proposal that follows. We believe that we are the right choice for FSSA, and we look forward to collaborating on this initiative. Our experience in the scope of this project decreases the risk of delivery while focusing on what truly matters: a best-in-class Medicaid program that has the financial capability to provide excellent care to all Medicaid members in the State of Indiana.

a) Programs we have initiated in other states

Deloitte has supported hundreds of health care organizations and 47 states on a wide range of technology, human services, and healthcare-related projects. These projects include Medicaid Management Information System (MMIS), medical management, Medicaid and integrated eligibility, mission support and program strategy, hospital information systems, Electronic Health Records (EHR), Health Insurance Exchanges (HIX), and Health Information Exchange (HIE) implementations, claim and encounter

medical review, FWA analytics, and other forensic services. Our State healthcare history includes working alongside agencies for more than 45 years in the Health and Human Services (HHS) business and more than 25 years implementing and supporting State claims, eligibility, and service delivery solutions.

[redacted]

Below, we have highlighted several projects that have provided us with the right experience to deliver this engagement successfully for the State of Indiana.

- [redacted]

[redacted]

b) Programs we intend to initiate

[redacted]

[redacted]

c) Collaborating in other states

[redacted]

[redacted]

[redacted]

[redacted]

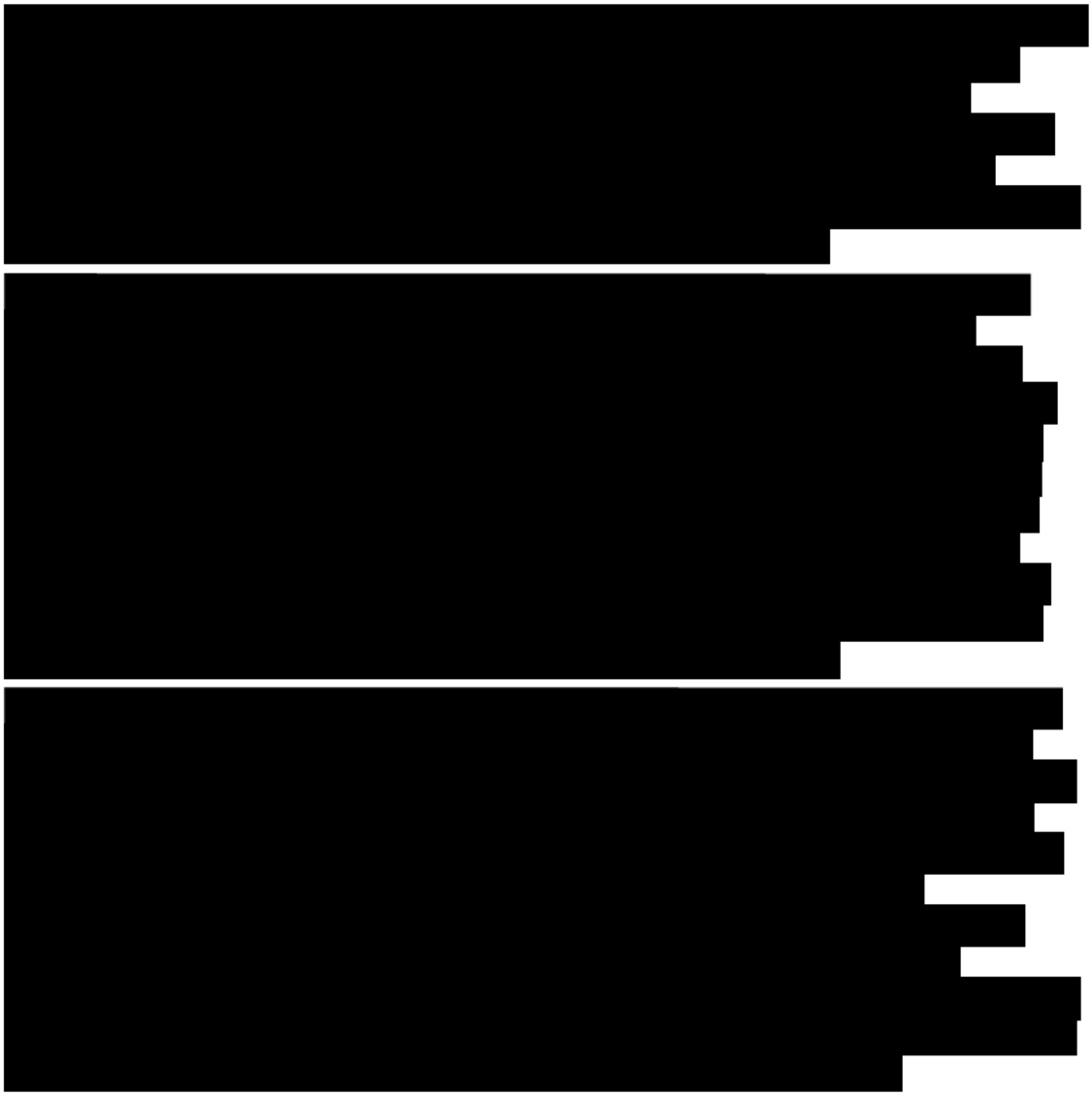
d) Sanctions

[redacted]

e) Corrective actions

[redacted]

f) Experience with State and federal compliance



g) Achieving our goals

Setting Our Goals

As with our previous experience supporting Medicaid projects in multiple states, we align our goals to the objectives of those projects. In FADS, the goals are to help the State improve the integrity of its Medicaid program by reducing improper payments, proactively detecting fraud, and driving improvement in the quality of care to Hoosiers. In the design of our approach, we thoughtfully incorporated the goals of FADS as we chose our experienced professionals, proven advanced technologies, and field-tested methodologies, to create a cost-effective solution.

In order to evaluate our progress towards our goals, we establish metrics that can be measured, tracked, and monitored, which will include the Performance Metrics required by Indiana (*Section 9.2*).

[redacted]

Performance Against Our Goals

[redacted]

SECTION 4. – Contractor Systems and Technology

Please explain how you propose to execute Section 4 by answering the question prompts in the boxes below. In answering these questions, please provide any relevant experience you may have.

Section 4 – Contractor Systems and Technology - Overview

a. *Provide an overview of the **components** and **features** of the technology, describing the **role** of each system and **how they integrate**, the **training planned** and how your technology suite will integrate with State technology (described in SOW section 2).*
b. *Describe what, in your proposed solution, is a **COTS product or platform product**. Describe what **percentage** of your solution you estimate will be available **"out of the box",** with configuration, or through customization. Provide this estimate by system (Provider Peer Comparison and Case Management).*
c. *Provide the **number and types of licenses** for each software system available to State employee use, if applicable.*

Contractor Systems and Technology

Section 4

Proven Ability	Impact
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

[redacted].

[redacted]

[redacted]

[redacted]

[redacted]

a) Overview of the components and features of the technology

[redacted]

	[redacted] [redacted] [redacted]
[redacted]	[redacted] [redacted] [redacted]

[redacted].

[redacted]. We understand the business processes in Indiana and have a working relationship with providers, resolving eligibility related issues and data integrity issues, related to Medicaid data.

[redacted]

b) COTS or platform product

[redacted]

c) Software Licenses

[redacted]

We affirm that we can accommodate the number of Indiana users requested and can increase the user base as needed. Our standard configuration accommodates up to 100 concurrent client users and we are able to easily scale up to incorporate any additional requested users.

As a part of the license, our team will provide Indiana with all initial and ongoing training related to each component piece of the platform. We already have training materials and a curriculum, and we will tailor these materials and other system documentation to OMPP's processes, regularly updating and delivering training as the platform continues to evolve with new releases. Current users have found the system easy to use, not only because of the intuitive nature of the screens, but because of our full training support. We will provide Indiana with tailored training modules based on the pieces of the system that specific users need to fulfill their business processes. For example, those who are interested in diving into the data will have the opportunity to be trained on the technical nuances of the self-service reporting module. Our training approach is outlined in *Section 4.4, Section 7.2.e* and our notional training plan can be found in *Section 8*.

Section 4.1 – Provider Peer Comparison Tool

a. *Provide an overview of your provider peer comparison tool (and whether it is a single system or a combination of tools and processes).*
b. *Describe how the tool will integrate with the EDW to maintain real-time data exchange.*
c. *Describe how the tool will integrate with your case management tools.*
d. *Describe any artificial intelligence, machine learning, and/or predictive analytic features.*
e. *Provide the time it takes to run a query in the system, the drivers of query speed, and any other limitations which impact the speed of the system (including the number of users across multiple clients).*
f. *Address the following components of the tool and how they will function:*
    i. *Provider type analysis*
    ii. *Reconciliation of provider credentialing data with claims data*
    iii. *Random or statistical sampling features*
    iv. *Geographic analysis*
    v. *Member-based analysis*
    vi. *Absence-of analysis (e.g. the ability to identify ambulance services without associated medical services for the same member)*
    vii. *The ability for all users (State or Contractor) to "drill down" into the Medicaid program data to view information on a claim or encounter basis*
    viii. *Automatic identification of providers enrolled with an IHCP that have been disenrolled from other states' Medicaid programs, in particular bordering states, and/or from Medicare*
    ix. *Detection of providers which are believed to be previously penalized or disenrolled providers who have re-enrolled under a new name and/or ownership structure (e.g. a disenrolled provider who re-enrolled under a new name and under the ownership of a spouse or family member of the original provider's owner)*
    x. *Comparison of a provider against a fraud profile and/or known fraud scheme for the same type of provider*
    xi. *Detection of providers who have worked with providers known or suspected of fraud, and/or other capabilities to detect multiparty fraud schemes*
    xii. *Detection of over-prescribing*
    xiii. *Any other basis of analyzing or detecting provider-based fraud, abuse or waste*

Section 4.1 – Provider Peer Comparison Tool

[redacted]

Healthcare FWA Analytics Engine and Algorithm Library

[redacted]

[redacted]

Risk Scoring Methodology

[redacted]

7. [redacted]

[redacted]

Provider Peer Comparison Tool Interface and Lead Selection

[redacted]

[redacted]

While the PPCT comes pre-configured with a standard set of analyses and visualizations, we will tailor the analytic insights so that the platform provides an experience that OMPP's investigators are accustomed to exploring when comparing risk among providers. We will further configure the interface to align to OMPP's terms and terminology within the State's EDW (SOW 4.1.A) to minimize disruption and improve adoption of the system.

[redacted]

Once OMPP has narrowed in on specific providers of interest, users will be able to select a specific provider within the PPCT and generate a lead within the Case Management system. Statistics and risk algorithms will be populated within a case, further driving process efficiencies and allowing auditors and investigators to maintain an audit trail of the information that drove the lead selection.

b) Maintaining real-time data exchange (SOW 4.1. Intro)

[redacted]

[redacted]

c) Integrating with your case management tools (SOW 4.1.0)

[redacted]

d) Using artificial intelligence, machine learning, and predictive analytic features. (SOW 4.1.N)

[redacted]

PROOF POINTS

- [redacted]

[redacted]


data-driven

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

e) Running system queries

[redacted]

[redacted]

f) Additional tool components

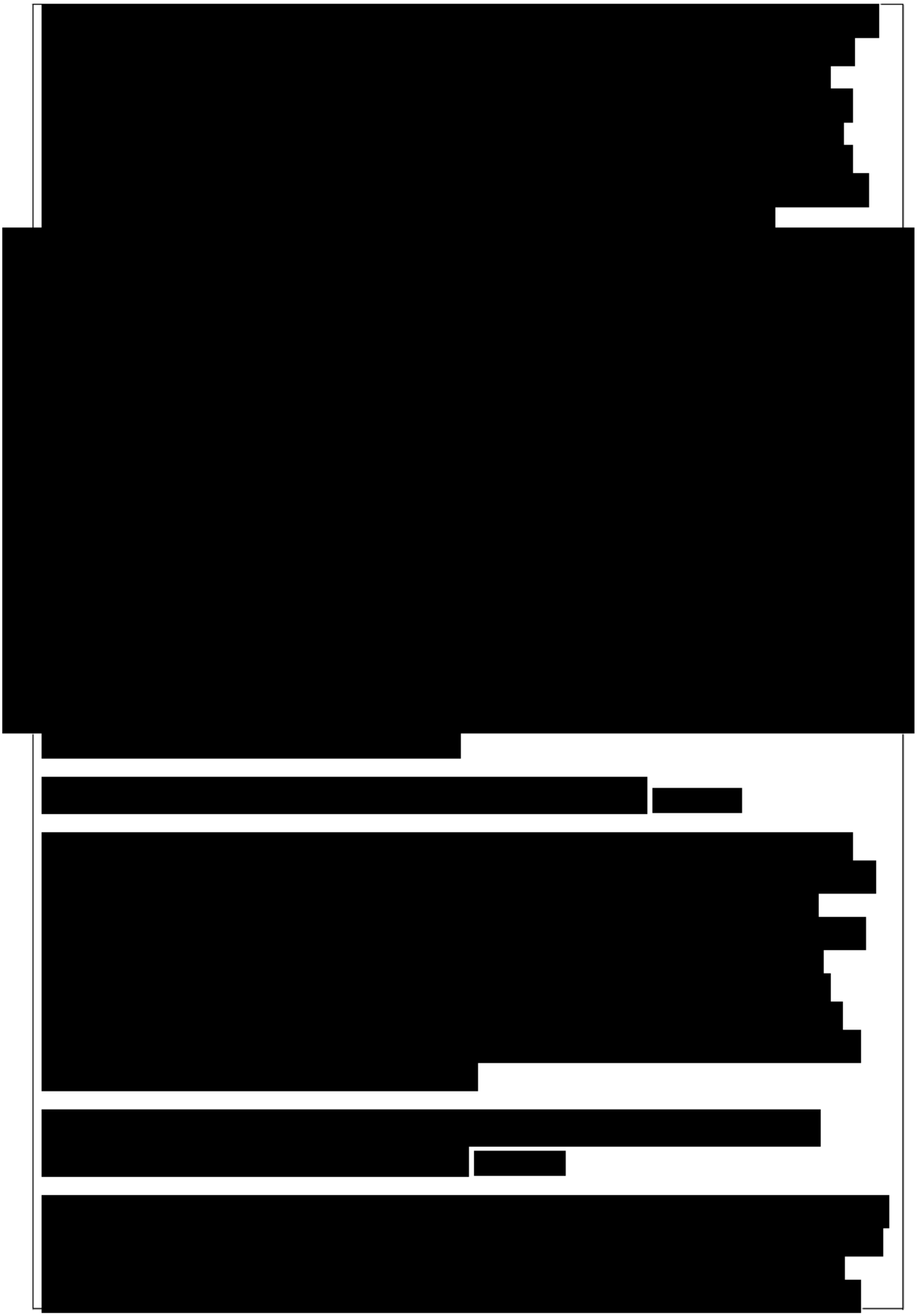
[redacted]

Ability to Sort Provider Types (i)

[redacted]

[redacted]

- **Algorithm Integration.** There are many indicators where the core concept is [redacted]



[redacted]

We have found that evaluating provider enrollment information is very helpful to identify potential issues of owners changing their business name to conceal previous behavior. This can be addressed by evaluating the ownership information that is submitted at the time of enrollment. Typically, providers seeking enrollment in Medicaid programs will need to disclose individuals who own ten percent or more of the company.

[redacted]

Comparison of a provider against a fraud profile (x) (SOW 4.1.K)

[redacted]

Detection of providers who have worked with providers known or suspected of fraud, and/or other capabilities to detect multiparty fraud schemes (xi) (SOW 4.1.L)

Detecting multiparty fraud schemes involves building out the network of relationships in the larger population of providers and members to trace behaviors across various actors and communities. Traditional relational databases oriented on querying transactions become computationally too complex when asked to traverse and model relational networks. [redacted]

Detection of over-prescribing (xii) (SOW 4.1.M)

[redacted]

- [redacted]
- [redacted]
- [redacted]

Any other basis of analyzing or detecting provider-based fraud, abuse or waste (xiii) (SOW 4.1.P)

Given the evolving nature of fraud detection, our healthcare investigations specialists routinely search for new potential schemes and patterns. In order to truly satisfy the need to explore new risks, [redacted]

[redacted]

Section 4.2 – Case Management System

a. *Provide an overview of your case management tool and its functionalities for tracking of investigations, overpayment recovery, and management of other FADS activities.*
b. *Address the following components of the tool and how they will function:*
    i. *Collaboration among users*
    ii. *Varying levels of access (e.g., partial, full) that can be toggled by FSSA*
    iii. *Audit log of all case activity*
    iv. *Creation of new log-ins for new users by FSSA*
    v. *Case activity dashboards*
    vi. *Query by relevant attributes*

Section 4.2 – Case Management System

Deloitte believes that an effective FWA solution provides transparency, control, and insight into the underlying data throughout the lifecycle of the process. [redacted]

a) Overview of Case Management System

[redacted] These components provide a comprehensive suite of web-enabled tools that will allow Indiana to effectively manage audits and investigations within the Medicaid program.

DISTINGUISHING FACTORS

- Advanced analytics engine which has a battery of configurable rules and models to combat FWA and improper payments
- Robust, configurable, transparent, and secure case management system that will be tailored to all Indiana requirements
- Dynamic reporting suite that gives Indiana access to all their data

[redacted] We understand the importance of effectively managing complex investigations, particularly in Medicaid where specific processes and guidelines need to be followed and actions must adhere to specific regulatory timelines. [redacted]

[redacted]

- [redacted]

[redacted]

b) Additional components of the tool:

Collaboration among users (i)

[redacted] allows for significant collaboration among users out of the box. Multiple users have the ability to open, edit, and disposition cases together depending on how roles are configured for OMPP. [redacted]

[redacted]

Varying levels of access (e.g., partial, full) that can be toggled by FSSA (ii)

[redacted] We recognize the need for multiple security roles to satisfy access requirements for different users. [redacted] The figure below outlines the roles that are currently available within [redacted]. These roles are tailored to their audit and investigations process.

[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

[redacted]

[redacted]

Audit log of all case activity (iii)

A key component of the Case Management system is detailed audit logging of all data ingested, added, deleted, and modified within the system. [redacted] For instance, every workflow status change is tracked and viewable within a case. The workflow pop-up, shown below, illustrates when and who moved the case to each status, and the note that they provided as justification.

[redacted]

This provides full traceability and accountability within the platform, allowing for an extra level of granularity in reports. [redacted]

[redacted]

Creation of new log-ins for new users by FSSA (iv)

[redacted] New users will receive an automated e-mail confirming access to the system with instructions on fully setting up their account.

Case activity dashboards (v)

[redacted] The platform comes pre-configured with a full suite of case reports through our reporting engine. We will collaborate with OMPP to review the reports to determine if any configuration is required. [redacted] Below are some examples of the case activity dashboards that are available out of the box:

- [redacted]
- [redacted]
- [redacted]
- [redacted]

[redacted]

- [redacted]
- [redacted]

Query by relevant attributes (vi)

Pallium allows users to search for exactly what they are looking for within the application. There are many ways that someone can search and identify a thread to pull. [redacted] Below are some examples of how users are able to navigate through the system:

- [redacted]
- [redacted]
- [redacted]
- [redacted]

[redacted]

Section 4.3 – Reporting

a. *Describe your system's report generation capabilities. If the system includes a self-service report building feature or tool, describe its functionalities.*
b. *Describe how you will meet the reporting requirements and any additional reports to the ones mentioned that you propose to provide as part of this contract.*
c. *Describe your process for ad hoc report requests.*
d. *Provide any relevant example reports.*

Section 4.3 – Reporting

Please refer to *d) Relevant example reports* for a consolidated representation of our Reports.

a) Reporting capabilities

[redacted] which is used for canned dashboards that are embedded into PPCT and case management, but it will also be the interface for self-service reporting. Through this component of our platform, users will have the ability to:

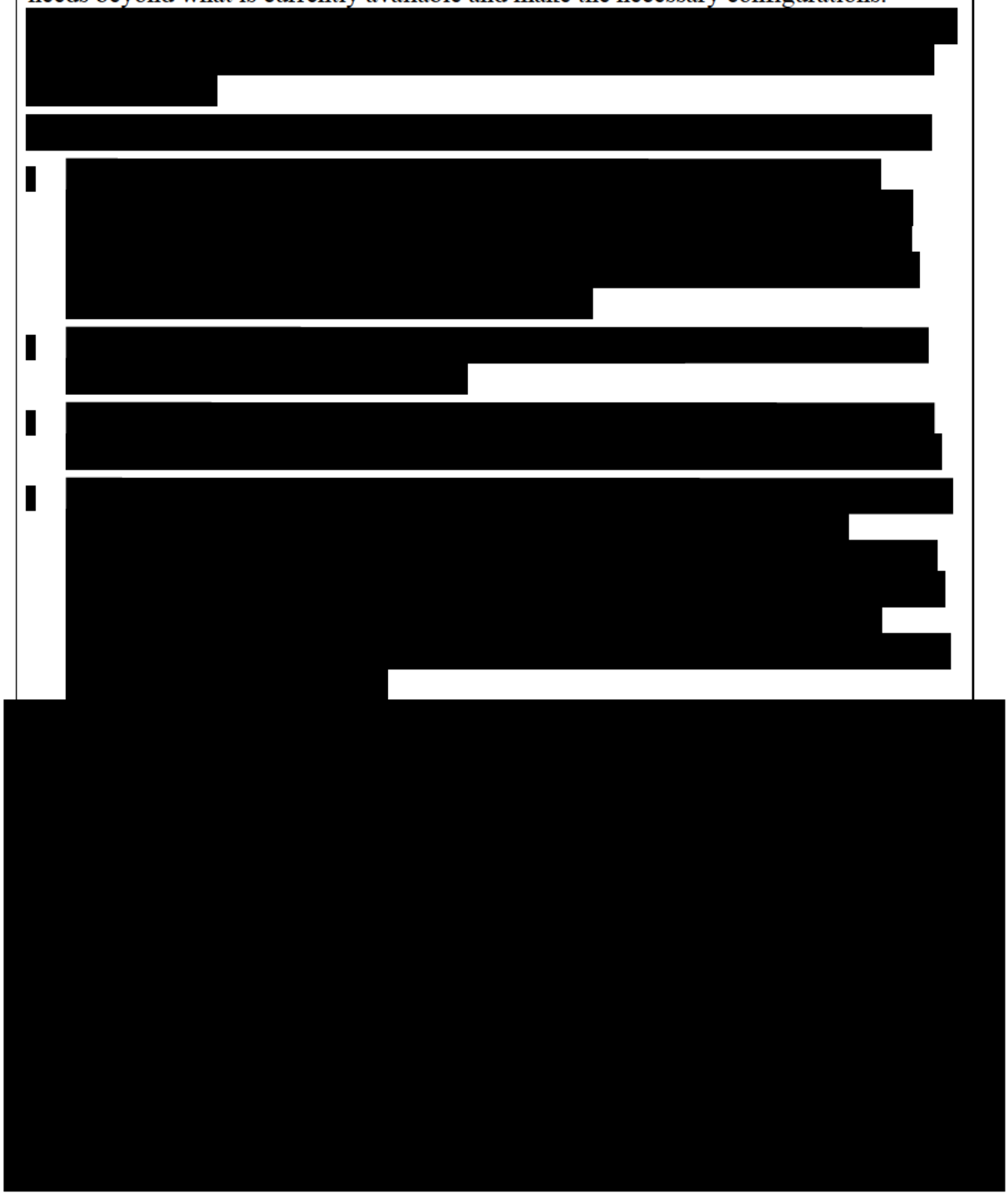
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]

We understand that Indiana needs interactive and innovative tools to effectively analyze the data and drive measurable outcomes. [redacted] Users will be able access reports and develop ad hoc views, providing access to the repository of Medicaid data sets and analytic outputs.

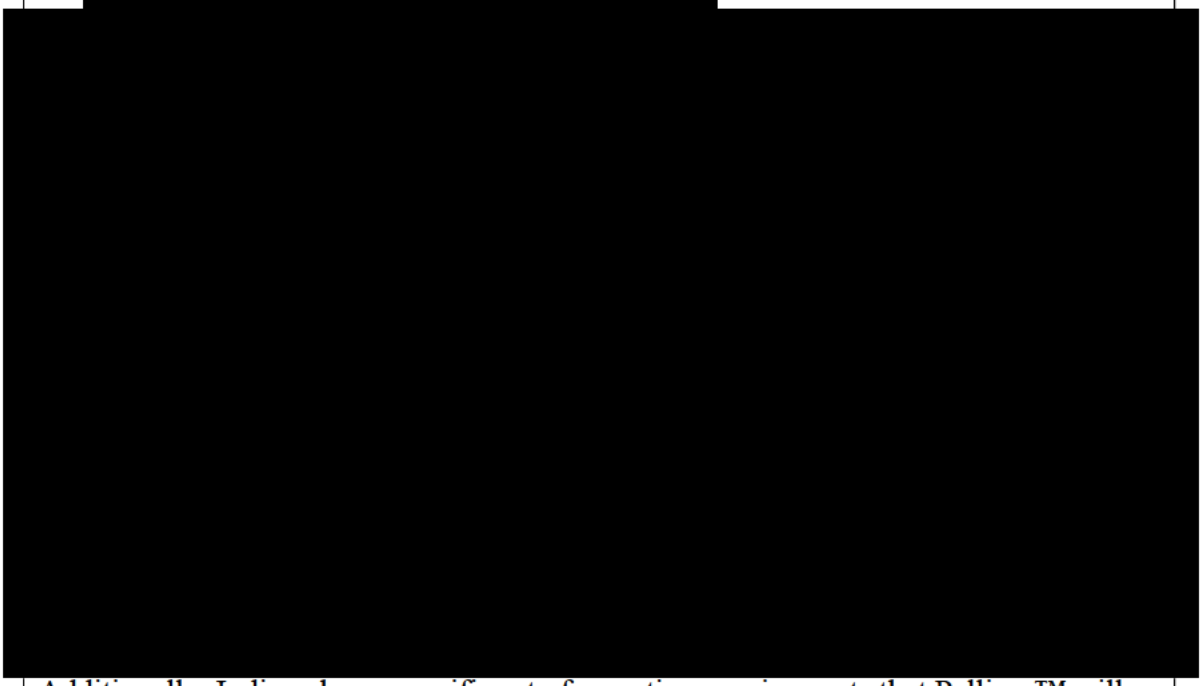
[redacted]

b) Meeting the reporting requirements

Pallium™ has a pre-built suite of reports and dashboards that can easily be configured to Indiana's specific use case. In the FADS implementation phase, we will load our reporting suite with Indiana's data and provide end users with access to the dashboards. We will have working sessions with key stakeholders to understand the current Indiana needs beyond what is currently available and make the necessary configurations.



- [redacted]



Additionally, Indiana has a specific set of reporting requirements that Pallium™ will support. *Section 8.1* will provide more information on the timing and key players involved in the creation of these reports. The next section will talk about how Pallium will enable our team to efficiently create the required reports. In the DDI phase, we will work with Indiana to tailor these to give them the information they want. As a result, it will be easily repeatable and drive efficiencies in our delivery.

- **Monthly Status Report.** Our dedicated vital professionals and their supporting team will work each month to provide Indiana with a comprehensive view of the FADS engagement for the last month, and for the life of the project. This report will provide an overview of our operations, leveraging data from the Case Management system. Our team will be able to easily access and pull the necessary data elements, [redacted]. P the information that they need on a monthly basis.
- **Annual Report.** Like the Monthly Reports, Pallium™ will be an enable our team to populate the Annual Reports quickly and efficiently. All the necessary analytics and case management data points are tracked within the system. Our dedicated Indiana-based team will be able to pull and analyze this information to provide Indiana with actionable information about the program. We will provide Indiana with all required information around audit and investigations. While we have the

ability to generate this report at any time upon request, we will formally submit the Annual Report along with the fourth quarter reports.

- **Quarterly Quality Assurance (QA) Report.** The flexibility and transparency of the Pallium™ platform will enable us to efficiently produce a quarterly report that assesses the quality of nearly every aspect of the engagement. We will be able to monitor system performance against uptime SLAs based on uptime reports and response metrics for each of our APIs and services. Through our process outlined in *Section 4.4*, we will track all bugs and defects in the platform (including severity) and how we were able to mitigate and correct them. Call center metrics will be tracked and reported on, focusing on abandonment rates, answer efficiency and returned call rates. [redacted]. We want to be in lock step with Indiana stakeholders regarding analytic performance and downstream effects. We will have regular meetings with Indiana to go over analytic results to identify how to proceed with potentially enhancing algorithms, which will help us to increase cost-effectiveness.
- **MCE Provider Reports.** All data elements needed to document and report on MCE providers who have been identified as suspicious are available within Pallium™ and can be packaged into a monthly report. [redacted] We will work with FSSA to understand the exact format needed and we will work to tailor the report to those requirements.
- **Other Monthly Reports.** Our platform is capable of producing the necessary data to create the other monthly reports that are listed below. We believe that some can even be built into dashboards so that users can see these data points in real time:
  - [redacted]
  - **Service Level Reporting.** All Service Level metrics can be tracked through Pallium™. Many of the metrics will be used for the quarterly quality assurance report, but we will be able to produce all these metrics at a minimum on a monthly basis and as needed.
  - **Indiana Health Coverage Programs (IHCP) Accuracy and Provider Compliance.** Our analytics suite will include policy-based compliance edits and

metrics that will help Indiana identify providers who are not compliant with IHCP guidelines. These analytics outputs can be displayed in a real-time report so that users can analyze key behaviors and decide on mitigation strategies.

We understand that these will not be the only reports that Indiana needs throughout the engagement. We have the right team, the right technology, and the right processes to tackle any ad hoc requests we receive from downstream users and other stakeholders.

c) Process for ad hoc reports

Deloitte understands that reporting requirements may change throughout the lifecycle of the project. We are prepared to provide analytic reports that provide increased understanding of the outcomes obtained. Our proposed Project Manager will oversee the reporting team and their development of agreed upon reports to drive improved outcomes for Indiana.

Pallium contains an ad hoc report feature that helps to accelerate the development of new reports. Deloitte will work with Indiana to define the scope and deadlines for ad hoc report requests that are submitted. Our team is able to quickly customize existing reports and create new reports to meet Indiana's needs. [redacted] we regularly generated ad hoc reports, following a formal process to respond to ad hoc State regulatory report requests, management performance reports, and analyses to identify emerging issues such as opioid diversion and COVID-19 fraud risks.

Our platform team understands that they will receive ad hoc report requests from both the OMPP and Deloitte teams. Our data science and analytics team will be able to prioritize and perform data pulls, creating ad-hoc dashboards that can assist the team in their investigations and audits. If Deloitte and Indiana agree that the request has a larger scope and should be created into an enterprise level dashboard, then we will lean on our Agile development process. This will include documenting the reporting requirements, working closely to develop wireframes, and iterating through the development, testing, and deployment process.

We will meet the necessary reporting requirements set forth by OMPP, employing our rigorous Agile development process and leveraging our Change Control Process to gain concurrence and properly prioritize the effort. Our reporting team works in two-week sprints to develop production-level reports. Our core team will work closely with Indiana stakeholders to understand requirements, the business need, and data nuances before diving into development. Our developers have a thorough knowledge of our data model and overall platform, allowing them to quickly develop prototypes that can be iterated on. Once a report is developed, we follow a similar promotion process to our core development team so that reports can be properly tested, and users can be effectively trained.

d) Relevant example reports

Examples of reports were exhibited throughout *Section 4, Reporting* are repeated below.

[redacted]

[redacted]

Section 4.4 – Maintenance and Operations of Systems

a. *Describe your plan for ensuring all systems are available, online and operational in line with the service levels outlined in the Scope of Work.*
b. *Describe your proposed system for working with the State regarding upgrades, changes and enhancements. Describe how this system secures state sign off.*
c. *Describe how you will manage system defects during this phase of the project.*

Section 4.4 – Maintenance and Operations (M&O) of Systems

a) Working within the Service Levels

Our team will be focused on meeting the system-focused Service Levels for Pallium defined in the Performance Metrics. [redacted]

We have never had issues with system SLAs. This clearly demonstrates our dedication to serving our clients and the strength and resiliency of our platform.

Our maintenance and operations (M&O) team benefits from the fact that our system incorporates monitoring capabilities throughout the various components. Our system contains automated health checks that will help us to identify and diagnose problems with the platform quickly. [redacted] Postmortems and root causes analyses are done as a matter of practice so that mitigation strategies are applied to prevent future occurrences.

[redacted]. Deloitte has 24/7 technical support on our infrastructure, allowing us to react quickly, minimize downtime, and avoid disruptions during business hours.

[redacted]

Finally, we recognize that availability is not the only critical metric for a system. Response times within the user interface are equally important, as a highly responsive system will increase user adoption and drive more efficiencies with the user community. Pallium™ is an API-based platform that allows our operations team to see response times in real time, allowing our maintenance and operations team to proactively identify where the system might be lagging or having issues. We will generate reports on API performance upon request.

[redacted]

b) Managing upgrades, changes, and enhancements

[redacted]

The Pallium™ development team uses an agile process for all solution development, which includes case management, analytics and reporting. As our teams get into a normal communications cadence, we will work to document enhancements that the State requests that are outside the initial requirements. We will follow the Change Control Process defined in *Section 7.2.d*, documenting enhancement requests, analyzing, estimating in terms of level of effort and importance to the State. Based on the estimations and approval by the Change Control Board (CCB), we will place the work into development sprints to be included in the platform.

Once an enhancement is developed, the State will have the ability to test the new feature in a user acceptance testing environment. Once the State has completed their vetting of the new feature, they will provide formal sign-off to the Deloitte Project Manager. At this point, the feature will be included in the next production release. For urgent enhancements or fixes, we will work with OMPP to agree on an off-cycle release, communicate potential planned downtimes to the user community, and implement the update.

The following describes our process and standard release schedule:

- [redacted]

[redacted]

c) Managing system defects

We recognize that defects can arise through continued use of the full system and we will provide users with access to a ticketing system to log system issues and defects. Our system monitoring capabilities will also be leveraged to proactively identify system issues for our M&O team, and they will create defect tickets accordingly. Defects are captured, prioritized, assigned, and tracked through remediation and retesting through to final resolution by our M&O team within Azure DevOps.

Each work item will be reviewed by our team to determine the severity level, taking into consideration the impact to the user community and whether workarounds exist to mitigate any affects to operational processes. The M&O team will also perform a root cause analysis of defects and provide details of the findings to the State. As defined in our Software License agreement, we will evaluate defects to assign the following severity levels:

Severity Level		Description	Response	Severity Level
	**High**	The Licensed Software is not accessible or not functioning	Within 1 business hour	4 business hours
	**Medium**	The performance of the Licensed Software is noticeably impaired but continues to be accessible and functional	Within 2 business hours	2 business days
	**Low**	Supported User requires information or assistance on the capabilities, configuration, or operation of the Licensed Software	Within 8 business hours	3 business days

Figure F.4.4-2. Severity Levels.

Defects will be communicated with the State according to the defined response times, and we will adhere to resolution times above based on the severity of the defect. Once the team has performed the appropriate analysis and determined a path forward to

resolve the issue, we will work with the CCB to gain concurrence on the priority and the plan to resolve the defect. We will discuss new defects and the status of outstanding defects through the CCB meetings. For urgent items, we may request an emergency meeting to allow our team to rapidly respond accordingly.

Throughout the defect process, Deloitte documents the defects, effort estimations, mitigation solutions, decisions, and root cause findings within Azure DevOps. Defects also have key attributes recorded including status (e.g., open, in progress, resolved, closed, cancelled, and escalated), resolution (e.g., fixed, incomplete, duplicate, cannot reproduce, cancelled, risk retired), and priority. This allows our M&O team to effectively track and manage to the log of defects, making certain that they are resolved in a timely fashion.

Section 4.5 – System Training and Support

a. *Describe your system training operations, included but not limited to in-person training, on-demand web training, and user manuals, and your proposed training schedule.*
b. *Describe your plan to keep training curriculum materials up to date.*
c. *Describe your proposed ongoing user support approach.*

Section 4.5 – System Training and Support

Training operations

As we prepare to go-live with the system, Deloitte will focus on training all different user groups. Training will include executing the end-to-end business process and understanding how the platform and processes work together to execute the overall objectives. We believe it is important that all stakeholders and reviewers involved understand the full platform and processes. We will provide focused training to Indiana resources on usage of all aspects of Pallium™, including a comprehensive understanding of the data sets, walkthroughs of the canned reports and functionality, and detailed information on creating and publishing reports. Additional details of our training plan are included in *Section 7.2.e*.

Deloitte will be responsible for creating the training materials and making certain that the materials are both relevant to Indiana's configuration and up-to-date with the latest release. We will leverage our standard training materials including training aids, user manuals, and quick reference guides to accelerate the development and tailoring of materials specific to the State's processes and preferences.

Trainings will be conducted with OMPP, MFCU, and other relevant user groups, with content tailored to Indiana's specific requirements. We will administer training in different ways, including in-person, on-demand web-based, and virtual. We find it best that initial, formal training sessions are done in person or virtual, followed by "office hours" where our platform team can sit side-by-side with Indiana users and help them through their questions and concerns. This approach has been successful for each of our clients as it helped users to understand how to use the system, and it helped us to understand how they wanted to use the system, helping to inform future changes and enhancements to the platform.

Keeping training up to date

Through our iterative and agile approach, the solution will continue to evolve to meet Indiana's needs in the changing PI landscape. As new features and analytics are released into the production version of the platform, we will conduct user trainings so that all users of the system understand how to use the new functionality or consume the new analytics data that is being created. Not only will we train on this new functionality, we will help keep users refreshed on the system and help understand how updates interact with existing features and functionality. Based on the scale of the training and demand, we can administer this training in person or remotely. Our standard approach is to provide bi-annual trainings in person and more frequent remote trainings to keep users recent on any changes in functionality. As part of this ongoing training effort, we will keep training documentation up to date and easily accessible to users so that they always have the latest and greatest information.

Ongoing support approach

As part of our response, we are proposing a group of talented Indiana-based professionals to fill the vital roles for this engagement. These professionals are experts on using Pallium™ and are able to provide ad hoc support to Indiana users on our implementation for FADS as necessary.

Pallium™ is integrated with both a toll-free number to access our help desk and an online ticketing system through ServiceNow for less urgent requests and account issues. In addition, specific to the PPCT, we will provide Indiana a platform analytics resource that will be available up to ten hours per week to train and support users as they navigate the tool and generate leads.

SECTION 5. – Contractor Services

Please explain how you propose to execute Section 5 by answering the question prompts in the boxes below. In answering these questions, please provide any relevant experience you may have.

Section 5.1 – Fraud and Abuse Detection

a. *Provide an overview for how you will provide these services including any relevant experience and expertise.*
b. *Describe your proposed team's subject matter expertise in Medicaid fraud, waste and abuse.*
c. *Describe how you will develop fraud, waste, and abuse leads through your FADS program, including from undeclared business relationships.*
d. *Describe how your proposed FADS program will identify potential fraud, waste and abuse through undeclared business relationships.*
e. *Discuss how these leads will be reviewed prior to their delivery to the State for further investigation.*
f. *Describe how you will refer suspected cases of fraud and abuse to the State for the State's further disposition. Describe also the standardized format these will take.*

Fraud and Abuse Detection

Section 5.1

The evolving nature of FWA requires a dedicated, systematic, yet dynamic approach to make sure that the right payment is made to the right person at the right time. The Deloitte team understands that FWA impacts FSSA financially by wasting taxpayer dollars, adversely affecting the quality of care for members, and eroding the trust in the institutions serving the public. We provide the State our advanced FADS solution, technology, and capabilities to help combat this growing issue.

SECTION HIGHLIGHTS

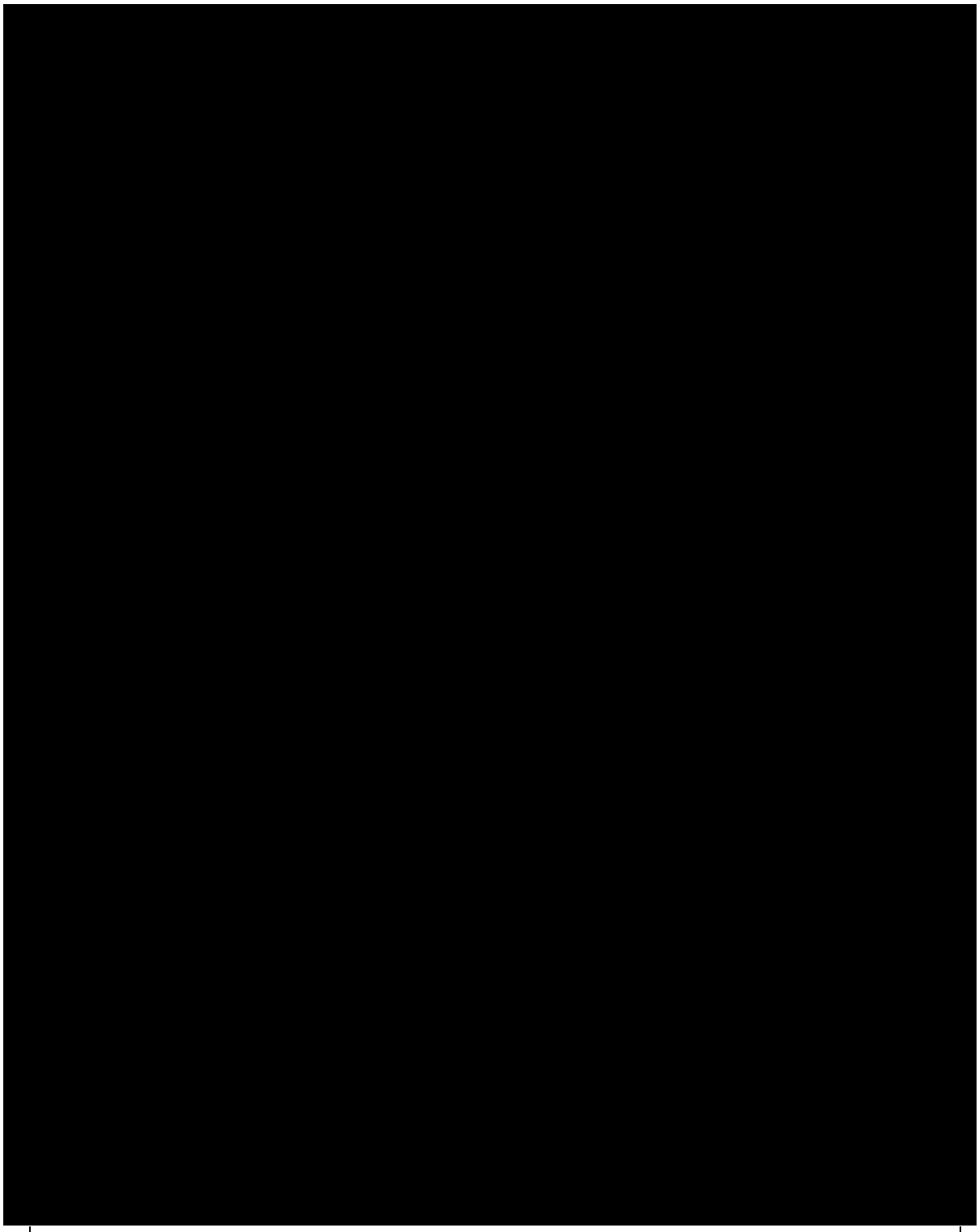
- [redacted]

Regardless of whether the dollars flow through fee-for-service (FFS) or managed care entities (MCE), payments to providers that deliver healthcare services to Medicaid members are a primary focus for reducing FWA. To assist FSSA in combatting FWA, Deloitte provides end-to-end services for program integrity (PI). [redacted]. Pallium represents years of knowledge and experience, gained through delivering FWA services to clients. It encapsulates the knowledge gained into a solution that enables cost-effectiveness and higher Return on Investment (ROI) through automation and artificial intelligence. We develop leads through our fraud detection system via machine learning algorithms that detect anomalies and suspicious trends in healthcare claims.

Proven Ability	Impact
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	

a) Overview of how we provide services

[redacted]



As set forth in *42 CFR 456.3*, Deloitte's established PI practice will assist OMPP in fighting FWA by developing FFS and MCE leads based on FFS- and MCE-specific algorithms that will result in identifying inappropriate use of Medicaid services and excess payments. We have an experienced team, described in *Section 5.1.b*, that has overseen the development of FFS and MCE algorithms to detect FWA in State Medicaid programs using statistical profiles for provider peer-class groups to monitor

the delivery and receipt of medical services. Examples of the types of FFS and MCE algorithms that have been developed and are included in the Pallium library are captured in the following figure. The outcome of the investigations based on the FWA algorithms may include further discussion with the State during the FADS Project meetings.

We provide additional discussion of the lead development process in *Section 5.1.c* and MCE Oversight in *Section 5.6.*

b) Our subject matter expertise in helping clients combat fraud, waste, and abuse

The Deloitte team has a dedicated practice committed to examining, tracking, and reporting FWA cases that are identified through FFS and MCE algorithms. [redacted] Our licensed, highly skilled, and experienced investigators perform reviews to confirm payment accuracy, focus on the reduction of payment error, and assess compliance with OMPP and managed care plan program policies for coverage, coding, and medical necessity requirements. They also identify suspected FWA in billing. [redacted]

The Deloitte team is built such that each workstream has dedicated leaders with substantial experience in project management, clinical care, and/or identifying FWA in Medicaid programs. In addition, we have provided certified medical coders and clinicians to support the workstreams from an audit, investigation, pre-payment, and algorithm development standpoint. Each Medical Coding Specialist is a Certified Professional Coder with extensive Medicaid coding and billing audit performance history. Further, our clinicians cover the gamut of clinical specialties to include providing care to Medicaid beneficiaries in professional, institutional, home health, and behavioral health settings. [redacted], one of our subcontractors, is one of the world's largest PI firms and brings clinicians and coding specialists with experience in Medicaid FWA to this project. In addition to their Medicaid FWA knowledge, these professionals combined have a high level of data analytics, information technology, internal audit, and project management experience and capabilities which will help to improve the efficiency and effectiveness of FADS.

[redacted]

- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]

c) How we develop fraud, waste, and abuse leads through our FADS system

The dynamic nature of fraud schemes demands that a vigilant approach be enacted with counter measures to thwart would-be perpetrators trying to exploit OMPP. The Deloitte team has established a four-phase approach to develop new FWA leads based on FFS and MCE claims data obtained from the EDW and CoreMMIS. Each phase allows us to be nimble to counter new and emerging trends and patterns as (or even before) they present themselves.

[redacted]

The exploration phase involves qualitative and quantitative measures. These qualitative measures involve converting ideas and fraud theories into tangible queries, indicators, and algorithms in FADS. [redacted] We will engage with our industry partners to understand what investigators are seeing in the field. [redacted].

From a quantitative standpoint, the Deloitte PI practice uses various statistical methods to identify vulnerabilities. Our analysis is based on analyzing and comparing providers with peer groups to identify misuse and aberrant practices. [redacted] Our subject matter specialists (SMSs) can further analyze and vet these anomalies to determine if a vulnerability exists. Deloitte brings extensive experience with complex machine learning FWA algorithms to identify new vulnerabilities where only a small handful of known improper payments exist. Deloitte brings OMPP innovative, advanced capabilities surrounding unstructured data analytics to identify new vulnerabilities unable to be tackled by traditional structured data methods.

Definition Phase

During the definition phase, our team will review the prioritized outputs from the exploration phase to begin documenting in pseudo-code the requirements to build out the new algorithm. The following steps are included to document the algorithm:

- [redacted]
- **Methodology.** Provide any Medicaid policy or procedure support to define the algorithm. This step will also include a summary of the medical codes and filters that are needed to test the algorithm being developed. The methodology will identify when a claim has been flagged for review.
- **Data Elements.** Provide a list of all data elements that are needed to run the algorithm.
- **Report Output.** Provide an ordered list of the resulting data element output for evaluation by the investigative team. The ordered list will include all primary and secondary sorting requirements.

[redacted]

[redacted]

Vetting Phase

During the vetting phase, our data analysts, program SMSs and clinical experts will evaluate claims and other data in the EDW and CoreMMIS to identify the potential impact and likelihood of the defined vulnerability. This phase is highly collaborative and iterative based on claims vulnerability testing by SMSs. These reviews may determine there is additional claim or data detail that influences (or possibly legitimizes) the billing activity. The analyst leading each new algorithm will consult with the team's clinical, investigative, and program SMSs to identify the most appropriate interventions for OMPP. Additionally, the investigative SMSs will make suggestions for maturing or refining the scope or definition of the vulnerability based upon standards for treatment, care, regulation, or payment of the services involved.

Execution Phase

During the execution phase, we will review each proposed new algorithm with OMPP to confirm that the material clearly articulates the relevant scheme or improper payment, demonstrates the scale of potential overpayments to OMPP including payment model affected (FFS or MCE payments), documents the relevant authorities to substantiate the algorithm, and provides our team's recommended intervention paths. Upon acceptance by OMPP, we will implement the algorithm within the PPCT to begin identifying new potential provider leads.

[redacted]


[redacted]


[redacted]


[redacted]

Quality of Care and Member Harm Lead Development

The processes outlined above provide a framework for how new provider leads will be developed. The Deloitte team will engage our clinical staff outlined in *Sections 6.1* and *6.2* to develop and evaluate quality of care and member harm leads.

[redacted]

The outcome of the above measures will be aggregated to the provider level to determine if a potential quality of care or member harm issue exists. Issues raised by the clinicians after a claim and medical record review will be documented and may be referred for further action to the Indiana Professional Licensing Agency (IPLA), Indiana State Department of Health (ISDH), or MFCU for investigation. The following

figure illustrates an example provider dashboard, which shows trigger events and adverse outcomes for members with asthma.

Leads from the Call Center (Section 5.1.c.ii)

Tip line, or Qui Tam, reports of suspected fraud are becoming increasingly more common. The Deloitte team's staff in the call center are trained to intake, process, and document the details from the caller, and subsequently create a case in the Case Management Tool. FADS contains a module to capture significant information that is reported of suspected FWA.

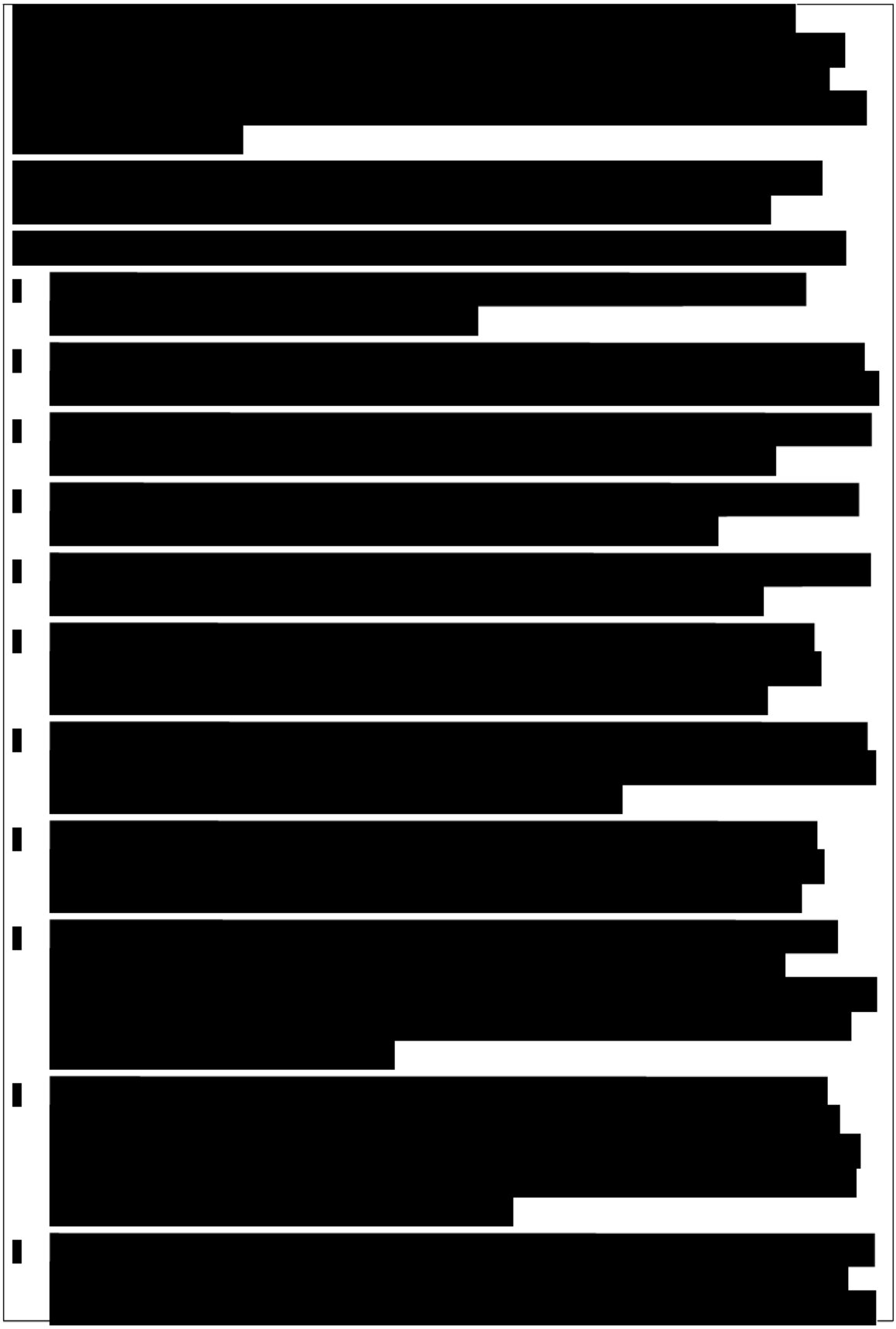
Once the report/allegation is received, it will be assigned to an investigator in the Audits & Investigations Team. Types of calls that may be received by the call center include:

- Member neglect by the provider
- Member abuse by the provider
- Improper billing by the provider
- Ineligible member
- Hiding of assets by the Member
- Unreported marriage by the Member
- Unreported income by the Member

Section 5.7 provides additional information on the call center.

Leads from Third Party Data and Other Sources (Section 5.1.c.iii)

In addition to investigating leads from the call center, undeclared business relationships, and algorithms already loaded into Pallium [redacted].



[redacted] ur team will work with the Program Integrity Unit, IPLA, ISDH, and MFCU to identify and prioritize the riskiest clinical areas for analysis.

d) How our FADS system identifies fraud, waste, and abuse through undeclared business relationships

[redacted]

Commercially Enabled Intelligence (CEI)

[redacted]

[redacted]

- **Exclusive referrals to a single entity that may suggest improper financial relationships.** Providers that are incentivized to prescribe specific prescription drugs by pharmaceutical companie or use certain diagnostic labs are not going to broadcast the benefits they receive. Pallium supports the detection of relationships that are undeclared in enrollment data. [redacted]
- **Ownership interests in a healthcare entity to which a provider may be legally prohibited from referring members (Stark Law)**. Kickback schemes can often involve improper relationships between relatives and spouses that are undetectable in licensing, claims, and enrollment files. The third-party information ingested into Pallium, along with its analytic capabilities, synthesizes information from all angles to detect improprieties. These case details are available for each case/lead worked, confirming that due diligence is applied to every subject.

Deloitte CEI Magnify Reports

[redacted]

[redacted]

Pallium Graph Analytics Module

[redacted]

[redacted]

Undisclosed business relationships can be difficult to identify using conventional analytics methods. The graph analytics module focuses on the interconnectivity of entities and their properties to compose descriptive and predictive metrics that can augment lead generation algorithms. [redacted]

Pre-built analytic models produce predictions of how likely entities are to have undeclared relationships, and that information is processed to determine how the undeclared relationship may impact an entity's FWA status. [redacted]. In addition, the module conducts entity resolution and allows for a user interface which an investigator can use to explore how entities of interest are connected and why an algorithm may have predicted two entities to have an undeclared relationship. This approach allows for use of predictive analytics while giving investigators insight into black-box algorithms through an easy-to-use exploratory graph interface.

e) How leads will be reviewed prior to delivery to State

Our Audit and Investigations team will access Pallium's case management system to review providers with high risk scores and strategically select providers for assignment that have **likelihood of success through the audit and investigations process, and eventual referral to Indiana**. Managers, investigators and auditors will have access to the full suite of scores and indicator results so that they can search, sort, filter, and prioritize providers to create leads that can be vetted and reviewed.

Lead Selection

The riskiest providers generated from Pallium's risk scoring will be prioritized. Indicators of high-risk providers include overutilization, behavioral anomalies, extreme outliers in drug diversion, diagnostic testing, and telehealth services during the pandemic, and a myriad of other issues and schemes that our analytics engine will identify. Through the PPCT, authorized users will be able to see all necessary scores and analytic results when deciding what leads to create. Users can directly create leads that will automatically enter into the case management workflow. The PPCT is discussed in further detail in *Section 4.1*.

Lead Review

Once a lead is generated, our Audit and Investigations team will evaluate the provider in accordance with the IHCP Provider Utilization Review procedures and determine if their behavior warrants a medical record review and eventual referral to Indiana. Before leads are referred to the State, investigations are conducted to identify patterns of possible aberrant activity and potential outlier activity. [redacted] he reviewer will consider the information including, but not limited to:

- Risk indicators that were flagged by the provider and the supporting claim line level detail
- Third-party data sources (both from Indiana and Deloitte's CEI capabilities featured in *Section 5.1.d*) [redacted]

The Case Management system allows the team to view individual score cards on each provider of interest, displaying overall risk scores and which risk indicators have been flagged. This risk score card will allow users to compare results of risk indicators and scores to a provider's peer group. The reviewer **can drill down to the claim line-level detail** for each risk indicator to view the supporting detail to assist the team manager's decision regarding assignment and next steps for a particular provider's lead. [redacted]

[redacted]

In conjunction with the State, the Deloitte team will decide whether to close a lead or investigate further, by making a simple workflow update with annotations and moving the lead to the next phase. Leads that are closed without any further action will be updated, and the information will feed back into the machine learning models to adjust their calculations accordingly. Leads that require investigation will be moved to the next workflow stage where users will navigate through Pallium and review relevant information related to providers, members, or specific claims. [redacted]

[redacted]

[redacted] Pallium will allow users to record a wide variety of metadata on documents including the source of the document, the date the document was received/identified, and annotated notes. When a decision has been made to proceed with next steps, often medical record review, the Deloitte team will update the workflow and build broader cases by linking other providers, members, and relevant facilities through the interface.

Medical Record Review

The strength of our medical record review approach is the ability to identify high risk claims and encounters with low false positive rates and turn around medical record reviews quickly. We recognize that this process can have a significant financial impact on providers which is why we focus heavily on minimizing false positives through our analytic and lead review process. When a provider is approved by key stakeholders for medical record review, our approach is focused on completing that review quickly and accurately. Our medical record review process is discussed in further detail in *Section 5.2* and *5.4*.

Preliminary Draft of Findings

At the conclusion of each medical record review, the Deloitte team will document its findings and recommendations on the next steps for a provider case. This will be clearly documented in a State-approved template showing supporting evidence based on Indiana policies, procedures, provider manuals, provider bulletins, medical guidelines and accepted practices, and any written communication that may have influenced the outcome of the case. We will include excerpts from our medical record review to support the recommended action against the provider (e.g., deny claim, adjustment to paid claim, reduction of payment). In situations where the medical record review shows that claims are appropriate, we have timely processes in place to communicate to Indiana and close the provider case properly in Pallium.

f) How suspected cases are referred to the State

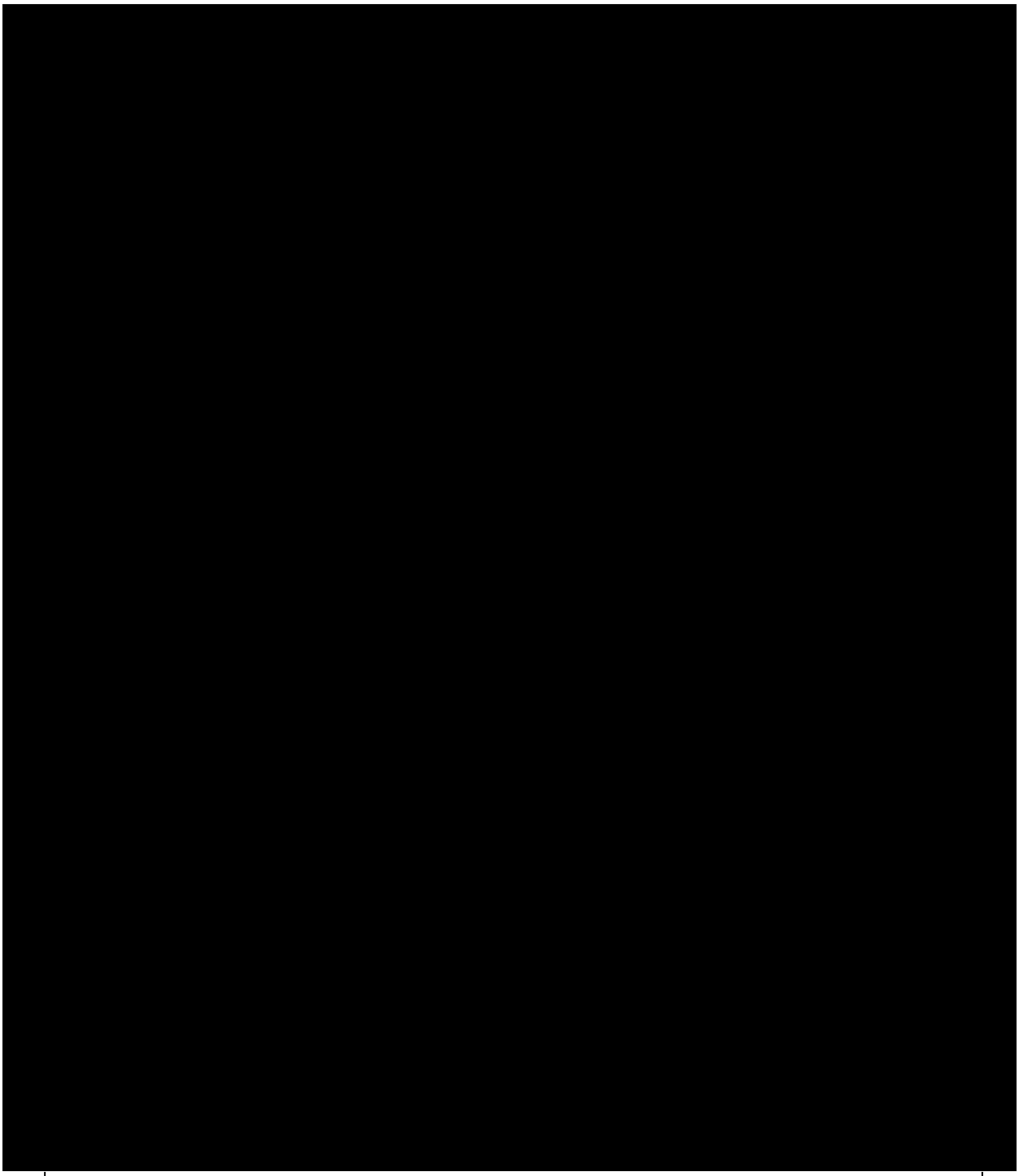
After Deloitte's comprehensive lead review, all cases where fraud is suspected shall be referred to the State for review and approval prior to any actions or recoupment efforts. Once the case has been referred, the Deloitte team will assist FSSA, HHS-OIG, MFCU, Assistant United States Attorneys, and any other applicable agencies with full-service investigation support including field investigations. Deloitte has experience supporting administrative appeals and court cases to over 20 Federal and State agencies.

Deloitte's PI practice provides support to the Division of Medicaid and MFCU on matters relating to suspected fraud. Referrals will be provided to the State in a format to be determined by FSSA. The Deloitte team will comply with Indiana's MFCU referral requirements as detailed on the Indiana Attorney General's website (https://indianaattorneygeneral.secure.force.com/MedicaidFraudComplaints/). Pallium will house all necessary data to create referrals to the State. All standardized referrals prepared by the Deloitte team include the following:

- Submittal information including key points of contact
- Unique case ID
- Dates submitted, received, updated, and adjudicated

- Provider demographics (NPI, any derogatory information, affiliations, etc.)
- Detailed allegation
- Claims analysis
- Detailed investigatory notes

[redacted]



Our solution will track and manage all case referrals, their lifecycle, and final disposition. Pallium comes out-of-the-box with standard referral tracking and reporting capabilities. These can be further configured to align to the State's processes and terminology. Deloitte will work with the State to determine if limited access to Pallium should be granted to external users so that they can make updates directly to assigned cases.

The Deloitte team has experience providing referrals to State agencies. Some [redacted]

- [redacted]
- [redacted]
- [redacted]

[redacted]

[redacted]

The Deloitte team will track the referral through Pallium and its integrated Case Management system and follow-up on significant referral milestones through our 'To-Do List' feature. The information will be available to OMPP and MFCU as needed to support ongoing cases. All referrals will be tracked from their submission to MFCU until further direction regarding case disposition is received. If the lead is accepted by MFCU and becomes an active case, Deloitte will continue to monitor the referral. Deloitte will coordinate with OMPP and provide support as needed to MFCU.

When needed, full-service investigations will adhere to healthcare FWA leading practices as it relates to interviewing techniques, surveillance, resolutions, and other pertinent factors. We have supported clients across the spectrum of appeals from administrative appeals boards to the United States Supreme Court. In healthcare, our team of has supported multiple appeals and has experience testifying in litigation hearings. Our team is dedicated to collaborating with OMPP by providing supporting

claim documentation and assisting OMPP in defending decisions based on our analyses of cases at pre-appeal and appeal hearings and conferences as deemed necessary by OMPP.

Throughout our investigative process, we adhere to State policies and laws to make certain that providers are afforded the rights and due processes. For example, in the event a case reaches the appeal or litigation phase, we will work closely with the State and other agency stakeholders to provide the necessary notices and track cases against policy timelines, giving providers the required time to request administrative reconsideration and appeals. Additional information regarding our approach to affording rights and due process is described further in *Section 5.2.g*.

Section 5.2 – Audits and Investigations

a. *Provide an overview for how you will provide these services including any relevant experience and expertise.*
b. *Describe your workflow for prepayment and post payment audits and field investigations for suspected cases of fraud, waste and abuse.*
c. *Describe your proposed program for quality of care reviews.*
d. *Describe your audit workflow for fee for service payments and all relevant reports that will be generated.*
e. *Describe how these processes differ between providers in the fee for service program and providers in the MCE program.*
f. *Describe your audit workflow for MCE payments and all relevant reports that will be generated.*
g. *Describe how your proposed FADS program will ensure providers and MCEs are afforded the rights and due process required by law.*

Audits and Investigations

Section 5.2

[redacted]

Deloitte's Audit and Investigations team has experience solving pre-existing and anticipated healthcare fraud challenges in Public and Private Health Programs. Deloitte will provide the State with veteran Medicaid Program Integrity leaders – including Certified Fraud Examiners (CFE) – who have delivered program integrity services in both FFS and managed care environments. Our leaders have a deep understanding of incorporating advanced FWA solutions to enable pre-payment and post-payment revie

The constantly evolving nature of FWA in healthcare requires a robust and experienced team to effectively manage and respond appropriately. These teams should have the ability to provide a strong, proven analytics engine; experienced investigators, registered nurses, and certified coders; and the ability to leverage their collective experience and knowledge to anticipate healthcare FWA. Deloitte and our 300+ US-based CFEs have been pioneers in identifying healthcare vulnerabilities through our support of Federal, State, and private healthcare insurers.

[redacted]

Deloitte was able to address several of the current public health emergency concerns early. As the COVID-19 pandemic grew, our algorithm developers were able to rapidly adjust and create analytical models to monitor for aberrant providers and behaviors. [redacted]

The Deloitte team has extensive experience conducting audits and investigations to include data analysis, requesting provider documentation, performing medical reviews and interviews, and providing education. [redacted]

a) Overview of how we will perform audits and investigations

The goal of Deloitte's audit and investigations approach is to provide the State with a full service, experienced team of analysts, investigators, nurses, and certified coders to establish a robust audit and investigations program. Our team will follow the IHCP Program Integrity Audit Process to conduct retrospective audits of IHCP providers, evaluating and documenting patterns of healthcare provided to members. We will align with *405 IAC 1-1. 4-9* regarding the appropriate look-back period for each audit. The audit and investigative program will identify payments that should not be made, regardless of whether they are unintentionally improper or intentionally fraudulent. This will be achieved by our experienced Deloitte team leveraging Pallium to support the identification of leads and manage our audit and investigations process. [redacted]

Deloitte will use a combination of sources to identify pre-payment and post-payment leads. Sources like Pallium analytics, State referrals, MCEs, call center leads, as well as, proactive claims reviews. Deloitte has performed audits at the Federal, State and

Plan levels. By identifying, reviewing, and investigating instances of FWA, Deloitte will assist the State in denying improperly billed claims or encounters before they are paid. This approach will result in cost avoidance by preventing specific payments and driving measurable changes in provider billing behaviors.

With respect to investigations, the Deloitte team has a track record of identifying suspect providers, investigating vulnerabilities, recovering overpayments and submitting referrals to Federal and State partners. We have supported healthcare investigations for Federal agencies, State agencies, and commercial plans, bringing our experienced investigators, clinicians, and coders to work cases with a keen focus on quality. Our investigators will perform desk reviews and field work investigations for the State.

Deloitte's desk reviews consist of provider background search, social media search, and risk assessment. Our investigative team is also experienced in a range of supplemental review processes including conducting telephonic and in-person interviews with providers and members, performing activity checks, and field quality of care reviews. Our interview methodologies include focusing on questions that will validate or disprove the data or alleged provider FWA.

Deloitte's audit and investigations team brings together an experienced team with the proven methodologies and approaches to provide the outcomes that OMPP needs to maintain program integrity. Our proven audit and investigations team includes:

Our team has resources who have current experience working together to execute our audit and investigations workflow. They also have a deep understanding of Pallium's functionality, particularly the Case Management system and Reporting module, and the risk algorithms embedded within the system today. This core team enables us to bring proven methodologies and be significantly more cost-effective by reducing the time to get resources up to speed on our processes and systems.

b) Workflow for pre-payment and post payment audits and field investigations

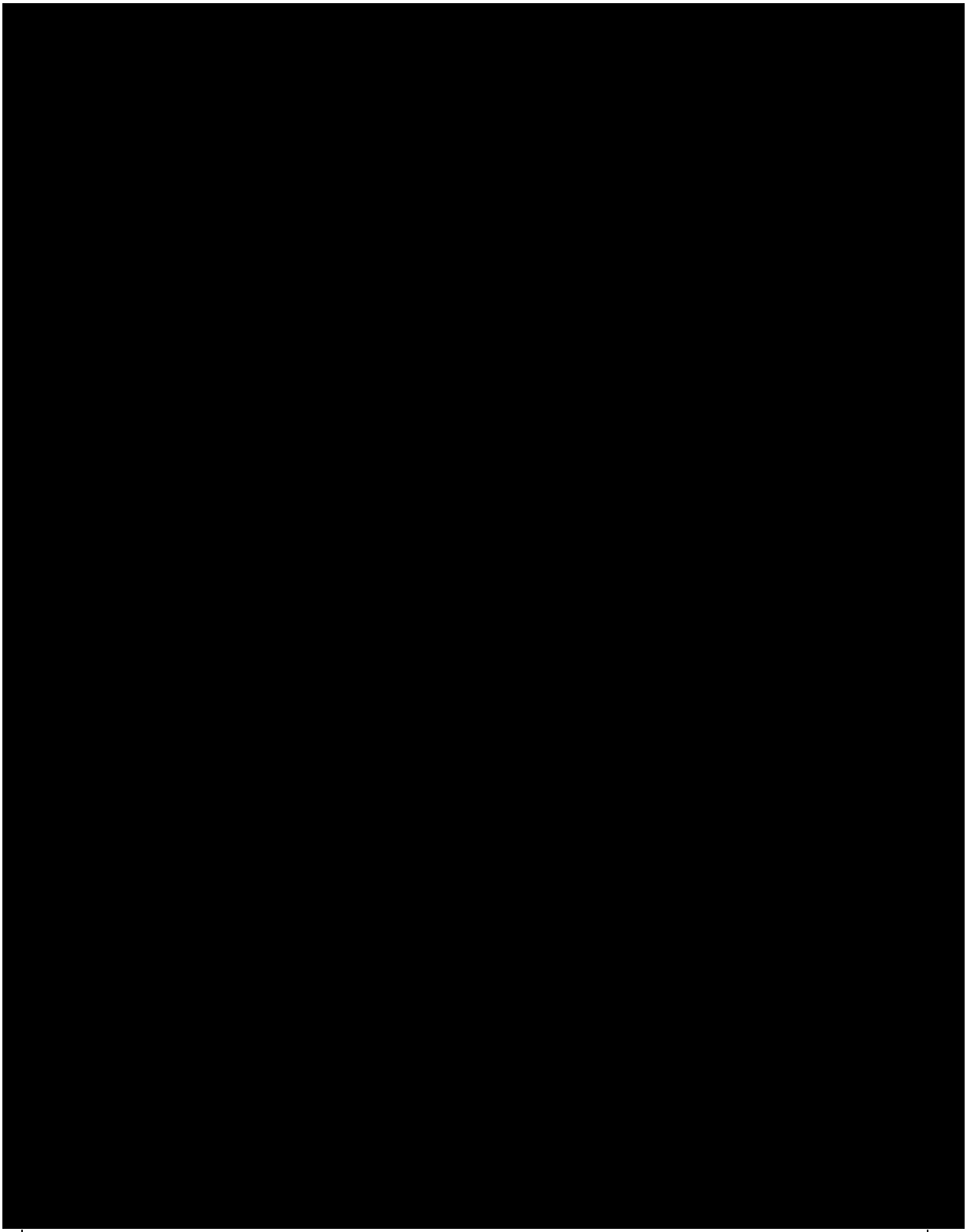
Pre-payment and post-payment audits have similarities in their processes but have significant differences in their outcomes and impact to program integrity. Post-payment audits focus on a "pay and chase" approach where services have already been reimbursed and the State is responsible for clawing back improper payments. This is a critical and necessary process, but one that places significant strain on PI resources, and given the potential uncertainties of the recovery process, post-payment tends to have lower ROI.

On the other hand, the value of a pre-payment review is that the State retains 100 percent of the dollar value, eliminating the need for improper payments to be clawed back. Pre-payment actions result in the pending of claims and related encounters for a provider. This impacts a provider's cash flow and delays payment in false positive situations. Delaying payment for properly billed claims is even more challenging during the public health emergency.

[redacted]

Providers are facing significant reductions in health care delivery, financial hardships, and other burdens on their administrative staff. Our team understands these impacts and underscores the importance of having an experienced team that is able to deliver with a clearly defined workflow and technology-enabled capabilities. Our team can minimize abrasion to providers and increase ROI to the State through more accurate and actionable analytics and investigative processes that emphasize quality, consistency, and efficiency. By taking a data-driven approach to identifying problematic providers, pre-payment and post-payment reviews and audits can incorporate a broader range of intervention at the provider level including provider education, provider termination, suspension or MFCU referrals.

Deloitte's pre-payment and post-payment workflows begin when leads are generated through various sources. The figure on the following page illustrates an overall unified workflow, detailing the steps our team will take to perform the review. Analytic-based sources will likely supply the bulk of leads, with Pallium generating risk scores and algorithm-driven leads, while the MMIS will flag providers for pre-payment review based on the edits and OMPP's provider selections within the system. Other sources of leads include State and Federal referrals, as well as call center complaints. The leads will be analyzed within Pallium by our team of investigators, CFEs, nurses, and certified coders. Initial analysis of leads will involve the review of reported risk indicators and allegations, as well as the high-level claims and encounter activities for a given provider. This is done to provide our investigators context into a provider, the behaviors in question, and a determination on the potential validity and value of the lead.



Once the initial analysis is completed, the lead will be moved into one of three categories: [redacted]. The workflows in the identified areas will have some variations based on whether it is a lead involves FFS or Managed Care. Investigative leads will take two approaches: desk reviews and field work. Deloitte's seasoned investigative team is well versed in all aspects of

investigative desk analysis and field work as is demonstrated through our support of commercial payors including [redacted] Investigators are experienced in conducting provider, member interviews, on-site reviews and provider activity checks.

Pre-payment and Post-payment Workflow

Once leads are triaged, they will be worked as either an audit or an investigation. Audits will involve either pre-payment review or post-payment review. Investigations will be worked in support of audits, standalone proactive reviews, or field work. The Deloitte team will communicate with the State to discuss leads that have been identified for either audit or investigative work. Once approval is received from the State, leads will continue development.

Pre-payment claims will be identified for review prior to paying out the claim while post-payment claims will incorporate a lookback period in accordance with *405 IAC 1-1 4-9* to capture and recoup any payments made in error. Claims that have been identified for review will be included in medical record requests drafted by Deloitte.

Medical record requests will follow the IHCP guidelines, including preparing a *Notice of Audit & Request for Records* letter. The letter will be reviewed by team supervisors to check for quality to make certain the requests are correct and appropriate. Our investigators will send out medical records requests to providers and track the process within Case Management. Communication with the provider will continue throughout the process of requesting medical records. Once notice of the letter delivery has been made through certified mail, Deloitte will monitor the 30-day period for the provider to submit the requested records and respond to questions regarding the medical records request. Providers are encouraged to reach out should they have any additional questions prior to submission of the medical records.

Deloitte's procedures for receiving and evaluating provider documentation adhere to the Health Insurance Portability and Accountability Act (HIPAA), and the State's individual privacy and security standards for PHI/PII. Deloitte's team uses the minimum information necessary to complete investigations.

Once the medical records are received by Deloitte, our team of nurses and certified coders will review each record in accordance with the *IHCP Onsite or In-House Medical Record Audit* criteria. Our medical record review specialists will discuss findings with State and MCE as appropriate at the conclusion of the review. Any identified overpayments will be calculated, validated, and recorded within the Case Management system's financial module. These will be tracked at the aggregate provider level and at the specific claim and claim line when applicable. The overpayment method, actual overpayment as opposed to statistically valid random sample and extrapolation, will comply with *Indiana Code IC 12-15-21-3(5.)*

Once the State has approved the overpayment, we will prepare the *Draft Audit Findings (DAF)* letter which will outline the claims that may have been billed inappropriately. The letter will include the overpayment amount, re-payment method, education, and appeal rights. Once approved by the State, we will send the DAF via certified mail to the provider, track the notice within Pallium, and upload an electronic copy of the letter to the specific provider case.

Deloitte will begin the overpayment collection process and support any appeals as needed. [redacted]

Our team recognizes that post-payment and pre-payment reviews can identify opportunities for provider education. Through our reviews, we may recommend provider education as an intervention and if the State agrees, we will develop and deliver the necessary education for providers. A copy of the education will be made available to the relevant MCEs if requested or needed.

Investigative Workflow

Deloitte will begin the investigative lead review process as a desk review. This process starts with additional data analysis to include LCD, NCD, and CMS rules and regulations research. The desk investigation process will include development of a full provider background search, open source information review, State-related licensing review, social media monitoring, a risk assessment, and risk sensing. Findings will be documented in Pallium's journal log and supporting documentation will be attached for quality reviews and evidentiary support.

At the State's request, field investigations may be conducted after the investigative finding's discussion or at any time during the investigative review process. Our team will be prepared to conduct unannounced or announced onsite provider visits. The onsite visit will first consist of diving deeper into identified desk analysis results to develop a field investigations plan. Afterwards, we will conduct provider interviews, site visits, and member interviews to further develop the case. At Deloitte, we have a team approach when performing field work – field investigations involve both a field investigator and a registered nurse, supporting a safety-first approach to field work. This also allows the field investigations to benefit from the investigator's FWA knowledge as well as the registered nurse's clinical knowledge.

Based on the desk and field investigations, we will provide a recommendation on the appropriate actions which may include MFCU referrals, provider education, and routing to the recovery process. We will leverage Pallium to document the findings and continue to track the case through the recommended actions. Deloitte will provide copies of investigative results, MFCU referral, education, and any other report deemed necessary by the State to the appropriate MCEs.

c) Proposed program for quality of care reviews

In an effort to make certain that the State Medicaid members are being cared for appropriately, Deloitte will conduct quality of care reviews. Quality of care leads can come from several sources to include the State, data analysis, or the call center.

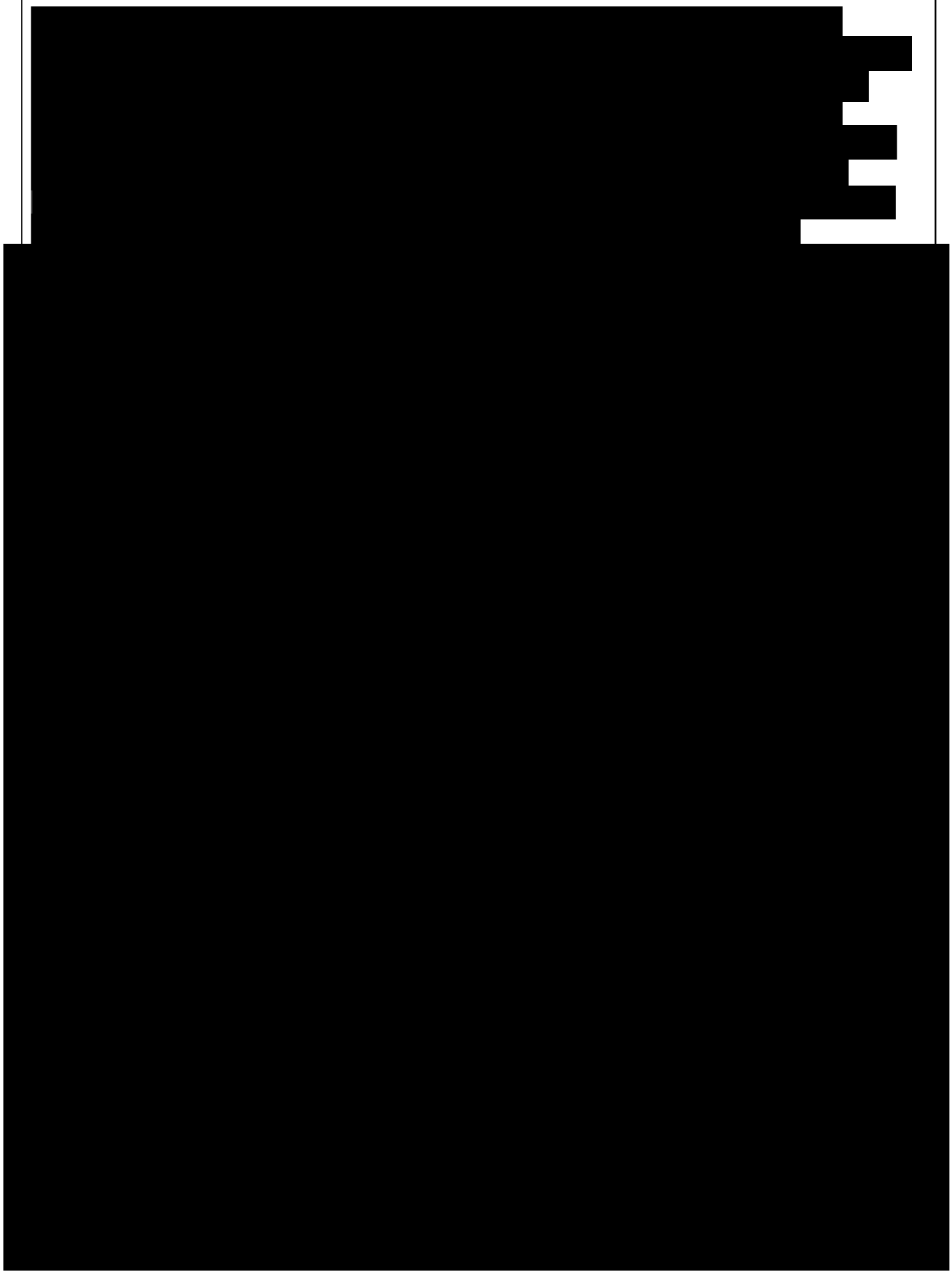
[redacted]

[redacted]

[redacted]

At the conclusion of the medical review, Deloitte will document the findings in the DAF letter and attach the letter to the case within Pallium for the State to review. If the review identifies member harm, our team will provide the necessary findings and reporting for the State to submit to the IPLA, the State Board of Health, Quality Improvement Organizations, or MFCU.

d) Our audit workflow for fee for service



Once the FFS audit lead is triaged from one of the intake sources (e.g., MMIS selection, Pallium FWA detection, call center complaints, State and/or Federal referrals), we will perform pre-payment or post-payment reviews following similar processes to those described above in *Section 5.2.b*. As FFS audits, there are slight nuances to the process which are described below:

- [redacted]

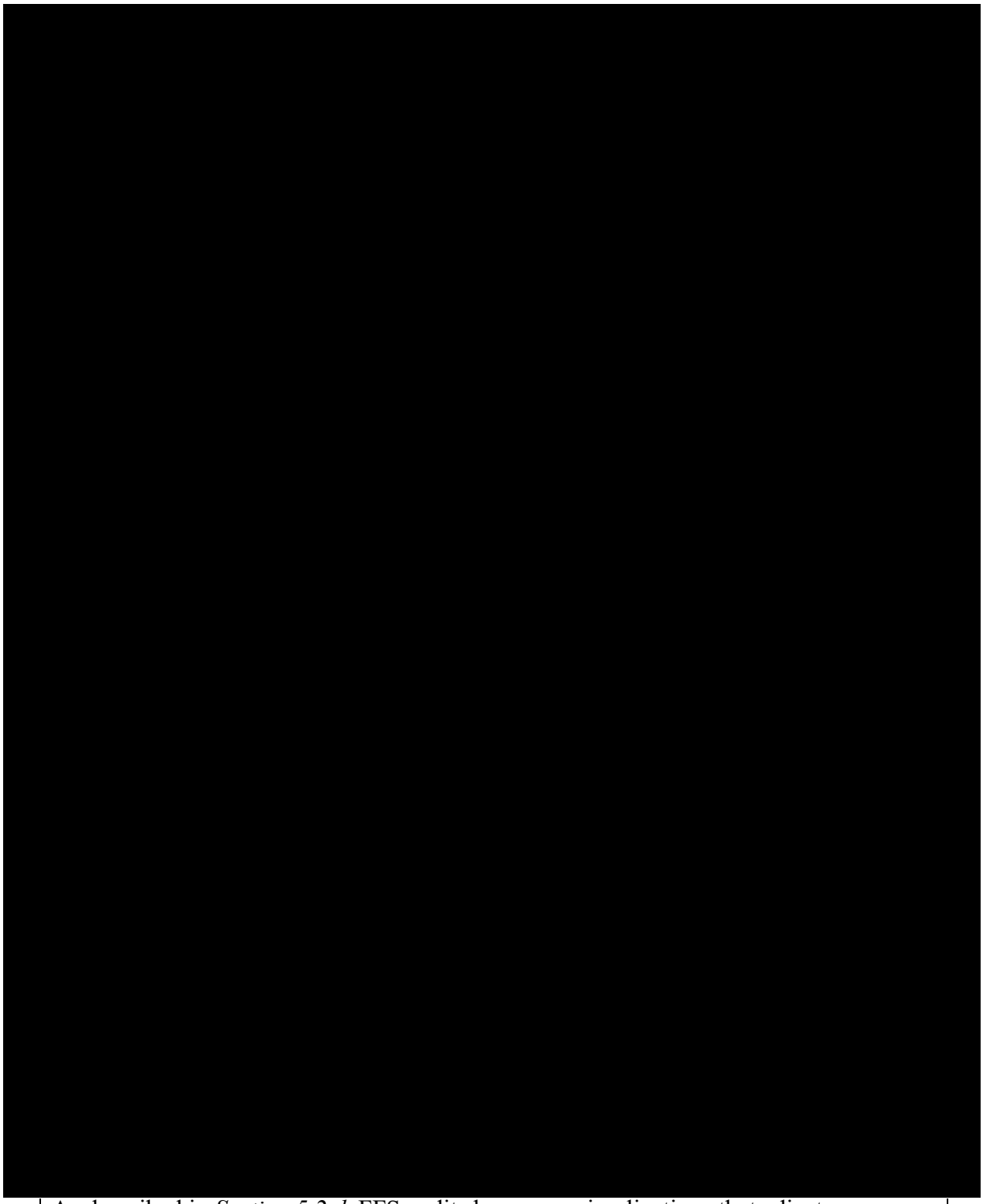
e) How processes differ between FFS and MCE programs

We have identified key differences in the audit and investigations processes related to providers in the FFS program as opposed to MCE programs.

- **Data Analysis.** [redacted]
- **Lead Sources.** While the audit and investigation leads will generally come from the same sources (e.g., MMIS selection, Pallium FWA detection, call center complaints, State and/or Federal referrals), MCE SIUs can also be a source of MCE provider leads to the State. Leads from MCEs will require review for potential deconfliction. In addition, these leads may require a determination on whether the State and Deloitte should assume ownership given the potential risk and exposure of a specific provider.

- **Applicable Policies and Reviews.** As described in the FFS audit process, FFS claims are subject to the State's policies and contracts. This requires our team to apply a slightly different lens when determining whether claims are overpaid and may impact the calculated overpayment. Since MCEs may have different negotiated rates with their providers, our team will account for those distinctions within the review.
- **Provider Communications.** Another identified difference will be the communication. As mentioned previously, the State communication will remain constant for both the FFS and MCE programs. In the FFS program, Deloitte will deal directly with the State and providers, allowing our team to be more efficient and identify a higher ROI.

f) Audit workflow for MCE payments and all reports



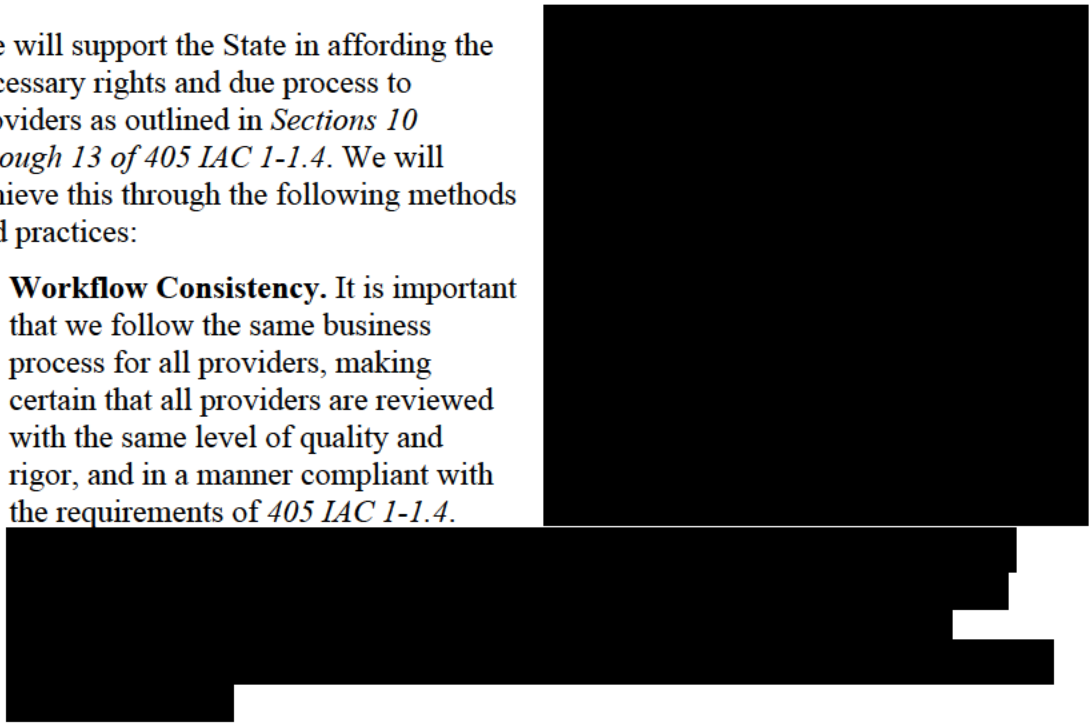
As described in *Section 5.2.d*, FFS audits have some implications that adjust our overall process. MCE audits follow our standard process but differ in an important early step that involves identifying potential conflicts with an MCE's workload. This is important as overlapping audits may result in miscommunication or additional burden on a provider, increasing provider abrasion. To avoid this, our team will need to review MCE referrals and potentially coordinate with the MCE to resolve potential audit or

investigative conflicts. If the MCE already has an open lead on a provider, our team will work with the State to determine the appropriate path forward and communicate the outcome to the MCE.

g) How are FADS program afforded necessary rights and due process

We will support the State in affording the necessary rights and due process to providers as outlined in *Sections 10 through 13 of 405 IAC 1-1.4*. We will achieve this through the following methods and practices:

- **Workflow Consistency.** It is important that we follow the same business process for all providers, making certain that all providers are reviewed with the same level of quality and rigor, and in a manner compliant with the requirements of *405 IAC 1-1.4*.



- **Statistical Rigor.** Our analytics platform has been designed with statistical rigor in mind, meaning our algorithms are consistently applied to the population and are defensible by the State. This extends to our statistically valid random sampling methodology to confirm that we are appropriately selecting claims and medical records for review.
- **Appeals Support and Adherence to Regulatory Timelines.** All providers will be allotted the designated time to appeal any overpayment decision identified. This will include providers submitting a *Request for Administrative Reconsideration* defined in *IC 12-15-13-3.4* and *IC 12-15-13-3.5* and adhering to the appeal guidelines in *Sections 10 through 13* of *405 IAC 1-1.4*. These timeframes will be specifically configured into Pallium's workflow engine, making certain that we are accurately tracking the timeline and allowing the provider to respond accordingly. All appeals will be contingent on the State or MCE's allotted appeal timeframe. In conjunction with the State's Audit Coordinator, the Deloitte team will review and assess any appeal documentation supplied by a provider. Appeal information will be reviewed and cross referenced against all applicable State or MCE rules, statutes, LCDs/NCDs, and waivers as appropriate prior to making a final determination.

- **Independence and Impartiality.** The appeal review will be conducted by a Deloitte medical reviewer or certified coder who did not perform the original review to allow for an impartial and transparent review of the claims. Once the review is completed, the appeal results will be communicated to the State.

Section 5.3 – Overpayment Recovery

a. *Provide an overview of your overpayment discovery process.*
b. *Describe how, for providers identified as receiving overpayments, your overpayment recovery process affords providers notice, a means to dispute overpayments, a forum to resolve disputes and a platform to track disputes, dispute resolution, and overpayment receipt.*
c. *Describe how your overpayment recovery solution will interface with the State's Accounts Receivable operations.*
d. *Describe how your overpayment recovery solution will retroactively correct associated claims information.*
e. *Describe how your overpayment recovery solution handles bankrupt, dissolved, or otherwise missing or nonresponsive providers.*
f. *Describe the provider-customer service platform of your overpayment recovery process which includes a description of telephonic and Internet availability to providers and method of tracking communications with providers.*

Overpayment and Recovery

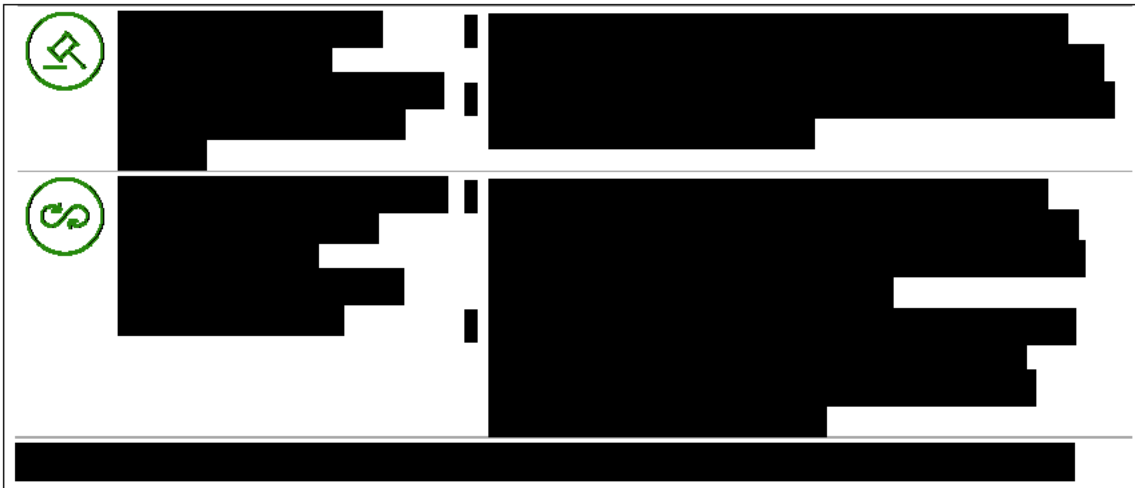
Section 5.3

[redacted]

Deloitte expects a positive fiscal impact for FSSA as we have extensive experience identifying providers abusing the system, cutting costs associated with fraudulent entities, and recovering overpayments. We have an industry-proven platform, Pallium, with demonstrated success applying healthcare FWA algorithms to drive prevention and detection of improper payments. Our team has successfully supported Federal agencies, State agencies, MCEs, and commercial payors in identifying and recovering overpayments and facilitating the recoupment of those funds. Our platform allows our teams to effectively manage the overpayment and recovery processes while enabling States to effectively measure progress, calculate ROI, track the Federal and State shares, and meet regulatory reporting requirements with CMS.

Our team of auditors, investigators, clinicians, and coders have proven experience supporting the entire lifecycle of a lead and case from overpayment identification through to recovery. We appreciate the importance of affording providers their appropriate rights and due process throughout the investigative and recovery process as outlined in *Sections 10 through 13* of *405 IAC 1-1.4*. We have an established overpayment and recovery process from end-to-end and have helped clients like [redacted] drastically improve their recoveries year-over-year. Our platform comes out-of-the-box with capabilities specific to the recovery process that streamline the overpayment and findings process. This includes automated letter generation, receivables and payment management, and recovery/appeals tracking. Each of these dimensions will allow our team to hit the ground running, effectively improving recoveries and driving higher ROI for the State.

[redacted]



a) Overview of overpayment discovery process

Deloitte's overpayment discovery process (i.e., the detection and validation of overpayments) starts with the lead generation process and incorporates our audit and investigations team who narrow in and determine the actionable population of claims. Leads may come from referrals and customer service complaints, but the bulk of larger overpayment-focused leads will be discovered by Pallium, our proposed FADS solution.

Pallium kicks off the overpayment discovery process by ingesting claims and encounters on a regular cadence (i.e., monthly), filtering and scoring the data against our library of healthcare FWA algorithms. Pallium comes pre-configured with these algorithms, many of which are specifically focused on policy violations that are indicative of overpayments. Our recovery-focused algorithms encompass behaviors that would allow FSSA to recoup the overpayments including inappropriate usage of codes, unbundling, medically unnecessary services, and other criteria defined in policies outlined in *405 IAC 1-1.4-9*.

We leverage the knowledge of our clinical and industry specialists along with our direct industry experiences to specifically focus our analytics on risk algorithms with not only a higher likelihood of confirmed overpayment, but also the highest likelihood of recovery. We also prioritize our algorithms by identifying policy violations and provider behaviors that may not require medical record reviews to recover, such as indicators related to locum tenens and duplicate billings. This allows our overpayment discovery process to focus on higher value leads that require a significantly less level of effort to recover. This is an approach we have used for each of our healthcare clients, focusing on higher ROI cases and ultimately driving higher financial results for clients like [redacted] and CMS.

In alignment with *405 IAC 1-1.4-9*, Pallium will be configured to adhere to the appropriate lookback period for audits, focusing on claims and encounters within the applicable timeframes. We will follow the policy to enable our discovery process to

identify claims that will be viable for recovery throughout the audit, overpayment and recovery, and appeal phases.

Once leads are populated into Case Management from the various sources, our overpayment discovery process follows a rigorous approach as described in *Section 5.2.* [redacted] Regardless of the source of the lead, we will follow the defined processes, leveraging our investigators, clinicians, and coders to dive into the claims in question. It is through the case review and medical record review where we perform our forensic claims reviews, narrowing in on a provider's overpayments.

A provider's liability will be determined by looking for services paid that could not be documented by the provider (*405 IAC 1-1 4.2*), inappropriate billing, validating contracts and policy violations, detecting medically unnecessary behaviors, and identifying claims unsubstantiated by the medical records. Our team compares the claims submitted against CMS's and the State's reimbursement policies. When violations of healthcare policies occur, our team will conduct claims damage assessments to determine the amount of funds owed back to FSSA.

b) How our process affords providers notice and tracks disputes

As described in *Section 5.2*, our audit and investigations workflows incorporate provider notices, with processes that provide a forum specific to handle and resolve disputes related to the overpayment findings. Pallium's Case Management system supports our workflows and notices with the functionality necessary to generate provider letters and track disputes, resolutions, and overpayment receipt.

Processes for Provider Notices

Within our audit and investigative processes, we have embedded our approach to effectively communicate with providers. These approaches include the steps necessary to notify a provider of an audit and associated medical record requests in addition to overpayment findings. The following areas are the specific touchpoints that detail the outlets to resolve service-related questions with providers and ultimately resolve disputes.

- **Audits and Record Requests.** Our team leverages Pallium to generate letters, including an automated approach to creating a *Notice of Audit & Request for Records* letter. In accordance with IHCP, we will send the notice via certified mail to the provider's address on file with the State. The document will contain information on the deadline for receiving records, instructions for providing records, and our team's contact information to support the providers during the process. Pallium will be used to track the notification through the workflow and store the letter as an attachment. Our system will incorporate the appropriate deadline (e.g., 30 days for record receipt), allowing our team to be notified of impending due dates and drive proactive outreach to providers.

- **Draft Audit Findings.** Our team will also be responsible for generating draft audit findings and sending the overpayment letter notices to the providers through certified mail. The overpayment letter will detail the claims in question, the specific regulations and policies associated with the overpayments, the source of the audit (e.g., claim review or sampling), and instructions for the provider to request administrative reconsideration. Our system will incorporate the appropriate deadline (e.g., 45 days for administrative reconsideration), allowing our team to track due dates and proactively follow up with providers. Any responses including a request for reconsideration will be tracked in the workflow, with the appropriate documentation and correspondence being uploaded into the system for reference. This phase of the overpayment process may result in a final findings report or a final overpayment letter.
- **Final Overpayment Notices.** After the reconsideration findings or the period for reconsideration has lapsed, we will initiate the final overpayment letter which will incorporate an updated calculation for the total overpayment amount and the repayment request on behalf of the State. Pallium will drive the letter generation based on the information captured by our team, with the template detailing the specific noncompliance issues, claim details, and information related to appeals. The system will incorporate the appropriate deadline (e.g., 60 days after the final overpayment letter), allowing our team to monitor for appeals requests and work with the State to track recoveries. The appropriate documentation and correspondence will be maintained within Pallium for reference.

Forum for Tracking and Resolving Disputes

We understand that providers have the right to contest the allegations against them through the administrative reconsideration and administrative appeals processes. Our approach to audits and investigations incorporates these important dispute processes. Our team serves as the initial entry point into the dispute forum by informing providers of their rights and the process to dispute decisions through the above notices. We will coordinate with the State on the formal process and support as needed. We will also track the disputes with specific processes and leveraging Case Management to operationalize the activities. Pallium's workflow and reconsideration/referral capabilities will be configured during the implementation phase of the system, implementing specific workflow steps and the required data fields. The following provides additional detail into the specific areas where Pallium will be configured to enable effective dispute tracking.

- [redacted]

[redacted]

- [redacted]

[redacted]

- **Case Actions and Provider Communications.** [redacted]
- **Overpayment Receipt.** [redacted]

c) How our solution interfaces with State's Accounts Receivable Operations

Our Case Management system contains a financial component for each case that will

[redacted]

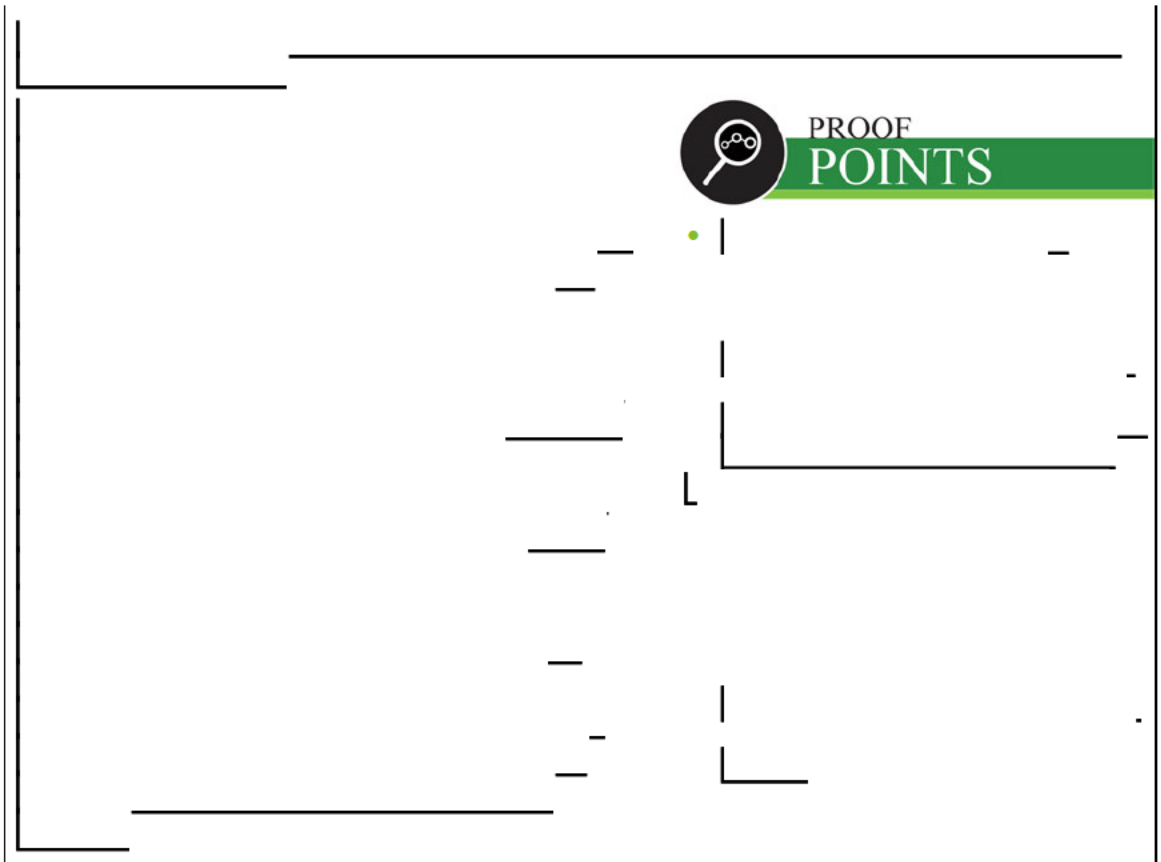
d) How our recovery solution retroactively corrects associated claims information

Deloitte will work with the MMIS vendor to define the appropriate solution to provide retroactive corrections to claims information resulting from the overpayment and recovery process. We recognize that our team will have access to CoreMMIS, and we will follow the processes defined in IHCP's Provider Reference Module to make the appropriate adjustments. In situations where individual claims or low volumes of claims need to be adjusted, we will perform the adjustments electronically, submitting the appropriate edits and subsequently recording new claim identifiers within Pallium for future tracking and reference.

Where possible, we will coordinate with the MMIS vendor to update claims in bulk, performing mass adjustments and providing the appropriate codes as defined in the Reference Module. We will look for opportunities to automate this process to increase efficiencies, drive cost-effectiveness, and minimize risk. We will work with the State and MMIS vendor to determine the best method, if desired.

e) How our overpayment recovery solution handles bankrupt, dissolved, or nonresponsive providers

Our approach to overpayments and recoveries incorporates steps within our process to identify and escalate situations where providers are bankrupt, dissolved, or nonresponsive to communications and requests.



Deloitte will assist the OMPP with internal and external communications regarding unresponsive providers based on the OMPP's prioritization of work activities. In situations where the provider is deemed bankrupt or dissolved, we will coordinate with OMPP and the fiscal operations stakeholders on the appropriate follow-up actions which may include writing off the overpayment. In addition, all related case information will be made available to OMPP to enable effective coordination with their

General Counsel to support further actions such as referral to OIG, referral to MFCU, or litigation.

f) How we offer provider customer service and track communications

Deloitte offers multiple avenues of provider customer service which includes an experienced call center, and Internet availability via e-mail and our Internet-based medical records portal. We manage communications using Pallium's communications tracking capabilities. We understand that Indiana has an Internet-based provider portal to allow documentation to be easily passed between organizations, and we will work with the State to incorporate this into our processes as well.

Telephonic Support. A key part of our provider customer service approach is our call center, [redacted], that will allow providers to call in and connect with our team. As discussed in *Section 5.7*, their call center is available from 8am to 9pm Eastern, Monday through Friday. The call center is staffed by experienced customer service professionals who understand the program integrity process and know how to respond to provider questions related to the overpayment and recovery process. The contact information for the call center will be included in written notifications to the provider.

Electronic Communications (E-mail and Internet Portal). While formal notices will need to be sent via certified mail, we will primarily leverage electronic methods to coordinate with providers including e-mail, Indiana's provider portal, and Pallium's medical records transfer site. Our team will request a centralized mailbox to allow the team to contact providers on behalf of the State. We understand that providers are registered with FSSA with e-mail addresses to stay updated on policies. If the data is available within the EDW feeds, we will incorporate the contact information into Case Management for the team to reference.

If preferred, Deloitte will request access to Indiana's provider portal to facilitate the transmission of documents and larger requests. This approach offers providers a consistent approach to interacting with the State and our team. If necessary, we will make Pallium's own file transfer site available, offering a secure site to upload requested documentation to support medical record reviews.

Communications Tracking in Case Management. All communications will be tracked within Pallium by our audit and investigations team. Pallium has standard capabilities to track correspondence with communication logging, investigative audit records, and document management. Communication attempts, successful or not, will be recorded within Pallium's communication log. We allow users to track the communication method, the date of the attempt, the outcome, and comments that summarize the contents of the interaction. Our system will allow our users to update a provider's contact information including their e-mail, phone number, and physical address. By incorporating our workflow engine and notifications, our team will have full transparency into provider communications. This allows Deloitte to escalate

challenges and resolve provider issues with OMPP quickly, driving a more cost-effective and impactful approach for the State.

Section 5.4 – Pre-payment Review

a. *Describe how you will identify providers subject to pre-payment review.*
b. *Describe your pre-payment review practices and methods.*
c. *Describe how your pre-payment review approach minimizes provider abrasion.*
d. *Describe the Coding and Reimbursement software you will furnish for conducting pre-payment review.*

Pre-payment Review

Section 5.4

Deloitte has the right team for pre-payment review with vast domain expertise and a battle-tested platform to successfully perform pre-payment reviews in conjunction with the State. Deloitte will implement Pallium, a robust system capable of identifying, monitoring, an reviewing providers subject to pre-payment review. Our pre-payment review team is staffed with veteran Medicaid Program Integrity leaders, registered nurses, and certified coders who understand healthcare FWA and with demonstrated experience in both fee-for-service and encounter claim environments. Our approach to pre-payment review will take a multifaceted look at providers and their claims.

SECTION HIGHLIGHTS

- [redacted]

We recognize that Indiana maintains an ongoing pipeline of providers within pre-payment review. We will work with OMPP understand the population by reviewing previous reports and provider education plans, gaining an understanding as to the reasons particular providers are under review, and analyzing the active claims population under review. This will allow our team to quickly assume responsibilities of current pre-payment reviews and inform our pre-payment selection methodologies.

[redacted]

Deloitte understands that the CoreMMIS system will be pending claim populations defined by the pre-payment review team. Our team will coordinate with the CoreMMIS vendor to receive the list of providers and claims that have been flagged by the system edits, ultimately loading the data into Pallium to manage and track the review process.

Our team of clinicians and certified professional coders will work together to evaluate medical records and clinical documentation for incomplete, imprecise, illegible, conflicting, or absent documentation of diagnoses, procedures, and treatments, as well as supporting clinical indicators to determine whether claims comply with state and federal policy. Our teams are experienced in communicating with the provider community in a way that minimizes the burden on the administrative staff. We will draw on our proven experiences identifying claims and conducting medical reviews for CMS, state Medicaid agencies, and Medicaid MCEs to drive a more efficient and cost-effective approach, to minimize provider burden and abrasion.

The Deloitte team and our subcontractors use tools to track and facilitate the review and manage the project in accordance with *405 IAC 1-1.4-7*. One of our subcontractors, CoventBridge, achieved an average of 97 percent Medical Record Quality Assurance Score as reported to CMS for the performance period 7/18/2018 – 7/18/2019 as a result of their nearly 125,000 pre- and post-payment reviews.

a) How providers are identified for pre-payment review

Providers for pre-payment review will be identified in several ways. The first method includes the established approach where the MMIS flags provider claims based on the Program Integrity Unit's pre-payment selections. The second method involves leveraging Pallium's risk algorithms and scoring model to identify providers for pre-payment review. Providers can also be identified in an ad hoc fashion using Pallium's PPCT where users can identify outliers and code-specific issues. Additionally, we will receive tips and complaints from the call center which may result in a decision to select a provider for pre-payment monitoring and review.

For providers already identified by MMIS system edits and audits, we will work with the MMIS vendor to determine the appropriate method to rapidly receive the claims population for review. This is critical as Deloitte will need to move quickly to adhere to specific timelines, and more importantly, minimize the potential financial impact to the provider. We will request the provider information and specific claim identifiers from the MMIS, taking the data and automatically creating pre-payment leads within Pallium for review by the team.

[redacted]

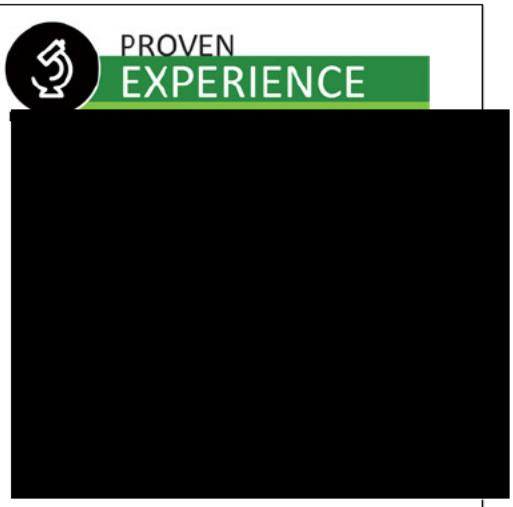
b) Pre-payment review practices and methods

Once providers have been identified for pre-payment selection, we will provide a list of providers with associated summary analyses and recommendations to the State's Program Integrity Director for review. The approved providers will be placed on pre-payment review. When the relevant claims by a provider have been flagged by the MMIS system and loaded into Pallium, our Pre-Payment Review Team Lead, [redacted], will be responsible for assigning the leads to the review team to perform the appropriate manual claims review, following the guidelines and policies outlined in *405 IAC 1-1.4-7*. Our pre-payment review team consists of a cadre of nurse reviewers, clinicians of varying specialties, coders, and quality assurance specialists to make certain that the results of the review are accurate, appropriate for the case, and able to be upheld in the case of an appeal. Should a case move to appeal, our experienced team is ready to support the State.

Our pre-payment review process will involve a review of claims for appropriate coding and documentation and identifying opportunities for provider education on appropriate billing practices. In accordance with *405 IAC 1-1.4-7(d)*, our team will be responsible for reviewing claims for medical necessity and appropriateness, making certain claims align to the appropriate policies, identifying illogical services, and other potential billing issues. Our team will use [redacted] to support the review, giving our team further confidence that decisions on coding practices are correct and subsequent provider education is accurate and appropriate.

The review will also identify any suspected waste or abuse. Our nurse reviewers and certified coders are trained to detect possible fraudulent activities while performing their reviews. If fraud is suspected, the nurse reviewer or certified coder will immediately refer the suspect claim or provider to the audit and investigations team for further analysis.

In addition, we will provide the requested monthly reporting to the Program Integrity Director to evaluate the pre-payment providers. This report will, at a minimum, include all providers on pre-payment, provider types, the length of time a provider has been on pre-payment review, the providers compliance rates for the provider's pre-payment review for the prior month.



In addition, we recognize that OMPP's Program Integrity Director has the right to request that a provider removed or added to the pre-payment selections in the following month. We will bring additional value to OMPP by regularly monitoring the flagged claims population to determine if providers may be overburdened by claims selections during a given period. For example, if a provider's billing behaviors change (e.g., due to the pandemic) resulting in an unexpected increase in the total number of pended claims for a provider, we will escalate the potential impact to the Program Integrity Director for review and decision in accordance with *405 IAC -1-.4-7(b)*.

c) Pre-payment review approach minimizes provider abrasion

Providers selected for pre-payment review will be documented and referred to the State for review and approval by the Program Integrity Unit. We will support the State by providing any additional information to support decision making. If a decision is made to place the provider on a pre-payment review, we will work with the State to assist with the administration of pending claims and encounters for medical review. Our recommendation will include whether all or only a focused area (e.g., Evaluation and Management codes) of claims and encounters should be reviewed.

Providers bear a large burden in the pre-payment review process both in terms of the burden to respond to the request for medical records and disruption of income. We are cognizant of that and only recommend the minimum necessary claims and encounters to make certain requests are manageable. Deloitte has taken different approaches related to our pre-payment methodology, tailoring our recommendations based on the provider's behaviors:

-

[redacted]

We will focus on reducing provider abrasion while maintaining a high-quality pre-payment review by first establishing open and transparent communication with providers. We will afford providers several methods of submitting the requested documents to include the web portal or, if necessary, secure email. Our team will complete the medical reviews in a timely and efficient manner, leveraging Pallium, to allow our team to effectively track and escalate urgent, outstanding items. Our reporting engine also enables our team to develop effective studies throughout the pre-payment review, allowing us to create provider education materials quickly.

In addition, we will provide comprehensive reporting to the Program Integrity Director regarding providers on the pre-payment list. We will identify metrics including the length of time providers have been subject to pre-payment review, calculate the percentage of claims and billings that have been pended, and summarize the outcomes of pre-payment claim reviews to date. These and other metrics represent measures of abrasion and will allow FSSA to clearly understand the direct impact of a review on each individual provider. These analyses will be offered monthly to inform the State's decision to continue or remove a provider from review.

[redacted]

The pre-payment review team will communicate regularly with the provider education team to execute the education program as outlined in *Section 5.5*.

d) Coding and reimbursement software furnished for pre-payment review

Deloitte will leverage the appropriate coding and reimbursement software that best meets the State specific rules and regulations around coding and reimbursement. Our teaming partner, [redacted], is currently using the [redacted]

[redacted], and we will incorporate it into our pre-payment review process. It is our understanding that the State [redacted] as well which will allow our teams to be consistent in decisions with OMPP. If requested by the State, we will consider incorporating different software.

Section 5.5 – Provider Education

a. *Describe your provider education program and how it addresses providers with billing issues.*
b. *Describe how your plan to measure the impact of the provider education program.*
c. *Describe how pre-payment and post-payment review will inform your educational efforts.*

Provider Education

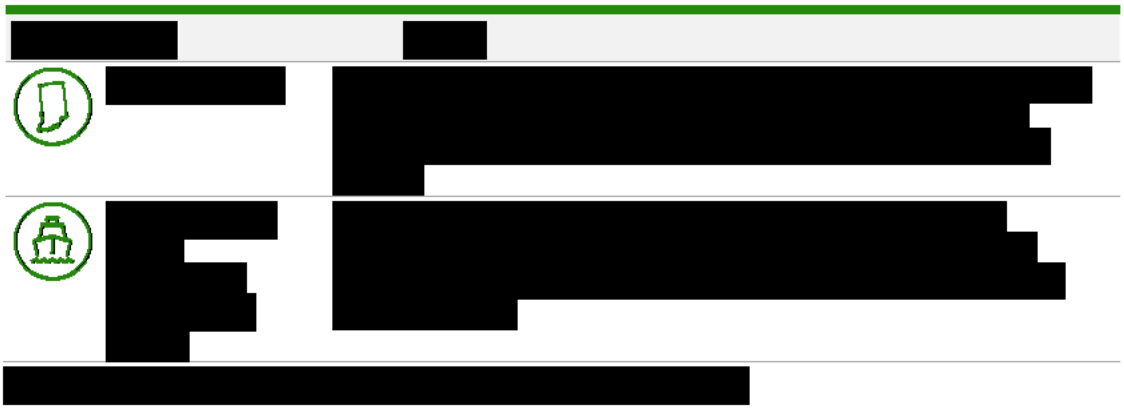
Section 5.5

Healthcare providers have a natural affinity towards education; it comes from the desire to continuously learn and improve as a clinician. That said, generally, improvement in billing or documentation practices is not considered a vital component of that life-long learning mindset. As such, the education program must tie the goals of the provider – creating a "win-win".

[redacted]

The Deloitte team specializes in the development of such programs for clinicians and their staff both as a part of the current FADS project and in Federal and State agencies.

Deloitte proposes a provider education program that is personalized to providers and their specific billing issues. It includes communication in the form of nudges and quick reference guides as well as educational modules which will be published quarterly. This approach helps to create real-time improvements and decreases rejected claims. It also demonstrates to providers that proper billing and coding leads to more claims being paid the first time which decreases provider burden and increases satisfaction with the Indiana Health Coverage Programs (IHCP).



a) Our provider education program

Many of the errors that are made by providers or their billing units are a result of negligence as opposed to abuse. In part due to fraudulent or abusive activity, billing

and coding for services, along with the associated documentation, has become increasingly complex. Through the FADS project, OMPP has created a series of modules available on the website which are in the form of a series of online, self-paced, self-guided courses. These are intended to address commonly seen errors and emerging issues and supplement the IHCP provider reference modules and other materials.

Upon contract award, our training specialist, certified medical coders, and clinicians will review the existing content to make certain that it is current. We will work with the State to identify any changes to policy or procedure that may have occurred, and provide updated versions as needed. In addition, we will add new content once per quarter, as specified in *Section 9.2* of the SOW.

Focusing on the provider's personal experience with billing and incorporating realistic and easily absorbed changes to their daily practice will make a difference in their lives, and the Medicaid system for providers with billing issues and historical overpayments. An ideal program to educate providers specifically on FWA billing issues will use strategic and proven adult-learning methodologies that will lead to more successful outcomes. [redacted]

[redacted]

While the existing content addresses a few commonly seen billing issues, we believe the State can improve the experience for providers by adding personalized training and support. As the number of providers recommended for pre-payment review is relatively small (currently less than 10 per month), direct contact from our Pre-Payment Review Program Educator, [redacted], can easily become a part of the training solution. [redacted] brings over 16 years of experience leading training and development as well as direct experience with FADS managing the provider education program.

[redacted]

-

We have built in secondary methods of provider contact if the educator cannot reach the provider. We will provide specific guidance by email, with a downloadable quick reference, a link to training, and another offer of coaching.

Once the issue is seen to have been corrected, the educator will follow up with an email message to acknowledging the actions taken by the provider and offering additional ways the provider can learn more or get technical support when needed. We will also add a link to a satisfaction survey, inviting the provider to answer a few questions about its impressions and level of satisfaction relating to the training experience.

b) Measuring the impact of the provider education program

Our pre-payment review team will work closely with the Provider Education team to relay changes and trends in billing habits by those providers in the program. Our organizational design puts the Provider Education team within the pre-payment workstream reporting directly to the Pre-payment Review Team Lead, She has a and will use that to inform our education program effectiveness as well as broaden the scope of pre-payment review and the subsequent education program to include more behavioral health professionals.

- [redacted]

We will compile results from all provider training events and summarize them quarterly. We will also gather benchmark statistics at the beginning of the term of service and will monitor trends over time.

Promotion of Training

If desired, we may also review the approach being used to promote the availability of training. We can conduct an audit of communications and outreach activities relating to available training and recommend updates to your outreach plan to confirm that providers are aware of these resources. We can also assist with messaging if new vehicles for promotion are identified.

By actively engaging with providers and monitoring their progress, we can track effectiveness of the remediation effort – monitoring training participation, length of time to improvement, and whether the approach needs any additional changes to be more effective. By tracking improvements more frequently through training, we can demonstrate benefits such as quicker payment to providers, improvements in provider enrollment and satisfaction with IHCP, and the resulting positive impact on the over 1.6 million Hoosiers in the Medicaid program.

c) How pre-payment and post-payment review will inform educational efforts

The Provider Education team not only will work in close conjunction with the Pre-Payment Review team (as described earlier in this section) to understand the reasons for a provider's placement in the pre-payment review process, but also with the Audit and Investigation team to garner insights on patterns seen in post-payment review. These teams will have regularly scheduled team meetings, organized by the Deputy Program Manager, [redacted], to discuss trends seen by provider type and specialty from both the IHCP and nationally in the Medicaid and Medicare programs. In addition, we have policies and procedures in place for the fraud examiners and investigators to immediately escalate any significant findings to [redacted] to disseminate to the Provider Education team. These findings can include emerging fraud schemes or provider billing issues based on changing regulations at both the state and national level. [redacted]

The Deloitte team provides world-class capabilities in transformational improvement, training program support, and continuous process improvement. Our approach will provide significant support to FSAA to accelerate change into lasting progress, thereby enhancing program integrity in the Medicaid program.

Section 5.6 – MCE Plan Oversight

a. *Describe the monitoring tool you will implement to ensure MCE plans are adhering to their program integrity obligations.*
b. *Describe the frequency of review for MCE plan compliance you will conduct.*
c. *Describe how you plan to provide to the State ongoing visibility into the program integrity operations of the MCE plans.*

MCE Plan Oversight

Section 5.6

SECTION HIGHLIGHTS

[redacted]

A central component to providing access to primary and preventive health care services is maintaining compliance with the State's MCE contracts for *Hoosier Healthwise*, *Healthy Indiana Plan (HIP) 2.0*, and *Hoosier Care Connect* program participants. Validating that providers are properly enrolled and meeting the contractual standards is essential to render proper care to low-income families and adults, pregnant women, and children. This section provides an overview of how Pallium will serve as the monitoring tool that helps FSSA evaluate MCE compliance universally across all plans, analyzes contract compliance performance, and addresses methods to improve visibility into the program integrity operations of the MCE plans.

We understand key governing standards of managed care including customer service requirements for managing complaints, prompt payment of eligible claims, overpayment and referral reporting, and implementation of corrective action. These are dimensions that which we have helped MCEs to manage and respond, and conversely, help states and CMS monitor. [redacted] In addition, we have supported multiple states with provider oversight tools allowing agencies to work with MCEs to address provider enrollment issues. These experiences give us a comprehensive understanding of the nuances of MCE contracts and the types of insights needed for FSSA to drive plan compliance. Our team's experience, coupled with Pallium's analytic capabilities, enables a broad set of highly relevant capabilities necessary to measure and monitor MCE compliance. The following figure details our proven experiences leveraging Pallium to support MCE compliance.

[redacted]

[redacted]

[redacted]

[redacted] **medications per patient** on a single date of service.

[redacted]

During the implementation phase, we will work with FSSA to identify additional metrics and analyses needed to enable effective oversight of MCEs. These will be documented as requirements and built into the library of MCE oversight dashboards.

a) Monitoring tool used for adherence

Deloitte Pallium will be used as the FADS tool for monitoring MCE plan compliance across contractual and legal requirements. The analytical rules and models in Pallium use a risk scoring methodology to evaluate encounter data that is submitted by each plan and analyze it to determine if the MCE plans are adhering to their program integrity obligations found in their contracts with the State and in the Managed Care Regulations and Program Integrity Regulations.

Our reporting module will be the primary interface for FSSA to access the MCE plan compliance reports. The reporting module will be directly linked to Pallium's data warehouse, allowing the tool to calculate metrics consistently across all plans. During the implementation phase, we will develop the data pipeline and provide FSSA the standard set of MCE compliance reports. State staff will have the ability to review the data elements and reports, identifying potential enhancements such as dashboard updates and new key performance indicators. Once the enhancements have been implemented into the reporting suite, we will obtain approval from FSSA for deployment and usage.

b) Frequency of review for MCE plan compliance

Deloitte will support detailed reviews for MCE plan compliance biannually (i.e., every six months). This enables more frequent reviews, exceeding the annual periodicity minimally requested, and allows the State to gather sufficient quantifiable information to determine if the MCE plan is adhering to the compliance standards or if corrective action needs to be implemented to bring the plan into compliance. Quarterly review cycles are likely too frequent, may result in friction with MCEs, and they do not reveal the necessary trends to be effective. Conversely, yearly reviews are too infrequent to create adequate oversight, leading to decreased compliance, and it may be more challenging to account for changes throughout the year (e.g., pandemic impacts, contract negotiations with provider networks, new CMS guidance).

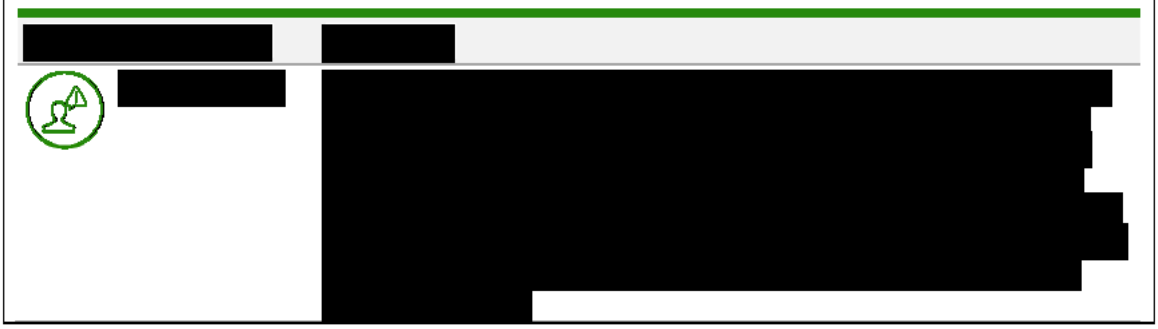
In addition to the biannual reviews, the MCE compliance dashboards will be available throughout the project. This allows our team and OMPP to perform ad hoc reviews of MCE performance on a regular basis and in a more cost-effective manner. Our team may also initiate reviews and escalate specific compliance issues to OMPP if we identify problematic trends during the audits, investigations, recoveries, and pre-payment processes.

c) Providing the State ongoing visibility

As described above, we will deliver MCE oversight reports within Pallium's reporting module to provide the State visibility into MCE plan compliance on an ongoing basis. Deloitte and State users will have pre-built reports that enable drilling into specific analyses, filtering and sorting across multiple dimensions, and exporting of reports for other program integrity purposes. Deloitte will develop these reports by linking important data sets within Pallium's analytic data warehouse; developing key performance indicators necessary to measure plan compliance; and designing, developing, and implementing the appropriate dashboard.

Our MCE oversight reporting benefits from our experience supporting State Medicaid and MCE program integrity units. For example, in our support of [redacted], we provide a library of reports that gives the MCE a point-in-time view of program integrity performance across each of their state plans. This includes reports on referral trends, recovery amounts, adverse actions, fraud risks, and aging of active cases. These are reports that are available on-demand and have been critical to helping [redacted] Special Investigations Unit comply with the States and inform operational decisions related to compliance with State contracts. Deloitte's support of [redacted] and State Medicaid agencies affords us unique perspectives from both sides of the managed care environment, giving us both a deeper understanding of MCE operations and better strategies to enhance visibility for the States. Our experiences have led to the development of metrics and dashboards that have demonstrated value to our clients by enhancing compliance for MCEs and improving oversight capabilities by the States.

By combining the above data elements, Pallium enables significant insights into MCE performance, driving a wide array of performance metrics that are tracked to measure an MCE's program integrity performance over time. The following figure provides an overview of some program integrity focus areas that the MCE oversight reports will cover, providing visibility into program integrity operations of the MCE plans.




[redacted]


[redacted]


[redacted]

The following are examples of standard Pallium reports that provide insight into MCE compliance:

- **Fraud Referral Performance.** The Fraud Referral Performance report provides comparisons of referral volumes and the associated allegations within each MCE plan. [redacted]

[redacted]

- **Overpayment Performance.** The Overpayment Performance report provides comparisons of overpayments identified and the drivers of overpayment risks within each MCE plan. [redacted]

[redacted]

These and other reports within our reporting suite will be enabled through our collection of a variety of critical data inputs. From EDW feeds to MCE referrals to Pallium's own analytic results, the following are important data elements and the value they bring to MCE oversight:

- **Claims and Encounters.** These records are the backbone of MCE oversight, facilitating the calculation of overpayments, potential fraud, quality of care insights, actual per-member-per-month spend, and other overarching MCE statistics. This data can also be leveraged to review the time between the date of service and the paid date, providing the State additional insights into compliance related to prompt payments of providers.
- **Risk Algorithm Results.** Analytic results at the encounter, line, and risk indicator level are used to specifically identify potential problematic areas of risk within each MCE including specific policies, provider types, claim types, and schemes. They directly facilitate program integrity risk key performance indicators.
- **Leads and Cases in Case Management**
  - **Customer Service Complaints.** Complaints are that are investigated provide additional insights into potential program integrity issues within MCEs.
  - **MCE Referrals.** Referrals serve as a key measure of program integrity performance. It is important to not only calculate referral volume from MCEs but also track the quality of referrals. This includes calculating the outcomes associated with referrals, including adverse actions, recoveries, and suspensions.
  - **Pallium Analytic Leads.** Our analytic leads serve as "quality validation", allowing our team to identify leads that have been missed by MCEs. We recognize that providers may spread risk across multiple MCEs, meaning an individual MCE may not have the complete picture of a provider's behaviors. However, as leads are investigated, they may highlight specific risk algorithms that are indicative of control deficiencies within specific MCEs.

Pallium's interactive reporting module, our broad program integrity data strategy, and experience-driven reports collectively enable highly effective transparency into MCE performance on an ongoing basis. In conjunction with our biannual reviews, Deloitte provides comprehensive MCE oversight capabilities and insights that will drive enhanced program integrity throughout the State, reduce unnecessary costs, and ultimately drive better quality of care to its constituents.

Section 5.7 – Call Center

a. *Describe the call center services you will provide, including number of staff.*
b. *Describe the training that call center staff will be provided to properly handle all relevant fraud, waste, and abuse calls.*

Call Center

Section 5.7

[redacted]

A central component of access to the State's health care recipients' concerns is having someone with whom Hoosiers can speak. Deloitte will leverage an existing, fully operational call center to accurately and efficiently capture the callers' concerns and complaints. Maintaining this open line of communication will also provide Deloitte with investigative leads. Using an already live call center will save the State time, money, and allow for a better handling of Qui Tam complaints and related inquiries. In this section, we will discuss the call center plan, including staffing, call monitoring, and staff training.

Deloitte and our teaming partner, [redacted], will provide the State with a call center that will perform all the State's required functions. CoventBridge is currently operating a call center which processes over 2,600 calls per month.

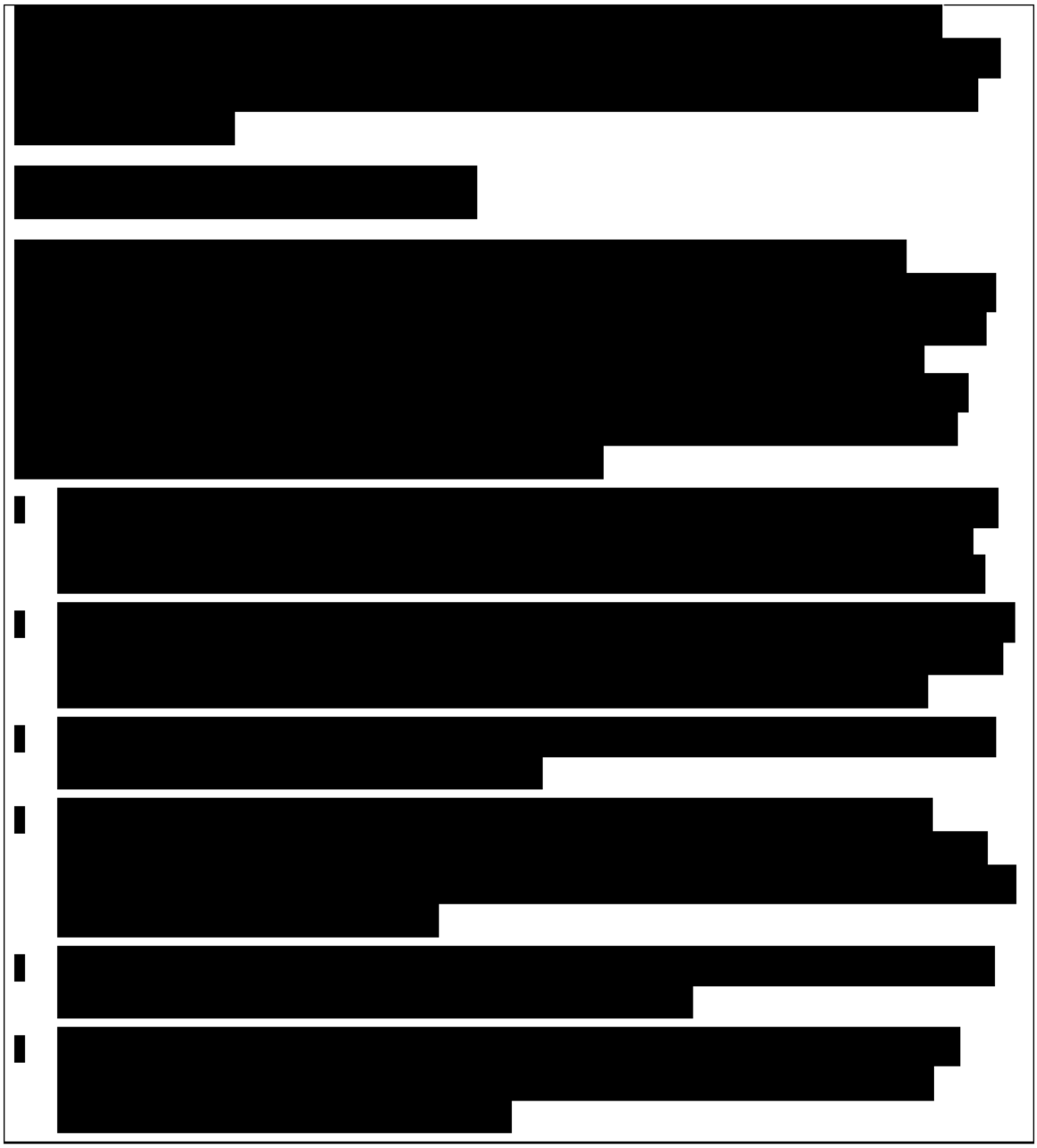
To perform the functions as required, Deloitte offers deployment of the customer contact system currently utilized by [redacted] for effective communication and customer service of commercial insurance and investigative services clients nationwide. [redacted].

a) Call center services

The call center will provide a central point for callers to reach customer service professionals who can triage and document their concerns. The call center will provide a place not only to report specific concerns related to FWA, but also to ask questions related to IN Medicaid concerns. Services will include but are not limited to:

- [redacted]
- [redacted]


PROOF
POINTS



Section 5.8 – Calculating Return on Investment

a. *Describe how you will calculate Return on Investment (ROI) for the contract.*

Calculating Return on Investment

Section 5.8

Calculating Return on Investment (ROI) is a key component of the reporting capabilities. We take a multifaceted approach in calculating this to include recoveries and cost avoidance, which is consistent with how CMS calculates ROI in Medicare. Our team and technology solution support this for a large MCE as well as a State Program Integrity Unit. Understanding the details of ROI calculation and reporting further elevates the Deloitte approach in maximizing value to FSSA.

SECTION HIGHLIGHTS

- [redacted]

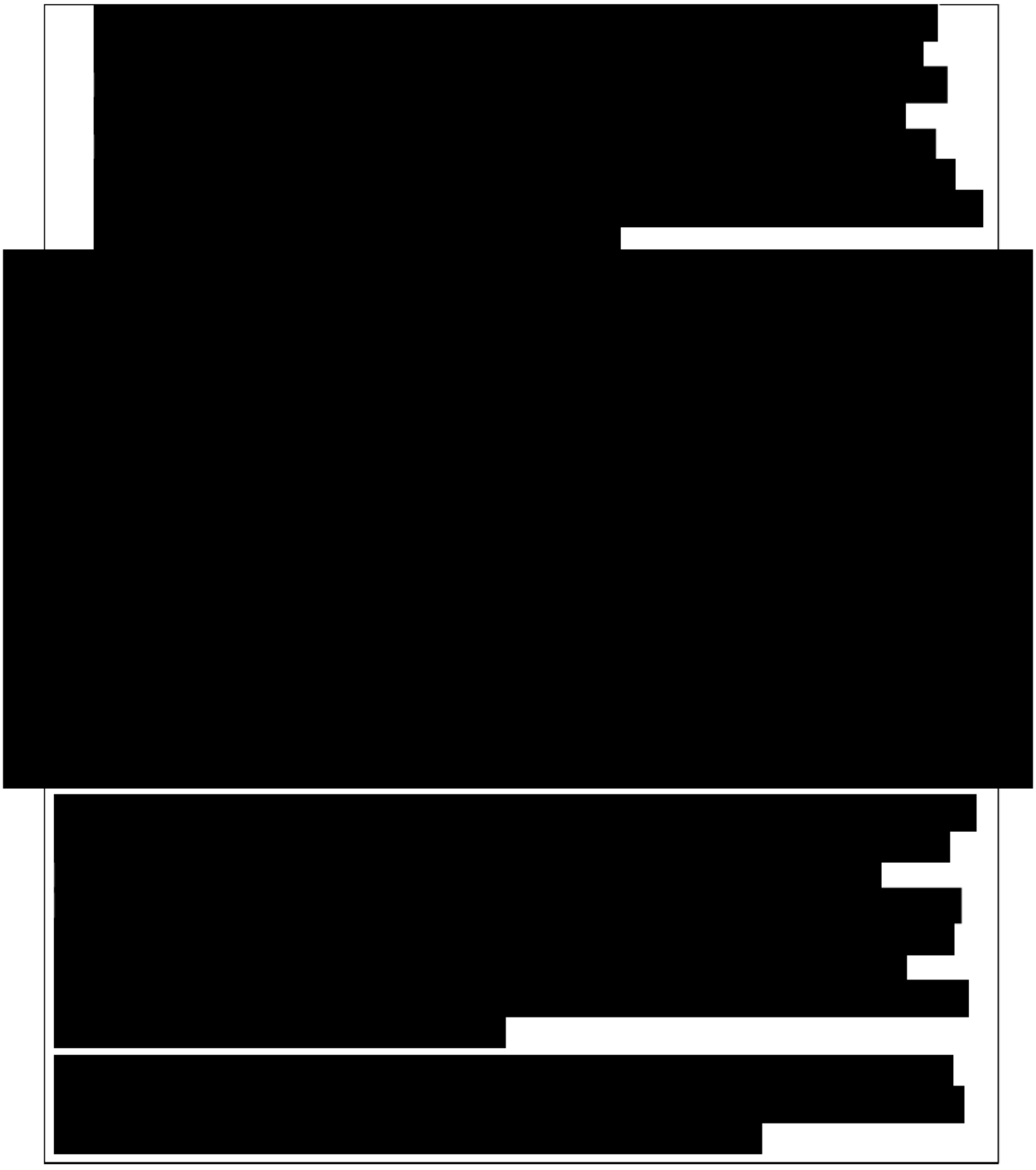
Reporting on the ROI of PI programs is a challenging task in many states due to CMS requirements and inaccurate cost avoidance calculation. [redacted]

[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

[redacted]

a) Calculating Return on Investment (ROI) for the contract.

[redacted]



SECTION 6. – Contractor Staff

Please explain how you propose to execute Section 6 by answering the question prompts in the boxes below. In answering these questions, please provide any relevant experience you may have.

Section 6.1 – Vital Positions

a. *Provide a narrative about your proposed Project Manager. Please also attach a resume or CV.*
b. *Provide a narrative about your proposed Team Leads. Please also attach a resume or CV.*
c. *Provide a narrative about your proposed Clinical Staff. Please also attach a resume or CV.*

Contractor Staff

Section 6

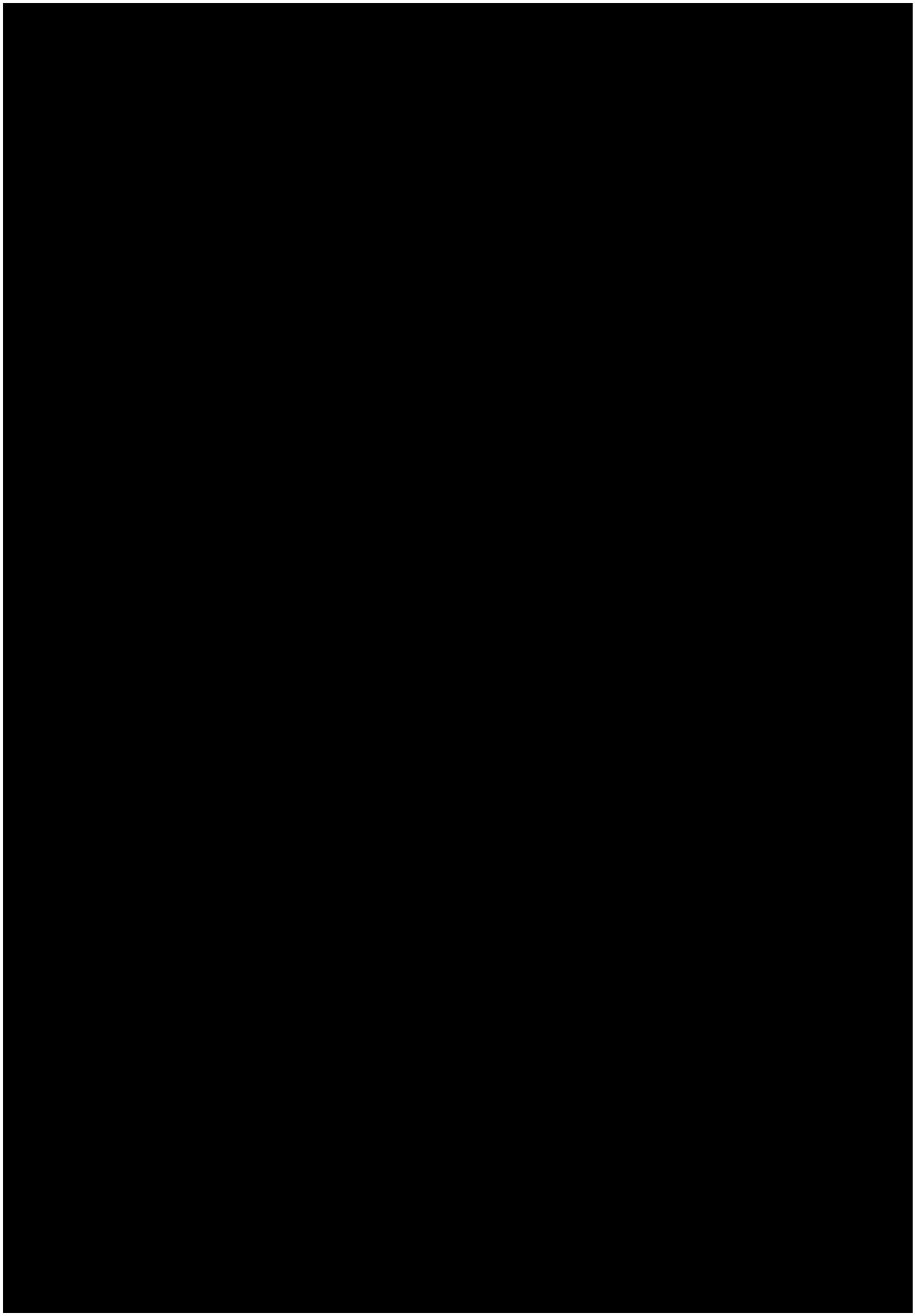
As the State of Indiana looks to implement this innovative approach to Program Integrity, finding a collaborator with an experienced team of professionals who not only can accomplish the outlined duties, but also can iterate on the process as schemes and conditions for fraud, waste, abuse, and errors (FWA) continue to evolve. The qualifications and experience of the personnel we are bringing to the program is a significant strength of Deloitte and will allow us to ramp up and produce positive outcomes quickly and throughout the duration of the project.

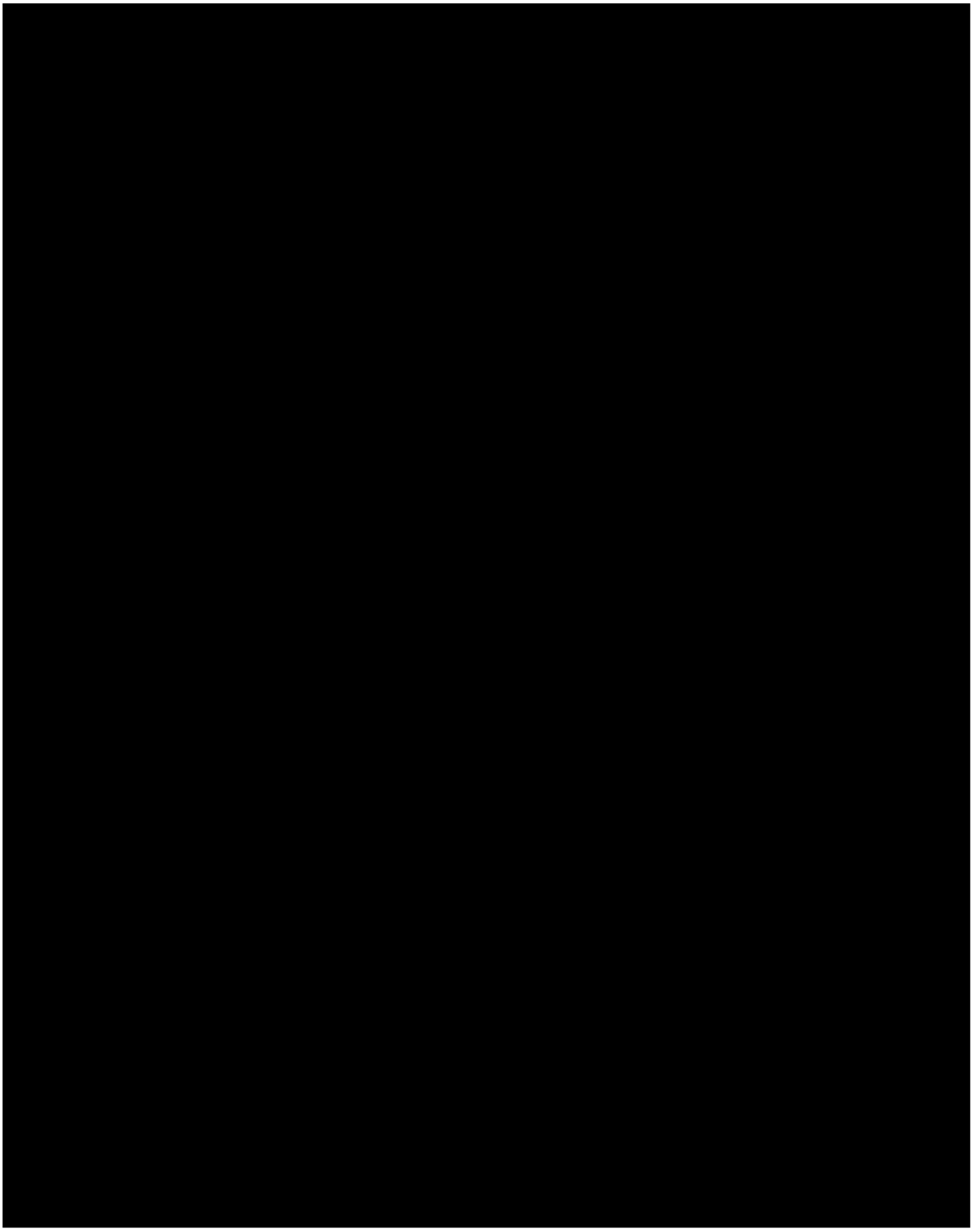
SECTION HIGHLIGHTS

[redacted]

Indiana is looking for a partner that has the right technology, processes, and most importantly, people to standup and administer this cutting-edge program integrity solution. Indiana needs a team with the right experience and high standards of performance, integrity, customer service, and fiscal awareness. We believe that the right team includes people of different background and perspectives that will help us to meet all of Indiana's requirements. In assembling our proposed team, we looked for a mix of the following professionals: Pallium specialists, healthcare specialists, and those with vast experience in the State of Indiana. Our team includes professionals who will not only play crucial roles, but reside in Indiana, where they will be able to provide stakeholders with hands-on support.

Our team consists of **Deloitte, CoventBridge, Briljent, STLogics, Vespa Group, and Medical Business Associates.** This unique combination of talent brings the right people together to provide Indiana with a truly end-to-end program integrity solution. Deloitte staff have substantial experience providing FWA analytics products and services across the healthcare industry, including State Medicaid agencies, CMS, Managed Care Entities (MCEs), the Department of Justice (DOJ), and the Drug Enforcement Agency (DEA). We also have vast experience with the State of Indiana, which includes work with FSSA, the Department of Child Services (DCS), and the Department of Revenue (DOR). Our team's structure and details about our subcontractors can be found in the following figures.





[redacted]

We propose Vital Personnel and a cadre of additional staff that are highly qualified, dedicated leaders who **all have experience delivering in their specific roles on projects of a similar size and scope**. [redacted]

[redacted]

Section 6.1 – Vital Positions

The vital individuals who are crucial to the success of our team are listed below and in greater depth (including their resumes and proof of certifications) can be found in *Appendix D, Vital Positions Resumes*.

a) Project Manager

[redacted]

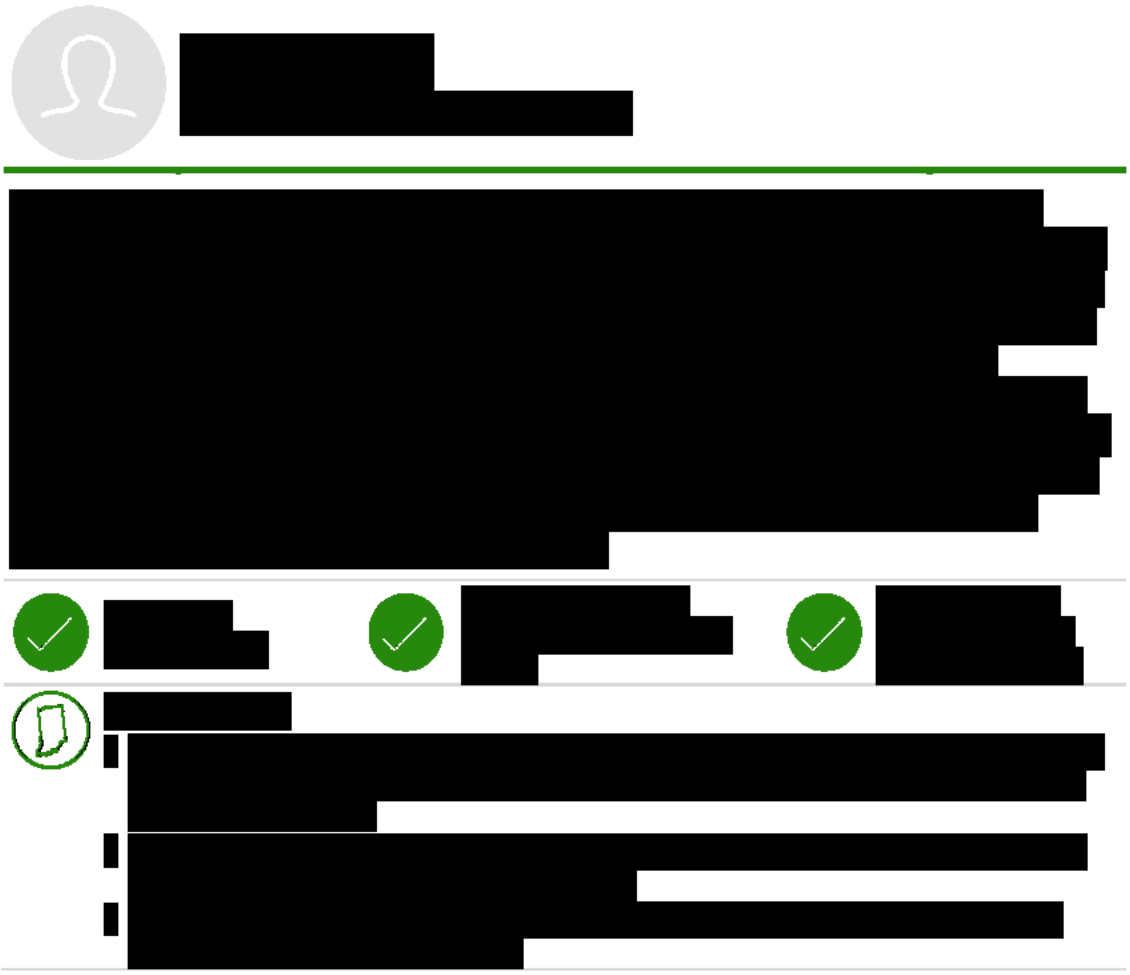
[redacted]

[redacted]

b) Team Leads

The four key individuals who are integral to the success of our leadership team are listed below and in greater depth in *Appendix D, Vital Positions Resumes* (including their resume, educational history, and relevant experience).

Audit Case Disposition Team Lead



Pre-Payment Review Team Lead/Clinician

[redacted]

Clinical Lead

[redacted]

Algorithm Development Team Lead

[redacted]

[redacted]

[redacted]

c) Clinical Staff

[redacted]

Section 6.2 – Additional Staff

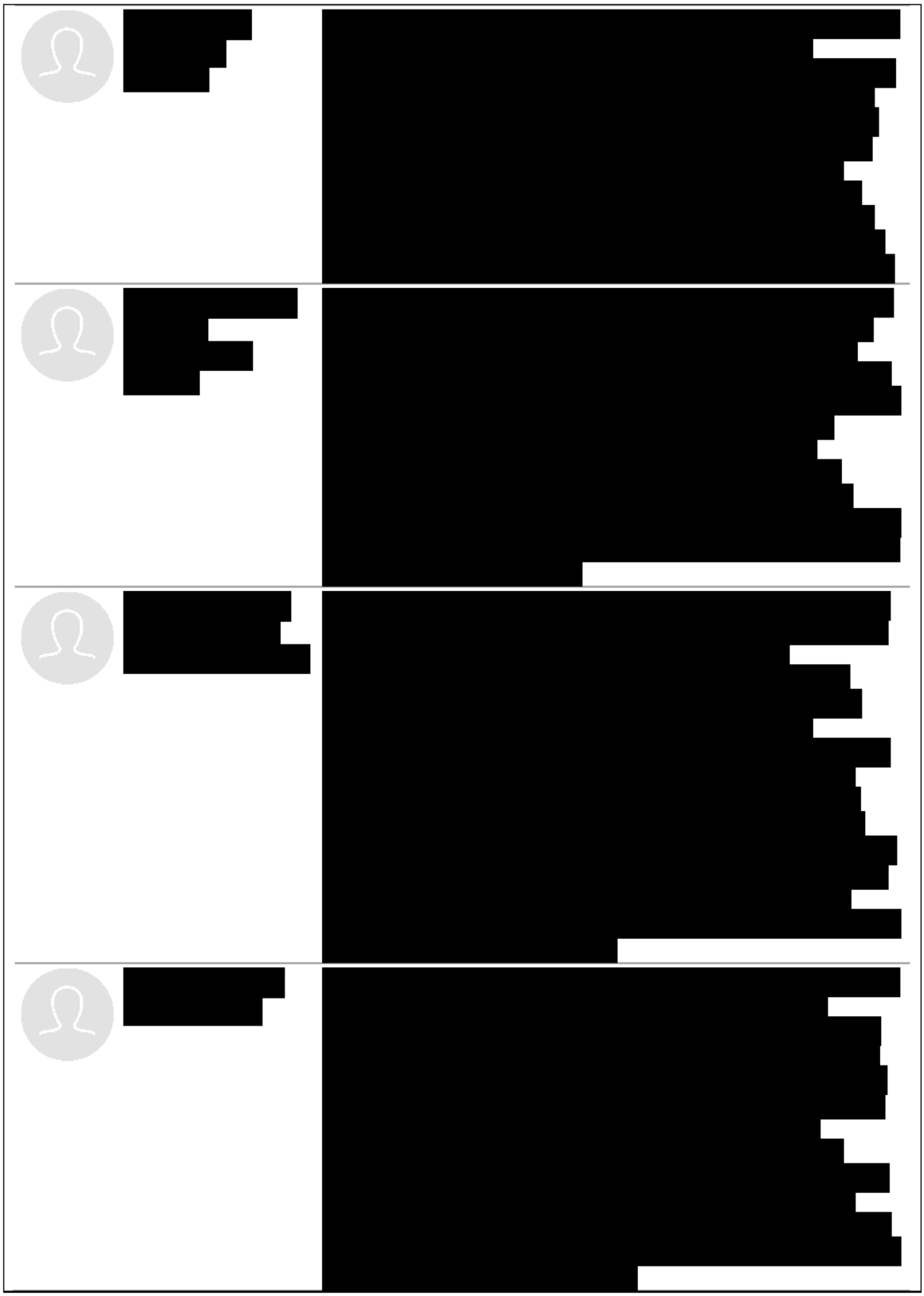
a. *Provide a narrative describing the Additional Staff contemplated by Section 6.2 Please provide the number of staff per position (Clinical Staff, Medical Coders, Fraud Examiners, Registered Health Information Administrators) that will work with the State. Describe whether they are full-time or part-time and provide proof of certification. As applicable, please attach resumes of any specific proposed candidates.*

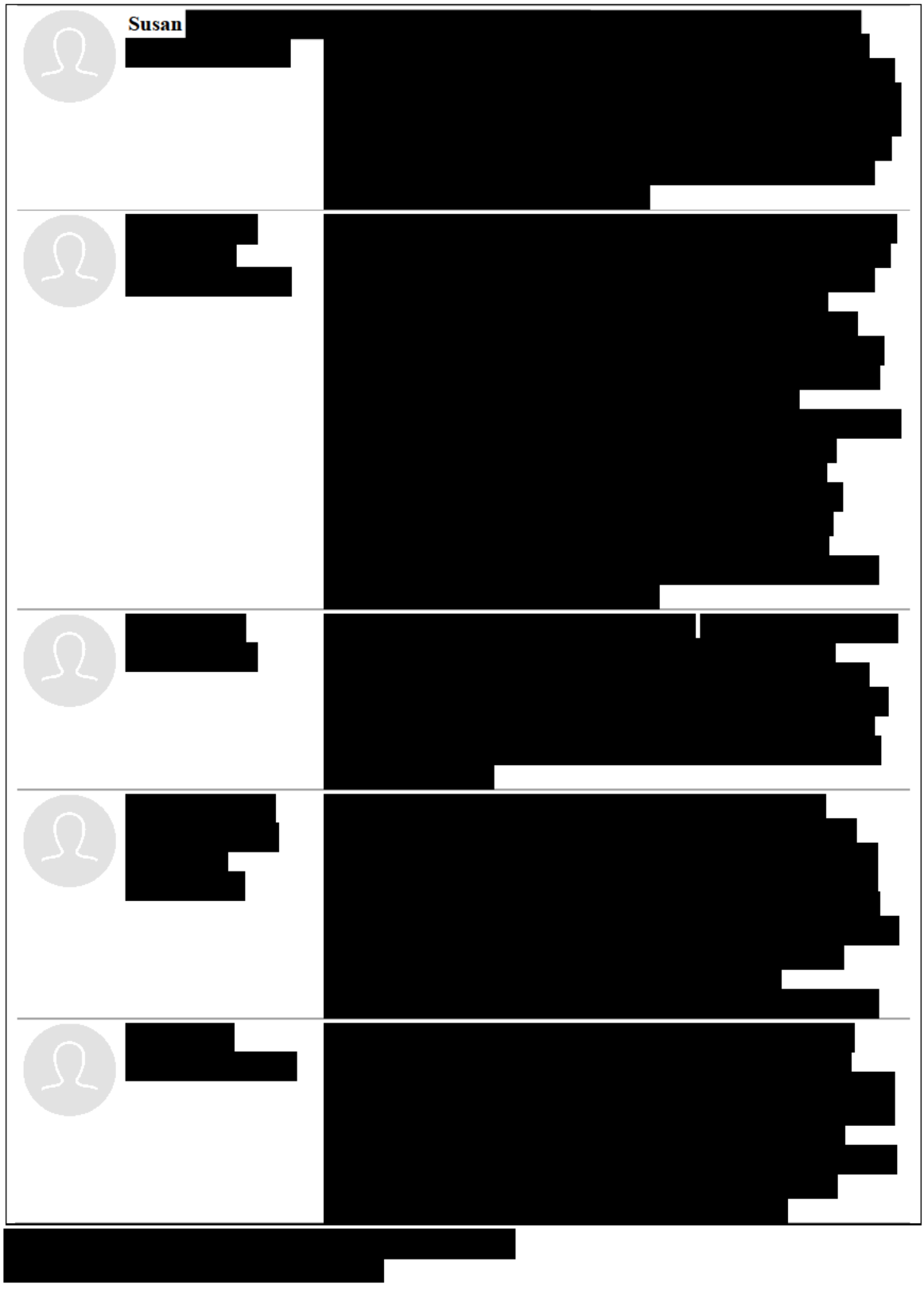
Section 6.2 – Additional Staff

a) Additional Staff

We are proposing the following Additional Staff to support this engagement for the State of Indiana. Our team has decades of experience in their competency areas and holds specialized educational degrees including Masters', PhD's, and professional certifications. (Please refer to *Appendix E, Additional Staff Resumes* for proof of certification.) As a result, the Deloitte team's professionals operate at the forefront of innovation, designing leading solutions that will meet Indiana's specific requirements. These specialists stand ready to support FSSA existing and potentially new workstreams that may develop over the life of the project.

[redacted]




Susan

SECTION 7. – Contractor Administrative Duties

Please explain how you propose to execute Section 7 by answering the question prompts in the boxes below. In answering these questions, please provide any relevant experience you may have.

Section 7.1 – Offices

a. *Describe the proposed location of your office which would be dedicated to the service of the State.*
b. *Describe your facility maintenance plan as well as your plan to acquire and/or maintain any necessary computer or software equipment.*

Contractor Administrative Duties

Section 7

The complex nature of the IN FADS project demands a clear and accountable approach in managing project administrative duties. Deloitte has proven experiences delivering large, complex programs for our clients in the State of IN, at FSSA, for dozens of other state and federal clients, and with commercial companies worldwide. This allows us to bring the right team, capabilities, and lessons learned to successfully perform the necessary work in the RFP and perform it in a timely, cost-effective, and efficient manner.

SECTION HIGHLIGHTS

Professiona

- Coordinating and executing outgoing transition activities

These activities and artifacts will make certain that all work listed in the RFP is performed on time, on budget, and according to FSSA's expectations.

Section 7.1 – Offices

The Deloitte team will use an established local office, including a local team of professionals to perform the necessary work for IN FADS. Given the public health emergency and its effect on remote work locations, Deloitte will confer with the State to determine the appropriate work location as the contract ensues. Deloitte professionals will use pre-allocated laptops that include the necessary software to perform all of the work listed in the SOW.

a) Our Working Location

b) Facilities & Electronics

Facility Maintenance Plan

Facility maintenance has proven a critical component for project team safety and success. Due to the challenges brought by the COVID-19 pandemic, the Deloitte facilities have adopted additional maintenance procedures designed to provide all employees and visitors experience a safe work environment, taking precautions per Federal and State guidance. Our facility maintenance plan is detailed below:

- **Elevators & Escalators.** Physical distancing is a critical part of protection from the COVID-19 virus. Signage will be placed in ground level elevator lobbies strongly suggesting elevator occupants to position themselves in near a corner location in the elevator cab. Additionally, for those individuals waiting for entry to an elevator cab, we advise following the (6')-rule in accordance with physical distancing recommendations while waiting for elevator access.
- **Restroom Use.** Signage will be placed on restroom doors as a reminder for all visitors to wash their hands after visiting a restroom.
- **Personal Protective Equipment (PPE).** Local, State, or Federal government agencies issued recommended or mandatory requirements on the wearing of facial masks, gloves, or other protection devices. We ask that all visitors adhere to government mandates when entering this facility.
- **Sanitization Stations.** Hand sanitizer stations/dispensers can be found throughout the office space.

Computers and Software

Section 7.2 – Project Management and other Documentation

a. *Describe your approach to developing the project management plan.*
b. *Describe your approach to updating the FADS User Manual and Operating Procedures Manual in collaboration with FSSA staff to ensure the most up to date material. (See SOW Section 7.2.2.1)*
c. *Describe your approach to developing and maintaining a plan to ensure compliance with all current State and federal laws, policies, procedures, and regulations, including those explicitly mentioned in the Scope of Work as well as others not explicitly mentioned. Describe your plan to stay up to date with all relevant rules and regulations. (See SOW Section 7.2.2.2)*
d. *Describe your approach to developing a change control plan that details the process by which Change Requests are identified, prepared, validated, monitored, approved, and reviewed. Describe how you will maintain a history of all change requests and their associated details. (See SOW Section 7.2.2.3)*
e. *Describe your approach to developing a training plan. (See SOW Section 7.2.2.4)*
f. *Describe your approach to developing an issue resolution plan, including how it will address trouble-shooting tools and how you will measure success of issue resolution efforts. (See SOW Section 7.2.2.5)*

Section 7.2 – Project Management and other Documentation

[redacted]

a) Project management plan approach

[redacted]



[redacted]

Quality, Timely, and Reliable Services and Technology

[redacted] and other associated plans that the team will leverage in their delivery to FSSA.

Quality Management Plan

[redacted]

Risk Management and Mitigation Plan

We will develop a risk management plan that incorporates a systematic risk and issue management process to manage and mitigate risks associated with cost, quality, and schedule. Our risk analysis and oversight framework, detailed in our response to *Section 7.5*, identifies the steps that we follow to analyze risks, estimate probabilities and impacts, identify mitigation strategies, and monitor and track risks until they are resolved. This is a proven framework that has enabled our successful delivery for other clients, helping our teams quickly identify and address risks, minimizing their impact on delivery, facilitating timely delivery of services, and supporting cost-effectiveness.

b) Updating the FADS User Manual and Operating Procedures Manual (SOW Section 7.2.2.1)

[redacted]

c) Compliance with all current State and federal laws (SOW Section 7.2.2.2)

[redacted]

d) Change Requests (SOW Section 7.2.2.3)

Change Control Plan

[redacted]

[redacted]

e) Training plan (SOW Section 7.2.2.4)

[redacted]

Initial Training

[redacted]

Section 7.3 – Meeting Requirements

a. *Describe your commitment and ability to attend and actively participate in required meetings. Describe any other proposed meetings, their purpose, and desired attendees for State consideration.*

Section 7.3 – Meeting Requirements

a) Meeting Participation

Deloitte understands that the complex nature of State Medicaid Program Integrity work requires active participation of our team members in Vital positions and key support roles in regular status meetings. For all regularly scheduled meetings, including the biweekly status meetings, our Vital personnel are committed to attending and actively participating.

Section 7.4 – End of Contract Duties

a. *Describe your commitment and ability to ensure smooth outgoing transition of activities and responsibilities to the succeeding contractor, if this becomes necessary.*

Section 7.4 – End of Contract Duties

a) Outgoing transition activities

[redacted]

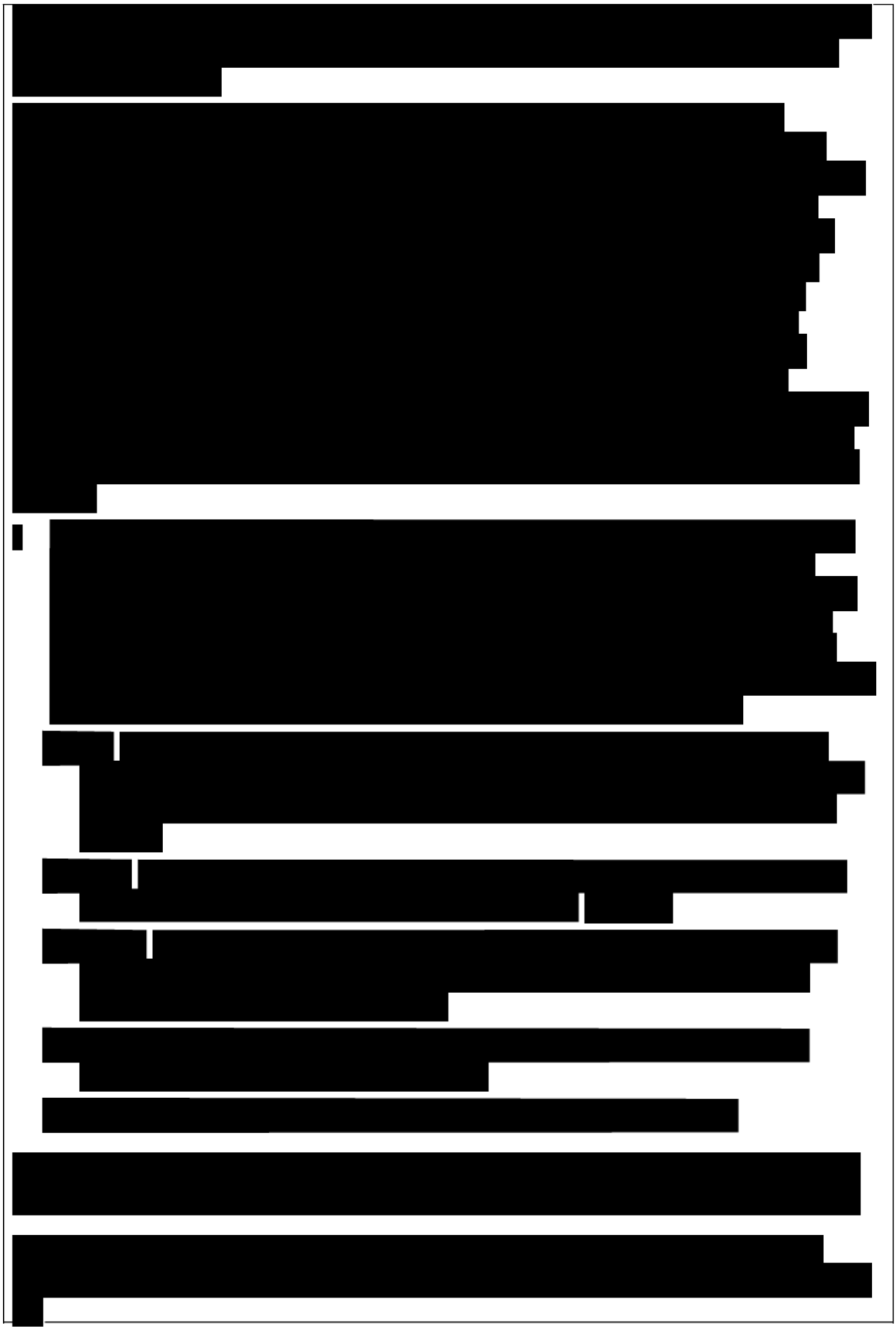
Section 7.5 – Security and Risk Mitigation

a. *Describe your approach to developing a Risk Management and Mitigation plan, including a **process for documenting and reporting risks and risk status to the State**. Describe how you will track, manage, and report risks to the State. Address any tools you will use. (See SOW Section 7.5.1)*
    i. *Maintaining Risk Register in which all project-related risks are documented and communicated in a timely manner to the State*
    ii. *Incorporates and documents:*
        i. *potential risk identification*
        ii. *recommendations for risk mitigation*
        iii. *management and tracking of mitigation steps*
        iv. *identify points when risks could worsen if not mitigated*
    iii. *Risk updates provided at regular intervals in biweekly status meetings and as requested*
    iv. *Dedicated project staff to identifying and communicating risks (?)*
b. *Describe your approach to developing and maintaining an information systems and data security policy that conforms with the State's information systems security policy. (See SOW Section 7.5.2)*
    i. *Confidential Information Management Plan (CIMP) – comprehensive, provides steps taken to ensure that PII/PHI is not used, disclosed, or maintained improperly (HIPAA)*
    ii. *Incorporate security audits to be shared with the State and architecture utilized to authorize users within the system*
c. *Describe your approach to developing and maintaining a comprehensive, fully tested IT business continuity/disaster recovery plan. (See SOW Section 7.5.3)*
    i.
d. *Describe what you view as the key risks to this project and how you would mitigate those risks.*
    i. *Large amount of beneficiary PHI/PII data poses a potential for data leaks/breaches*
        i. *Adherence to Confidential Information Management Plan noted in Section 7.5.2 to mitigate risk of beneficiary data mismanagement*

Section 7.5 – Security and Risk Mitigation

a) Risk Management and Mitigation (SOW Section 7.5.1)


DISTINGUISHING



- [redacted]

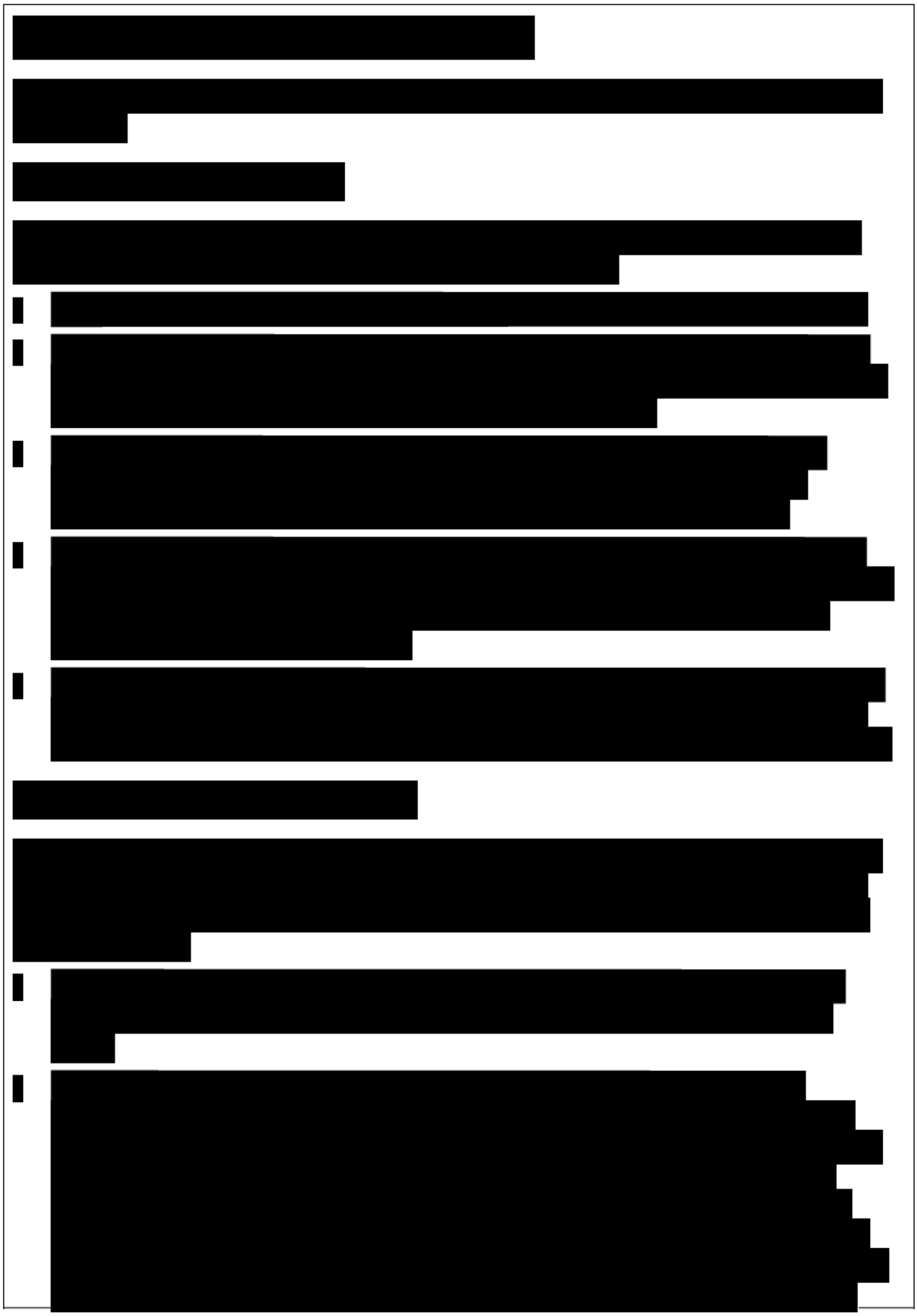
[redacted]

[redacted]

c) IT business continuity/disaster recovery plan (SOW Section 7.5.3)

[redacted]

[redacted]



SECTION 8. – Transition from Current Solution

Please explain how you propose to execute Section 8 by answering the question prompts in the boxes below. In answering these questions, please provide any relevant experience you may have.

Section 8.1 System Transition Services

a. *Describe any systems that may require design, development and implementation. (See SOW Section 8.1.1)*
b. *Provide a high-level overview of your proposed work plan for incoming transition activities that demonstrates your understanding of the scope and complexity of the incoming transition activities required for the Scope of Work. (See SOW Section 8.1.2)*
c. *Describe your approach to developing and submitting the Requirements Plan as described in Section 8.1.3 in the Scope of Work.*
d. *Describe your proposed testing activities. Describe your approach to developing and submitting a testing plan that covers all developed and proposed solution. (See SOW Section 8.1.4)*
e. *Describe your plan to migrate data to your proposed system.*
f. *Describe your proposed approach to training Contractor, State and State designee staff. Describe your approach to developing and submitting a training plan that covers all developed and proposed solution. (See Sow Section 8.1.5)*
g. *Describe any other non-system transition related services you propose.*

Transition from Current Solution

Section 8

Pallium is built for Medicaid Program Integrity. We have developed an advanced fraud and abuse detection syste with many components that are configurable to meet FSSA's specific requirements. Our platform is proven in the State Medicaid space and we have multiple experiences going live in a cost-effective manner, on time and on budget. Our experience with CMS certification gives us the confidence that our system meets Indiana and provides a foundation for the State's success.

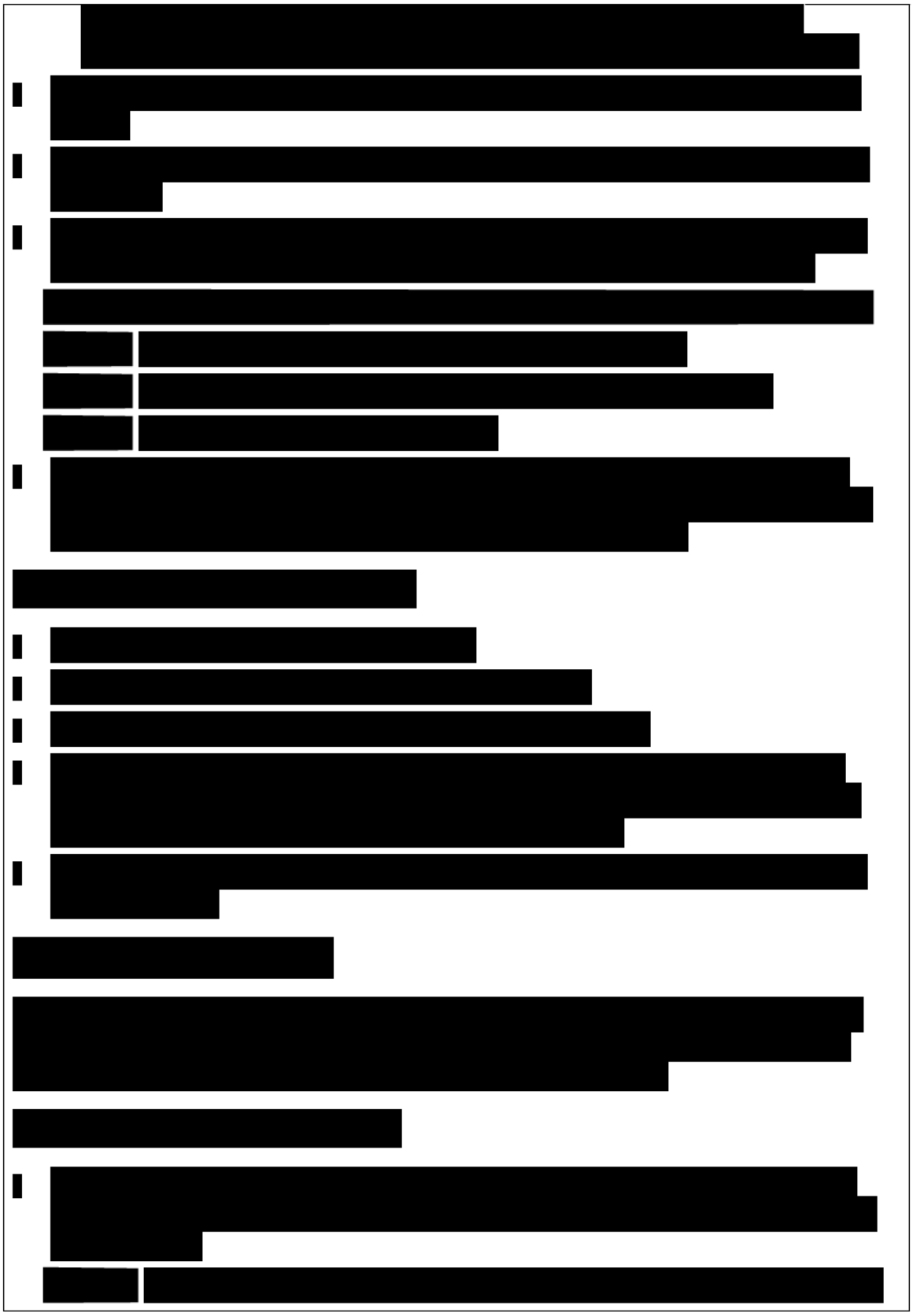
Our goal is to provide FSSA with a seamless transition from their current program integrity technology so that there is no loss of work or pause in their efforts. Since our platform is software-as-a-service, our platform will be configured for Indiana quickly. We are proposing an 18-week system DDI phase. This process includes configuration, connecting to CoreMMIS, migrating legacy case information, testing, and training. The following sections describe our transition process and our approach to the requested plans.

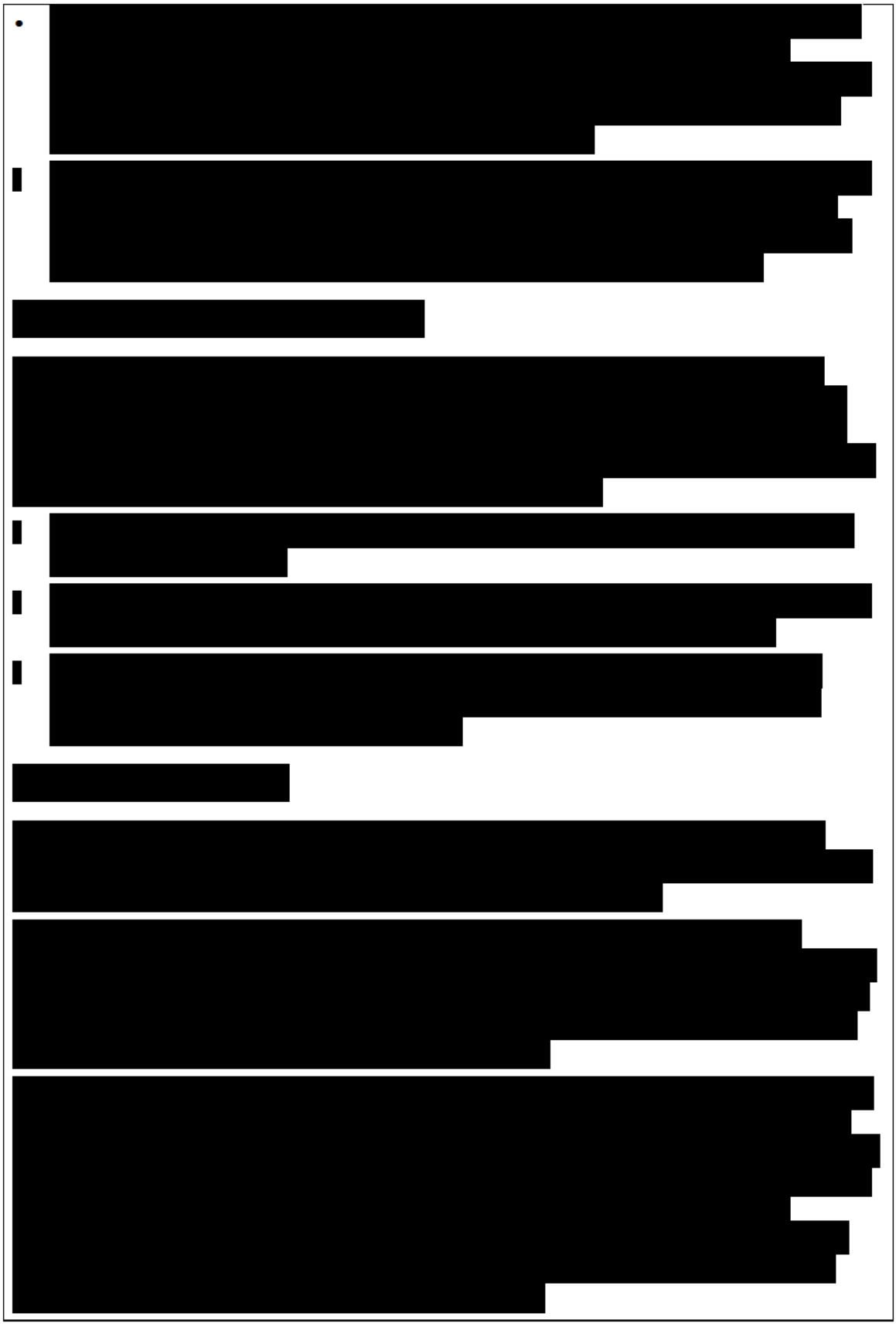
Section 8.1 System Transition Services

a) Systems that may require design, development and implementation. (SOW Section 8.1.1)

Standing up Pallium to meet Indiana's requirements

[redacted]

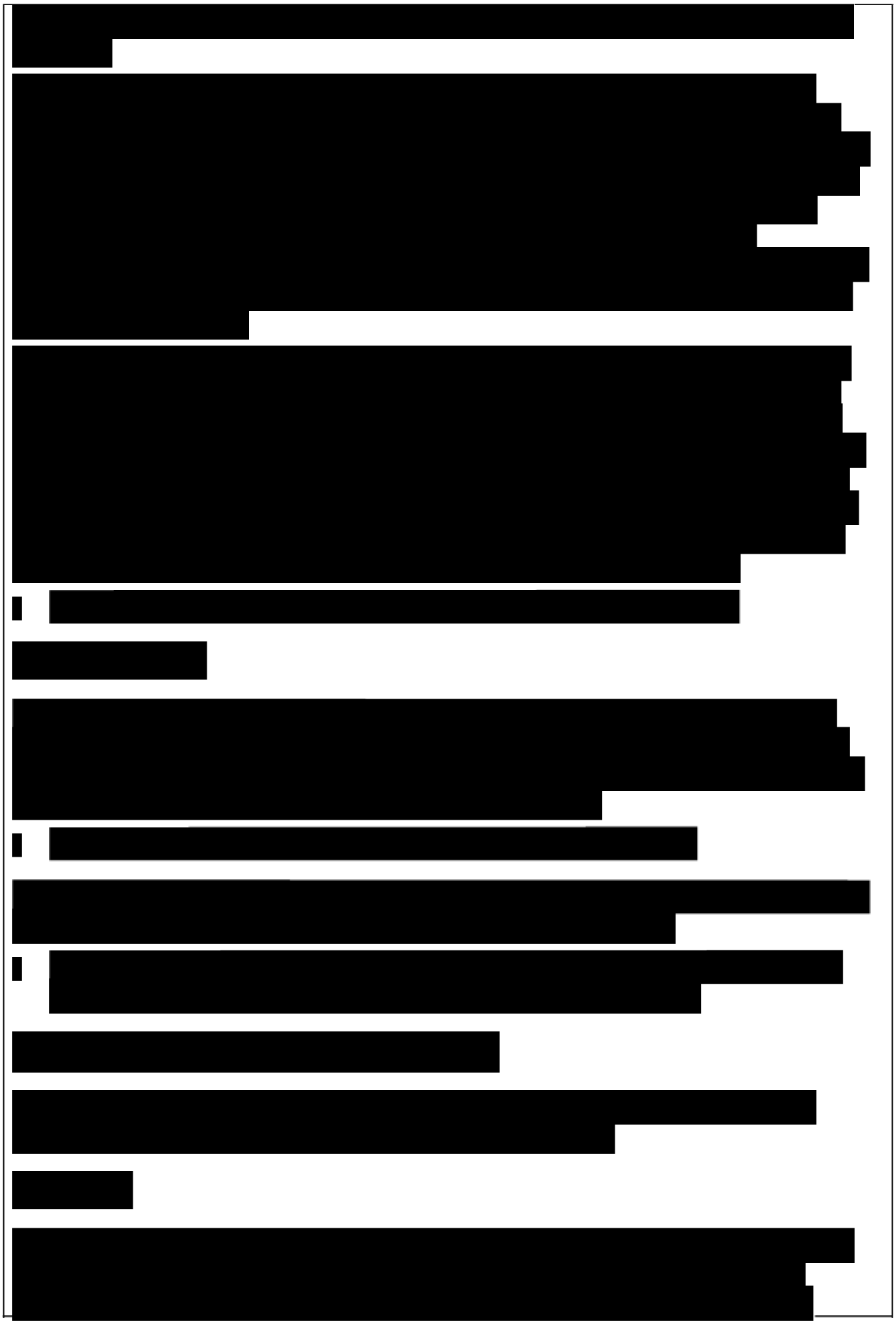


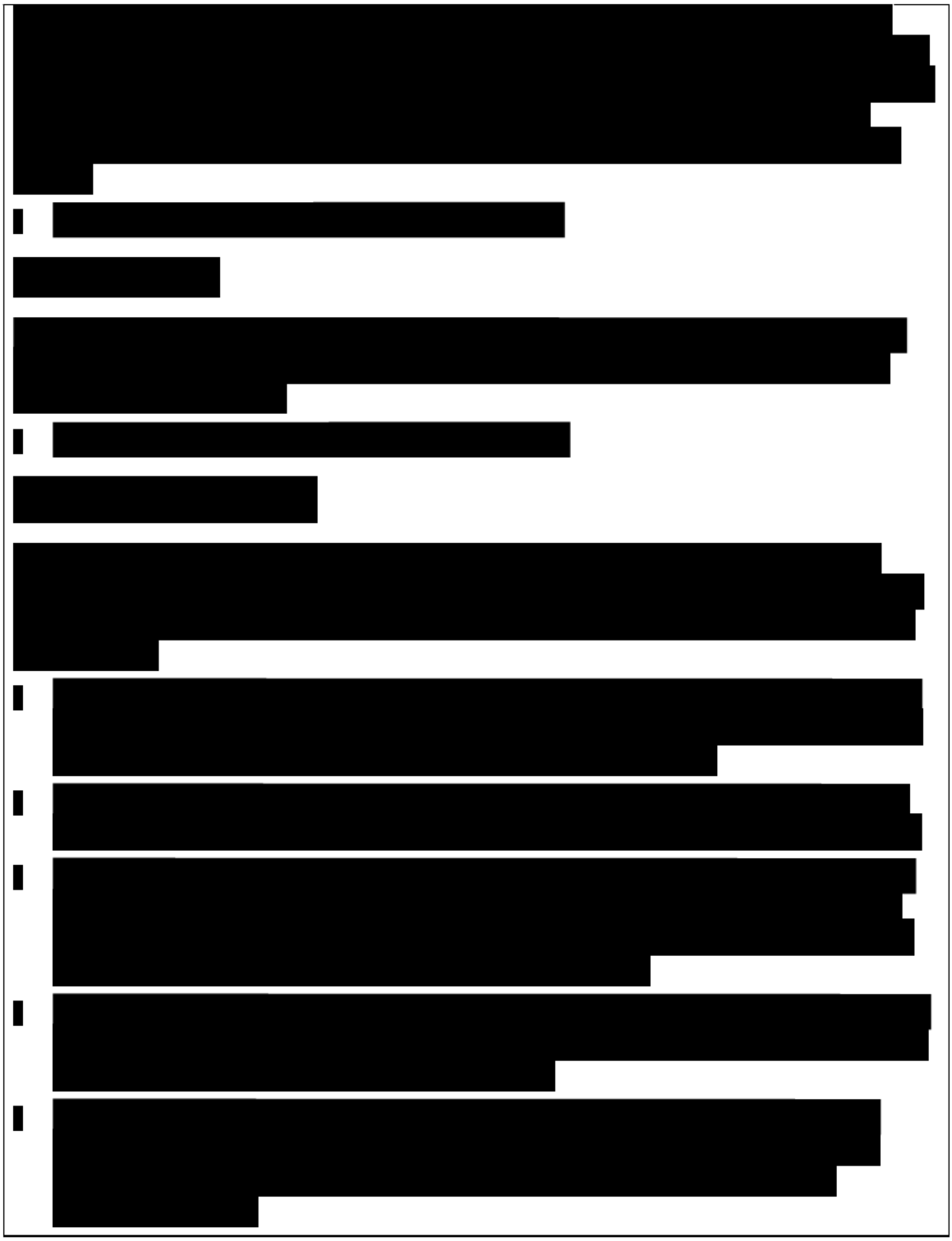


The initial step in our DDI process will be to develop the full work plan for submission to Indiana. Deloitte is committed to providing Indiana with a proposed work plan that

will explain the necessary activities to design, test, and implement the platform to Indiana's specifications. Below is a preview of the tasks, notional due dates, deliverables, and key professionals that will be for all phases of DDI, and will include all required deliverables as outlined in the SOW.

Planning Phase





SECTION 9. – Service Levels and Performance Incentives

Please explain how you propose to execute Section 9 in its entirety, including but not limited to the specific elements highlighted below, and describe all relevant experience.

Section 9.1 and 9.2 – Performance Management

a. *Affirm your commitment to and understanding of the Performance Management and invoice withhold system stated in SOW Section 9.1.*
b. *Describe how you plan to meet or exceed the performance metrics set forth in SOW Section 9.2*
c. *Propose any other Performance Metrics for State consideration.*

Service Levels and Performance Incentives

Section 9